Review of PPB Case #06-84962
In Custody Death
Officer Chris Humphreys #32784
Sergeant Kyle Nice #26853
Officer Bret Burton #43860
October 1, 2008
Training Division Class Room

Introductions
Assistant Chief Brian Martinek

Investigative Overview
Captain John Tellis

Detective Division / Internal Affairs Presentation
Investigator Lynn Courtney
Investigator Michael Barkley

Lunch 1200-1330

Detective Division / Internal Affairs Presentation
(continued if necessary)
Investigator Lynn Courtney
Investigator Michael Barkley

Training Division
Lieutenant Dave Famous

Command Analysis
Commander Donna Henderson

Day One Closing Comments

October 2, 2008

Executive Session

9-15-08

CITY OF PORTLAND, OREGON

Bureau of Police
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DATE: August 26, 2008

TO: Captain John Tellis
Internal Affairs Division
(Through Channels)

FROM: Commander Donna Henderson
North Precinct

SUBJECT: IAD Findings 2006-B-0016 In-Custody Death
Sergeant Kyle Nice #26853
Officer Chris Humphreys #32784

I have reviewed the case files from Homicide and IAD as well as the Training Division's analysis of this in-custody death. I have also reviewed City Code, ORS and Bureau of Police policy and procedures and based on the listed information the following is my analysis and findings:

Relevant City Codes:

1.01.140 Violations - Penalty.

It is unlawful for any person to violate any provision or to fail to comply with any requirement of this Code. Any person violating any provision or failing to comply with any requirement of this Code, unless provision is otherwise made herein, shall upon conviction thereof, be punished by a fine of not more than $500, or by imprisonment for a period of not more than 6 months, or by both such fine and imprisonment. However, no greater penalty shall be imposed than the penalty prescribed by the Oregon statute for the same act or omission. Each such person shall be guilty of a separate offense for each and every day during any portion of which any violation of any provision of this Code is committed, continued, or permitted by such person and may be punished accordingly. In addition to the penalties herein above provided, any condition caused or permitted to exist in violation of any provision of this Code is a public nuisance and may be summarily abated by the City as authorized by this Code. In addition, property shall be forfeited and City license may be suspended or revoked as provided in this Code.

3.20.110 Duties of Police Force.

The police force of the City shall at all times of the day and night within the boundaries of the City preserve the public peace, prevent crime, arrest offenders, protect rights of persons and property, guard the public health, preserve order, remove nuisances existing in streets, roads, public places, and highways, report all leaks and other defects in water pipes and sewers, and street lights not burning to the proper authorities, provide a proper force at every fire in order that thereby the firemen and property may be protected, protect strangers and travelers at the steamboat and ship landings and railroad stations, and generally obey and enforce all ordinances of the City Council and criminal laws of the State and of the United States.

14A.40.030 Indecent Exposure: It is unlawful for any person to expose his or her genitalia while in a public place or place visible from a public place, if the public place is open or available to persons of the opposite sex.

I find that the Foot Pursuit initiated by Officer Humphreys and the subsequent push by Officer Humphreys is IN POLICY with a DEBRIEFING.

The crux of this case hinges on Officer Humphreys justification for chasing Mr. Chasse. Training's analysis states that urinating in public is not a crime and therefore is not a reason to initiate a foot pursuit and deploy the knock-down technique. Even though urinating in public is a class B misdemeanor under City Code 14A.40.030 I agree that it would be egregious to knock someone to the ground simply because they were urinating. I do not believe that Officer Humphreys chased Mr. Chasse simply because he urinated. Officer Humphreys has worked downtown many times and when working downtown you see people urinating. 99% of the time you contact the person that person says they are sorry, had to go, won't do it again and they walk away. Due to Mr. Chasse's behavior before and after is what caused this particular event to be different, it got the Officer's attention. Officer Humphreys reasonably believed that a crime was committed (**14A.40.030 Indecent Exposure:** *It is unlawful for any person to expose his or her genitalia while in a public place or place visible from a public place, if the public place is open or available to persons of the opposite sex)* and because of Mr. Chasse's behavior Officer Humphreys believed that Mr. Chasse was involved in something more.

- Officers Humphreys and Burton observed Mr. Chasse prior to the foot chase stiff legged and rocking back and forth and caring a back pack.
- When Mr. Chasse observed the officers, he immediately walked east bound away from the officers. Officer Humphreys' perception was that Mr. Chasse was trying not to attract attention to himself while leaving as quickly as he could to avoid the police.
- Nine minutes later as Officers Humphreys and Burton were leaving the area where they were covering Sgt. Nice, they see Mr. Chasse again this time near a tree with his back towards the officers and it appeared as if he was urinating in public. City Code Crime (**14A.40.030 Indecent Exposure:** It is unlawful for any person to expose his or her genitalia while in a public place or place visible from a public place, if the public place is open or available to persons of the opposite sex.)
- Officer Humphreys wanted to talk to Mr. Chasse because he believed at the very least Mr. Chasse shouldn't be walking the streets because he was either extremely drunk or on drugs.
- Officer Humphreys notices that Mr. Chasse bent over by a tree and has a large wet spot on his pants reinforcing the belief that Mr. Chasse had been urinating in public. Officer Humphreys observes Mr. Chasse pick up his back pack and begin walking, Officer Burton makes their presence know to Mr. Chasse.
- Mr. Chasse turns his upper torso in a stiff manner and makes direct eye contact with Officer Humphreys.
- Officer Humphreys describes a look on Mr. Chasse's face as that of sheer terror, because of this look and the other behaviors described Officer Humphreys reached the conclusion that Mr. Chasse must be afraid of being caught because he either had a warrant, weapons or drugs on him.

Analysis:

Officer Humphrey's has a legal right to stop Mr. Chasse to investigate, arrest and cite for City Code 14A.40.030 and Officer Humphrey's believed based on his observations and his interpretations of those observations that there was something more going on with Mr. Chasse. Officers use pretext stops daily and on many occasions those pretext stops develop into

something much larger. I do not believe anyone could have predicted the outcome of this chain of events.

In this case Officer Humphreys was tragically incorrect in his interpretation of Mr. Chasse's behavior. Should Officer Humphreys have realized the behaviors Mr. Chasse was exhibiting were behaviors from someone who was severely mentally ill as oppose to someone who had criminal intent? Even the trained professionals AMR paramedics who arrived at the scene to evaluate Mr. Chasse, assessed Mr. Chasse's condition as something due to toxicological issues (drugs). We spend tens of thousands of dollars and hundreds of hours on police officers teaching them how to stay safe while still doing their jobs: defensive tactics, shooting, driving skills, PIT, how to deal with violent criminal behavior, how to conduct a traffic stops, reinforcing how dangerous domestic violence calls are, developing probable cause, recognizing reasonable suspicion, pushing the envelope, be proactive, and a multitude of other things. Officer Humphreys received a two hour class on Mental Health Awareness eight months before this incident. I do not believe a two hour class is enough to teach an officer to differentiate between Schizophrenia psychosis and Drug psychosis. The following are ***Symptoms Associated With Drug Abuse:***

- Symptoms of Anxiety or Panic
- Symptoms of Depression
- Destructive thoughts, feelings and behaviors
- Suicidal thoughts, feelings or behaviors
- Violent thoughts, feelings and behavior
- Strange, bizarre or psychotic thoughts, feelings and behaviors

These symptoms are almost identical to those that Mr. Chasse exhibited. The Transit Police Division receives a barrage of complaints about the drug dealing that happens around MAX. Years prior, TCRT (Under cover Team) was created and one of its missions was to interdict in the drug trade on the Transit system. Officer Humphreys was an active member of TCRT. Transit became very proactive in its attempts to eradicate drug dealing and using, as well as other nuisance behaviors on and around the system. Officer Humphreys believed that narcotics played a part in Mr. Chasse's behavior; it was not an unreasonable belief. The complaints that TRIMET receives as well as the complaints from the Downtown Corridor all hinge on drug activity, either selling or using and all of the aberrant behaviors that go with street usage.

It is my opinion that Officer Humphreys had a legal right to stop and detain Mr. Chasse for the purposes of investigating 14A.40.030 and given what Officer Humphreys observed that night it was not unreasonable for Officer Humphreys to believe that Mr. Chasse was involved in additional illegal activities. Officers Humphreys' push of Mr. Chasse did not violate State Statues, City Code or the Bureau's Directives. Use of Force Directive 1010.20 *Members may use physical force only when they reasonably believe it is necessary to:*
b. Lawfully take a person into custody, make an arrest or prevent an escape.
e. Accomplish some official purpose that is authorized by law, by judicial decree or is performed in the reasonable exercise of the member's official power, duty or function.

With hindsight I believe it is fair to say that because of Mr. Chasse's state of mind any contact with the police would have provoked a violent (fear) based reaction. Regardless of methods used to take Mr. Chasse into custody there would have been a fight. Neither Officer Humphreys nor anyone else without the gift of hindsight could have predicted that pushing Mr. Chasse down to the ground in order to terminate a foot pursuit would be a precipitating event leading to his death. With that said there are things we are trained to do that could have been done better. In this situation going out on the air stating they would be contacting a subject would have made other officers in the area aware and theoretically they could have responded sooner to help in the custody. Communication between Deputy Burton and Officer Humphreys prior to contacting Mr. Chasse could have been better.

I find that both Officer Humphreys and Sergeant Nice used reasonable force and were IN POLICY once Mr. Chasse was on the ground to get him under control to take him into custody.

Mr. Chasse had 14 fractured ribs and 27 separate fractures. The Medical Examiner Karen Gunson listed Mr. Chasse's death as accidental with the cause of death due to broad base blunt force trauma to the chest. Dr. Gunson stated in her opinion the broad base trauma could not have occurred by officers kicking or punching Chasse. She also stated that Chasse's bones were more brittle than average due in part to his poor nutrition. There was no evidence of any officer jumping on, sitting on, or delivering any crushing blows to Chasse that would result in the broad based trauma found by Dr. Gunson.

The arrest of Mr. Chasse was lawful (14A.40.030 Indecent Exposure). Once the officers tried to get Mr. Chasse under control, Mr. Chasse fought violently. Due to the actions of Mr. Chasse the officers were in a position to have to use force to get him under control. There was nothing in any of the information to indicate that any of the force was out of policy. Officer Humphreys hit Mr. Chasse with his forearm and a closed fist after Mr. Chasse attempted to bite him. Sergeant Nice stated that he used the instep of his boot into Mr. Chasse's chest after Mr. Chasse bit Sergeant Nice and had grabbed Sergeant Nice's pant leg in an attempt to bite him again. Mr. Chasse bit Sergeant Nice in the right calf and attempted to bite Officer Humphreys. Mr. Chasse was tased with no effect. The Officers used strikes, kicks and the taser to overcome aggressive physical resistance at close quarters all of which was within policy.

I find that Officer Humphreys and Sergeant Nice acted appropriately and were IN POLICY after Mr. Chasse was taken into custody.

Sergeant Nice asked for Medical Code 3. Sergeant Nice gave the information to radio that they had a subject who appeared to be unconscious and had been fighting with the police. Given that Mr. Chasse was still fighting it was reasonable to have him put in Maximum Restraint. Medical had cleared Mr. Chasse to be taken to jail. Officer Humphreys monitored Mr. Chasse all the way to the jail.

I find that Officer Humphreys acted appropriately and was IN POLICY when transporting Mr. Chasse to Portland Adventist.

The medical staff at the jail stated they wouldn't take Mr. Chasse until he had been cleared by a Doctor. The reason was not because he looked as though he had internal injuries but because the

nurse observed a twitching type episode, his suspected drug use and she had a concern about possible infection he might have because of sores on his body. Officer Humphreys watched Mr. Chasse on their way to the hospital which was how he caught the fact Mr. Chasse had slumped over. Officer Humphreys made a good decision to get off of the freeway to check Mr. Chasse. They did take Mr. Chasse out of the car to start CPR and that would have been very dangerous for all if they had to do it on the Freeway. Code 3 ambulance was immediately called.

Any recommendations I might have had have already been outline very well in the Training Division's recommendations.

PORTLAND POLICE BUREAU
TRAINING DIVISION
IN CUSTODY DEATH REVIEW
Case #06-84962

The Portland Police Bureau (PPB) Training Division reviewed the case file of this incident. This review was:

Prepared by - Lieutenant Dave Famous
Consulted- Officer Don Livingston – Lead Defensive Tactics Instructor
Reviewed by - Captain Eric Hendricks

This incident was broken down into the following elements:

1. The initial contact with Mr. Chasse
2. Foot Pursuit
3. Custody Procedure
4. Custody and Transportation

Training Background

At the time of this incident:

Officer Chris Humphreys had been a Portland Police Officer for about 7.5 years and previous to that a Wheeler County Sheriff Deputy for about three years. During that time he received 1420 hours of training. He passed a two hour Crisis Intervention Team (CIT) Mental Health Awareness In-Service class on January 3, 2005. Additionally, Officer Humphreys passed a four (4) hour Foot Pursuit/Full Body Search In-Service class on May, 25, 2006 and was CPR certified.

MCSO Deputy Bret Burton had been a Deputy Sheriff for about 2.5 years. He had attended the Multnomah County Sheriff's Office annual In-Service training and was certified to carry the X-26 Taser. Deputy Burton stated he had not received any CIT training prior to this incident.

Sergeant Kyle Nice had been a Portland Police Officer for about 14.5 years. He was promoted to the rank of sergeant on October 23, 2003. During that time he received 3052 hours of training and was certified to carry the X-26 Taser.

Officer Troy Pahlke had been a Portland Police Officer for nearly 10 years. During that time he had received 1511 hours of training.

Officer Carl Weldon had been a Portland Police Officer for about 1.5 years. During that time he received 789 hours of training. He was certified to carry the Hobble Leg Restraint on June 6, 2005.

Incident Overview:

On September 17, 2006, Mr. James Phillip Chasse was initially observed by Officer Chris Humphreys and Deputy Bret Burton while covering Sergeant Kyle Nice when he was contacting another person at NW 18th/Everett Street. The officers described Mr. Chasse as acting in a bizarre manner as if he was under the influence of intoxicants or possibly suffering from a mental disorder. Once Mr. Chasse made eye contact with the officers, he immediately left the area in the opposite direction.

The officers again observed Mr. Chasse standing in the 1300 block of Northwest Everett Street. Based on Mr. Chasse's body language and actions, Officer Humphreys believed he might have been urinating on the street. The officers approached Mr. Chasse on foot and came to within 15 feet of him, at which point Mr. Chasse turned around, saw the officers approaching and ran in the opposite direction. Officers pursued Mr. Chasse on foot. As they reached him, Officer Humphreys pushed Mr. Chasse in the back with his forearm which caused Mr. Chasse to stumble to the ground. Mr. Chasse resisted the officer's attempts to take him into custody. During the incident, Mr. Chasse bit Sergeant Nice on the leg and attempted to bite Officer Humphreys on the arm. Deputy Burton used his Taser in the drive-stun mode, which had no apparent affect on Mr. Chasse.

After being taken into custody, Sergeant Nice requested medical attention for Mr. Chasse because he appeared to have lost consciousness. An ambulance crew and Portland Fire Bureau personnel responded to the scene, evaluated Mr. Chasse and determined his vital signs were normal. They relayed the information to the arresting officers who then transported Mr. Chasse to the Multnomah County Detention Center (MCDC) to lodge him on charges of "Assaulting a Public Safety Officer" and "Resisting Arrest".

While at the booking facility, Mr. Chasse was evaluated by the nursing staff who determined Mr. Chasse should receive further medical evaluation at a hospital prior to being accepted for booking. Mr. Chasse was transported towards Portland Adventist Hospital by Officer Humphreys and Deputy Burton. During the transport, Officer Humphreys noticed that Mr. Chasse was unresponsive. The officers pulled over at the nearest and safest location which was determined to be NE 33rd/Clackamas St. They immediately requested medical personnel respond to the location while they attempted to resuscitate Mr. Chasse. Medical personnel eventually arrived on scene and took over the resuscitation efforts. Mr. Chasse was later pronounced dead after arriving at Providence Hospital.

Analysis – Prior to the Foot Pursuit:

Officer Humphreys' observations and perceptions of Mr. Chasse while covering Sergeant Nice at NW 18th/Everett Street:

- Mr. Chasse's appearance and demeanor.
  - ✓ He looked disheveled and appeared to be a transient. *(Observation)*
  - ✓ He was rocking back and forth stiff legged with his back to the officers for several minutes. *(Observation)*
  - ✓ He probably was intoxicated and waiting for a bus. *(Perception)*
  - ✓ He sees officers in the area and immediately and rapidly walked away from the officers crossing the street. (Officer Humphreys thought Mr. Chasse risked being struck by a car at the intersection when he crossed the street so quickly. However, Mr. Chasse crossed "with the light" successfully.) *(Observation)*

Officer Humphreys told Detectives that, according to his training and experience over the years, it looked like Mr. Chasse was probably intoxicated, or under the influence of something. Officer Humphreys believed that Mr. Chasse walked rapidly away from them because he probably didn't want police contact—an example being he probably had a warrant.

Deputy Burton's observations and perceptions of Mr. Chasse while covering Sergeant Nice at NW 18th/Everett Street:

- Mr. Chasse's appearance and demeanor.
  - ✓ He was shuffling, gesturing, maybe talking to no one while he was by himself on the corner. *(Observation)*
  - ✓ He was possibly intoxicated, mentally ill, or had an outstanding warrant. *(Perception)*
  - ✓ "He had made a bee-line out of there—clearly indicating that he wanted no police contact." *(Perception)*

Sergeant Nice did not observe Mr. Chasse while conducting his stop at NW 18th/Everett Street.

Sergeant Nice did state that he heard Officer Humphreys say something to the effect, "Guy down the block bee-lining away from us". Sergeant Nice stated that, "This is typical behavior of someone who has committed a crime or is wanted…to see the police, change direction and go somewhere else. So this obviously caught Officer Humphreys attention".

When Sergeant Nice completed his stop, Officer Humphreys and Deputy Burton told Sergeant Nice something similar to; "If we get a chance, we're going to try to stop and talk to that guy (who walked away). They thought the guy (Mr. Chasse) probably had a warrant for drinking in public. *(At 5:16 p.m., Sergeant Nice, Officer Humphreys and Deputy Burton clear the contact at NW 18th/Everett St.)*

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Note: Deputy Burton stated that he had not received CIT training prior to this incident.

Note: Officer Humphreys passed a two hour CIT Mental Health Awareness In-Service Class on January 3, 2005. In the overview of this class it states, "This class is not meant to substitute for a 40 hour CIT (certification) class". However, during this instruction, basic information was presented pertaining to three types of mental illness including Schizophrenia.

When discussing symptoms related to Schizophrenia, one area of discussion presented in this class described the following behavior:

Disorganized Symptoms:

- The person will talk to you and appear to be talking in circles. The person may be dressed poorly, have bad hygiene, and may not be able to hold onto an idea long enough to even answer a simple question.

- They may pace in circles, or do repetitive behavior.

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Officer Humphreys and Deputy Burton got into their marked patrol car and drove through the area looking for Mr. Chasse. They found Mr. Chasse standing by a tree, with his back towards them, mid-block 13th to 14th on NW Everett Street.

Officer Humphreys said that Mr. Chasse had a backpack down by his feet, and he was hunched over with his hands in his front waistband area. Officer Humphreys said he looked like he was either urinating or had just finished urinating. Additionally, Officer Humphreys told Detectives that, "I know from my training and experience that guys will stop and use something to shield themselves while they're using drugs".

Deputy Burton said they noticed Mr. Chasse standing near a tree, bent over at the waist, possibly touching his pants or handling something in his pants. Deputy Burton said he believed Mr. Chasse sensed their approach, and appeared to be trying to get rid of something. This raised his suspicion that Mr. Chasse was doing something suspicious. Deputy Burton described Mr. Chasse's behavior as acting odd and thought Mr. Chasse was possibly intoxicated or under the influence a controlled substance.

The initial contact with Mr. Chasse:

Deputy Burton stopped the patrol car and Officer Humphreys got out from the passenger side and took one or two steps toward Mr. Chasse. Deputy Burton exited the vehicle as well. Mr. Chasse reached down and grabbed his backpack and started to walk away with a stiffed legged gait. Officer Humphreys noticed a fresh wet outline on the rear and mid to upper thigh of Mr. Chasse's pants which led him to believe that Mr. Chasse had urinated on himself.

(The estimated time that the officers make contact with Mr. Chasse is 5:18 p.m. Neither Officer Humphreys nor Deputy Burton advised dispatch that they would be contacting an individual at the location. Sergeant Nice requested another car to respond to the location at 5:20 p.m. This is the first time dispatch or other officers are aware that a police action is taking place in the 1300 Block of NW Everett St.)

Deputy Burton whistled or yelled something similar to, "hey you!" Mr. Chasse turned and made direct eye contact with Officer Humphreys who described the look in Mr. Chasse's eyes as that of "absolute sheer terror". Officer Humphreys told Detectives that, "On his face, his eyes go wide and instantly when he sees me, it's just sheer terror. I have been a police officer for 10 years. I've had a number of subjects run on me before in the same scenario. I've never seen anyone look at me with sheer terror in their eyes. I knew instantly that he was going to run. He screams something, I don't know what it was, and I'm already saying he's going to run. I yell stop at least twice and I'm chasing him on foot going eastbound. At that point, with all of those prior facts, and especially now with the look on his face, I thought he either has a warrant, he's got drugs on him, he's got a weapon of some sort, or just the huge safety considerations because I'll never forget seeing that face."

Officer Humphreys told Detectives that he caught up with Mr. Chasse as they approached the southwest corner of NW 13th/Everett St. "I'm kind of matching his speed and I gave him a really hard shove with my forearms on his back as we're trained to do in foot pursuits. You run up behind them and hit them in the back to trip up their steps, break the rhythm of their steps, and that's exactly what I did. I think maybe he took one step after I hit him and he went down and I went right past him about one step. I tripped up my own rhythm too when I hit him and I took maybe one step and then I just went boom, down right on the ground. As I landed on the pavement, I rolled and as I rolled I went up on my left side."

Officer Humphreys said that he fell on the side walk as he went over and past him to his left. "He veered right and I basically went straight ahead. I went right over and did a shoulder roll. I flipped over on my stomach to crab walk...and started to get up. I see Mr. Chasse is starting to get up. At that point, Sergeant Nice is grabbing his arm and trying to get a hold of him." When Detectives asked Officer Humphreys if he landed on him in any way, Officer Humphreys replied, "no".

Deputy Burton said that as Officer Humphreys contacted Mr. Chasse, he used his body weight to knock him to the ground. Deputy Burton stated that he didn't know if Officer Humphreys pushed him, wrapped his arms around him, or if he landed on him. Deputy Burton stated, "All I know is they collided running in the same direction and both of them went to the ground".

Sergeant Nice stated that after he cleared his stop, he noticed Officer Humphreys and Deputy Burton pull to the curb to talk with a person, who was later identified as Mr. Chasse. Sergeant Nice assumed that this was the same person Officer Humphreys and Deputy Burton saw earlier. He didn't know specifically why they were contacting Mr. Chasse, and originally, he had no intention of stopping to assist.

Sergeant Nice watched them as he drove by and saw Mr. Chasse run. Sergeant Nice continued eastbound and pulled ahead of him, activated his lights, stopped and got out of his car and attempted to intercept Mr. Chasse. *Training Division Doctrine - Cover/Contact Foots Pursuits: The officer may choose the tactic of cutting off the path of the fleeing suspect. However, this may place the officer in front of the suspect at close quarters.*

Sergeant Nice said he believed Officer Humphreys wrapped both arms around Mr. Chasse and they fell to the ground fast. Sergeant Nice stated that, "It was just a straight bear hug type of tackle, I guess. It appeared that Officer Humphreys landed slightly off of the subject, kind of half on his right side and half on the ground."

Civilian witness statements also vary as to how Mr. Chasse was forced to the ground. For example, one witness stated that it was probably a push that knocked Mr. Chasse to the ground; another witness described the action as a flying tackle, almost like a football tackle, during which Mr. Chasse was driven to the ground.

Foot Pursuit Training:

Since at least the 1997-1998 In-Service, the Training Division has presented training on Foot Pursuit Tactics. This presentation is taught to Advanced Academy's as well. Officer Humphreys attended the Tactical Update Foot Pursuit Class given at In-Service on May 25, 2006.

Training Division Foot Pursuit Tactical Doctrine:

Pursuing subjects on foot is one of the most dangerous police actions that officers can engage in. A police officer involved in a foot pursuit is at a total disadvantage unless a cover officer is present. Many foot pursuits end with the subject being tackled by the officer and a grappling match ensuing. Because of a police officer's instinct to pursue and apprehend a fleeing subject (the predator-prey instinct), the adrenaline rush and "must catch" mindset often overshadow safe tactics in apprehending the subject.

1 – Advantages and Disadvantages of Foot Pursuits:

A. Advantages

1. The immediate apprehension of the subject.
2. More likely to locate and/or recover evidence or contraband in the suspect's possession.

B. Disadvantages

1. Action-reaction principle applied against the officer by the suspect.

    a. The suspect stops and turns around on the officer while the officer's momentum takes him into the suspect.
    b. The suspect pulls out a weapon (gun or knife) before the officer has time to react.
    c. Because of the close proximity of the suspect, the officer has minimal time to assess a threat.

2. Predator-Prey Instinct

    a. Because police officers are ingrained to catch those who run, they end up tackling a potentially armed suspect and risk losing their weapons to the suspect.
    b. Many times, officers chase individuals who run for no reason, and the officer doesn't know why he is chasing someone until he catches him.

3. Apprehension Dangers

    a. Because officers run at different speeds, one may outrun her cover. When the officer catches up to the suspect, she may be alone when she attempts custody.
    b. Many times when a suspect is taken down, there is a physical confrontation during the custody.

2 - Danger versus Public Safety:

Risk to public safety versus benefit of capture is an issue that should be part of an officer's thinking at the onset of a foot pursuit. Factors such as severity of the crime, environment, availability of additional officers, are just a few of the considerations that should be part of the officer(s) evaluation.

Personal considerations such as physical limitations, familiarity with the area and ones own knowledge of the subject are factors that also influence considerations.

3. Knock-Down Technique:

When officers catch up to the suspect, they often grab onto him and take him to the ground. To maintain a position of advantage and the officers' balance, the knock-down technique was developed.

The technique also allows the officers to use more options of control while the suspect is on the ground and the officers are on their feet.

A. Technique:

While the officer is paralleling the suspect and gets close enough to touch the suspect, the officer should shove the suspect hard from the rear, in the middle of the back between the shoulders.

This will cause the suspect's body to go ahead of his feet and fall forward onto the ground.

The officers (cover and contact) will then veer off at an angle away from the suspect's arms and get distance between the officers and the suspect, while the officers then move to the head of the suspect.

The officer will then give verbal commands to the suspect to stay on the ground and get into a prone position, as follows: "Hands out away from your body. Palms up. Cross your feet. Put your ear on the ground."
The officer also has some time to consider options while the suspect is trying to recover from the fall. The options include:

1. Physical control with the cover officer there (two on one control to custody).
2. The use of pepper spray or the baton.
3. High risk, if the situation dictates.

In-Service Class 2005-2006 Tactical Update – Foot Pursuits:

One of the issues discussed during the Foot Pursuit Update class addresses physically terminating a foot pursuit.

"Pursuing officer(s) may have the opportunity to employ the defensive tactic of pushing the subject to the ground and allowing them to physically terminate the foot pursuit in its early stages. Early termination of a foot pursuit will favor the officer(s) involved, and would significantly reduce the risk to public safety."

"After a foot pursuit has been physically terminated by the officers(s), correct procedures should be followed. Proper defensive tactics, firearms skills and correct custody procedures should be adhered to."

FOOT PURSUIT - ANALYSIS:

The Portland Police Bureau (PPB) Training Division teaches all officers to try and adhere to certain concepts and philosophies that make up the framework for its Tactical Doctrine. I have reviewed this incident within the framework of the Fundamental Concepts of Tactics and Tactical Advantages.

The Fundamental Concepts of Tactics are:

1. Have a Leader
2. Have a Plan
3. Be Adaptable
4. Don't Assume
5. Communicate
6. Correct Mistakes

The Tactical Advantages are:

1. Cover and Concealment
2. Numerical Superiority
3. Distance
4. Element of Surprise

Since at least 1999, the Portland Police Bureau's Advanced Academy Patrol Tactics curriculum has included training that is directly related to contacting individuals on the street. The Course Title of this class is called, "Individual Encounter's". Two components of this class are listed below.

Initial Assessment:

1. Type of contact. Is it a call driven contact, or a self-initiated contact?
2. Number of subjects being contacted.
3. Is there a mention of weapons?
4. Are there drugs or alcohol present? What is the demeanor or condition of the individual?

Radio Procedure:

1. Try to broadcast on the radio before you arrive, or at least as you arrive if possible.
2. Try to give basic information:

    a. Number of subjects
    b. Reason for contact
    c. Sex, race, age
    d. Location

When stopping and contacting a person or suspect on the street, the Training Division teaches officers to advise dispatch of their location and the circumstances. This is for the officer's safety, the safety of citizens nearby, and the safety of any responding units who may end up being called to the scene. This is consistent with the Fundamental Concept, "Communication," and is standard practice in the Portland Police Bureau. Stopping individuals on the street, without advising dispatch of the location and circumstances, is in-consistent with the Training Division's Tactical Doctrine.

Analysis of the initial contact with Mr. Chasse:

Upon review of this case file, no articulated information was found that documented the fact that Mr. Chasse had committed a crime; or that he displayed behavior, that indicated he was dangerous to himself and/or others, prior to the initiation of the foot pursuit and knock-down technique. The following observations and perceptions are factors that Officer Humphreys said he used when he decided to pursue Mr. Chasse:

a. The belief that Mr. Chasse had urinated in public.
b. Mr. Chasse possibly had an outstanding warrant for his arrest.
c. Mr. Chasse possibly had illegal drugs in his possession.
d. Mr. Chasse might have been armed with some sort of weapon.
e. Mr. Chasse screamed, had the look of sheer terror on his face, and ran from the police.

Although the belief that Mr. Chasse had urinated in public may be reason enough to contact him on the street, initiating the foot pursuit and deploying the knock-down technique, based on the above information, is in-consistent with the Training Division's Tactical Doctrine.

Officer Humphreys, believing that Mr. Chasse may have committed a crime, relied on his instinct to pursue and apprehend a fleeing subject; rather than observing significant criminal or dangerous behavior prior to engaging in the foot pursuit and deploying the knock-down technique.
Risk to public safety versus benefit of capture is an issue that should be part of an officer(s) thinking at the onset of a foot pursuit. Risk to public safety includes the safety of the person being pursued. The severity of the crime; ones own knowledge of the subject, including physical condition, perceived or observed physical limitations of the subject, and the immediate environment are factors that should be included in the officer(s) evaluation when deciding whether or not to pursue an individual on foot. These factors are especially important when deciding whether or not to push the subject to the ground.

The physical application of the Knock-Down Technique:

The fact that Officer Humphreys tripped and fell while initiating the knock-down technique is understandable given the slight downward slope of the sidewalk, coupled with the full-blown sprint and the likely adrenaline rush experienced as he pursued Mr. Chasse on foot running at full speed.

Although tripping and falling can occur unexpectedly at times when performing the knock-down technique, the knock-down technique is tactically superior to a traditional tackle with an immediate grappling match occurring on the ground.

After Officer Humphreys landed on the ground, he started to get up. *This is consistent with the Tactical Advantage – Distance.* Officers are taught to obtain distance between the officer(s) and the suspect once the suspect is on the ground. Obtaining distance allows the officer(s) time to consider options. *Officer Humphreys attempt to get back on his feet is also consistent with the Fundamental Concepts - Be Adaptable* and *Correct Mistakes.* By getting back up on his feet, Officer Humphreys could regain a position of advantage and regain his balance; this would afford him more options of control while Mr. Chasse is on the ground.

Pushing Mr. Chasse to the ground, in the effort to terminate the foot pursuit, allowed Mr. Chasse the opportunity to physically terminate the foot pursuit by surrendering. *This is consistent with the training Officer Humphreys received during In-Service.* Instead of surrendering and physically terminating the foot pursuit by staying on the ground, Mr. Chasse started to get up.

At this point, Sergeant Nice grabbed Mr. Chasse by the left arm and Deputy Burton tried to control his legs joining Officer Humphreys attempt to gain control in the effort to place Mr. Chasse into custody. *This is consistent with the training given at In-Service which states,* "After a foot pursuit has been physically terminated by the officers(s), correct procedures should be followed. Proper defensive tactics, firearms skills and correct custody procedures should be adhered to."

Physical control with the cover officer(s) there, (two on one control to custody), is a basic custody procedure taught to officers by the Portland Police Bureau's Training Division.

Analysis - Custody Procedure:

Once on the ground, Officer Humphreys, Deputy Burton, and Sergeant Nice struggled to handcuff Mr. Chasse and place him into custody. Mr. Chasse was screaming, kicking, and resisting their efforts to have him roll over onto his stomach. Deputy Burton was trying to control Mr. Chasse's legs, while Sergeant Nice tried to control his left arm, and Officer Humphreys grabbed his right arm.

Sergeant Nice's Perspective:

Sergeant Nice grabbed Mr. Chasse's left wrist and elbow and rotated his arm momentarily pinning him to the ground. Sergeant Nice attempted to pin his shoulder down by placing his knee on Mr. Chasse's left shoulder blade but couldn't get into a good position.

As he did this, he felt a sharp pain in his lower leg. Sergeant Nice looked down and could see Mr. Chasse biting the inside of his right calf. Sergeant Nice was surprised at what he saw and pulled his leg away. "After he bit me, I told him, do not bite me." As the struggle continued, Sergeant Nice felt a tugging on his right leg again. He looked down and Mr. Chasse had gotten hold of the cuff of his right pant leg with his teeth. Sergeant Nice pulled his right foot back and kicked Mr. Chasse in the upper chest while telling him, "Don't bite me". After the second attempt to bite Sergeant Nice, he pinned Mr. Chasse's jaw to the ground with his right boot, "for a while to keep him from biting me".

Sergeant Nice stated that Mr. Chasse also attempted to bite Officer Humphreys. He observed Officer Humphreys punch Mr. Chasse once or twice in the face, with a closed fist, as Mr. Chasse attempted to bite him.

Deputy Burton's Perspective:

As Mr. Chasse was screaming and kicking, Deputy Burton tried to grab his legs but he could only hold onto one leg as Mr. Chasse continued to kick.

Deputy Burton said he removed his Taser from the holster and removed the cartridge preparing to drive- stun Mr. Chasse. (He decided he wasn't going to use the cartridge probes when he applied the Taser to Mr. Chasse because of the close distance.) At the time, Sergeant Nice didn't feel that the Taser would be effective so he told him, "No, don't use the Taser".

Deputy Burton believed he punched Mr. Chasse in the back, as a pain compliance tactic, in the effort to get him to stop resisting. He also used the knuckle of his right index finger and pressure pointed Mr. Chasse's ribs as a pain compliance tactic to gain control. When these techniques failed, Deputy Burton drive- stunned Mr. Chasse with the Taser. "It wasn't more than a few cycles. It was obvious that it was having no affect on him; so I re-holstered and went about trying to control him again." Sergeant Nice asked dispatch to send another car to their location. He felt that they had fought Mr. Chasse to a stand still, but needed help handcuffing his hands behind his back.

Officer Humphreys Perspective:

As Officer Humphreys grabbed Mr. Chasse's right arm and attempted get him onto his stomach, he heard Sergeant Nice say, "Stop biting". Officer Humphreys said he saw Sergeant Nice strike Mr. Chasse one time with a closed fist in the head/shoulder area. He didn't actually see where the blow landed.

Officer Humphreys told Detectives, "All of a sudden I feel this heat on my right forearm...I see Mr. Chasse on his side, but his head is turned towards my arm which is on his shoulder trying to keep him locked down. His teeth are on my right arm. I draw my forearm back and it strikes him across the face and then I come down with a closed fisted strike across Mr. Chasse's face and I'm yelling don't, no, stop biting."

Officer Humphreys said he saw Deputy Burton apply the Taser to Mr. Chasse ("He believed it was into his leg") but the Taser had no affect.

Analysis: Strikes - Kicks – Arm Bar / Knee Application - Taser

Portland Police Bureau Levels of Control:

Adequate control is essential. It is imperative that the police officer establish and maintain superior control in any law enforcement situation. The police officer should approach each control situation with a margin of advantage that ensures success and is reasonable for the situation. The police officer should never use control at a level less than he or she feels necessary. The level of control a police officer uses will be dictated by the facts of the particular situation.

The **Five Levels of Control** are a basic breakdown of control methods.
They are:

a. Mere presence and demeanor
b. Verbal control
c. Physical control, aerosol restraints, Taser
d. Impact weapons and less lethal specialty munitions
e. Deadly physical force

Strikes (*punches*) and kicks are included in the following Level of Control:

Impact Weapons:

Impact weapons are those methods of control that are readily capable of causing injury to a subject. These impact weapons may vary as continuous research develops more effective ways to control violent and aggressive individuals. Impact weapons are designed to deliver immediate force to individuals to alter their behavior.

> **Strikes & Kicks** - Strikes and kicks are not the safest methods to control a subject's violent resistance, because of the possibility of injuries to the officer's hands or legs. Strikes and kicks may be used as a reasonable option when other options are not accessible or available, or when the distances are too close and the reaction time limits consideration of other options.

The Baton, Strikes and Kicks are authorized as a method of control to be used by the officer when the subject engages in Aggressive Physical Resistance (or when the subject indicates the intent to engage in aggressive physical resistance).

Aggressive Physical Resistance defined: *Physical actions of attack or threat of attack, coupled with the ability to carry out the attack, which may cause physical injury. Examples include, but are not limited to striking, kicking, biting, throwing objects capable of causing injury, head butting and taking a fighting stance.*

Officer Humphreys, Sergeant Nice and Deputy Burton were engaged at close quarters on the ground when struggling with Mr. Chasse. They were struggling to gain control when Mr. Chasse bit Sergeant Nice, and attempted to bite Officer Humphreys. The distance was too close, and the reaction time was too limited (immediate), for them to reasonably consider using the baton.

Sergeant Nice said he placed his right foot on Mr. Chasse's jaw line in the effort to pin his jaw to the ground. He hoped that this would prevent Mr. Chasse from biting him again. *(Using his foot in this manner was not a strike. It was an attempt to stop Mr. Chasse from biting him again by stabilizing his jaw.)*

Sergeant Nice was using both of his hands, while trying to control Mr. Chasse's left arm and complete the handcuffing procedure. *Using his foot to control Mr. Chasse's head, in the effort to prevent him from biting again, is not an un-reasonable option.* The only other option, in this moment, may have been to deliver additional kicks. Releasing the arm bar, at this point in the struggle, would not have been a reasonable option as Sergeant Nice would have lost the advantage of the control hold he had obtained up to this point; and this might have increased the probability that additional strikes and kicks would need to be applied. Attempting to pin Mr. Chasse's head to the ground in this manner, most likely would cause less injury to Mr. Chasse, then delivering additional strikes and/or kicks to his body.

The technique Sergeant Nice used, when he applied the arm bar, reverse wrist lock, and knee on the shoulder blade attempting to pin Mr. Chasse's shoulder to the ground, *is consistent with the Basic Prone Custody Procedure.* Note: Officers are instructed to keep the knee off of the back or spine.

Utilizing strikes and kicks to overcome aggressive physical resistance, at close quarters, is consistent with the training Officer Humphreys and Sergeant Nice received in Defensive Tactics as taught by the Portland Police Bureau's Training Division.

Taser:

(Although Deputy Burton was not a member of the Portland Police Bureau at the time of this incident, I have reviewed his deployment of the Taser from the Portland Police Bureau Training Division's perspective.)

The Taser is a less lethal weapon system that delivers electrical energy, and is deployed against subjects who are placing themselves or others in danger of physical injury and/or death. The Taser is designed to incapacitate a person rather than injure him/her. This allows members to take a combative person into custody with a minimum risk of injury to all of the parties involved. The amount of control or force used in the encounter will be governed by the circumstances of each situation taken as a whole in accordance with the Bureau's levels of control.

The Taser is included in the following Level of Control:

Physical Control:

The method of control that is used in every arrest situation is physical control. Physical control consists of the physical application of control holds and pressure points, aerosol restraints, and the use of the Taser. The degree of physical control that is necessary to take subjects into custody or control their behavior, is determined by the level of resistance of the subject.

Deputy Burton said he removed his Taser from the holster and removed the cartridge as he prepared to drive-stun Mr. Chasse. (He decided he wasn't going to use the cartridge probes when he applied the Taser to Mr. Chasse because of the close distance). Sergeant Nice told him not to use the Taser because he didn't believe it would be effective at the time.

Deputy Burton knew that Mr. Chasse was biting at both Officer Humphreys and Sergeant Nice. He said that he punched Mr. Chasse in the back and pressure pointed him in the ribs because Mr. Chasse was biting and kicking and wouldn't put his hands behind his back. When this had no affect, he deployed the Taser in the drive-stun mode on the upper leg or butt. The Taser had no apparent affect on Mr. Chasse and the struggle continued.

Deploying the Taser in the drive-stun mode is a pain compliance technique and does not have the advantage of "locking up" any muscle groups. Deputy Burton decided not to deploy his Taser, using the cartridge probes, because of the close distance. He thought that it would be better to remove the cartridge and drive-stun Mr. Chasse.

Portland Police Bureau Training Division's Recommendation: Rather than use the Taser in a Pain Compliance Mode, "Dart" the subject then drive-stun in another part of the body to lock up some muscle groups in order to gain more physical control over the subject, or to distract him long enough to complete the handcuffing procedure.

Handcuffing – Hobble (Maximum Restraint):

Officer Troy Pahlke arrived at the location and helped Officer Humphreys and Sergeant Nice handcuff Mr. Chasse and roll him onto his right side in a recovery position. Officer Carl Weldon arrived shortly after Mr. Chasse was handcuffed.

Sergeant Nice asked Dispatch to send Medical Code 3 to the scene. He advised that they had a subject who appeared to be unconscious and had been fighting with police. AMR and PFB arrived and evaluated Mr. Chasse. Sergeant Nice confirmed with AMR that Mr. Chasse was medically stable. Sergeant Nice stated to Detectives, "They asked if I wanted him transported. I said, no, we have criminal charges on him. He'll be going to jail." Sergeant Nice also told Detectives, "Without any specific reason or desire by ambulance (AMR) to take him to a hospital, he was going to jail. As soon as we started to search him, he became combative again. I didn't want to fight with him anymore. So, I directed them to put him in maximum restraint."

Maximum Restraint defined:

Placing an in-custody person with hands secured behind the back, legs secured together, and the legs and hands connected together behind the back of the subject with the legs flexed at the knees. The length of the hobble restraint cord used to secure the hands to the feet will be such that the lower legs are no closer than a 90-degree angle in relationship to the person's trunk.

Members are authorized to use hobble restraint cords when necessary to subdue or secure a violent or unruly person. Restraint cords should not be used in lieu of handcuffs.

Officer Carl Weldon applied his hobble restraint cord to Mr. Chasse at the direction of Sergeant Nice thereby placing Mr. Chasse in maximum restraint. Officer Weldon told Detectives, "I wrapped it around his feet once, tightened it, then fed the loop up and around the handcuffs and then back down to the loop, effectively keeping his legs bent at about a 90-degree angle, preventing him from kicking or rolling."

Officer Weldon's application of the hobble leg restraint cord is consistent with the training he received when he was certified to carry the hobble by the PPB Training Division.

After the hobble restraint cord was applied, Mr. Chasse was immediately placed on his side to allow free movement of his chest and stomach for breathing functions. The intent is to not allow body weight or the restraints to restrict the lung's ability to fill and expel air.

After medical personnel (AMR) evaluated Mr. Chasse, Officer Humphreys was presented with a medical release form to sign since Mr. Chasse was restrained and was unable to sign for himself. Officer Humphreys couldn't remember ever having to sign a medical release form as an officer but went ahead and signed it.

Sergeant Nice stated that Mr. Chasse was carried to the patrol car, (still kicking and screaming), while in maximum restraint, by himself, Officer Humphreys and Officer Pahlke. Mr. Chasse was placed into the back of the patrol car and laid onto his side, seat belted in, so he wouldn't lie on his stomach.

Deputy Burton and Officer Humphreys transported Mr. Chasse to MCDC. *(This is consistent with the Training Division Tactical Doctrine that states: "A subject who is transported in the maximum restraint position shall have a two-officer transport. The second officer shall monitor the subject for changes in behavior and signs of distress.")* Officer Humphreys observed Mr. Chasse and spoke with him in route to MCDC as Deputy Burton drove the patrol car.

Prior to arriving at jail, Deputy Burton called MCDC and said, "We got a guy who needs a spit sock, is bleeding and combative, he's hobbled and we're going to need assistance." *(Officers are directed to notify jail personnel that a subject has been transported in the maximum restraint position.)*

The techniques used to hobble, carry, secure, observe, and transport Mr. Chasse to MCDC, are consistent with the hobble leg restraint training doctrine taught by the Portland Police Bureau's Training Division.

When Officer Humphreys and Deputy Burton arrived at MCDC, Officer Humphreys and Jail Deputies carried Mr. Chasse from the car to an isolation cell in the maximum restraint position. They removed the hobble restraint cord and exited the cell.

Nursing staff observed and then refused to accept Mr. Chasse at MCDC for booking until he had been evaluated further at a hospital. Officer Humphreys said that after the nurse refused to accept Mr. Chasse, she walked away. Officer Humphreys and Deputy Burton did not receive any information from the Jail Nurse to suggest that there was an urgency regarding his condition. The nurse didn't advise the officers that Mr. Chasse needed to be transported to the hospital by ambulance; and no official at MCDC offered to call an ambulance. Officer Humphreys said, "Great! So medical clears him to come here, but jail won't take him so now we are stuck in the middle." Officer Humphreys told Deputy Burton that they would now need to transport Mr. Chasse to Portland Adventist Hospital.

(The Jail contracts with Portland Adventist Hospital for care of in-custody individuals. Officers and Deputies routinely transport persons, who are in-custody, to this hospital for minor medical treatment prior to being lodged at MCDC.)

Officer Humphreys and Deputy Burton discussed options pertaining to the type of restraint they would need to apply to Mr. Chasse during transport. Because of the distance and time it would take to drive to the hospital, Officer Humphreys didn't want Mr. Chasse placed in the maximum restraint position.

Jail Deputies offered to let them use leg chains to secure his feet. Officer Humphreys and Deputy Burton agreed. Deputies re-handcuffed Mr. Chasse and applied leg chains to his ankles. *(The leg chains have about a foot and a half of chain, between each leg, so that he would have been able to walk slowly. He would have been able to straighten out his legs, unlike the maximum restraint position.)* Deputy Burton said that Mr. Chasse started resisting again as they re-handcuffed and applied the leg chains.

Deputies carried Mr. Chasse out to the patrol car and laid him in the back seat on his side. As they left MCDC, Mr. Chasse sat up in the seat and started yelling and became animated again. As they drove towards the freeway, Officer Humphreys could hear Mr. Chasse mumbling. Officer Humphreys rolled up the windows as they got on the freeway so he could monitor Mr. Chasse closely. As he did this, he looked back and noticed Mr. Chasse was now leaning up against the passenger door.

Officer Humphreys made the following observations as they proceeded on the freeway:

- ✓ Mr. Chasse was leaning against the passenger door.
- ✓ Mr. Chasse had stopped mumbling and was quiet.
- ✓ He couldn't tell if Mr. Chasse was breathing.
- ✓ Mr. Chasse's left arm "looked stark white".

Officer Humphreys instructed Deputy Burton to take the next exit (NE 33rd Avenue) and to call for medical as they pulled to the curb off the exit ramp. Mr. Chasse was removed from the backseat. Officer Humphreys noted that Mr. Chasse wasn't breathing. Chest compressions were started and resuscitation efforts continued until medical arrived. Mr. Chasse was transported to Providence Hospital by ambulance where he was later pronounced deceased.

TACTICAL SUMMARY:

Officer Humphreys and Deputy Burton did not advise dispatch that they were contacting a person (Mr. Chasse) in the 1300 Block of NW Everett St.

The Training Division realizes that there may be times when officers are confronted with an emergency situation on the street that requires immediate action and response. During an immediate emergency response, it may not be practical or safe to broadcast information on the radio, until action is taken and the situation stabilizes. This is discussed in Patrol Tactics training and is sound Tactical Doctrine.

Upon review of this case file, no articulated information was found that indicated Officer Humphreys and Deputy Burton were seeking the initial contact with Mr. Chasse due to an emergency situation. In fact, Deputy Burton told Detectives that he told Sergeant Nice, just prior to leaving NW 18th/Everett St., "We may be going to go look for that guy (later identified as Mr. Chasse)... 'It was sort of a casual search'... 'We were going to stop him just to chat him up and see what he had to say.'"

- *Based on the above information, the fact that Officer Humphreys and Deputy Burton contacted Mr. Chasse on the street, without advising dispatch of the location and circumstances, is in-consistent with the Training Division's Tactical Doctrine.*

Sergeant Nice observed Officer Humphreys and Deputy Burton stop and contact Mr. Chasse on the street; *he originally had no intention of stopping to assist.* As he drove by *he observed the officers in foot pursuit; he immediately* pulled over and attempted to intercept Mr. Chasse. When the situation became relatively stable, he advised dispatch of the location and circumstances and requested another unit to assist at the scene. The Training Division considers a foot pursuit to be an emergency situation.

- *Due to his close proximity to this foot pursuit, the immediate response and delay in notifying dispatch of the situation by Sergeant Nice, is consistent with the Training Division's Tactical Doctrine.*

- *Initiating the foot pursuit and deploying the knock-down technique, based on the information contained in the case file, is in-consistent with the Training Division's Tactical Doctrine.*

- *The physical techniques applied during the application of the knock-down technique, as described by Officer Humphreys, are consistent with the Training Division's Tactical Doctrine.*

- *Utilizing strikes and kicks to overcome aggressive physical resistance, at close quarters, is consistent with the training Officer Humphreys and Sergeant Nice received during Defensive Tactics instruction; and is consistent with the Training Division's Tactical Doctrine.*

- *The deployment of the Taser by Deputy Burton, in the effort to overcome aggressive physical resistance, is an option that is consistent with the Training Division's Tactical Doctrine.*

- *Officer Weldon's application of the hobble restraint cord is consistent with the training he received when he was certified to carry the hobble by the Training Division.*

- *The techniques used to hobble, carry, secure, observe, and transport Mr. Chasse to MCDC, are consistent with the hobble leg restraint training doctrine taught by the Portland Police Bureau's Training Division.*

- *Providing a two officer transport towards Portland Adventist Hospital, provided Officer Humphreys the ability to constantly monitor Mr. Chasse for changes in behavior and signs of distress. This is consistent with the Training Division's Tactical Doctrine. This afforded the opportunity for Officer Humphreys and Deputy Burton to initiate emergency medical aid procedures quickly when Mr. Chasse's condition deteriorated rapidly.*

RECOMMENDATIONS:

1- Offer the forty (40) hour Crisis Intervention Team (CIT) training to all uniform officers and sergeants in the Portland Police Bureau. *(This has been mandated by the Chief of Police and the Bureau is currently in the process of completing this mandate.)*

2- Revise emergency medical procedures to include the following:

A. Direct Bureau members to advise EMS personnel of the custody status of the subject, as well as any use of force used against the subject, when EMS is called to the scene.
B. Direct Bureau members not to sign a medical refusal form on behalf of the subject.
C. Decide who will have the responsibility of determining the appropriate mode of transporting the subject to the hospital, when medical staff at MCDC refuses to admit him or her for booking.
D. Direct Bureau Members not to transport a subject who appears to be suffering from excited delirium unless cleared by on-scene EMS.

These and related issues have been addressed in the new directive, 630.45 Emergency Medical Custody Transports, which became effective on January 30, 2007.

3- In-Service Training:

A. Review person encounter doctrine through scenario-based training; and include the following performance objectives:
    1. Demonstrate effective communication skills.
    2. Demonstrate good defensive tactic skills.
    3. Demonstrate the proper use of force.
    4. Demonstrate proper positioning.
    5. Demonstrate the proper use of cover.

B. Review Directive 1010.20 - Use of Physical Force; through scenario-based training and classroom instruction. The performance objectives should include demonstrating a thorough understanding of the Levels of Resistance which are:

    1. Passive resistance: Actions that do not prevent or attempt to prevent the members attempt to control a subject. Examples include when the subject merely goes limp and/or fails to comply with verbal commands with no other overt signs of physical resistance.

    2. Physical resistance: Actions that prevent or attempt to prevent a member's attempt to control a subject, but do not involve attempts to harm the member. Examples include, but are not limited to, tensing muscles, pulling away, and fleeing.

    3. Aggressive physical resistance: Physical actions of attack or threat of attack, coupled with the ability to carry out the attack, which may cause physical injury. Examples include, but are not limited to striking, kicking, biting, throwing objects capable of causing injury, head butting and taking a fighting stance.

4- Advanced Academy Training:

A. Introduce Crisis Intervention Team (CIT) training incrementally over time during the Advanced Academy.
B. Include CIT scenario-based training, during Patrol Tactics instruction interwoven with other disciplines, incrementally over time throughout the Advanced Academy.
C. Reinforce person encounter doctrine, and applicable statutes and policies related to initiating foot pursuits, through scenario-based training and classroom instruction, incrementally over time throughout the academy session.

5- Develop and disseminate a roll-call video to Bureau members, produced by the Training Division, pertaining to foot pursuits; highlighting the dangers of foot pursuits and the Knock-Down technique.

6- Develop and disseminate a roll call video to Bureau members, produced by the Training Division, discussing the proper application of the Taser when engaged at close quarters with a violent individual.

7- Expand the Training Division's Foot Pursuit Tactical Doctrine when discussing Danger versus Public Safety. Provide additional emphasis outlining factors that should be considered at the onset of a foot pursuit; including the severity of the crime, applicable statutes and policies, ones own knowledge of the subject including physical descriptors (i.e. male or female, size ratio to the member, and muscularity), and the immediate environment.

8- Some of the symptoms displayed by Mr. Chasse, during this incident, were symptoms commonly associated with "excited delirium" and are listed below:

1) - Violent resistance or physical struggling with officers.
2) - Incoherent screaming/yelling.
3) - Subject suddenly goes unconscious after a struggle.
4) - Talking incoherently.
5) - Profuse sweating.

It would be beneficial for members of the Police Bureau, AMR, and the Medical Examiners Office, to attend the National Sudden Death and Excited Delirium Conference, which is presented annually to first responders, investigators, and medical professionals. This would provide continuing opportunity to incorporate up-to-date information, when developing on-going policies and protocols.

Portland Police Bureau

James Chasse
In Custody Death Investigation
Case # 06-84962

Lead Detectives: Jon Rhodes and Lynn Courtney
IAD Investigators: Michael Barkley and Derek Rodrigues

In Custody Death Investigation
September 17, 2006

Deceased Subject:
James Philip Chasse
MW, DOB 05/07/1964 (42 yrs)

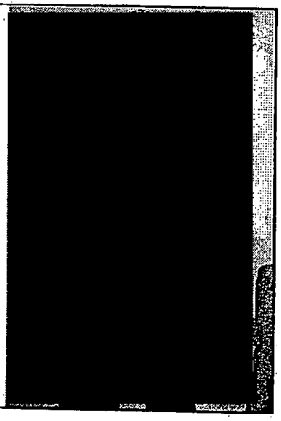
Location / Time: NW 13th Av. / NW Everett St.

Time: 5:18pm

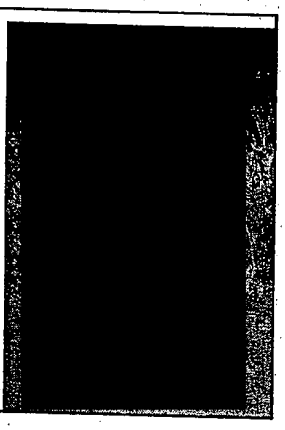
Officer Chris Humphreys

7 ½ Years PPB
3 Years Wheeler County S.O.

Transit Police Division
Afternoon Relief with partner
MCSO Deputy Bret Burton.

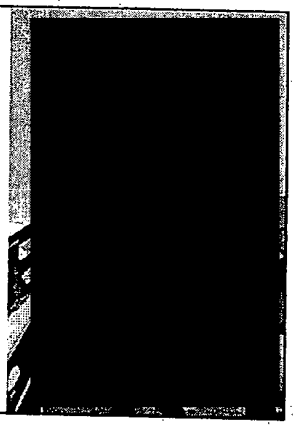


MCSO Deputy Bret Burton
Hired 01/02/04
Assigned Transit Police Division
Afternoon Relief
Partner Chris Humphreys



Sgt. Kyle Nice
14 ½ yrs PPB
3 yrs Sgt.

Assigned Central Precinct / Afternoon Relief



Investigative Team

- PPB Homicide Detail Detectives
- 4 East County Major Crimes Team Dets.
- PPB Criminalists
- OSP Crime Lab personnel
- Oregon State Medical Examiners Office
- Multnomah County DA's Office

James P. Chasse

- M/W, 42 yrs old
- 5' 9" tall, slender build
- 145 lbs.

Chasse Background

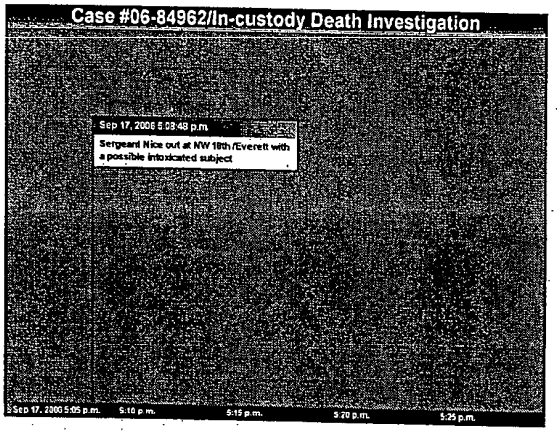
- Two minor prior arrests for Theft and Resist Arrest. (1979 & 1982)
- Cited in 1994 by PPB for Trespass II which was his last PPDS entry prior to this incident.
- One prior mental commitment report by PPB in 1990.

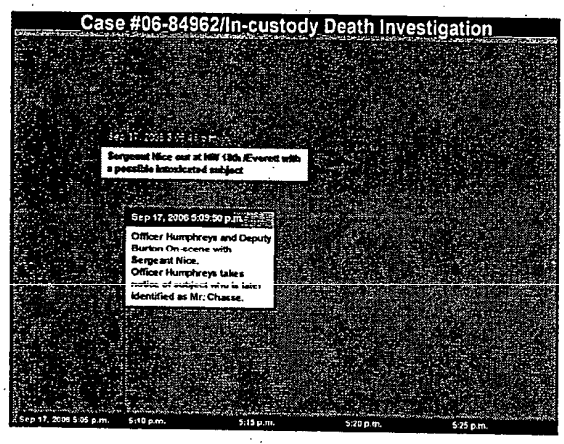
Chasse Mental Health Records

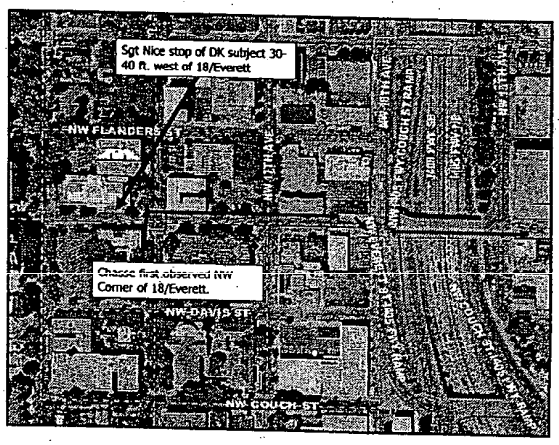
- Under the Care of Cascadia Behavioral Health.
- Schizophrenic, Obsessive-Compulsive Disorder, with increased Paranoia.
- Weeks and months prior to incident Mr. Chasse was showing signs of "decompensating", not taking his medication, disorganized and losing weight.
- Report on 09/08/06 indicated Mr. Chasse was in need of inpatient care to return to baseline.

- 09/15/06 at 1:15pm Mr. Chasse's case worker Ela Howard called police to assist her in contacting Mr. Chasse in an attempt to place a hold on him and have him transported to the hospital.
- PPB Officer Jason Worthington was dispatched.
- Mr. Chasse paranoid and evasive. Would not open his door, said he was fine.
- Further coaxing, Mr. Chasse opened door then ran down and out of the residential building.
- Officer Worthington asked case worker if he should chase Mr. Chasse and was told not to.

- Officer Worthington noted in his report how Mr. Chasse looked at him and repeated "Don't hurt me".
- Case worker report noted Mr. Chasse was suspicious and primarily focused on the presence of the police officer.
- Mr. Chasse's case worker noted in her report she asked the officer not to chase Mr. Chasse due to the possibility of a confrontation that would put him (Chasse) in danger.







Officers First Observations of Mr. Chasse at NW 18th / Everett per Detective Interviews

Officers First Observations of Mr. Chasse at NW 18th / Everett per Internal Affairs Interviews

N.W Everett Street and 18th Avenue Observations and Reasons to Contact

- **Sergeant Nice:**
  - Did not recall observing or **discussing Mr. Chasse.**
- **Officer Humphreys:**
  - Observed Mr. Chasse who appeared to be a transient.
  - Thought he was drunk or high on drugs.
  - Mr. Chasse continued to move his feet.
  - After looking at the officers, Mr. Chasse quickly left.

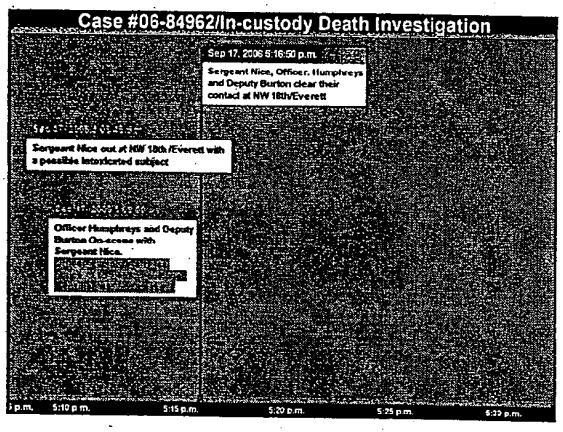
N.W. Everett Street and 18th Avenue Observations and Reasons to Contact

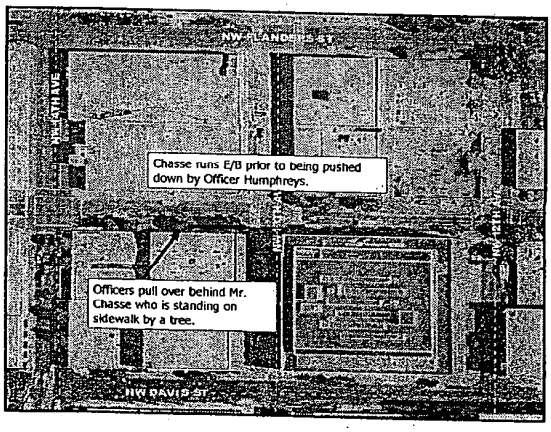
- **Officer Humphreys, cont'd:**
  - Officer Humphreys' thoughts were:
    1. "Primary concern" was Mr. Chasse would be struck by a passing vehicle.
    2. Mr. Chasse had a warrant.
    3. Mr. Chasse would get on a bus and be a problem.
- **Deputy Burton:**
  - Observed Mr. Chasse who he described as "peculiar" and "strange."

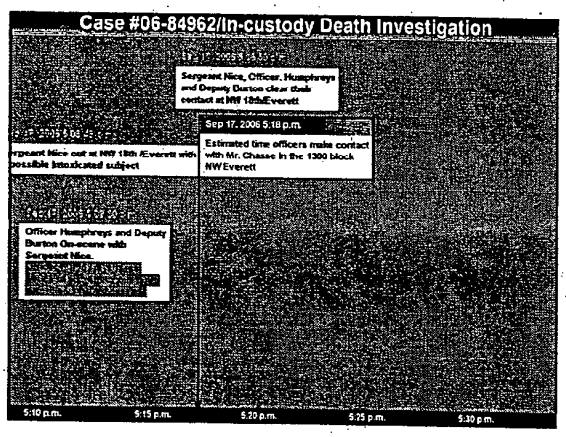
N.W. Everett Street and 18th Avenue. Observations and Reasons to Contact

- **Deputy Burton, cont'd:**
  - Deputy Burton had a number of thoughts regarding Mr. Chasse:
    1. Possible warrant
    2. Possibly possessed drugs
    3. Possibly intoxicated
    4. Possibly needing to be taken to Detox
    5. Possibly needing to talk with Project Respond

Officer Humphreys recorded IAD Statements regarding NW Everett and 18th.







Officers Contact and Chase of Mr. Chasse in 1300 Block of NW Everett per Detective Interviews

Observations and Reasons for contact of Mr. Chasse in 1300 Block of NW Everett per Internal Affairs Interviews.

B.O.E.C.

- B.O.E.C. (police dispatch) was not advised by Officer Humphreys or Deputy Burton they would be contacting Mr. Chasse in the 1300 block of N.W. Everett Street

1300 Block of N.W. Everett Street Observations and Reasons to Contact

- **Sergeant Nice:**
  - He was unaware of reasons to contact Mr. Chasse until after he was in custody.
- **Officer Humphreys:**
  - Observed Mr. Chasse standing near a tree with his back to the officers.
  - Officer Humphreys' thoughts were:
    1. Mr. Chasse had urinated in public
    2. He had possibly injected drugs
    3. Mr. Chasse was intoxicated and unable to care for himself.

1300 Block of N.W. Everett Street Observations and Reasons to Contact

- **Officer Humphreys, cont'd**
  - Officer Humphreys stated he "reasonable suspicion" to contact Mr. Chasse due to:
    1. Public urination
    2. Possibly intoxicated and unable to care for himself
- **Deputy Burton:**
  - After Deputy Burton observed Mr. Chasse standing near a tree, his thought was he had "reasonable suspicion" Mr. Chasse had dumped something, possibly drugs.

1300 Block of N.W. Everett Street Observations and Reasons to Contact

Deputy Burton, cont'd

- Deputy Burton believed Mr. Chasse had committed or was about to commit a crime:
  1. Possible possession of drugs
  2. Possible public urination or exposing himself

B.O.E.C.

- B.O.E.C. (police dispatch) was not advised by Officer Humphreys, Deputy Burton or Sergeant Nice of the foot pursuit.

Reasons for Foot Pursuit

- **Sergeant Nice:**
  - He was not aware of the reason(s) until after Mr. Chasse was in custody.
  - Sergeant Nice was advised:
    1. Mr. Chasse possessed "bunk" drugs
    2. He had urinated in public

Reasons for Foot Pursuit

- **Officer Humphreys' thoughts for pursuing Mr. Chasse were:**
  1. He had urinated in public
  2. Mr. Chasse was intoxicated and unable to care for himself
  3. He possibly had a warrant
  4. Mr. Chasse possibly possessed drugs
- **Deputy Burton believed:**
  - "Reasonable suspicion" existed due to Mr. Chasse failed to obey a "lawful order to stop" given by Officer Humphreys to stop

Officer Humphreys' *Recorded* I.A.D. Statements

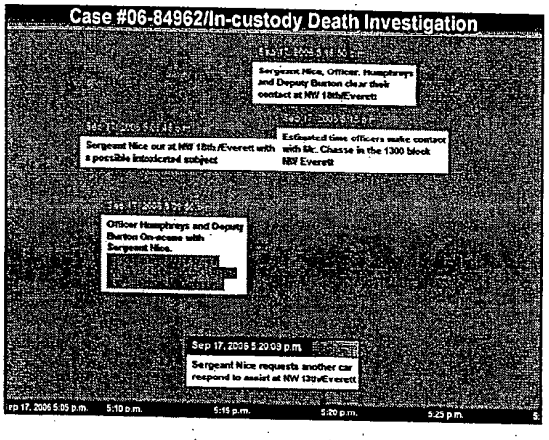
- The following are Officer Humphreys' recorded statements during the Internal Affairs Division interview regarding:

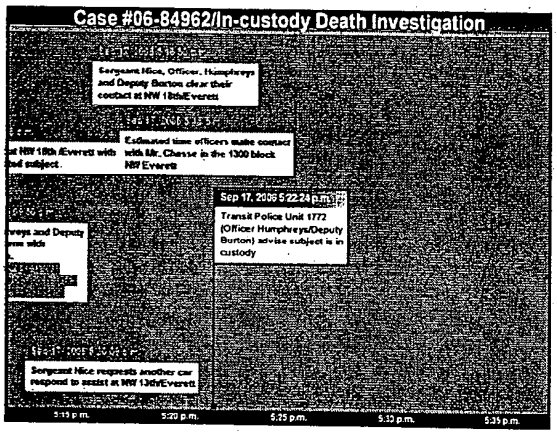
1. Observations of Mr. Chasse at the 1300 block of N.W. Everett Street and reasons to contact him.
2. Reasons for foot pursuit of Mr. Chasse.

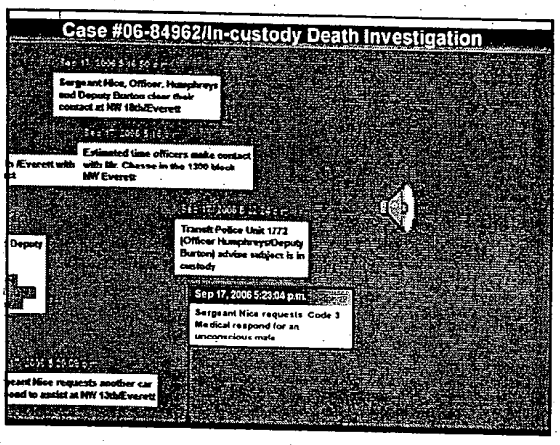
Statements made to Detectives by Involved Officers and Witnesses regarding the struggle to get Mr. Chasse into custody.

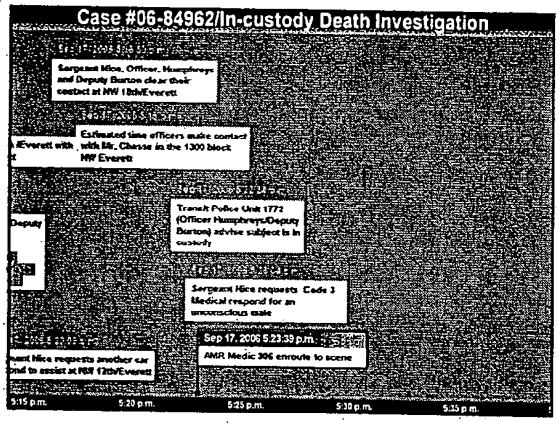
Witness Officer Statements

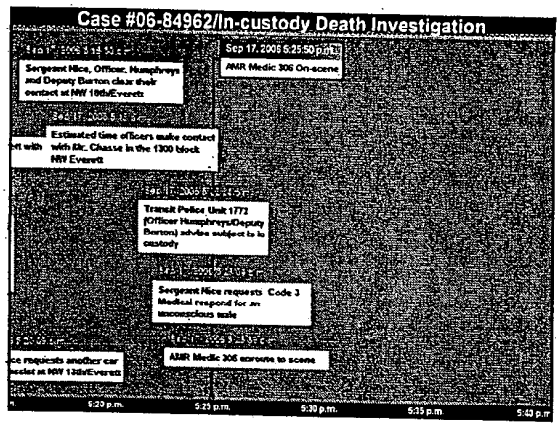
Officer Troy Pahlke
Officer Carl Weldon
Sgt. Jeffrey Niiya
Officer Michael Bledsoe
Officer Jason Lile
Officer Edward Johnson

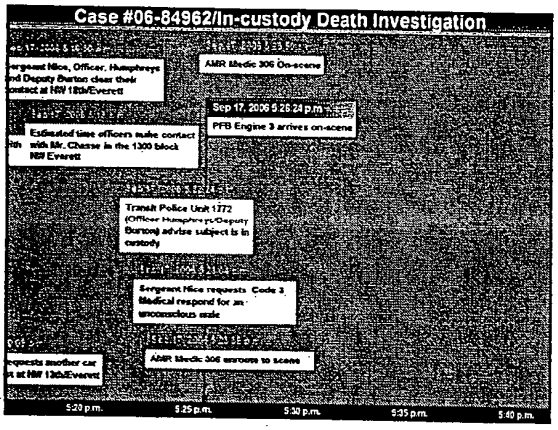


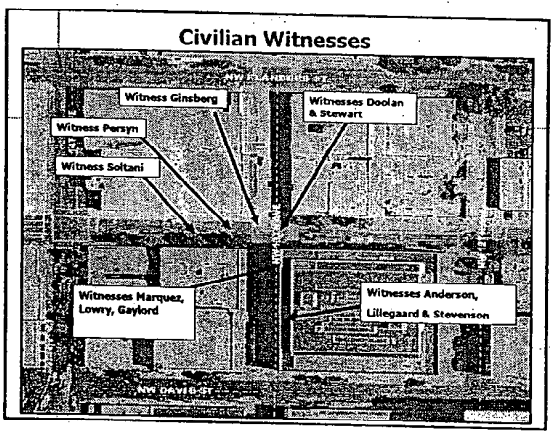

Case #06-84962/In-custody Death Investigation
Sergeant Nice, Officer, Humphreys and Deputy Burton clear their contact at NW 18th/Everett
Estimated time officers make contact with Mr. Chasse in the 1300 block NW Everett
Sep 17, 2006 5:22:24 p.m.
Transit Police Unit 1772 (Officer Humphreys/Deputy Burton) advise subject is in custody
Sergeant Nice requests another car respond to assist at NW 13th/Everett
5:15 p.m.
5:20 p.m.
5:25 p.m.
5:30 p.m.
5:35 p.m.

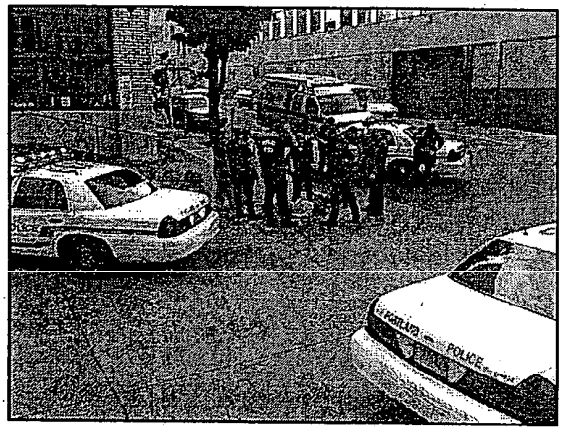

Case #06-84962/In-custody Death Investigation
Sergeant Nice, Officer, Humphreys and Deputy Burton clear their contact at NW 18th/Everett
Estimated time officers make contact with Mr. Chasse in the 1300 block NW Everett
Transit Police Unit 1772 (Officer Humphreys/Deputy Burton) advise subject is in custody
Sep 17, 2006 5:23:04 p.m.
Sergeant Nice requests Code 3 Medical respond for an unconscious male

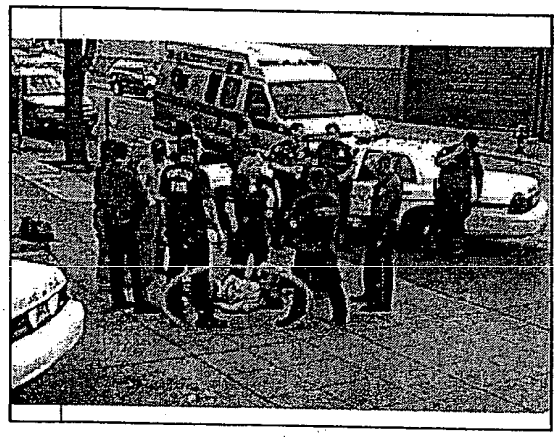

Case #06-84962/In-custody Death Investigation
Sergeant Nice, Officer, Humphreys and Deputy Burton clear their contact at NW 18th/Everett
Estimated time officers make contact with Mr. Chasse in the 1300 block NW Everett
Transit Police Unit 1772 (Officer Humphreys/Deputy Burton) advise subject is in custody
Sergeant Nice requests Code 3 Medical respond for an unconscious male
Sep 17, 2006 5:23:39 p.m.
AMR Medic 306 enroute to scene
5:15 p.m.
5:20 p.m.
5:25 p.m.
5:30 p.m.
5:35 p.m.

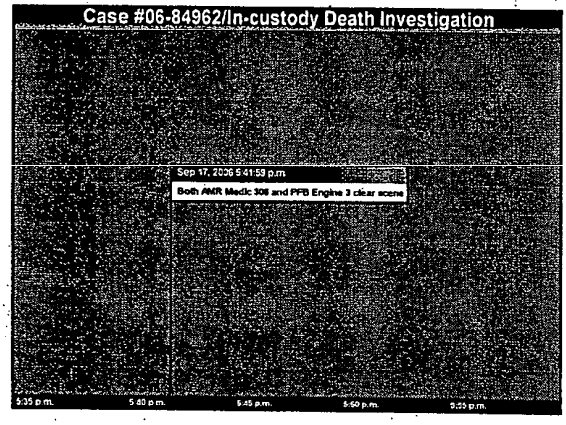

Case #06-84962/In-custody Death Investigation
Sergeant Nice, Officer, Humphreys and Deputy Burton clear their contact at NW 18th/Everett
Sep 17, 2006 5:25:50 p.m.
AMR Medic 306 On-scene
Estimated time officers make contact with Mr. Chasse in the 1300 block NW Everett
Transit Police Unit 1772 (Officer Humphreys/Deputy Burton) advise subject is in custody
Sergeant Nice requests Code 3 Medical respond for an unconscious male
AMR Medic 306 enroute to scene
5:20 p.m.
5:25 p.m.
5:30 p.m.
5:35 p.m.


Case #06-84962/In-custody Death Investigation
AMR Medic 306 On-scene
Sep 17, 2006 5:25:24 p.m.
PFB Engine 3 arrives on-scene
Estimated time officers make contact with Mr. Chasse in the 1300 block NW Everett
Transit Police Unit 1772 (Officer Humphreys/Deputy Burton) advise subject is in custody
Sergeant Nice requests Code 3 Medical respond for an unconscious male
AMR Medic 306 enroute to scene
5:20 p.m.
5:25 p.m.
5:30 p.m.
5:35 p.m.
5:40 p.m.


Civilian Witnesses
Witness Ginsberg
Witnesses Doolan & Stewart
Witness Persyn
Witness Soltani
Witnesses Marquez, Lowry, Gaylord
Witnesses Anderson, Lillegaard & Stevenson







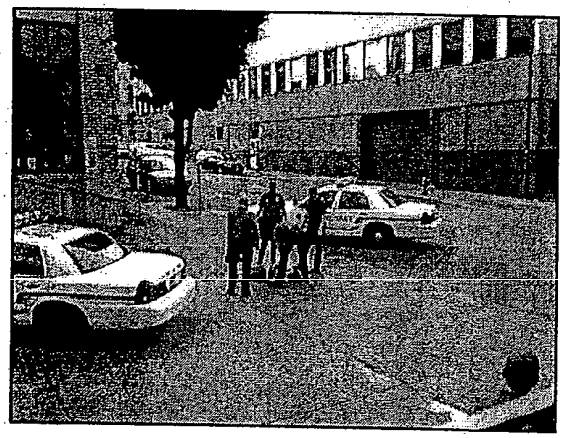
AMR Pre-Hospital Care Report

- AMR Paramedics Tamara Hergert and Kevin Stucker arrive 1725 hours and clear at 1741 hours (16 min.)
- Vital Signs within normal limits.
  - * BP 110/73
  - * Pulse 100
  - * Respirations 18
  - * Blood Glucose 119mg
- Primary Assessment : Toxicological – Illicit Drug(s)

- AMR Paramedic Tami Hergert presented a patient release form for Chasse and requested officers to sign the form for him. Officer Humphreys signed the form as requested.

PFB Responders

- Report by Bill Koppy of PFB
- Noted Chasse did not respond to any questions throughout.
- Small lacerations to both lips, minor bleeding.
- Various small abrasions to head and both arms.
- No other visible trauma.
- Pt. had purposeful movement to all extremities.
- Pt. was rather combative and uncooperative throughout.
- Vitals normal.
- Assessment: Possible drug use.



Mr. Chasse in Patrol Car prior to leaving for jail

- Chasse mumbling according to Officer Humphreys.
- Officer Humphreys asks his name, replies "Chelsy"
- Gives his first name of James, gave DOB of 1964.
- Asked for walled, Chasse lifted up right hip, said "in there"
- Wallet ultimately found in left front pocket. Wallet and pants soaked.

Directive 1010.20
Physical Force

Directive 1051.00
Taser, Less Lethal

Physical Force Used, cont'd

- Analysis of the actions by **Sergeant Nice, Officer Humphreys** and **Deputy Burton** were *not* limited to simply the actions themselves, but the officers' *observations, perceptions and thoughts* at the time.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Officer Humphreys

Officer Humphreys' I.A.D. Statement:

- Officer Humphreys stated he "knocked" Mr. Chasse to the ground by pushing out with his forearms and struck him in the back.
- He stated he did *not* tackle him.
- Officer Humphreys stated he *may* have fallen onto Mr. Chasse.
- He stated he did not observe any other officer fall onto Mr. Chasse.
- He stated he grabbed Mr. Chasse's right hand / arm and utilized an arm bar.
- Officer Humphreys stated he was not on top of Mr. Chasse's back or stomach area.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Officer Humphreys

Officer Humphreys' I.A.D. Statement:

- Officer Humphreys stated he struck Mr. Chasse in the face with a closed fist.
- Officer Humphreys stated he pushed and pulled "really hard" on Mr. Chasse shoulders.

Deputy (Officer) Burton's I.A.D. Statement:

- Deputy Burton stated he observed Officer Humphreys "collide" with Mr. Chasse and both fell to the sidewalk.
- Deputy Burton was not sure whether Officer Humphreys pushed or his hands were around Mr. Chasse.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Officer Humphreys

Deputy (Officer) Burton's I.A.D. Statement:

- Deputy Burton stated he was not sure if Officer Humphreys landed on top of Mr. Chasse.
- He observed Officer Humphreys grab Mr. Chasse's arm.

Sergeant Nice's I.A.D. Statement:

- Sergeant Nice described Officer Humphreys arms made contact with Mr. Chasse's upper back / shoulders and then they fell to the pavement.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Officer Humphreys

Sergeant Nice's I.A.D. Statement:

- Sergeant Nice clarified his description "his (Officer Humphreys) arms come up *around* the mid-chest area; I assumed that he *tackled* Mr. Chasse, based on the way they fell down together."
- He observed Officer Humphreys place Mr. Chasse's right arm in a possible reverse wrist lock.
- He believed Officer Humphreys had his knee on Mr. Chasse's back.
- Sergeant Nice stated he believed Officer Humphreys struck Mr. Chasse with a closed fist in the face.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Deputy Burton

Officer Humphreys' I.A.D. Statement:

- Officer Humphreys stated Deputy Burton pushed down on Mr. Chasse's legs.
- He stated Deputy Burton was not on Mr. Chasse's back, stomach or side of ribs.
- Officer Humphreys observed Deputy Burton deploy the Taser- drive stun to Mr. Chasse's lower leg thigh area.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Deputy Burton

Deputy Burton's I.A.D. Statement:

- Deputy Burton stated he attempted to control Mr. Chasse's legs.
- He deployed his Taser- drive stun.
- Deputy Burton stated he struck Mr. Chasse once or more with a closed fist in the back.
- Deputy Burton described using his right index finger knuckle as pain compliance on Mr. Chasse's side to back ribs.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Deputy Burton

Sergeant Nice's I.A.D. Statement:

- Sergeant Nice observed Deputy Burton attempt to secure Mr. Chasse's legs.
- He described Deputy Burton deploying the Taser- drive stun to Mr. Chasse's upper right leg or buttocks area.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Sergeant Nice

Officer Humphreys' I.A.D. Statement:

- Officer Humphreys observed Sergeant Nice grab Mr. Chasse's left arm.
- He stated Sergeant Nice was not on Mr. Chasse's back, stomach or side of ribs.
- Officer Humphreys stated he did not observe Sergeant Nice kick Mr. Chasse.
- However, Officer Humphreys stated he was advised by his attorney, Steve Meyers, after the Grand Jury that Sergeant Nice had kicked Mr. Chasse due to being bit. He was not told how many times Mr. Chasse was kicked.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Sergeant Nice

Deputy Burton's I.A.D. Statement:

- Deputy Burton stated Sergeant Nice grabbed Mr. Chasse's arm.

Sergeant Nice's I.A.D. Statement:

- Sergeant Nice stated he placed Mr. Chasse's left wrist in a reverse wrist lock and applied pressure downward.
- He kneeled on Mr. Chasse's shoulder area.
- Regarding Sergeant Nice kicking Mr. Chasse, he stated "... I, uh, *tapped* him on the chest with the instep of my boot ..." This occurred following Mr. Chasse biting him on the right calf and then grabbing his right pant leg with his teeth.

Physical Force Used, cont'd Officers' Actions

Observed Physical Force Used By Sergeant Nice

Sergeant Nice's I.A.D. Statement:

- Sergeant Nice clarified the kick as "It was not a full power kick." "This was the instep of my boot; it was not with the toe; it was a flat, uh, low-power kick to get his attention."
- He believed the kick contacted Mr. Chasse's front upper chest.
- Sergeant Nice described the kick as not being hard enough to cause a fracture.
- He stated he knelt on Mr. Chasse's back in order to pin him.
- Sergeant Nice stated he placed the sole of his boot on Mr. Chasse's jaw to prevent him from biting.

Physical Force Used, cont'd Officers' Actions

Physical Force Observed By Ms. Doolan

Ms. Constance Doolan's I.A.D. Statement:

- Ms. Doolan was an out of town citizen who witnessed the confrontation involving Mr. Chasse.
- Ms. Doolan stated she observed Mr. Chasse and all three officers land on the pavement.
- She stated Mr. Chasse was "tackled" hard and fell hard.
- Ms. Doolan described some of the officers being on top of Mr. Chasse but did not stay on him long.
- She did hear someone yell the word "bite."

Physical Force Used, cont'd Officers' Actions

Physical Force Observed By Ms. Doolan

Ms. Constance Doolan's I.A.D. Statement:

- Ms. Doolan did not observe Mr. Chasse bite the officers, but she did observe him attempting to bite.
- She stated the police officer who Mr. Chasse attempted to bite, kicked him two or three times with the toe area of his shoe in the back or mid-body area and then slapped him with an open hand on the head.
- She believed the kicks were hard enough to cause substantial injury.

Physical Force Used, cont'd Officers' Actions

Physical Force Observed By Ms. Doolan

Ms. Constance Doolan's I.A.D. Statement:

- Ms. Doolan did not observe any police officer strike Mr. Chasse with a closed fist.
- Ms. Doolan described the Taser being deployed at approximately the same time Mr. Chasse was being kicked and slapped.
- She stated she did not believe the Taser probes were deployed.
- Ms. Doolan stated she heard three Taser clicking sounds.
- She stated the Taser was applied to Mr. Chasse's back or mid-body.

Physical Force Used, cont'd Officers' Actions

Physical Force Observed By Ms. Doolan

Ms. Constance Doolan's I.A.D. Statement:

- Ms. Doolan was shown eleven photographs of all of known police officers at the location. She was unable to identify any of the officers involved with tackling, kicking, slapping and applying the Taser.
- She described Mr. Chasse as being handcuffed, feet tied together and carried approximately a half block "like a dead deer."

Directive 1051.00 Taser

- "Conditions and Behavior Requiring Medical Treatment After Deployment":
- "EMS will be summoned when the Taser is deployed on the following individuals. *EMS will also transport them to a hospital:*
  - e. "A person suffering from hyper stimulation (before, during or after deployment). This includes the following: behaviors such as rapid speech, agitation, apprehension, excitation, restlessness, verbalization of impeding doom, emotional instability; ... pale skin ..."

Taser, cont'd

f. "A person suffering from agitated delirium (before, during or after deployment). This includes the following: severe agitation, over-amped or wired; paranoia; delirium (an abnormal mental state characterized by disorientation, fear and irritability), altered mental status (a change in the level of consciousness or the content of consciousness)..."

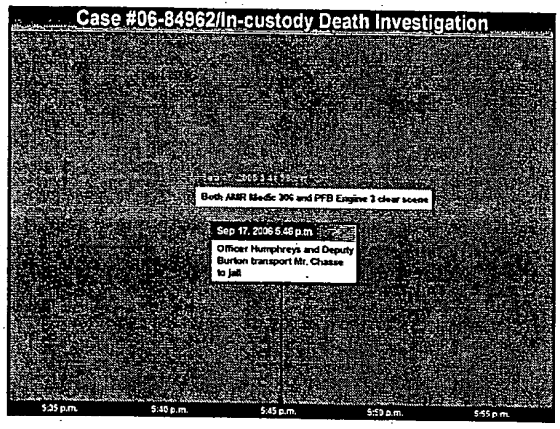
Taser, cont'd

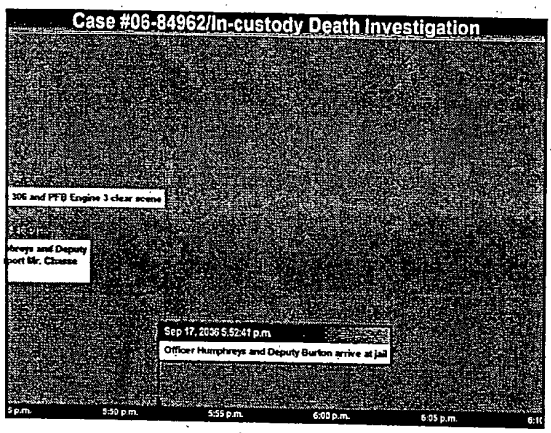
Ms. Hergert's and Mr. Stucker's I.A.D. Statements:

- Ms. Hergert was not advised Mr. Chasse had been tasered.
- Mr. Stucker stated he heard a police officer mention they had attempted to taser Mr. Chasse and the taser did not have an effect.
- Mr. Stucker assumed the probes did not stick.
- Ms. Hergert stated she asked Sergeant Nice twice if they wanted Mr. Chasse transported. Sergeant Nice stated no.

1300 Block of N.W. Everett Street

- Whether Sergeant Nice, Officer Humphreys and Deputy Burton provided adequate information to AMR and Portland Fire Bureau paramedics regarding the circumstances of the physical confrontation with Mr. Chasse at the 1300 block of N.W. Everett Street.
- Were the paramedics provided adequate information to properly assess possible injuries sustained by Mr. Chasse?



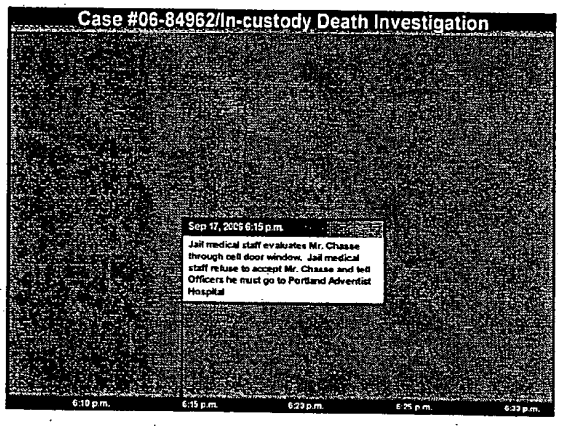


Justice Center Jail Video

- 18:06:45 Mr. Chasse brought inside
- 18:11:20 Nurses (2) check Chasse
- 18:12:42 Nurses leave intake area
- 18:14:00 Humphreys conversation
- 18:18:24 Mr. Chasse is carried out.

- Less than 12 minutes inside the Jail reception area.

Jail Video



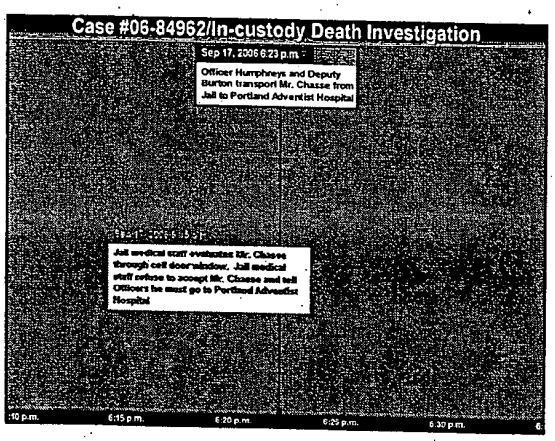
Multnomah County Detention Center

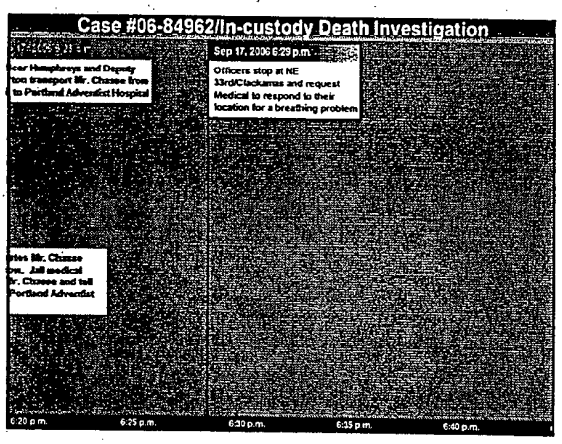
1010.20: PHYSICAL FORCE, USE OF:
"Post Use of Force Medical Attention":
3 (g) "Immediately upon arrival at the correctional facility, the member
shall notify a corrections staff member of the extent of the subject's injuries and medical treatment given..."

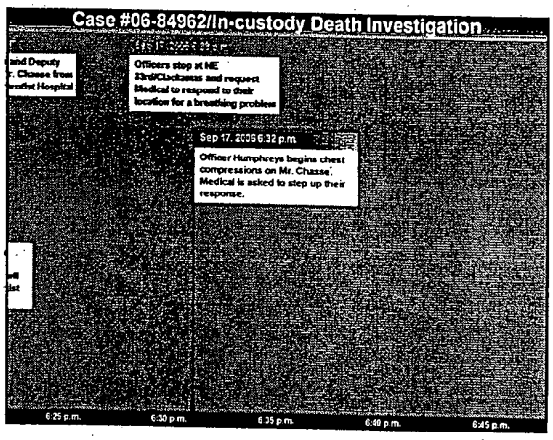
- Officer Humphreys stated he believed he advised a deputy Mr. Chasse had passed out earlier.
- Deputy Burton stated he did not recall whether he or Officer Humphreys advised M.C.D.C. medical staff of what had occurred at N.W. Everett Street and 13th Avenue; specifically, Mr. Chasse had stopped breathing.
- Deputy Burton stated he was sure the information was provided
"... cause it's an important conversation to have."

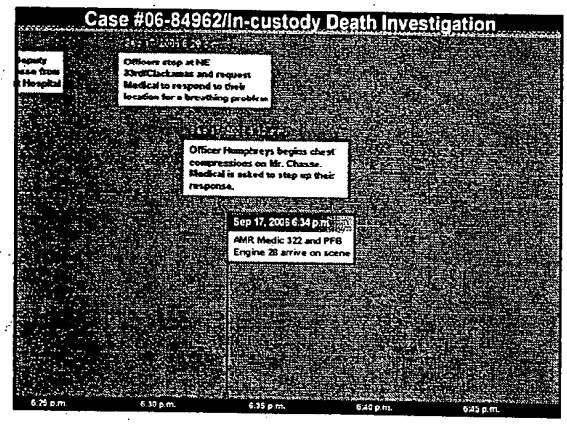
M.C.D.C.

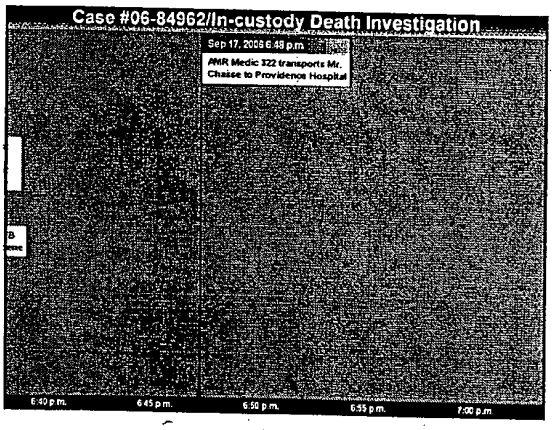
- Whether Officer Humphreys and Deputy Burton provided adequate information to the staff at the Multnomah County Detention Center regarding the circumstances of the physical confrontation with Mr. Chasse at the 1300 block of N.W. Everett Street.
- Was M.C.D.C. staff provided adequate information to properly assess possible injuries sustained by Mr. Chasse?

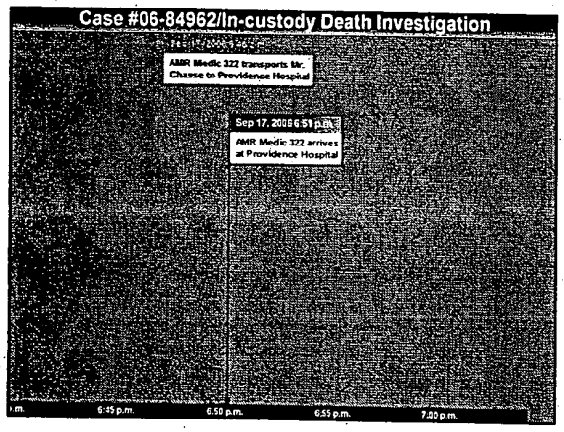


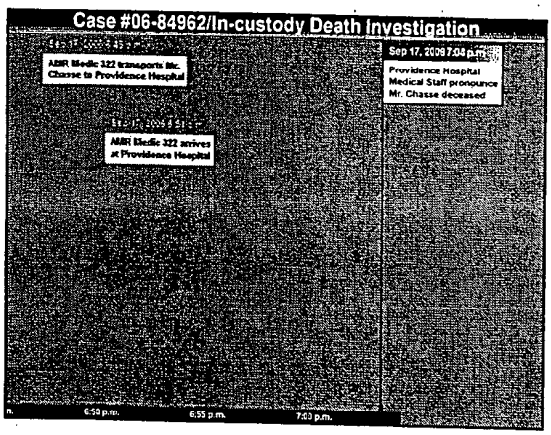

Case #06-84962/In-custody Death Investigation
Sep 17, 2006 6:29 p.m.
Officers stop at NE 33rd/Clackamas and request Medical to respond to their location for a breathing problem
6:20 p.m.
6:25 p.m.
6:30 p.m.
6:35 p.m.
6:40 p.m.


Case #06-84962/In-custody Death Investigation
Officers stop at NE 33rd/Clackamas and request Medical to respond to their location for a breathing problem
Sep 17, 2006 6:32 p.m.
Officer Humphreys begins chest compressions on Mr. Chasse. Medical is asked to step up their response.
6:25 p.m.
6:30 p.m.
6:35 p.m.
6:40 p.m.
6:45 p.m.


Case #06-84962/In-custody Death Investigation
Officers stop at NE 33rd/Clackamas and request Medical to respond to their location for a breathing problem
Officer Humphreys begins chest compressions on Mr. Chasse. Medical is asked to step up their response.
Sep 17, 2006 6:34 p.m.
AMR Medic 322 and PFB Engine 28 arrive on scene
6:25 p.m.
6:30 p.m.
6:35 p.m.
6:40 p.m.
6:45 p.m.


Case #06-84962/In-custody Death Investigation
Sep 17, 2006 6:48 p.m.
AMR Medic 322 transports Mr. Chasse to Providence Hospital
6:40 p.m.
6:45 p.m.
6:50 p.m.
6:55 p.m.
7:00 p.m.


Case #06-84962/In-custody Death Investigation
AMR Medic 322 transports Mr. Chasse to Providence Hospital
Sep 17, 2006 6:51 p.m.
AMR Medic 322 arrives at Providence Hospital
6:45 p.m.
6:50 p.m.
6:55 p.m.
7:00 p.m.


Case #06-84962/In-custody Death Investigation
AMR Medic 322 transports Mr. Chasse to Providence Hospital
Sep 17, 2006 7:08 p.m.
Providence Hospital Medical Staff pronounce Mr. Chasse deceased
AMR Medic 322 arrives at Providence Hospital
6:50 p.m.
6:55 p.m.
7:00 p.m.

Investigative Chronology

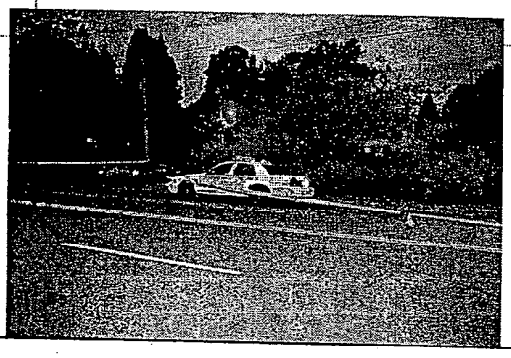
- 1905 hrs. on-call homicide detectives were paged, arriving on scene at 1937 hrs.
- Involved Officers were identified, separated, and available nearby.
- Witness officers to the arrest of Mr. Chasse were identified and ordered to report to detective division.
- Involved officers and later witness officers were all photographed and uniforms seized as appropriate.
- Communication restriction orders were issued to all involved and witness PPB Officers.
- Deputy District Attorney Chris Mascal arrived on scene for consultation and briefing.

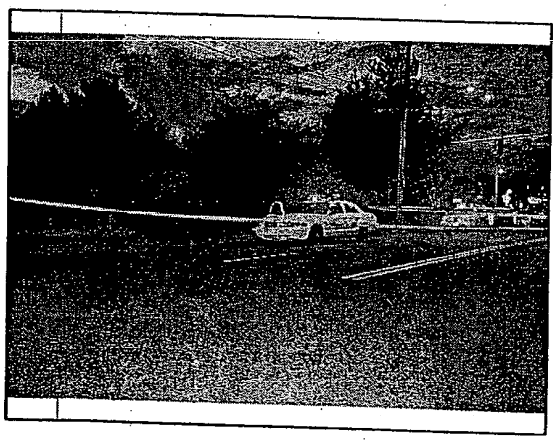
- AMR and PFB responders were identified for future contact.
- Crime scene detectives and criminalists helped locate, identify, photograph and collect evidence.
- Detectives contacted Justice Center Jail staff to identify, locate and interview jail staff who had contact with Mr. Chasse.
- Detectives and a Criminalist returned to the area of NW 13th and Everett with Officer Humphrey's who provided a brief walk through on their initial contact with Mr. Chasse.
- Photographs were taken of the area where Mr. Chasse was first observed and arrested.
- Possible evidence (white powder) collected.

- Witness Officers Jason Lile, Timothy Bledsoe and Lamont Johnson along with Sgt. Jeff Niiya were interviewed that same night.
- Sgt. Kyle Nice, Officers Chris Humphreys, Troy Pahlke, Carl Weldon along with Deputy Bret Burton were all interviewed within the next couple of days.
- Deputy Burton's Taser was seized and information on its use was downloaded by training division. As a result the taser was deployed with 4 different trigger pulls lasting 6, 5, 1, and 2 seconds each for a total of 14 seconds.
- Detectives attended a post mortem examination on Chasse conducted at the State Medical Examiners Office.
- Within days of this incident detectives interviewed jail corrections staff including the two MCDC nurses who examined Mr. Chasse at the jail.

- Detectives spent the next few weeks attempting to identify, locate and interview all witnesses known to this incident.
- Detectives served Grand Jury subpoenas to witnesses as appropriate.
- Grand Jury subpoena was served on AMR for copies of their reports on this incident.
- A court order was obtained to get mental health records on Chasse.
- Detectives assisted the DA's office as needed during the Grand Jury presentation which started on 10/03/06.

NE 33rd / NE Clackamas St.

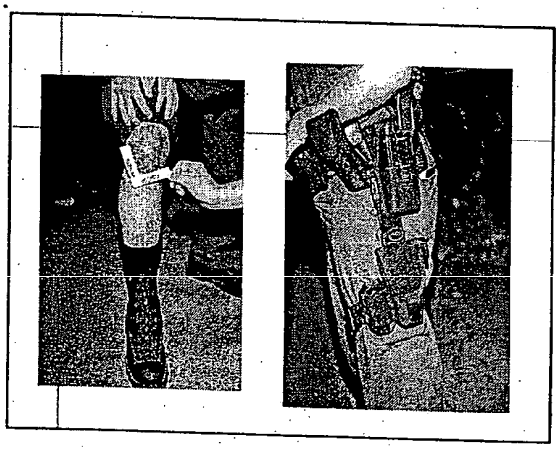




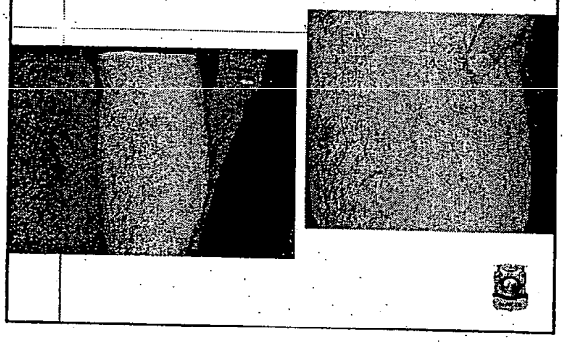
Evidence found and seized from NE 33rd and Clackamas Scene.

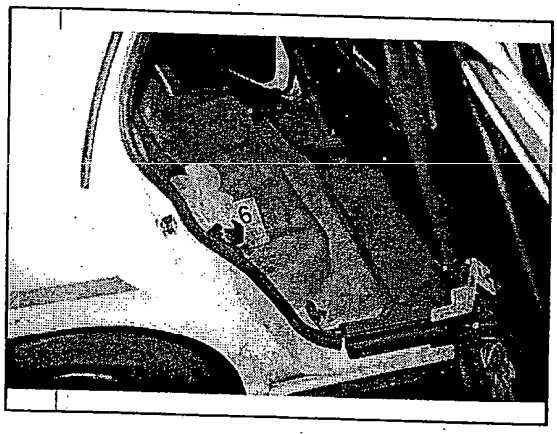
- Taser Holster
- Taser
- 3 unspent taser cartridges.

All of the above seized from Deputy Bret Burton.

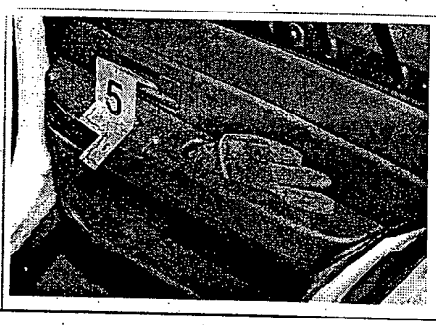


Bite mark to Sgt. Nice's right calf



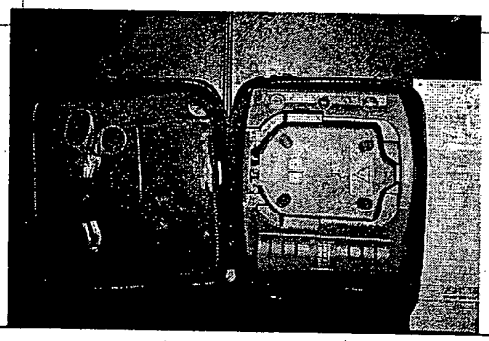


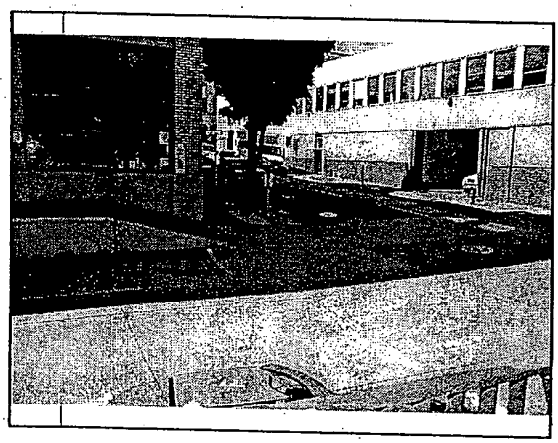
#5 Blood and Glove on inside Right Rear Passenger Door

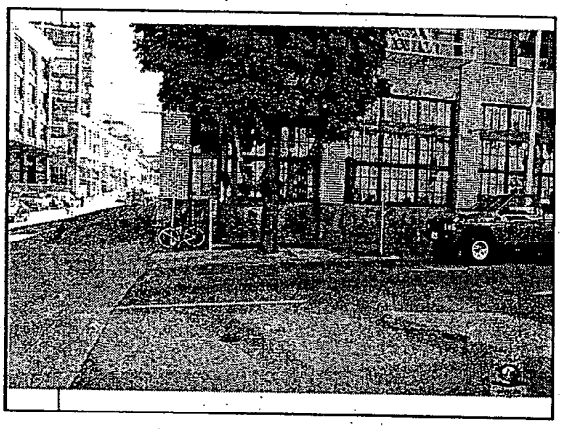


#6 Bloody hood sock and blood on rear patrol car seat.

Heartstart Defibrillator Unit seized from witness Jon Olson.







Post Mortem Examination

- Conducted 09/18/06 at the Oregon State Medical Examiners Officer by Dr. Karen Gunson.
- Cause of Death determined to be from Blunt Force Trauma.

- Anterior Ribs 3-8 are found to be fractured both on the left and right side.
- Anterior Rib fractures according to Dr. Gunson were consistent with CPR application.
- Posterior Left Ribs 3-12 are found to be fractured.
- Posterior Right Ribs 3-6 were fractured.
- Left lung punctured by fractured Rib.
- 300 cc's of blood found in left chest cavity.

- Dr. Gunson also noted multiple contusions and abrasions on Chasse's upper and lower extremity and chest area including large abrasion on right shoulder.
- Also noted were circumferential contusions of the wrists and ankles which were consistent with handcuff placement and ankle cuffing.

What wasn't found during this autopsy

- Any evidence of a skull fracture.
- Any evidence of brain contusion or hemorrhage.
- Any sign of a weapon or instrument used to cause injury.
- No drugs or alcohol found in Mr. Chasse's system.

Conclusions and Opinions of Dr. Gunson

- Frontal fractures of Mr. Chasse's ribs most likely caused by CPR application.
- Posterior fractures could have occurred when and if an officer fell on his back when taking him to the ground.
- Broad based trauma could not, in her opinion, have occurred by officers kicking or punching Mr. Chasse.
- Noted Mr. Chasse's bone density and the fact his bones were more brittle than average due in part to poor nutrition.

Dr. Gunson

- During the first interview, Dr. Gunson explained:
  1. Fractures were consistent with someone falling onto Mr. Chasse.
  2. Mr. Chasse's were brittle.
  3. Mr. Chasse's fatal injuries were sustained at the 1300 block of N.W. Everett Street.
  4. Prior to our interview, Dr. Gunson had *not* received the AMR Pre-Hospital Care Report from 1300 block N.W. Everett Street. The report indicated Mr. Chasse's vital signs to be normal.
  5. Dr. Gunson would expect the vital signs to be "much, much higher."

Dr. Gunson

- Following our interview with Dr. Gunson, we interviewed the two AMR paramedics who provided us with a printout of Mr. Chasse's vital signs. The vital signs were within normal ranges.
- Dr. Gunson agreed the vital readings may have been accurate and within normal limits at the time; however, the vital readings may not have been normal for Mr. Chasse.
- Dr. Gunson stated her opinion was Mr. Chasse's rib fractures were sustained during the confrontation and possibly the fractures were *not* displaced at the time.

Dr. Gunson

- Dr. Gunson explained the possibility that the rib fractures were exacerbated, displaced and the lung perforation occurred while Mr. Chasse was being carried by his shoulders and legs.
- She explained the fashion in which he was carried would cause stress and strain on his rib cage.

Applicable Directives

- Directive 1010.20 Physical force
- Directive 1051.00 Taser, Less Lethal
- Directive 315.00 Laws, Rules & Orders
- Directive 315.30 Unsatisfactory Performance

Directives to Consider

- Directive 612.00 Radio Use
- Directive 630.50 Emergency Medical Aid
- Directive 830.00 Arrest Without Warrant
- Directive 850.10 Custody, Civil Holds

EXECUTIVE ORDER "Foot Pursuits"

- "Foot Pursuits" EXECUTIVE ORDER dated July 13, 2006.
- Published as DIRECTIVE 630.15 in January 2007.
- Stated:
  - "A sworn member has the authority to stop any person reasonably suspected of having committed or is about to commit a crime, violation or traffic violation."
  - "The decision to pursue should be made with an awareness of the degree of risk to which the sworn member exposes himself/herself and others."

EXECUTIVE ORDER "Foot Pursuits", cont'd

- "No sworn member shall be criticized for deciding against initiating, discontinuing his/her involvement in or terminating a foot pursuit."

Additional Areas Reviewed

- Training Division In-Service 2005-2006 Tactical Update Foot Pursuits
- Training Division "Foot Pursuits" Lesson Plan; "Knock-Down Techniques"
- The Training Division will address the police officers' performance in terms of acceptable standards and training.

Grand Jury Review

- Led by Multnomah County Deputy District Attorney Chris Mascal.
- Testimony heard from 30 witnesses over a five day period.
- Grand Jurors also reviewed exhibits, photographs and records pertaining to the case.
- Chasse family attorney was allowed to review reports and call his own witnesses if desired. (1 called)

Grand Jury Result

- On Oct. 17, 2006 Multnomah County District Attorney Michael Schrunk issued a press release advising the Grand Jury voted unanimously not to return a criminal indictment against any individual in connection with the death of James Chasse.

Questions?

October 1, 2008

Noll, Cheryl

From: Baptista, Mary-Beth
Sent: Friday, September 26, 2008 2:28 PM
To: Exchange.CITY.pbbrianm
Cc: Sandrock, Pete; Exchange.CITY.PBLYNNB; Exchange.CITY.PBBRETS; Exchange.CITY.PBJOHNT; Exchange.CITY.PBDONNAH
Subject: CONFIDENTIAL: Force Review Board (Chasse)
Attachments: TEXT.HTM; Force Review Board (Chasse).doc

Assistant Chief Martinek:

Please accept this courtesy email copy of the attached document. I have sent original copies to all of the addressees in sealed envelopes marked "confidential." I appreciate your time and consideration in advance.

Sincerely,

Mary-Beth Baptista — Director – IPR
Pete Sandrock — Assistant Director - IPR

Mary-Beth Baptista, Director
City of Portland/City Auditor
Independent Police Review Division (IPR)
1221 SW 4th Avenue, Room 320
Portland, OR 97204-1900
503-823-0146
Interoffice Address: 131/320
mary-beth.baptista@ci.portland.or.us
www.portlandonline.com/auditor/ipr

CITY OF

PORTLAND, OREGON

OFFICE OF THE CITY AUDITOR

Independent Police Review Division
Mary-Beth Baptista, Director
1221 SW 4th Ave, Room 320
Portland, Oregon 97204
Phone: (503) 823-0146
Fax: (503) 823-3530

October 2, 2008

Assistant Chief Brian Martinek
Central Precinct
1111 SW 2nd Room 1526
Portland Or 97204

Re: Force Review Board (in-custody death of James Chasse)

Dear Assistant Chief Martinek:

IPR respects its role as an outside observer in the Force Review Board's evaluation of the Chasse case.

We are, however, outside observers with unique perspective, having worked closely with the Bureau, the Police Assessment Research Center, the Force Task Force, and the Citizen Review Committee on the management of lethal and non-lethal force over a number of years. We recently reported that the Bureau has made significant progress in both areas.

In addition to our policy-level involvement with force issues in closed cases, we have reviewed the criminal and internal investigations in this case, as well as the training analysis and commander's recommended findings. We received unrestricted access to the internal investigation as it developed and made a number of suggestions about issues that should be covered and questions that should be asked. We are pleased with the fairness and objectivity with which the investigation was conducted.

It is with this background that IPR offers several observations, which we hope will assist the Board in its deliberations.

From IPR's perspective and we suspect from yours as well, there are two fundamental questions. Your answers and the way you explain them will have far-reaching significance both inside and outside the Bureau. Your task is complicated because this incident occurred before the Bureau adopted the new use of force policy. It is further complicated by the implication in Commander Henderson's Findings Memo that the officers may have used tactics that were encouraged or tolerated by the unit's supervisors and commanders.

The two fundamental questions:

1. Should Officer Humphreys have pursued James Chasse? If the Board decides that Officer Humphreys had the legal authority to detain Mr. Chasse for urinating in public, was the pursuit justified by the Bureau's directive and training on foot pursuits?

   According to one line of reasoning, exemplified by Commander Henderson's memo, the pursuit was justified because it was legal, it was not unreasonable for the officer to believe

that Mr. Chasse was intoxicated or under the influence of drugs as opposed to being mentally ill, and drug dealing was a significant problem in the area.

Under another line of reasoning, exemplified by Lt. Famous's training analysis, the pursuit and knock-down were not justified even if they were legal. According to the analysis, the officers were trained to consider additional factors before pursuing and, in this case, the other factors dictated against a pursuit.

The Board might want to analyze the underlying issues in this order:

- Did the officer have a reasonable suspicion that Mr. Chasse had committed a crime? What crime?
- If the officer reasonably suspected a crime and therefore had the legal authority to stop Mr. Chasse, is that enough to justify a foot pursuit or does the Bureau require officers to consider additional factors?
- If the Bureau requires officers to consider other factors before initiating a foot pursuit, how does the Board evaluate those factors in this case? For example, did Mr. Chasse present such a risk to himself or to others that it would justify a foot pursuit? Was it reasonable for the officers not to at least consider the possibility that Mr. Chasse was mentally ill? Did a foot pursuit at that time and place create an unacceptable risk to the public, the subject, and the officers in relation to the severity of the suspected offense?
- If the Board decides that the surrounding circumstances made the foot pursuit unwise, did the pursuit in this case deviate so far from policy and training that the Board should sustain a finding against the officer? Whatever the Board decides, and however it explains its decision, will have important and long-lasting consequences.

2. <u>If the pursuit was not justified, could force be used to terminate it</u>? The Board could decide that the Bureau strictly limits foot pursuits because they are likely to result in force and may result in injury as this case demonstrated. Under this line of reasoning, the pursuit and the force used to terminate it are inextricably linked: if the pursuit was improper, so was the force. Using this approach, it would not matter whether the force was analyzed under the old or the new force policy because no amount of force was justified. The Board's decision would stand for the Bureau's long-held principle that an unjustifiable tactical decision cannot justify a need to use force.

   Some may argue that the Board should analyze the force separately from the pursuit. This approach will work easily enough if the Board first decides that the pursuit was justified. But if the pursuit was not justified, the Board loses its starting point for analyzing force. Even under the old policy, force could be used only for lawful purposes. In order to do a separate analysis, therefore, you will need to selectively assume that the stop would have been legal and selectively ignore that the then-existing directive and training prohibited the stop if it required a pursuit. Even if picking and choosing among the facts does not create an appearance of bias, it certainly affects the clarity of your findings.

As we noted above, Commander Henderson's Findings Memo at least implies that the officers used tactics that were encouraged or tolerated by the unit's supervisors and commanders as a means of addressing public complaints about drug dealing and other nuisance activities. While the Board may wish to consider this question more broadly in its recommendations, it should not

deter the Board from answering the two most fundamental questions on the basis of the training and directives that governed the officers' actions at the time. The Board might also wish to consider the implications of Commander Henderson's memo if and when it makes disciplinary recommendations to the Chief.

Thank you for considering our thoughts on this difficult and tragic case.

Sincerely,

Mary-Beth Baptista
Director

Pete Sandrock
Assistant Director

CC: Assistant Chief Lynnae Berg
Assistant Chief Bret Smith
Captain John Tellis
Commander Donna Henderson
Portland Police Association President Robert King

Portland Police Bureau
Training Division

In Custody Death Review
1300 Block NW Everett Street
September 17, 2006

In Custody Death
1300 Block NW Everett Street

- Members of the Training Division staff reviewed this case including:

- Lieutenant Dave Famous

- Tactical Consultant - Sergeant Don Livingston – Lead Defensive Tactics Instructor

- Commander Eric Hendricks

Training Division Analysis

- Initial observations and perceptions made at NW 18th/Everett Street

- The initial contact with Mr. Chasse
- The Foot Pursuit & Knock-Down Technique
- Custody Procedure
- Custody & Transportation
- Recommendations

Officer Humphreys - NW 18th/Everett St.

- He looked disheveled and appeared to be a transient. (*Observation*)
- He was rocking back and forth stiff legged with his back to the officers for several minutes. (*Observation*)
- He probably was intoxicated and waiting for a bus. (*Perception*)
- He sees officers in the area and immediately and rapidly walked away from the officers crossing the street. (*Observation*)

Deputy Burton – NW 18th/Everett St.

- He was shuffling, gesturing, maybe talking to no one while he was by himself on the corner. (*Observation*)

- He was possibly intoxicated, mentally ill, or had an outstanding warrant. (*Perception*)

- "He had made a bee-line out of there – clearly indicating that he wanted no police contact." (*Perception*)

- Sergeant Nice did not observe Mr. Chasse while conducting his stop at NW 18th/Everett Street.

Crisis Intervention Team Training

- Deputy Burton stated he had not received CIT training prior to this incident.

- Officer Humphreys passed a two (2) hour CIT Mental Health Awareness In-Service Class on January 3, 2005.

Individual Encounters

- The Initial Assessment
- Radio Procedure

Initial Assessment

- Factors included in the Initial Assessment are:
  - Type of contact. Is it a call driven contact, or self-initiated contact?
  - Number of subjects being contacted.
  - Is there a mention of weapons?
  - Are there drugs or alcohol present? What is the demeanor or condition of the individual?

Radio Procedure

– Factors included in Radio Procedure are:

- Try to broadcast on the radio before you arrive, or at least as you arrive if possible.

- Try to give basic information including:
  - Number of subjects
  - Reason for contact
  - Sex, race age
  - Location

Radio Procedure

- Officer Humphreys and Deputy Burton did not advise dispatch that they were contacting a person (later identified as Mr. Chasse) in the 1300 Block of NW Everett St.

Radio Procedure

- Upon review of this case file, no articulated information was found that indicated Officer Humphreys and Deputy Burton were seeking the initial contact with Mr. Chasse due to an emergency situation.

Radio Procedure

- Sergeant Nice observed Officer Humphreys and Deputy Burton stop and contact Mr. Chasse; he originally had no intention of stopping to assist.

- As he drove by, he observed the officers in foot pursuit; he immediately pulled over and attempted to intercept Mr. Chasse.

Analysis of the Initial Contact

- Foot Pursuit
- Knock-Down Technique

Analysis of the Initial Contact

- The belief that Mr. Chasse had urinated in public.
- Mr. Chasse possibly had an outstanding warrant for his arrest.
- Mr. Chasse possibly had illegal drugs in his possession.
- Mr. Chasse might have been armed with some sort of weapon.
- Mr. Chasse screamed, had the look of sheer terror on his face, and ran from the police.

Analysis of the Initial Contact

- Foot Pursuit
- Knock-Down Technique
- Danger versus Public Safety

Foot Pursuit Doctrine

- Officer Humphreys attended the PPB In-Service Class titled, 2005-2006 Tactical Update – Foot Pursuits:

Foot Pursuit Analysis

- After Officer Humphreys landed on the ground, he started to get up.

- Tactical Advantage:
  - Distance.

- Fundamental Concepts:
  - Be Adaptable & Correct Mistakes.

Foot Pursuit Analysis

- Pushing Mr. Chasse to the ground, in the effort to terminate the foot pursuit, allowed Mr. Chasse the opportunity to physically terminate the foot pursuit by surrendering.

- This is consistent with the training Officer Humphreys received during In-Service. Instead of surrendering and physically terminating the foot pursuit by staying on the ground, Mr. Chasse started to get up.

Foot Pursuit Analysis

- At this point, Sergeant Nice grabbed Mr. Chasse by the left arm and Deputy Burton tried to control his legs joining Officer Humphreys attempt to gain control in the effort to place Mr. Chasse into custody.

Custody Procedure

– Once on the ground, Officer Humphreys, Deputy Burton, and Sergeant Nice struggled to handcuff Mr. Chasse and place him into custody. Mr. Chasse was screaming, kicking, and resisting their efforts to have him roll over onto his stomach.

Analysis: Strikes-Kicks-Arm Bar- Knee

- Portland Police Bureau Levels of Control:
  - Directive 1010.20 "Physical Force" was most recently updated on March 17, 2008.
  - A more expansive discussion related to the Bureau's levels of control model is contained in the updated Directive, as opposed to Directive that was applicable on September 17, 2006.

Levels of Control

- The Five Levels of Control are a basic breakdown of control methods.
- They are:
  - A - Mere presence and demeanor
  - B - Verbal Control
  - C - Physical control, including aerosol restraints, Taser
  - D - Impact weapons and less lethal specialty munitions
  - E - Deadly physical force

Levels of Control

- Strikes (including punches) and kicks are included in the following Level of Control:

- Impact Weapons:

Taser

- The deployment of the Taser by Deputy Burton, in the effort to overcome aggressive physical resistance, is an option that is consistent with the Training Division's Tactical Doctrine.

Hobble – Maximum Restraint

- Sergeant Nice directed the officers to place Mr. Chasse in maximum restraint, because Mr. Chasse continued to be combative, even while handcuffed.

Maximum Restraint

- Members are authorized to use hobble restraint cords when necessary to subdue or secure a violent or unruly person. Restraint cords should not be used in lieu of handcuffs.

Custody Transportation

- Officer Humphreys and Deputy Burton discussed options pertaining to the type of restraint they would need to apply to Mr. Chasse during transport.

- Because of the distance and time it would take to drive to the hospital, Officer Humphreys did not want Mr. Chasse placed in the maximum restraint position.

Custody Transportation

- Providing a two officer transport towards Portland Adventist Hospital, provided Officer Humphreys the ability to constantly monitor Mr. Chasse for changes in behavior and signs of distress.

Custody Transportation

- Officer Humphreys made the following observations as they proceeded on the freeway:

- Mr. Chasse was leaning against the passenger door.
- Mr. Chasse has stopped mumbling and was quiet.
- He couldn't tell if Mr. Chasse was breathing.
- Mr. Chasse's left arm "looked stark white".

Recommendations

- Offer the forty (40) hour Crisis Intervention Team (CIT) training to all uniform officers and sergeants in the Portland Police Bureau.

- Revise emergency medical procedures:

Recommendations

- **In-Service Training:**

  - Review person encounter doctrine through scenario-based training; and include the following performance objectives:

  - Demonstrate effective communication skills.
  - Demonstrate good defensive tactic skills.
  - Demonstrate proper use of force.
  - Demonstrate proper positioning.
  - Demonstrate proper use of cover.

Recommendations

- Review Directive 1010.20 – Use of physical Force; through scenario-based training and classroom instruction.

- In-Service 2008 - Includes a scheduled class pertaining to 1010.20 Use of Physical Force: Supervisor Responsibilities

- Review of the current Use of Force Policy will be included during In-Service 2009.

Recommendations

- **Advanced Academy Training:**
  - Introduce Crisis Intervention Team (CIT) training incrementally over time during the Advanced Academy.
  - The 2008 Advanced Academy now features scenarios every Wednesday, thereby enabling recruits to practice skills learned up to that point in time, including CIT Training.

Recommendations

- **Roll Call Video**
  - Foot Pursuit
  - Knock-Down Technique
  - Taser

Recommendations

- Expand the Training Division's Foot Pursuit Tactical Doctrine when discussing:

- Danger versus Public Safety.

Recommendations

- Some of the symptoms displayed by Mr. Chasse, during this incident, were symptoms commonly associated with "excited delirium" and are listed below:

  - Violent resistance or physical struggling with officers.
  - Incoherent screaming/yelling.
  - Subject suddenly goes unconscious after struggle.
  - Talking incoherently.
  - Profuse sweating.

Recommendations

- The Tips and Techniques bulletin dated July 20, 2008, and distributed to Bureau members, discusses Recommendations for Response to Excited Delirium Calls.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Recommendations – Updated on September 29, 2008

In relationship to the original Training Division document, the following updates are noted in reference to Recommendations 1-2-3-4 and 8:

1 – Offer the forty (40) hour Crisis Intervention Team (CIT) training to all uniform officers and sergeants in the Portland Police Bureau.

The Bureau is currently in the process of completing this mandate and is scheduled to be complete in December of 2008.

2 – Revise emergency medical procedures.

These and related issues have been addressed in Directive 630.45, Emergency Medical Custody Transports, which became effective on January 30, 2007. Additionally, a roll call training video dated July 31, 2008, discussing the Emergency Medical Transport Directive was distributed to all Bureau members.

3 – In-Service Training:

A - In-Service 2009 is scheduled to include, "Hands on Defensive Tactics training" & Review of the current Use of Force Policy.

B – In-Service 2008 includes: A scheduled class discussing supervisor responsibilities in relationship to Directive 1010.20. Review of this Directive will be included during In-Service 2009, when discussing the current Use of Force Policy with front line police officers and sergeants.

4 - Advanced Academy Training:

The 2008 Advanced Academy now features scenarios every Wednesday, thereby enabling recruits to practice skills learned up to that point in time, including CIT training.

5 – Develop and disseminate a roll-call video to Bureau members pertaining to foot pursuits; highlighting the dangers of foot pursuits and the Knock-Down Technique.

Updated Recommendations

6 – Develop and disseminate a roll-call video to Bureau members, discussing the proper application of the Taser when engaged at close quarters with a violent individual.

7 – Expand the Training Division's Foot Pursuit Tactical Doctrine when discussing Danger versus Public Safety. Provide additional emphasis outlining factors that should be considered at the onset of a foot pursuit; including the severity of the crime, applicable statutes and policies, ones own knowledge of the subject including physical descriptors (i.e. male or female, size ratio to the officer, and muscularity), and the immediate environment.

8 – National Sudden Death and Excited Delirium Conference:

Portland Police Bureau members assigned to the Training Division, the Detective Division and the Internal Affairs Division, began attending this conference in December of 2007. Attendance at this conference by Bureau members is scheduled to continue.

Additionally, the Tips and Techniques bulletin dated July 20, 2008, and distributed to Bureau members, discusses Recommendations for Response to Excited Delirium Calls.

PORTLAND POLICE BUREAU
TRAINING DIVISION
IN CUSTODY DEATH REVIEW
Draft - Case #06-84962 - ***Draft***

The Portland Police Bureau (PPB) Training Division reviewed the case file of this incident. This review was:

Prepared by - Lieutenant Dave Famous
Consulted- Officer Don Livingston – Lead Defensive Tactics Instructor
Reviewed by - Captain Eric Hendricks

This incident was broken down into the following elements:

1. The initial contact with Mr. Chasse
2. Foot Pursuit
3. Custody Procedure
4. Custody and Transportation

Training Background

At the time of this incident:

Officer Chris Humphreys had been a Portland Police Officer for about 7.5 years and previous to that a Wheeler County Sheriff Deputy for about three years. During that time he received 1420 hours of training. He passed a two hour Crisis Intervention Team (CIT) Mental Health Awareness In-Service class on January 3, 2005. Additionally, Officer Humphreys passed a four (4) hour Foot Pursuit/Full Body Search In-Service class on May, 25, 2006 and was CPR certified.

MCSO Deputy Bret Burton had been a Deputy Sheriff for about 2.5 years. He had attended the Multnomah County Sheriff's Office annual In-Service training and was certified to carry the X-26 Taser. Deputy Burton stated he had not received any CIT training prior to this incident.

Sergeant Kyle Nice had been a Portland Police Officer for about 14.5 years. He was promoted to the rank of sergeant on October 23, 2003. During that time he received 3052 hours of training and was certified to carry the X-26 Taser.

Officer Troy Pahlke had been a Portland Police Officer for nearly 10 years. During that time he had received 1511 hours of training.

Officer Carl Weldon had been a Portland Police Officer for about 1.5 years. During that time he received 789 hours of training. He was certified to carry the Hobble Leg Restraint on June 6, 2005.

Incident Overview:

On September 17, 2006, Mr. James Phillip Chasse was initially observed by Officer Chris Humphreys and Deputy Bret Burton while covering Sergeant Kyle Nice when he was contacting another person at NW 18th/Everett Street. The officers described Mr. Chasse as acting in a bizarre manner as if he was under the influence of intoxicants or possibly suffering from a mental disorder. Once Mr. Chasse made eye contact with the officers, he immediately left the area in the opposite direction.

The officers again observed Mr. Chasse standing in the 1300 block of Northwest Everett Street. Based on Mr. Chasse's body language and actions, Officer Humphreys believed he might have been urinating on the street. The officers approached Mr. Chasse on foot and came to within 15 feet of him, at which point Mr. Chasse turned around, saw the officers approaching and ran in the opposite direction. Officers pursued Mr. Chasse on foot. As they reached him, Officer Humphreys pushed Mr. Chasse in the back with his forearm which caused Mr. Chasse to stumble to the ground. Mr. Chasse resisted the officer's attempts to take him into custody. During the incident, Mr. Chasse bit Sergeant Nice on the leg and attempted to bite Officer Humphreys on the arm. Deputy Burton used his Taser in the drive-stun mode, which had no apparent affect on Mr. Chasse.

After being taken into custody, Sergeant Nice requested medical attention for Mr. Chasse because he appeared to have lost consciousness. An ambulance crew and Portland Fire Bureau personnel responded to the scene, evaluated Mr. Chasse and determined his vital signs were normal. They relayed the information to the arresting officers who then transported Mr. Chasse to the Multnomah County Detention Center (MCDC) to lodge him on charges of "Assaulting a Public Safety Officer" and "Resisting Arrest".

While at the booking facility, Mr. Chasse was evaluated by the nursing staff who determined Mr. Chasse should receive further medical evaluation at a hospital prior to being accepted for booking. Mr. Chasse was transported towards Portland Adventist Hospital by Officer Humphreys and Deputy Burton. During the transport, Officer Humphreys noticed that Mr. Chasse was unresponsive. The officers pulled over at the nearest and safest location which was determined to be NE 33rd/Clackamas St. They immediately requested medical personnel respond to the location while they attempted to resuscitate Mr. Chasse. Medical personnel eventually arrived on scene and took over the resuscitation efforts. Mr. Chasse was later pronounced dead after arriving at Providence Hospital.

Analysis – Prior to the Foot Pursuit:

Officer Humphreys' observations and perceptions of Mr. Chasse while covering Sergeant Nice at NW 18th/Everett Street:

- Mr. Chasse's appearance and demeanor.
  - ✓ He looked disheveled and appeared to be a transient. *(Observation)*
  - ✓ He was rocking back and forth stiff legged with his back to the officers for several minutes. *(Observation)*
  - ✓ He probably was intoxicated and waiting for a bus. *(Perception)*
  - ✓ He sees officers in the area and immediately and rapidly walked away from the officers crossing the street. (Officer Humphreys thought Mr. Chasse risked being struck by a car at the intersection when he crossed the street so quickly. However, Mr. Chasse crossed "with the light" successfully.) *(Observation)*

Officer Humphreys told Detectives that, according to his training and experience over the years, it looked like Mr. Chasse was probably intoxicated, or under the influence of something. Officer Humphreys believed that Mr. Chasse walked rapidly away from them because he probably didn't want police contact—an example being he probably had a warrant.

Deputy Burton's observations and perceptions of Mr. Chasse while covering Sergeant Nice at NW 18th/Everett Street:

- Mr. Chasse's appearance and demeanor.
  - ✓ He was shuffling, gesturing, maybe talking to no one while he was by himself on the corner. *(Observation)*
  - ✓ He was possibly intoxicated, mentally ill, or had an outstanding warrant. *(Perception)*
  - ✓ "He had made a bee-line out of there—clearly indicating that he wanted no police contact." *(Perception)*

Sergeant Nice did not observe Mr. Chasse while conducting his stop at NW 18th/Everett Street.

Sergeant Nice did state that he heard Officer Humphreys say something to the effect, "Guy down the block bee-lining away from us". Sergeant Nice stated that, "This is typical behavior of someone who has committed a crime or is wanted…to see the police, change direction and go somewhere else. So this obviously caught Officer Humphreys attention".

When Sergeant Nice completed his stop, Officer Humphreys and Deputy Burton told Sergeant Nice something similar to; "If we get a chance, we're going to try to stop and talk to that guy (who walked away). They thought the guy (Mr. Chasse) probably had a warrant for drinking in public. *(At 5:16 p.m., Sergeant Nice, Officer Humphreys and Deputy Burton clear the contact at NW 18th/Everett St.)*

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Note: Deputy Burton stated that he had not received CIT training prior to this incident.

Note: Officer Humphreys passed a two hour CIT Mental Health Awareness In-Service Class on January 3, 2005. In the overview of this class it states, "This class is not meant to substitute for a 40 hour CIT (certification) class". However, during this instruction, basic information was presented pertaining to three types of mental illness including Schizophrenia.

When discussing symptoms related to Schizophrenia, one area of discussion presented in this class described the following behavior:

<u>Disorganized Symptoms:</u>

- The person will talk to you and appear to be talking in circles. The person may be dressed poorly, have bad hygiene, and may not be able to hold onto an idea long enough to even answer a simple question.

- They may pace in circles, or do repetitive behavior.

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Officer Humphreys and Deputy Burton got into their marked patrol car and drove through the area looking for Mr. Chasse. They found Mr. Chasse standing by a tree, with his back towards them, mid-block 13th to 14th on NW Everett Street.

Officer Humphreys said that Mr. Chasse had a backpack down by his feet, and he was hunched over with his hands in his front waistband area. Officer Humphreys said he looked like he was either urinating or had just finished urinating. Additionally, Officer Humphreys told Detectives that, "I know from my training and experience that guys will stop and use something to shield themselves while they're using drugs".

Deputy Burton said they noticed Mr. Chasse standing near a tree, bent over at the waist, possibly touching his pants or handling something in his pants. Deputy Burton said he believed Mr. Chasse sensed their approach, and appeared to be trying to get rid of something. This raised his suspicion that Mr. Chasse was doing something suspicious. Deputy Burton described Mr. Chasse's behavior as acting odd and thought Mr. Chasse was possibly intoxicated or under the influence a controlled substance.

The initial contact with Mr. Chasse:

Deputy Burton stopped the patrol car and Officer Humphreys got out from the passenger side and took one or two steps toward Mr. Chasse. Deputy Burton exited the vehicle as well. Mr. Chasse reached down and grabbed his backpack and started to walk away with a stiffed legged gait. Officer Humphreys noticed a fresh wet outline on the rear and mid to upper thigh of Mr. Chasse's pants which led him to believe that Mr. Chasse had urinated on himself.

(The estimated time that the officers make contact with Mr. Chasse is 5:18 p.m. Neither Officer Humphreys nor Deputy Burton advised dispatch that they would be contacting an individual at the location. Sergeant Nice requested another car to respond to the location at 5:20 p.m. This is the first time dispatch or other officers are aware that a police action is taking place in the 1300 Block of NW Everett St.)

Deputy Burton whistled or yelled something similar to, "hey you!" Mr. Chasse turned and made direct eye contact with Officer Humphreys who described the look in Mr. Chasse's eyes as that of "absolute sheer terror". Officer Humphreys told Detectives that, "On his face, his eyes go wide and instantly when he sees me, it's just sheer terror. I have been a police officer for 10 years. I've had a number of subjects run on me before in the same scenario. I've never seen anyone look at me with sheer terror in their eyes. I knew instantly that he was going to run. He screams something, I don't know what it was, and I'm already saying he's going to run. I yell stop at least twice and I'm chasing him on foot going eastbound. At that point, with all of those prior facts, and especially now with the look on his face, I thought he either has a warrant, he's got drugs on him, he's got a weapon of some sort, or just the huge safety considerations because I'll never forget seeing that face."

Officer Humphreys told Detectives that he caught up with Mr. Chasse as they approached the southwest corner of NW 13th/Everett St. "I'm kind of matching his speed and I gave him a really hard shove with my forearms on his back as we're trained to do in foot pursuits. You run up behind them and hit them in the back to trip up their steps, break the rhythm of their steps, and that's exactly what I did. I think maybe he took one step after I hit him and he went down and I went right past him about one step. I tripped up my own rhythm too when I hit him and I took maybe one step and then I just went boom, down right on the ground. As I landed on the pavement, I rolled and as I rolled I went up on my left side."

Officer Humphreys said that he fell on the side walk as he went over and past him to his left. "He veered right and I basically went straight ahead. I went right over and did a shoulder roll. I flipped over on my stomach to crab walk...and started to get up. I see Mr. Chasse is starting to get up. At that point, Sergeant Nice is grabbing his arm and trying to get a hold of him." When Detectives asked Officer Humphreys if he landed on him in any way, Officer Humphreys replied, "no".

Deputy Burton said that as Officer Humphreys contacted Mr. Chasse, he used his body weight to knock him to the ground. Deputy Burton stated that he didn't know if Officer Humphreys pushed him, wrapped his arms around him, or if he landed on him. Deputy Burton stated, "All I know is they collided running in the same direction and both of them went to the ground".

Sergeant Nice stated that after he cleared his stop, he noticed Officer Humphreys and Deputy Burton pull to the curb to talk with a person, who was later identified as Mr. Chasse. Sergeant Nice assumed that this was the same person Officer Humphreys and Deputy Burton saw earlier. He didn't know specifically why they were contacting Mr. Chasse, and originally, he had no intention of stopping to assist.

Sergeant Nice watched them as he drove by and saw Mr. Chasse run. Sergeant Nice continued eastbound and pulled ahead of him, activated his lights, stopped and got out of his car and attempted to intercept Mr. Chasse. *Training Division Doctrine - Cover/Contact Foots Pursuits: The officer may choose the tactic of cutting off the path of the fleeing suspect. However, this may place the officer in front of the suspect at close quarters.*

Sergeant Nice said he believed Officer Humphreys wrapped both arms around Mr. Chasse and they fell to the ground fast. Sergeant Nice stated that, "It was just a straight bear hug type of tackle, I guess. It appeared that Officer Humphreys landed slightly off of the subject, kind of half on his right side and half on the ground."

Civilian witness statements also vary as to how Mr. Chasse was forced to the ground. For example, one witness stated that it was probably a push that knocked the Mr. Chasse to the ground; another witness described the action as a flying tackle, almost like a football tackle, during which Mr. Chasse was driven to the ground.

Foot Pursuit Training:

Since at least the 1997-1998 In-Service, the Training Division has presented training on Foot Pursuit Tactics. This presentation is taught to Advanced Academy's as well. Officer Humphreys attended the Tactical Update Foot Pursuit Class given at In-Service on May 25, 2006.

Training Division Foot Pursuit Tactical Doctrine:

Pursuing subjects on foot is one of the most dangerous police actions that officers can engage in. A police officer involved in a foot pursuit is at a total disadvantage unless a cover officer is present. Many foot pursuits end with the subject being tackled by the officer and a grappling match ensuing. Because of a police officer's instinct to pursue and apprehend a fleeing subject (the predator-prey instinct), the adrenaline rush and "must catch" mindset often overshadow safe tactics in apprehending the subject.

1 – Advantages and Disadvantages of Foot Pursuits:

A. Advantages

1. The immediate apprehension of the subject.
2. More likely to locate and/or recover evidence or contraband in the suspect's possession.

B. Disadvantages

1. Action-reaction principle applied against the officer by the suspect.

    a. The suspect stops and turns around on the officer while the officer's momentum takes him into the suspect.
    b. The suspect pulls out a weapon (gun or knife) before the officer has time to react.
    c. Because of the close proximity of the suspect, the officer has minimal time to assess a threat.

2. Predator-Prey Instinct

    a. Because police officers are ingrained to catch those who run, they end up tackling a potentially armed suspect and risk losing their weapons to the suspect.
    b. Many times, officers chase individuals who run for no reason, and the officer doesn't know why he is chasing someone until he catches him.

3. Apprehension Dangers

    a. Because officers run at different speeds, one may outrun her cover. When the officer catches up to the suspect, she may be alone when she attempts custody.
    b. Many times when a suspect is taken down, there is a physical confrontation during the custody.

2 - Danger versus Public Safety:

Risk to public safety versus benefit of capture is an issue that should be part of an officer's thinking at the onset of a foot pursuit. Factors such as severity of the crime, environment, availability of additional officers, are just a few of the considerations that should be part of the officer(s) evaluation.

Personal considerations such as physical limitations, familiarity with the area and ones own knowledge of the subject are factors that also influence considerations.

3. Knock-Down Technique:

When officers catch up to the suspect, they often grab onto him and take him to the ground. To maintain a position of advantage and the officers' balance, the knock-down technique was developed.

The technique also allows the officers to use more options of control while the suspect is on the ground and the officers are on their feet.

A. Technique:

While the officer is paralleling the suspect and gets close enough to touch the suspect, the officer should shove the suspect hard from the rear, in the middle of the back between the shoulders.

This will cause the suspect's body to go ahead of his feet and fall forward onto the ground.

The officers (cover and contact) will then veer off at an angle away from the suspect's arms and get distance between the officers and the suspect, while the officers then move to the head of the suspect.

The officer will then give verbal commands to the suspect to stay on the ground and get into a prone position, as follows: "Hands out away from your body. Palms up. Cross your feet. Put your ear on the ground."
The officer also has some time to consider options while the suspect is trying to recover from the fall. The options include:

1. Physical control with the cover officer there (two on one control to custody).
2. The use of pepper spray or the baton.
3. High risk, if the situation dictates.

In-Service Class 2005-2006 Tactical Update – Foot Pursuits:

One of the issues discussed during the Foot Pursuit Update class addresses physically terminating a foot pursuit.

"Pursuing officer(s) may have the opportunity to employ the defensive tactic of pushing the subject to the ground and allowing them to physically terminate the foot pursuit in its early stages. Early termination of a foot pursuit will favor the officer(s) involved, and would significantly reduce the risk to public safety."

"After a foot pursuit has been physically terminated by the officers(s), correct procedures should be followed. Proper defensive tactics, firearms skills and correct custody procedures should be adhered to."

FOOT PURSUIT - ANALYSIS:

The Portland Police Bureau (PPB) Training Division teaches all officers to try and adhere to certain concepts and philosophies that make up the framework for its Tactical Doctrine. I have reviewed this incident within the framework of the Fundamental Concepts of Tactics and Tactical Advantages.

The Fundamental Concepts of Tactics are:

1. Have a Leader
2. Have a Plan
3. Be Adaptable
4. Don't Assume
5. Communicate
6. Correct Mistakes

The Tactical Advantages are:

1. Cover and Concealment
2. Numerical Superiority
3. Distance
4. Element of Surprise

Since at least 1999, the Portland Police Bureau's Advanced Academy Patrol Tactics curriculum has included training that is directly related to contacting individuals on the street. The Course Title of this class is called, "Individual Encounter's". Two components of this class are listed below.

Initial Assessment:

1. Type of contact. Is it a call driven contact, or a self-initiated contact?
2. Number of subjects being contacted.
3. Is there a mention of weapons?
4. Are there drugs or alcohol present? What is the demeanor or condition of the individual?

Radio Procedure:

1. Try to broadcast on the radio before you arrive, or at least as you arrive if possible.
2. Try to give basic information:

    a. Number of subjects
    b. Reason for contact
    c. Sex, race, age
    d. Location

When stopping and contacting a person or suspect on the street, the Training Division teaches officers to advise dispatch of their location and the circumstances. This is for the officer's safety, the safety of citizens nearby, and the safety of any responding units who may end up being called to the scene. This is consistent with the Fundamental Concept, "Communication," and is standard practice in the Portland Police Bureau. Stopping individuals on the street, without advising dispatch of the location and circumstances, is in-consistent with the Training Division's Tactical Doctrine.

Analysis of the initial contact with Mr. Chasse:

Upon review of this case file, no articulated information was found that documented the fact that Mr. Chasse had committed a crime; or that he displayed behavior, that indicated he was dangerous to himself and/or others, prior to the initiation of the foot pursuit and knock-down technique. The following observations and perceptions are factors that Officer Humphreys said he used when he decided to pursue Mr. Chasse:

a. The belief that Mr. Chasse had urinated in public.
b. Mr. Chasse possibly had an outstanding warrant for his arrest.
c. Mr. Chasse possibly had illegal drugs in his possession.
d. Mr. Chasse might have been armed with some sort of weapon.
e. Mr. Chasse screamed and had the look of sheer terror on his face.

Although the belief that Mr. Chasse had urinated in public may be reason enough to contact him on the street, initiating the foot pursuit and deploying the knock-down technique, based solely on this information, is in-consistent with the Training Division's Tactical Doctrine.

Officer Humphreys, believing that Mr. Chasse may have committed a crime, relied on his instinct to pursue and apprehend a fleeing subject, rather than observing actual criminal behavior prior to engaging in the foot pursuit. *Risk to public safety versus benefit of capture is an issue that should be part of an officer(s) thinking at the onset of a foot pursuit.* Risk to public safety includes the safety of the person being pursued. Ones own knowledge of the subject, including physical condition, perceived or observed physical limitations of the subject, and the immediate environment are factors that should be included in the officer(s) evaluation when deciding whether or not to pursue an individual on foot. These factors are especially important when deciding whether or not to push the subject to the ground.

The physical application of the Knock-Down Technique:

The fact that Officer Humphreys tripped and fell while initiating the knock-down technique is understandable given the slight downward slope of the sidewalk, coupled with the full-blown sprint and the likely adrenaline rush experienced as he pursued Mr. Chasse on foot running at full speed.

Although tripping and falling can occur unexpectedly at times when performing the knock-down technique, the knock-down technique is tactically superior to a traditional tackle with an immediate grappling match occurring on the ground.

After Officer Humphreys landed on the ground, he started to get up. *This is consistent with the Tactical Advantage – Distance.* Officers are taught to obtain distance between the officer(s) and the suspect once the suspect is on the ground. Obtaining distance allows the officer(s) time to consider options. *Officer Humphreys attempt to get back on his feet is also consistent with the Fundamental Concepts - Be Adaptable* and *Correct Mistakes.* By getting back up on his feet, Officer Humphreys could regain a position of advantage and regain his balance; this would afford him more options of control while Mr. Chasse is on the ground.

Pushing Mr. Chasse to the ground, in the effort to terminate the foot pursuit, allowed Mr. Chasse the opportunity to physically terminate the foot pursuit by surrendering. *This is consistent with the training Officer Humphreys received during In-Service.* Instead of surrendering and physically terminating the foot pursuit by staying on the ground, Mr. Chasse started to get up.

At this point, Sergeant Nice grabbed Mr. Chasse by the left arm and Deputy Burton tried to control his legs joining Officer Humphreys attempt to gain control in the effort to place Mr. Chasse into custody. *This is consistent with the training given at In-Service which states,* "After a foot pursuit has been physically terminated by the officers(s), correct procedures should be followed. Proper defensive tactics, firearms skills and correct custody procedures should be adhered to." *Physical control with the cover officer(s) there, (two on one control to custody), is a basic custody procedure taught to officers by the Portland Police Bureau's Training Division.*

Analysis - Custody Procedure:

Once on the ground, Officer Humphreys, Deputy Burton, and Sergeant Nice struggled to handcuff Mr. Chasse and place him into custody. Mr. Chasse was screaming, kicking, and resisting their efforts to have him roll over onto his stomach. Deputy Burton was trying to control Mr. Chasse's legs, while Sergeant Nice tried to control his left arm, and Officer Humphreys grabbed his right arm.

***Sergeant Nice's Perspective*:**

Sergeant Nice grabbed Mr. Chasse's left wrist and elbow and rotated his arm momentarily pinning him to the ground. Sergeant Nice attempted to pin his shoulder down by placing his knee on Mr. Chasse's left shoulder blade but couldn't get into a good position.

As he did this, he felt a sharp pain in his lower leg. Sergeant Nice looked down and could see Mr. Chasse biting the inside of his right calf. Sergeant Nice was surprised at what he saw and pulled his leg away. "After he bit me, I told him, do not bite me." As the struggle continued, Sergeant Nice felt a tugging on his right leg again. He looked down and Mr. Chasse had gotten hold of the cuff of his right pant leg with his teeth. Sergeant Nice pulled his right foot back and kicked Mr. Chasse in the upper chest while telling him, "Don't bite me". After the second attempt to bite Sergeant Nice, he pinned Mr. Chasse's jaw to the ground with his right boot, "for a while to keep him from biting me".

Sergeant Nice stated that Mr. Chasse also attempted to bite Officer Humphreys. He observed Officer Humphreys punch Mr. Chasse once or twice in the face, with a closed fist, as Mr. Chasse attempted to bite him.

Deputy Burton's Perspective:

As Mr. Chasse was screaming and kicking, Deputy Burton tried to grab his legs but he could only hold onto one leg as Mr. Chasse continued to kick.

Deputy Burton said he removed his Taser from the holster and removed the cartridge preparing to drive- stun Mr. Chasse. (He decided he wasn't going to use the cartridge probes when he applied the Taser to Mr. Chasse because of the close distance.) At the time, Sergeant Nice didn't feel that the Taser would be effective so he told him, "No, don't use the Taser".

Deputy Burton believed he punched Mr. Chasse in the back, as a pain compliance tactic, in the effort to get him to stop resisting. He also used the knuckle of his right index finger and pressure pointed Mr. Chasse's ribs as a pain compliance tactic to gain control. When these techniques failed, Deputy Burton drive- stunned Mr. Chasse with the Taser. "It wasn't more than a few cycles. It was obvious that it was having no affect on him; so I re-holstered and went about trying to control him again." Sergeant Nice asked dispatch to send another car to their location. He felt that they had fought Mr. Chasse to a stand still, but needed help handcuffing his hands behind his back.

Officer Humphreys Perspective:

As Officer Humphreys grabbed Mr. Chasse's right arm and attempted get him onto his stomach, he heard Sergeant Nice say, "Stop biting". Officer Humphreys said he saw Sergeant Nice strike Mr. Chasse one time with a closed fist in the head/shoulder area. He didn't actually see where the blow landed.

Officer Humphreys told Detectives, "All of a sudden I feel this heat on my right forearm...I see Mr. Chasse on his side, but his head is turned towards my arm which is on his shoulder trying to keep him locked down. His teeth are on my right arm. I draw my forearm back and it strikes him across the face and then I come down with a closed fisted strike across Mr. Chasse's face and I'm yelling don't, no, stop biting."

Officer Humphreys said he saw Deputy Burton apply the Taser to Mr. Chasse ("He believed it was into his leg") but the Taser had no affect.

Analysis: Strikes - Kicks – Arm Bar / Knee Application - Taser

Portland Police Bureau Levels of Control:

Adequate control is essential. It is imperative that the police officer establish and maintain superior control in any law enforcement situation. The police officer should approach each control situation with a margin of advantage that ensures success and is reasonable for the situation. The police officer should never use control at a level less than he or she feels necessary. The level of control a police officer uses will be dictated by the facts of the particular situation.

The **Five Levels of Control** are a basic breakdown of control methods.
They are:

a. Mere presence and demeanor
b. Verbal control
c. Physical control, aerosol restraints, Taser
d. Impact weapons and less lethal specialty munitions
e. Deadly physical force

Strikes (punches) and kicks are included in the following Level of Control:

Impact Weapons:

Impact weapons are those methods of control that are readily capable of causing injury to a subject. These impact weapons may vary as continuous research develops more effective ways to control violent and aggressive individuals. Impact weapons are designed to deliver immediate force to individuals to alter their behavior.

> **Strikes & Kicks** - Strikes and kicks are not the safest methods to control a subject's violent resistance, because of the possibility of injuries to the officer's hands or legs. Strikes and kicks may be used as a reasonable option when other options are not accessible or available, or when the distances are too close and the reaction time limits consideration of other options.

The Baton, Strikes and Kicks are authorized as a method of control to be used by the officer when the subject engages in Aggressive Physical Resistance (or when the subject indicates the intent to engage in aggressive physical resistance).

Aggressive Physical Resistance defined: *Physical actions of attack or threat of attack, coupled with the ability to carry out the attack, which may cause physical injury. Examples include, but are not limited to striking, kicking, biting, throwing objects capable of causing injury, head butting and taking a fighting stance.*

Officer Humphreys, Sergeant Nice and Deputy Burton were engaged at close quarters on the ground when struggling with Mr. Chasse. They were struggling to gain control when Mr. Chasse bit Sergeant Nice, and attempted to bite Officer Humphreys. The distance was too close, and the reaction time was too limited (immediate), for them to reasonably consider using the baton.

Sergeant Nice said he placed his right foot on Mr. Chasse's jaw line in the effort to pin his jaw to the ground. He hoped that this would prevent Mr. Chasse from biting him again. *(Using his foot in this manner was not a strike. It was an attempt to stop Mr. Chasse from biting him again by stabilizing his jaw.)*

Sergeant Nice was using both of his hands, while trying to control Mr. Chasse's left arm and complete the handcuffing procedure. *Using his foot to control Mr. Chasse's head, in the effort to prevent him from biting again, is not an un-reasonable option.* The only other option, in this moment, may have been to deliver additional kicks. Releasing the arm bar, at this point in the struggle, would not have been a reasonable option as Sergeant Nice would have lost the advantage of the control hold he had obtained up to this point; and this might have increased the probability that additional strikes and kicks would need to be applied. Attempting to pin Mr. Chasse's head to the ground in this manner, most likely would cause less injury to Mr. Chasse, then delivering additional strikes and/or kicks to his body.

The technique Sergeant Nice used, when he applied the arm bar, reverse wrist lock, and knee on the shoulder blade attempting to pin Mr. Chasse's shoulder to the ground, *is consistent with the Basic Prone Custody Procedure.* Note: Officers are instructed to keep the knee off of the back or spine.

Utilizing strikes and kicks to overcome aggressive physical resistance, at close quarters, is consistent with the training Officer Humphreys and Sergeant Nice received in Defensive Tactics as taught by the Portland Police Bureau's Training Division.

Taser:

(Although Deputy Burton was not a member of the Portland Police Bureau at the time of this incident, I have reviewed his deployment of the Taser from the Portland Police Bureau Training Division's perspective.)

The Taser is a less lethal weapon system that delivers electrical energy, and is deployed against subjects who are placing themselves or others in danger of physical injury and/or death. The Taser is designed to incapacitate a person rather than injure him/her. This allows members to take a combative person into custody with a minimum risk of injury to all of the parties involved. The amount of control or force used in the encounter will be governed by the circumstances of each situation taken as a whole in accordance with the Bureau's levels of control.

The Taser is included in the following Level of Control:

Physical Control:

The method of control that is used in every arrest situation is physical control. Physical control consists of the physical application of control holds and pressure points, aerosol restraints, and the use of the Taser. The degree of physical control that is necessary to take subjects into custody or control their behavior, is determined by the level of resistance of the subject.

Deputy Burton said he removed his Taser from the holster and removed the cartridge as he prepared to drive-stun Mr. Chasse. (He decided he wasn't going to use the cartridge probes when he applied the Taser to Mr. Chasse because of the close distance). Sergeant Nice told him not to use the Taser because he didn't believe it would be effective at the time.

Deputy Burton knew that Mr. Chasse was biting at both Officer Humphreys and Sergeant Nice. He said that he punched Mr. Chasse in the back and pressure pointed him in the ribs because Mr. Chasse was biting and kicking and wouldn't put his hands behind his back. When this had no affect, he deployed the Taser in the drive-stun mode on the upper leg or butt. The Taser had no apparent affect on Mr. Chasse and the struggle continued.

Deploying the Taser in the drive-stun mode is a pain compliance technique and does not have the advantage of "locking up" any muscle groups. Deputy Burton decided not to deploy his Taser, using the cartridge probes, because of the close distance. He thought that it would be better to remove the cartridge and drive-stun Mr. Chasse.

Portland Police Bureau Training Division's Recommendation: Rather than use the Taser in a Pain Compliance Mode, "Dart" the subject then drive-stun in another part of the body to lock up some muscle groups in order to gain more physical control over the subject, or to distract him long enough to complete the handcuffing procedure.

Handcuffing – Hobble (Maximum Restraint):

Officer Troy Pahlke arrived at the location and helped Officer Humphreys and Sergeant Nice handcuff Mr. Chasse and roll him onto his right side in a recovery position. Officer Carl Weldon arrived shortly after Mr. Chasse was handcuffed.

Sergeant Nice asked Dispatch to send Medical Code 3 to the scene. He advised that they had a subject who appeared to be unconscious and had been fighting with police. AMR and PFB arrived and evaluated Mr. Chasse. Sergeant Nice confirmed with AMR that Mr. Chasse was medically stable. Sergeant Nice stated to Detectives, "They asked if I wanted him transported. I said, no, we have criminal charges on him. He'll be going to jail." Sergeant Nice also told Detectives, "Without any specific reason or desire by ambulance (AMR) to take him to a hospital, he was going to jail. As soon as we started to search him, he became combative again. I didn't want to fight with him anymore. So, I directed them to put him in maximum restraint."

Maximum Restraint defined:

Placing an in-custody person with hands secured behind the back, legs secured together, and the legs and hands connected together behind the back of the subject with the legs flexed at the knees. The length of the hobble restraint cord used to secure the hands to the feet will be such that the lower legs are no closer than a 90-degree angle in relationship to the person's trunk.

Members are authorized to use hobble restraint cords when necessary to subdue or secure a violent or unruly person. Restraint cords should not be used in lieu of handcuffs.

Officer Carl Weldon applied his hobble restraint cord to Mr. Chasse at the direction of Sergeant Nice thereby placing Mr. Chasse in maximum restraint. Officer Weldon told Detectives, "I wrapped it around his feet once, tightened it, then fed the loop up and around the handcuffs and then back down to the loop, effectively keeping his legs bent at about a 90-degree angle, preventing him from kicking or rolling."

Officer Weldon's application of the hobble leg restraint cord is consistent with the training he received when he was certified to carry the hobble by the PPB Training Division.

After the hobble restraint cord was applied, Mr. Chasse was immediately placed on his side to allow free movement of his chest and stomach for breathing functions. The intent is to not allow body weight or the restraints to restrict the lung's ability to fill and expel air.

After medical personnel (AMR) evaluated Mr. Chasse, Officer Humphreys was presented with a medical release form to sign since Mr. Chasse was restrained and was unable to sign for himself. Officer Humphreys couldn't remember ever having to sign a medical release form as an officer but went ahead and signed it.

Sergeant Nice stated that Mr. Chasse was carried to the patrol car, (still kicking and screaming), while in maximum restraint, by himself, Officer Humphreys and Officer Pahlke. Mr. Chasse was placed into the back of the patrol car and laid onto his side, seat belted in, so he wouldn't lie on his stomach.

Deputy Burton and Officer Humphreys transported Mr. Chasse to MCDC. *(This is consistent with the Training Division Tactical Doctrine that states: "A subject who is transported in the maximum restraint position shall have a two-officer transport. The second officer shall monitor the subject for changes in behavior and signs of distress.")* Officer Humphreys observed Mr. Chasse and spoke with him in route to MCDC as Deputy Burton drove the patrol car.

Prior to arriving at jail, Deputy Burton called MCDC and said, "We got a guy who needs a spit sock, is bleeding and combative, he's hobbled and we're going to need assistance." *(Officers are directed to notify jail personnel that a subject has been transported in the maximum restraint position.)*

The techniques used to hobble, carry, secure, observe, and transport Mr. Chasse to MCDC, are consistent with the hobble leg restraint training doctrine taught by the Portland Police Bureau's Training Division.

When Officer Humphreys and Deputy Burton arrived at MCDC, Officer Humphreys and Jail Deputies carried Mr. Chasse from the car to an isolation cell in the maximum restraint position. They removed the hobble restraint cord and exited the cell.

Nursing staff observed and then refused to accept Mr. Chasse at MCDC for booking until he had been evaluated further at a hospital. Officer Humphreys said that after the nurse refused to accept Mr. Chasse, she walked away. Officer Humphreys and Deputy Burton did not receive any information from the Jail Nurse to suggest that there was an urgency regarding his condition. The nurse didn't advise the officers that Mr. Chasse needed to be transported to the hospital by ambulance; and no official at MCDC offered to call an ambulance. Officer Humphreys said, "Great! So medical clears him to come here, but jail won't take him so now we are stuck in the middle." Officer Humphreys told Deputy Burton that they would now need to transport Mr. Chasse to Portland Adventist Hospital.

(The Jail contracts with Portland Adventist Hospital for care of in-custody individuals. Officers and Deputies routinely transport persons, who are in-custody, to this hospital for minor medical treatment prior to being lodged at MCDC.)

Officer Humphreys and Deputy Burton discussed options pertaining to the type of restraint they would need to apply to Mr. Chasse during transport. Because of the distance and time it would take to drive to the hospital, Officer Humphreys didn't want Mr. Chasse placed in the maximum restraint position.

Jail Deputies offered to let them use leg chains to secure his feet. Officer Humphreys and Deputy Burton agreed. Deputies re-handcuffed Mr. Chasse and applied leg chains to his ankles. *(The leg chains have about a foot and a half of chain, between each leg, so that he would have been able to walk slowly. He would have been able to straighten out his legs, unlike the maximum restraint position.)* Deputy Burton said that Mr. Chasse started resisting again as they re-handcuffed and applied the leg chains.

Deputies carried Mr. Chasse out to the patrol car and laid him in the back seat on his side. As they left MCDC, Mr. Chasse sat up in the seat and started yelling and became animated again. As they drove towards the freeway, Officer Humphreys could hear Mr. Chasse mumbling. Officer Humphreys rolled up the windows as they got on the freeway so he could monitor Mr. Chasse closely. As he did this, he looked back and noticed Mr. Chasse was now leaning up against the passenger door.

Officer Humphreys made the following observations as they proceeded on the freeway:

- ✓ Mr. Chasse was leaning against the passenger door.
- ✓ Mr. Chasse had stopped mumbling and was quiet.
- ✓ He couldn't tell if Mr. Chasse was breathing.
- ✓ Mr. Chasse's left arm "looked stark white".

Officer Humphreys instructed Deputy Burton to take the next exit (NE 33rd Avenue) and to call for medical as they pulled to the curb off the exit ramp. Mr. Chasse was removed from the backseat. Officer Humphreys noted that Mr. Chasse wasn't breathing. Chest compressions were started and resuscitation efforts continued until medical arrived. Mr. Chasse was transported to Providence Hospital by ambulance where he was later pronounced deceased.

TACTICAL SUMMARY:

Officer Humphreys and Deputy Burton did not advise dispatch that they were contacting a person (Mr. Chasse) in the 1300 Block of NW Everett St.

The Training Division realizes that there may be times when officers are confronted with an emergency situation on the street that requires immediate action and response. During an immediate emergency response, it may not be practical or safe to broadcast information on the radio, until action is taken and the situation stabilizes. This is discussed in Patrol Tactics training and is sound Tactical Doctrine.

Upon review of this case file, no articulated information was found that indicated Officer Humphreys and Deputy Burton were seeking the initial contact with Mr. Chasse due to an emergency situation. In fact, Deputy Burton told Detectives that he told Sergeant Nice, just prior to leaving NW 18th/Everett St., "We may be going to go look for that guy (later identified as Mr. Chasse)... 'It was sort of a casual search'... 'We were going to stop him just to chat him up and see what he had to say.'"

- *Based on the above information, the fact that Officer Humphreys and Deputy Burton contacted Mr. Chasse on the street, without advising dispatch of the location and circumstances, is in-consistent with the Training Division's Tactical Doctrine.*

Sergeant Nice observed Officer Humphreys and Deputy Burton stop and contact Mr. Chasse on the street; *he originally had no intention of stopping to assist.* As he drove by *he observed the officers in foot pursuit; he immediately* pulled over and attempted to intercept Mr. Chasse. When the situation became relatively stable, he advised dispatch of the location and circumstances and requested another unit to assist at the scene. The Training Division considers a foot pursuit to be an emergency situation.

- *Due to his close proximity to this foot pursuit, the immediate response and delay in notifying dispatch of the situation by Sergeant Nice, is consistent with the Training Division's Tactical Doctrine.*

- *Initiating the foot pursuit and deploying the knock-down technique, based on the information obtained in the case file, is in-consistent with the Training Division's Tactical Doctrine.*

- *The physical techniques applied during the application of the Knock-Down Technique, as described by Officer Humphreys, are consistent with the Training Division's Tactical Doctrine.*

- *Utilizing strikes and kicks to overcome aggressive physical resistance, at close quarters, is consistent with the training Officer Humphreys and Sergeant Nice received during Defensive Tactics instruction; and is consistent with the Training Division's Tactical Doctrine.*

- *The deployment of the Taser by Deputy Burton, in the effort to overcome aggressive physical resistance, is an option that is consistent with the Training Division's Tactical Doctrine.*

- *Officer Weldon's application of the hobble restraint cord is consistent with the training he received when he was certified to carry the hobble by the Training Division.*

- *The techniques used to hobble, carry, secure, observe, and transport Mr. Chasse to MCDC, are consistent with the hobble leg restraint training doctrine taught by the Portland Police Bureau's Training Division.*

- *Providing a two officer transport towards Portland Adventist Hospital, provided Officer Humphreys the ability to constantly monitor Mr. Chasse for changes in behavior and signs of distress. This is consistent with the Training Division's Tactical Doctrine. This afforded the opportunity for Officer Humphreys and Deputy Burton to initiate emergency medical aid procedures quickly when Mr. Chasse's condition deteriorated rapidly.*

RECOMMENDATIONS:

1- Offer the forty (40) hour Crisis Intervention Team (CIT) training to all uniform officers and sergeants in the Portland Police Bureau. *(This has been mandated by the Chief of Police and the Bureau is currently in the process of completing this mandate.)*

2- Revise emergency medical procedures to include the following:

   A. Direct Bureau members to advise EMS personnel of the custody status of the subject, as well as any use of force used against the subject, when EMS is called to the scene.
   B. Direct Bureau members not to sign a medical refusal form on behalf of the subject.
   C. Decide who will have the responsibility of determining the appropriate mode of transporting the subject to the hospital, when medical staff at MCDC refuses to admit him or her for booking.
   D. Direct Bureau Members not to transport a subject who appears to be suffering from excited delirium unless cleared by on-scene EMS.

   These and related issues have been addressed in the new directive, 630.45 Emergency Medical Custody Transports, which became effective on January 30, 2007.

3- In-Service Training:

A. Review person encounter doctrine through scenario-based training; and include the following performance objectives:
    1. Demonstrate good defensive tactic skills.
    2. Demonstrate proper positioning.
    3. Demonstrate effective communication skills.
    4. Demonstrate proper use of force.
    5. Demonstrate proper use of cover.

B. Review Directive 1010.20 - Use of Physical Force; through scenario-based training and classroom instruction. The performance objectives should include demonstrating a thorough understanding of the Levels of Resistance which are:

    1. Passive resistance: Actions that do not prevent or attempt to prevent the members attempt to control a subject. Examples include when the subject merely goes limp and/or fails to comply with verbal commands with no other overt signs of physical resistance.

    2. Physical resistance: Actions that prevent or attempt to prevent a member's attempt to control a subject, but do not involve attempts to harm the member. Examples include, but are not limited to, tensing muscles, pulling away, and fleeing.

    3. Aggressive physical resistance: Physical actions of attack or threat of attack, coupled with the ability to carry out the attack, which may cause physical injury. Examples include, but are not limited to striking, kicking, biting, throwing objects capable of causing injury, head butting and taking a fighting stance.

4- Advanced Academy Training:

   A. Introduce Crisis Intervention Team (CIT) training incrementally over time during the Advanced Academy.
   B. Include CIT scenario-based training, during Patrol Tactics instruction interwoven with other disciplines, incrementally over time throughout the Advanced Academy.
   C. Reinforce person encounter doctrine, and applicable statutes and policies related to initiating foot pursuits, through scenario-based training and classroom instruction, incrementally over time throughout the academy session.

5- Develop and disseminate a roll-call video to Bureau members, produced by the Training Division, pertaining to foot pursuits; highlighting the dangers of foot pursuits and the Knock-Down technique.

6- Develop and disseminate a roll call video to Bureau members, produced by the Training Division, discussing the proper application of the Taser when engaged at close quarters with a violent individual.

7- Expand the Training Division's Foot Pursuit Tactical Doctrine when discussing Danger versus Public Safety. Provide additional emphasis outlining factors that should be considered at the onset of a foot pursuit; including applicable statutes and policies, ones own knowledge of the subject including physical descriptors (i.e. male or female, size ratio to the member, and muscularity), and the immediate environment.

8- Some of the symptoms displayed by Mr. Chasse, during this incident, were symptoms commonly associated with "excited delirium" and are listed below:

   1) - Violent resistance or physical struggling with officers.
   2) - Incoherent screaming/yelling.
   3) - Subject suddenly goes unconscious after a struggle.
   4) - Talking incoherently.
   5) - Profuse sweating.

   It would be beneficial for members of the Police Bureau, AMR, and the Medical Examiners Office, to attend the National Sudden Death and Excited Delirium Conference, which is presented annually to first responders, investigators, and medical professionals. This would provide continuing opportunity to incorporate up-to-date information, when developing on-going policies and protocols.

PORTLAND POLICE BUREAU
TRAINING DIVISION
IN CUSTODY DEATH REVIEW
Case #06-84962

The Portland Police Bureau (PPB) Training Division reviewed the case file of this incident. This review was:

Prepared by - Lieutenant Dave Famous
Consulted- Officer Don Livingston – Lead Defensive Tactics Instructor
Reviewed by - Captain Eric Hendricks

This incident was broken down into the following elements:

1. The initial contact with Mr. Chasse
2. Foot Pursuit
3. Custody Procedure
4. Custody and Transportation

Training Background

At the time of this incident:

Officer Chris Humphreys had been a Portland Police Officer for about 7.5 years and previous to that a Wheeler County Sheriff Deputy for about three years. During that time he received 1420 hours of training. He passed a two hour Crisis Intervention Team (CIT) Mental Health Awareness In-Service class on January 3, 2005. Additionally, Officer Humphreys passed a four (4) hour Foot Pursuit/Full Body Search In-Service class on May, 25, 2006 and was CPR certified.

MCSO Deputy Bret Burton had been a Deputy Sheriff for about 2.5 years. He had attended the Multnomah County Sheriff's Office annual In-Service training and was certified to carry the X-26 Taser. Deputy Burton stated he had not received any CIT training prior to this incident.

Sergeant Kyle Nice had been a Portland Police Officer for about 14.5 years. He was promoted to the rank of sergeant on October 23, 2003. During that time he received 3052 hours of training and was certified to carry the X-26 Taser.

Officer Troy Pahlke had been a Portland Police Officer for nearly 10 years. During that time he had received 1511 hours of training.

Officer Carl Weldon had been a Portland Police Officer for about 1.5 years. During that time he received 789 hours of training. He was certified to carry the Hobble Leg Restraint on June 6, 2005.

Incident Overview:

On September 17, 2006, Mr. James Phillip Chasse was initially observed by Officer Chris Humphreys and Deputy Bret Burton while covering Sergeant Kyle Nice when he was contacting another person at NW 18th/Everett Street. The officers described Mr. Chasse as acting in a bizarre manner as if he was under the influence of intoxicants or possibly suffering from a mental disorder. Once Mr. Chasse made eye contact with the officers, he immediately left the area in the opposite direction.

The officers again observed Mr. Chasse standing in the 1300 block of Northwest Everett Street. Based on Mr. Chasse's body language and actions, Officer Humphreys believed he might have been urinating on the street. The officers approached Mr. Chasse on foot and came to within 15 feet of him, at which point Mr. Chasse turned around, saw the officers approaching and ran in the opposite direction. Officers pursued Mr. Chasse on foot. As they reached him, Officer Humphreys pushed Mr. Chasse in the back with his forearm which caused Mr. Chasse to stumble to the ground. Mr. Chasse resisted the officer's attempts to take him into custody. During the incident, Mr. Chasse bit Sergeant Nice on the leg and attempted to bite Officer Humphreys on the arm. Deputy Burton used his Taser in the drive-stun mode, which had no apparent affect on Mr. Chasse.

After being taken into custody, Sergeant Nice requested medical attention for Mr. Chasse because he appeared to have lost consciousness. An ambulance crew and Portland Fire Bureau personnel responded to the scene, evaluated Mr. Chasse and determined his vital signs were normal. They relayed the information to the arresting officers who then transported Mr. Chasse to the Multnomah County Detention Center (MCDC) to lodge him on charges of "Assaulting a Public Safety Officer" and "Resisting Arrest".

While at the booking facility, Mr. Chasse was evaluated by the nursing staff who determined Mr. Chasse should receive further medical evaluation at a hospital prior to being accepted for booking. Mr. Chasse was transported towards Portland Adventist Hospital by Officer Humphreys and Deputy Burton. During the transport, Officer Humphreys noticed that Mr. Chasse was unresponsive. The officers pulled over at the nearest and safest location which was determined to be NE 33rd/Clackamas St. They immediately requested medical personnel respond to the location while they attempted to resuscitate Mr. Chasse. Medical personnel eventually arrived on scene and took over the resuscitation efforts. Mr. Chasse was later pronounced dead after arriving at Providence Hospital.

Analysis – Prior to the Foot Pursuit:

Officer Humphreys' observations and perceptions of Mr. Chasse while covering Sergeant Nice at NW 18th/Everett Street:

- Mr. Chasse's appearance and demeanor.
  - ✓ He looked disheveled and appeared to be a transient. *(Observation)*
  - ✓ He was rocking back and forth stiff legged with his back to the officers for several minutes. *(Observation)*
  - ✓ He probably was intoxicated and waiting for a bus. *(Perception)*
  - ✓ He sees officers in the area and immediately and rapidly walked away from the officers crossing the street. (Officer Humphreys thought Mr. Chasse risked being struck by a car at the intersection when he crossed the street so quickly. However, Mr. Chasse crossed "with the light" successfully.) *(Observation)*

Officer Humphreys told Detectives that, according to his training and experience over the years, it looked like Mr. Chasse was probably intoxicated, or under the influence of something. Officer Humphreys believed that Mr. Chasse walked rapidly away from them because he probably didn't want police contact—an example being he probably had a warrant.

Deputy Burton's observations and perceptions of Mr. Chasse while covering Sergeant Nice at NW 18th/Everett Street:

- Mr. Chasse's appearance and demeanor.
  - ✓ He was shuffling, gesturing, maybe talking to no one while he was by himself on the corner. *(Observation)*
  - ✓ He was possibly intoxicated, mentally ill, or had an outstanding warrant. *(Perception)*
  - ✓ "He had made a bee-line out of there—clearly indicating that he wanted no police contact." *(Perception)*

Sergeant Nice did not observe Mr. Chasse while conducting his stop at NW 18th/Everett Street.

Sergeant Nice did state that he heard Officer Humphreys say something to the effect, "Guy down the block bee-lining away from us". Sergeant Nice stated that, "This is typical behavior of someone who has committed a crime or is wanted…to see the police, change direction and go somewhere else. So this obviously caught Officer Humphreys attention".

When Sergeant Nice completed his stop, Officer Humphreys and Deputy Burton told Sergeant Nice something similar to; "If we get a chance, we're going to try to stop and talk to that guy (who walked away). They thought the guy (Mr. Chasse) probably had a warrant for drinking in public. *(At 5:16 p.m., Sergeant Nice, Officer Humphreys and Deputy Burton clear the contact at NW 18th/Everett St.)*

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Note: Deputy Burton stated that he had not received CIT training prior to this incident.

Note: Officer Humphreys passed a two hour CIT Mental Health Awareness In-Service Class on January 3, 2005. In the overview of this class it states, "This class is not meant to substitute for a 40 hour CIT (certification) class". However, during this instruction, basic information was presented pertaining to three types of mental illness including Schizophrenia.

When discussing symptoms related to Schizophrenia, one area of discussion presented in this class described the following behavior:

Disorganized Symptoms:

- The person will talk to you and appear to be talking in circles. The person may be dressed poorly, have bad hygiene, and may not be able to hold onto an idea long enough to even answer a simple question.

- They may pace in circles, or do repetitive behavior.

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Officer Humphreys and Deputy Burton got into their marked patrol car and drove through the area looking for Mr. Chasse. They found Mr. Chasse standing by a tree, with his back towards them, mid-block 13th to 14th on NW Everett Street.

Officer Humphreys said that Mr. Chasse had a backpack down by his feet, and he was hunched over with his hands in his front waistband area. Officer Humphreys said he looked like he was either urinating or had just finished urinating. Additionally, Officer Humphreys told Detectives that, "I know from my training and experience that guys will stop and use something to shield themselves while they're using drugs".

Deputy Burton said they noticed Mr. Chasse standing near a tree, bent over at the waist, possibly touching his pants or handling something in his pants. Deputy Burton said he believed Mr. Chasse sensed their approach, and appeared to be trying to get rid of something. This raised his suspicion that Mr. Chasse was doing something suspicious. Deputy Burton described Mr. Chasse's behavior as acting odd and thought Mr. Chasse was possibly intoxicated or under the influence a controlled substance.

The initial contact with Mr. Chasse:

Deputy Burton stopped the patrol car and Officer Humphreys got out from the passenger side and took one or two steps toward Mr. Chasse. Deputy Burton exited the vehicle as well. Mr. Chasse reached down and grabbed his backpack and started to walk away with a stiffed legged gait. Officer Humphreys noticed a fresh wet outline on the rear and mid to upper thigh of Mr. Chasse's pants which led him to believe that Mr. Chasse had urinated on himself.

(The estimated time that the officers make contact with Mr. Chasse is 5:18 p.m. Neither Officer Humphreys nor Deputy Burton advised dispatch that they would be contacting an individual at the location. Sergeant Nice requested another car to respond to the location at 5:20 p.m. This is the first time dispatch or other officers are aware that a police action is taking place in the 1300 Block of NW Everett St.)

Deputy Burton whistled or yelled something similar to, "hey you!" Mr. Chasse turned and made direct eye contact with Officer Humphreys who described the look in Mr. Chasse's eyes as that of "absolute sheer terror". Officer Humphreys told Detectives that, "On his face, his eyes go wide and instantly when he sees me, it's just sheer terror. I have been a police officer for 10 years. I've had a number of subjects run on me before in the same scenario. I've never seen anyone look at me with sheer terror in their eyes. I knew instantly that he was going to run. He screams something, I don't know what it was, and I'm already saying he's going to run. I yell stop at least twice and I'm chasing him on foot going eastbound. At that point, with all of those prior facts, and especially now with the look on his face, I thought he either has a warrant, he's got drugs on him, he's got a weapon of some sort, or just the huge safety considerations because I'll never forget seeing that face."

Officer Humphreys told Detectives that he caught up with Mr. Chasse as they approached the southwest corner of NW 13th/Everett St. "I'm kind of matching his speed and I gave him a really hard shove with my forearms on his back as we're trained to do in foot pursuits. You run up behind them and hit them in the back to trip up their steps, break the rhythm of their steps, and that's exactly what I did. I think maybe he took one step after I hit him and he went down and I went right past him about one step. I tripped up my own rhythm too when I hit him and I took maybe one step and then I just went boom, down right on the ground. As I landed on the pavement, I rolled and as I rolled I went up on my left side."

Officer Humphreys said that he fell on the side walk as he went over and past him to his left. "He veered right and I basically went straight ahead. I went right over and did a shoulder roll. I flipped over on my stomach to crab walk...and started to get up. I see Mr. Chasse is starting to get up. At that point, Sergeant Nice is grabbing his arm and trying to get a hold of him." When Detectives asked Officer Humphreys if he landed on him in any way, Officer Humphreys replied, "no".

Deputy Burton said that as Officer Humphreys contacted Mr. Chasse, he used his body weight to knock him to the ground. Deputy Burton stated that he didn't know if Officer Humphreys pushed him, wrapped his arms around him, or if he landed on him. Deputy Burton stated, "All I know is they collided running in the same direction and both of them went to the ground".

Sergeant Nice stated that after he cleared his stop, he noticed Officer Humphreys and Deputy Burton pull to the curb to talk with a person, who was later identified as Mr. Chasse. Sergeant Nice assumed that this was the same person Officer Humphreys and Deputy Burton saw earlier. He didn't know specifically why they were contacting Mr. Chasse, and originally, he had no intention of stopping to assist.

Sergeant Nice watched them as he drove by and saw Mr. Chasse run. Sergeant Nice continued eastbound and pulled ahead of him, activated his lights, stopped and got out of his car and attempted to intercept Mr. Chasse. *Training Division Doctrine - Cover/Contact Foots Pursuits: The officer may choose the tactic of cutting off the path of the fleeing suspect. However, this may place the officer in front of the suspect at close quarters.*

Sergeant Nice said he believed Officer Humphreys wrapped both arms around Mr. Chasse and they fell to the ground fast. Sergeant Nice stated that, "It was just a straight bear hug type of tackle, I guess. It appeared that Officer Humphreys landed slightly off of the subject, kind of half on his right side and half on the ground."

Civilian witness statements also vary as to how Mr. Chasse was forced to the ground. For example, one witness stated that it was probably a push that knocked the Mr. Chasse to the ground; another witness described the action as a flying tackle, almost like a football tackle, during which Mr. Chasse was driven to the ground.

Foot Pursuit Training:

Since at least the 1997-1998 In-Service, the Training Division has presented training on Foot Pursuit Tactics. This presentation is taught to Advanced Academy's as well. Officer Humphreys attended the Tactical Update Foot Pursuit Class given at In-Service on May 25, 2006.

Training Division Foot Pursuit Tactical Doctrine:

Pursuing subjects on foot is one of the most dangerous police actions that officers can engage in. A police officer involved in a foot pursuit is at a total disadvantage unless a cover officer is present. Many foot pursuits end with the subject being tackled by the officer and a grappling match ensuing. Because of a police officer's instinct to pursue and apprehend a fleeing subject (the predator-prey instinct), the adrenaline rush and "must catch" mindset often overshadow safe tactics in apprehending the subject.

1 – Advantages and Disadvantages of Foot Pursuits:

A. Advantages

1. The immediate apprehension of the subject.
2. More likely to locate and/or recover evidence or contraband in the suspect's possession.

B. Disadvantages

1. Action-reaction principle applied against the officer by the suspect.

    a. The suspect stops and turns around on the officer while the officer's momentum takes him into the suspect.
    b. The suspect pulls out a weapon (gun or knife) before the officer has time to react.
    c. Because of the close proximity of the suspect, the officer has minimal time to assess a threat.

2. Predator-Prey Instinct

    a. Because police officers are ingrained to catch those who run, they end up tackling a potentially armed suspect and risk losing their weapons to the suspect.
    b. Many times, officers chase individuals who run for no reason, and the officer doesn't know why he is chasing someone until he catches him.

3. Apprehension Dangers

    a. Because officers run at different speeds, one may outrun her cover. When the officer catches up to the suspect, she may be alone when she attempts custody.
    b. Many times when a suspect is taken down, there is a physical confrontation during the custody.

2 - Danger versus Public Safety:

Risk to public safety versus benefit of capture is an issue that should be part of an officer's thinking at the onset of a foot pursuit. Factors such as severity of the crime, environment, availability of additional officers, are just a few of the considerations that should be part of the officer(s) evaluation.

Personal considerations such as physical limitations, familiarity with the area and ones own knowledge of the subject are factors that also influence considerations.

3. Knock-Down Technique:

When officers catch up to the suspect, they often grab onto him and take him to the ground. To maintain a position of advantage and the officers' balance, the knock-down technique was developed.

The technique also allows the officers to use more options of control while the suspect is on the ground and the officers are on their feet.

A. Technique:

While the officer is paralleling the suspect and gets close enough to touch the suspect, the officer should shove the suspect hard from the rear, in the middle of the back between the shoulders.

This will cause the suspect's body to go ahead of his feet and fall forward onto the ground.

The officers (cover and contact) will then veer off at an angle away from the suspect's arms and get distance between the officers and the suspect, while the officers then move to the head of the suspect.

The officer will then give verbal commands to the suspect to stay on the ground and get into a prone position, as follows: "Hands out away from your body. Palms up. Cross your feet. Put your ear on the ground."
The officer also has some time to consider options while the suspect is trying to recover from the fall. The options include:

1. Physical control with the cover officer there (two on one control to custody).
2. The use of pepper spray or the baton.
3. High risk, if the situation dictates.

In-Service Class 2005-2006 Tactical Update – Foot Pursuits:

One of the issues discussed during the Foot Pursuit Update class addresses physically terminating a foot pursuit.

"Pursuing officer(s) may have the opportunity to employ the defensive tactic of pushing the subject to the ground and allowing them to physically terminate the foot pursuit in its early stages. Early termination of a foot pursuit will favor the officer(s) involved, and would significantly reduce the risk to public safety."

"After a foot pursuit has been physically terminated by the officers(s), correct procedures should be followed. Proper defensive tactics, firearms skills and correct custody procedures should be adhered to."

FOOT PURSUIT - ANALYSIS:

The Portland Police Bureau (PPB) Training Division teaches all officers to try and adhere to certain concepts and philosophies that make up the framework for its Tactical Doctrine. I have reviewed this incident within the framework of the Fundamental Concepts of Tactics and Tactical Advantages.

The Fundamental Concepts of Tactics are:

1. Have a Leader
2. Have a Plan
3. Be Adaptable
4. Don't Assume
5. Communicate
6. Correct Mistakes

The Tactical Advantages are:

1. Cover and Concealment
2. Numerical Superiority
3. Distance
4. Element of Surprise

Since at least 1999, the Portland Police Bureau's Advanced Academy Patrol Tactics curriculum has included training that is directly related to contacting individuals on the street. The Course Title of this class is called, "Individual Encounter's". Two components of this class are listed below.

Initial Assessment:

1. Type of contact. Is it a call driven contact, or a self-initiated contact?
2. Number of subjects being contacted.
3. Is there a mention of weapons?
4. Are there drugs or alcohol present? What is the demeanor or condition of the individual?

Radio Procedure:

1. Try to broadcast on the radio before you arrive, or at least as you arrive if possible.
2. Try to give basic information:

    a. Number of subjects
    b. Reason for contact
    c. Sex, race, age
    d. Location

When stopping and contacting a person or suspect on the street, the Training Division teaches officers to advise dispatch of their location and the circumstances. This is for the officer's safety, the safety of citizens nearby, and the safety of any responding units who may end up being called to the scene. This is consistent with the Fundamental Concept, "Communication," and is standard practice in the Portland Police Bureau. Stopping individuals on the street, without advising dispatch of the location and circumstances, is in-consistent with the Training Division's Tactical Doctrine.

Analysis of the initial contact with Mr. Chasse:

Upon review of this case file, no articulated information was found that documented the fact that Mr. Chasse had committed a crime; or that he displayed behavior, that indicated he was dangerous to himself and/or others, prior to the initiation of the foot pursuit and knock-down technique. The following observations and perceptions are factors that Officer Humphreys said he used when he decided to pursue Mr. Chasse:

a. The belief that Mr. Chasse had urinated in public.
b. Mr. Chasse possibly had an outstanding warrant for his arrest.
c. Mr. Chasse possibly had illegal drugs in his possession.
d. Mr. Chasse might have been armed with some sort of weapon.
e. Mr. Chasse screamed, had the look of sheer terror on his face, and ran from the police.

Although the belief that Mr. Chasse had urinated in public may be reason enough to contact him on the street, initiating the foot pursuit and deploying the knock-down technique, based on the above information, is in-consistent with the Training Division's Tactical Doctrine.

Officer Humphreys, believing that Mr. Chasse may have committed a crime, relied on his instinct to pursue and apprehend a fleeing subject; rather than observing significant criminal or dangerous behavior prior to engaging in the foot pursuit and deploying the knock-down technique.
Risk to public safety versus benefit of capture is an issue that should be part of an officer(s) thinking at the onset of a foot pursuit. Risk to public safety includes the safety of the person being pursued. The severity of the crime; ones own knowledge of the subject, including physical condition, perceived or observed physical limitations of the subject, and the immediate environment are factors that should be included in the officer(s) evaluation when deciding whether or not to pursue an individual on foot. These factors are especially important when deciding whether or not to push the subject to the ground.

The physical application of the Knock-Down Technique:

The fact that Officer Humphreys tripped and fell while initiating the knock-down technique is understandable given the slight downward slope of the sidewalk, coupled with the full-blown sprint and the likely adrenaline rush experienced as he pursued Mr. Chasse on foot running at full speed.

Although tripping and falling can occur unexpectedly at times when performing the knock-down technique, the knock-down technique is tactically superior to a traditional tackle with an immediate grappling match occurring on the ground.

After Officer Humphreys landed on the ground, he started to get up. *This is consistent with the Tactical Advantage – Distance.* Officers are taught to obtain distance between the officer(s) and the suspect once the suspect is on the ground. Obtaining distance allows the officer(s) time to consider options. *Officer Humphreys attempt to get back on his feet is also consistent with the Fundamental Concepts - Be Adaptable* and *Correct Mistakes.* By getting back up on his feet, Officer Humphreys could regain a position of advantage and regain his balance; this would afford him more options of control while Mr. Chasse is on the ground.

Pushing Mr. Chasse to the ground, in the effort to terminate the foot pursuit, allowed Mr. Chasse the opportunity to physically terminate the foot pursuit by surrendering. *This is consistent with the training Officer Humphreys received during In-Service.* Instead of surrendering and physically terminating the foot pursuit by staying on the ground, Mr. Chasse started to get up.

At this point, Sergeant Nice grabbed Mr. Chasse by the left arm and Deputy Burton tried to control his legs joining Officer Humphreys attempt to gain control in the effort to place Mr. Chasse into custody. *This is consistent with the training given at In-Service which states,* "After a foot pursuit has been physically terminated by the officers(s), correct procedures should be followed. Proper defensive tactics, firearms skills and correct custody procedures should be adhered to."

Physical control with the cover officer(s) there, (two on one control to custody), is a basic custody procedure taught to officers by the Portland Police Bureau's Training Division.

Analysis - Custody Procedure:

Once on the ground, Officer Humphreys, Deputy Burton, and Sergeant Nice struggled to handcuff Mr. Chasse and place him into custody. Mr. Chasse was screaming, kicking, and resisting their efforts to have him roll over onto his stomach. Deputy Burton was trying to control Mr. Chasse's legs, while Sergeant Nice tried to control his left arm, and Officer Humphreys grabbed his right arm.

***Sergeant Nice's Perspective*:**

Sergeant Nice grabbed Mr. Chasse's left wrist and elbow and rotated his arm momentarily pinning him to the ground. Sergeant Nice attempted to pin his shoulder down by placing his knee on Mr. Chasse's left shoulder blade but couldn't get into a good position.

As he did this, he felt a sharp pain in his lower leg. Sergeant Nice looked down and could see Mr. Chasse biting the inside of his right calf. Sergeant Nice was surprised at what he saw and pulled his leg away. "After he bit me, I told him, do not bite me." As the struggle continued, Sergeant Nice felt a tugging on his right leg again. He looked down and Mr. Chasse had gotten hold of the cuff of his right pant leg with his teeth. Sergeant Nice pulled his right foot back and kicked Mr. Chasse in the upper chest while telling him, "Don't bite me". After the second attempt to bite Sergeant Nice, he pinned Mr. Chasse's jaw to the ground with his right boot, "for a while to keep him from biting me".

Sergeant Nice stated that Mr. Chasse also attempted to bite Officer Humphreys. He observed Officer Humphreys punch Mr. Chasse once or twice in the face, with a closed fist, as Mr. Chasse attempted to bite him.

Deputy Burton's Perspective:

As Mr. Chasse was screaming and kicking, Deputy Burton tried to grab his legs but he could only hold onto one leg as Mr. Chasse continued to kick.

Deputy Burton said he removed his Taser from the holster and removed the cartridge preparing to drive- stun Mr. Chasse. (He decided he wasn't going to use the cartridge probes when he applied the Taser to Mr. Chasse because of the close distance.) At the time, Sergeant Nice didn't feel that the Taser would be effective so he told him, "No, don't use the Taser".

Deputy Burton believed he punched Mr. Chasse in the back, as a pain compliance tactic, in the effort to get him to stop resisting. He also used the knuckle of his right index finger and pressure pointed Mr. Chasse's ribs as a pain compliance tactic to gain control. When these techniques failed, Deputy Burton drive- stunned Mr. Chasse with the Taser. "It wasn't more than a few cycles. It was obvious that it was having no affect on him; so I re-holstered and went about trying to control him again." Sergeant Nice asked dispatch to send another car to their location. He felt that they had fought Mr. Chasse to a stand still, but needed help handcuffing his hands behind his back.

Officer Humphreys Perspective:

As Officer Humphreys grabbed Mr. Chasse's right arm and attempted get him onto his stomach, he heard Sergeant Nice say, "Stop biting". Officer Humphreys said he saw Sergeant Nice strike Mr. Chasse one time with a closed fist in the head/shoulder area. He didn't actually see where the blow landed.

Officer Humphreys told Detectives, "All of a sudden I feel this heat on my right forearm...I see Mr. Chasse on his side, but his head is turned towards my arm which is on his shoulder trying to keep him locked down. His teeth are on my right arm. I draw my forearm back and it strikes him across the face and then I come down with a closed fisted strike across Mr. Chasse's face and I'm yelling don't, no, stop biting."

Officer Humphreys said he saw Deputy Burton apply the Taser to Mr. Chasse ("He believed it was into his leg") but the Taser had no affect.

Analysis: Strikes - Kicks – Arm Bar / Knee Application - Taser

Portland Police Bureau Levels of Control:

Adequate control is essential. It is imperative that the police officer establish and maintain superior control in any law enforcement situation. The police officer should approach each control situation with a margin of advantage that ensures success and is reasonable for the situation. The police officer should never use control at a level less than he or she feels necessary. The level of control a police officer uses will be dictated by the facts of the particular situation.

The **Five Levels of Control** are a basic breakdown of control methods.
They are:

a. Mere presence and demeanor
b. Verbal control
c. Physical control, aerosol restraints, Taser
d. Impact weapons and less lethal specialty munitions
e. Deadly physical force

Strikes (*punches*) and kicks are included in the following Level of Control:

Impact Weapons:

Impact weapons are those methods of control that are readily capable of causing injury to a subject. These impact weapons may vary as continuous research develops more effective ways to control violent and aggressive individuals. Impact weapons are designed to deliver immediate force to individuals to alter their behavior.

> **Strikes & Kicks** - Strikes and kicks are not the safest methods to control a subject's violent resistance, because of the possibility of injuries to the officer's hands or legs. Strikes and kicks may be used as a reasonable option when other options are not accessible or available, or when the distances are too close and the reaction time limits consideration of other options.

The Baton, Strikes and Kicks are authorized as a method of control to be used by the officer when the subject engages in Aggressive Physical Resistance (or when the subject indicates the intent to engage in aggressive physical resistance).

Aggressive Physical Resistance defined: *Physical actions of attack or threat of attack, coupled with the ability to carry out the attack, which may cause physical injury. Examples include, but are not limited to striking, kicking, biting, throwing objects capable of causing injury, head butting and taking a fighting stance.*

Officer Humphreys, Sergeant Nice and Deputy Burton were engaged at close quarters on the ground when struggling with Mr. Chasse. They were struggling to gain control when Mr. Chasse bit Sergeant Nice, and attempted to bite Officer Humphreys. The distance was too close, and the reaction time was too limited (immediate), for them to reasonably consider using the baton.

Sergeant Nice said he placed his right foot on Mr. Chasse's jaw line in the effort to pin his jaw to the ground. He hoped that this would prevent Mr. Chasse from biting him again. *(Using his foot in this manner was not a strike. It was an attempt to stop Mr. Chasse from biting him again by stabilizing his jaw.)*

Sergeant Nice was using both of his hands, while trying to control Mr. Chasse's left arm and complete the handcuffing procedure. *Using his foot to control Mr. Chasse's head, in the effort to prevent him from biting again, is not an un-reasonable option.* The only other option, in this moment, may have been to deliver additional kicks. Releasing the arm bar, at this point in the struggle, would not have been a reasonable option as Sergeant Nice would have lost the advantage of the control hold he had obtained up to this point; and this might have increased the probability that additional strikes and kicks would need to be applied. Attempting to pin Mr. Chasse's head to the ground in this manner, most likely would cause less injury to Mr. Chasse, then delivering additional strikes and/or kicks to his body.

The technique Sergeant Nice used, when he applied the arm bar, reverse wrist lock, and knee on the shoulder blade attempting to pin Mr. Chasse's shoulder to the ground, *is consistent with the Basic Prone Custody Procedure.* Note: Officers are instructed to keep the knee off of the back or spine.

Utilizing strikes and kicks to overcome aggressive physical resistance, at close quarters, is consistent with the training Officer Humphreys and Sergeant Nice received in Defensive Tactics as taught by the Portland Police Bureau's Training Division.

Taser:

(Although Deputy Burton was not a member of the Portland Police Bureau at the time of this incident, I have reviewed his deployment of the Taser from the Portland Police Bureau Training Division's perspective.)

The Taser is a less lethal weapon system that delivers electrical energy, and is deployed against subjects who are placing themselves or others in danger of physical injury and/or death. The Taser is designed to incapacitate a person rather than injure him/her. This allows members to take a combative person into custody with a minimum risk of injury to all of the parties involved. The amount of control or force used in the encounter will be governed by the circumstances of each situation taken as a whole in accordance with the Bureau's levels of control.

The Taser is included in the following Level of Control:

Physical Control:

The method of control that is used in every arrest situation is physical control. Physical control consists of the physical application of control holds and pressure points, aerosol restraints, and the use of the Taser. The degree of physical control that is necessary to take subjects into custody or control their behavior, is determined by the level of resistance of the subject.

Deputy Burton said he removed his Taser from the holster and removed the cartridge as he prepared to drive-stun Mr. Chasse. (He decided he wasn't going to use the cartridge probes when he applied the Taser to Mr. Chasse because of the close distance). Sergeant Nice told him not to use the Taser because he didn't believe it would be effective at the time.

Deputy Burton knew that Mr. Chasse was biting at both Officer Humphreys and Sergeant Nice. He said that he punched Mr. Chasse in the back and pressure pointed him in the ribs because Mr. Chasse was biting and kicking and wouldn't put his hands behind his back. When this had no affect, he deployed the Taser in the drive-stun mode on the upper leg or butt. The Taser had no apparent affect on Mr. Chasse and the struggle continued.

Deploying the Taser in the drive-stun mode is a pain compliance technique and does not have the advantage of "locking up" any muscle groups. Deputy Burton decided not to deploy his Taser, using the cartridge probes, because of the close distance. He thought that it would be better to remove the cartridge and drive-stun Mr. Chasse.

Portland Police Bureau Training Division's Recommendation: Rather than use the Taser in a Pain Compliance Mode, "Dart" the subject then drive-stun in another part of the body to lock up some muscle groups in order to gain more physical control over the subject, or to distract him long enough to complete the handcuffing procedure.

Handcuffing – Hobble (Maximum Restraint):

Officer Troy Pahlke arrived at the location and helped Officer Humphreys and Sergeant Nice handcuff Mr. Chasse and roll him onto his right side in a recovery position. Officer Carl Weldon arrived shortly after Mr. Chasse was handcuffed.

Sergeant Nice asked Dispatch to send Medical Code 3 to the scene. He advised that they had a subject who appeared to be unconscious and had been fighting with police. AMR and PFB arrived and evaluated Mr. Chasse. Sergeant Nice confirmed with AMR that Mr. Chasse was medically stable. Sergeant Nice stated to Detectives, "They asked if I wanted him transported. I said, no, we have criminal charges on him. He'll be going to jail." Sergeant Nice also told Detectives, "Without any specific reason or desire by ambulance (AMR) to take him to a hospital, he was going to jail. As soon as we started to search him, he became combative again. I didn't want to fight with him anymore. So, I directed them to put him in maximum restraint."

Maximum Restraint defined:

Placing an in-custody person with hands secured behind the back, legs secured together, and the legs and hands connected together behind the back of the subject with the legs flexed at the knees. The length of the hobble restraint cord used to secure the hands to the feet will be such that the lower legs are no closer than a 90-degree angle in relationship to the person's trunk.

Members are authorized to use hobble restraint cords when necessary to subdue or secure a violent or unruly person. Restraint cords should not be used in lieu of handcuffs.

Officer Carl Weldon applied his hobble restraint cord to Mr. Chasse at the direction of Sergeant Nice thereby placing Mr. Chasse in maximum restraint. Officer Weldon told Detectives, "I wrapped it around his feet once, tightened it, then fed the loop up and around the handcuffs and then back down to the loop, effectively keeping his legs bent at about a 90-degree angle, preventing him from kicking or rolling."

Officer Weldon's application of the hobble leg restraint cord is consistent with the training he received when he was certified to carry the hobble by the PPB Training Division.

After the hobble restraint cord was applied, Mr. Chasse was immediately placed on his side to allow free movement of his chest and stomach for breathing functions. The intent is to not allow body weight or the restraints to restrict the lung's ability to fill and expel air.

After medical personnel (AMR) evaluated Mr. Chasse, Officer Humphreys was presented with a medical release form to sign since Mr. Chasse was restrained and was unable to sign for himself. Officer Humphreys couldn't remember ever having to sign a medical release form as an officer but went ahead and signed it.

Sergeant Nice stated that Mr. Chasse was carried to the patrol car, (still kicking and screaming), while in maximum restraint, by himself, Officer Humphreys and Officer Pahlke. Mr. Chasse was placed into the back of the patrol car and laid onto his side, seat belted in, so he wouldn't lie on his stomach.

Deputy Burton and Officer Humphreys transported Mr. Chasse to MCDC. *(This is consistent with the Training Division Tactical Doctrine that states: "A subject who is transported in the maximum restraint position shall have a two-officer transport. The second officer shall monitor the subject for changes in behavior and signs of distress.")* Officer Humphreys observed Mr. Chasse and spoke with him in route to MCDC as Deputy Burton drove the patrol car.

Prior to arriving at jail, Deputy Burton called MCDC and said, "We got a guy who needs a spit sock, is bleeding and combative, he's hobbled and we're going to need assistance." *(Officers are directed to notify jail personnel that a subject has been transported in the maximum restraint position.)*

The techniques used to hobble, carry, secure, observe, and transport Mr. Chasse to MCDC, are consistent with the hobble leg restraint training doctrine taught by the Portland Police Bureau's Training Division.

When Officer Humphreys and Deputy Burton arrived at MCDC, Officer Humphreys and Jail Deputies carried Mr. Chasse from the car to an isolation cell in the maximum restraint position. They removed the hobble restraint cord and exited the cell.

Nursing staff observed and then refused to accept Mr. Chasse at MCDC for booking until he had been evaluated further at a hospital. Officer Humphreys said that after the nurse refused to accept Mr. Chasse, she walked away. Officer Humphreys and Deputy Burton did not receive any information from the Jail Nurse to suggest that there was an urgency regarding his condition. The nurse didn't advise the officers that Mr. Chasse needed to be transported to the hospital by ambulance; and no official at MCDC offered to call an ambulance. Officer Humphreys said, "Great! So medical clears him to come here, but jail won't take him so now we are stuck in the middle." Officer Humphreys told Deputy Burton that they would now need to transport Mr. Chasse to Portland Adventist Hospital.

(The Jail contracts with Portland Adventist Hospital for care of in-custody individuals. Officers and Deputies routinely transport persons, who are in-custody, to this hospital for minor medical treatment prior to being lodged at MCDC.)

Officer Humphreys and Deputy Burton discussed options pertaining to the type of restraint they would need to apply to Mr. Chasse during transport. Because of the distance and time it would take to drive to the hospital, Officer Humphreys didn't want Mr. Chasse placed in the maximum restraint position.

Jail Deputies offered to let them use leg chains to secure his feet. Officer Humphreys and Deputy Burton agreed. Deputies re-handcuffed Mr. Chasse and applied leg chains to his ankles. *(The leg chains have about a foot and a half of chain, between each leg, so that he would have been able to walk slowly. He would have been able to straighten out his legs, unlike the maximum restraint position.)* Deputy Burton said that Mr. Chasse started resisting again as they re-handcuffed and applied the leg chains.

Deputies carried Mr. Chasse out to the patrol car and laid him in the back seat on his side. As they left MCDC, Mr. Chasse sat up in the seat and started yelling and became animated again. As they drove towards the freeway, Officer Humphreys could hear Mr. Chasse mumbling. Officer Humphreys rolled up the windows as they got on the freeway so he could monitor Mr. Chasse closely. As he did this, he looked back and noticed Mr. Chasse was now leaning up against the passenger door.

Officer Humphreys made the following observations as they proceeded on the freeway:

- ✓ Mr. Chasse was leaning against the passenger door.
- ✓ Mr. Chasse had stopped mumbling and was quiet.
- ✓ He couldn't tell if Mr. Chasse was breathing.
- ✓ Mr. Chasse's left arm "looked stark white".

Officer Humphreys instructed Deputy Burton to take the next exit (NE 33rd Avenue) and to call for medical as they pulled to the curb off the exit ramp. Mr. Chasse was removed from the backseat. Officer Humphreys noted that Mr. Chasse wasn't breathing. Chest compressions were started and resuscitation efforts continued until medical arrived. Mr. Chasse was transported to Providence Hospital by ambulance where he was later pronounced deceased.

TACTICAL SUMMARY:

Officer Humphreys and Deputy Burton did not advise dispatch that they were contacting a person (Mr. Chasse) in the 1300 Block of NW Everett St.

The Training Division realizes that there may be times when officers are confronted with an emergency situation on the street that requires immediate action and response. During an immediate emergency response, it may not be practical or safe to broadcast information on the radio, until action is taken and the situation stabilizes. This is discussed in Patrol Tactics training and is sound Tactical Doctrine.

Upon review of this case file, no articulated information was found that indicated Officer Humphreys and Deputy Burton were seeking the initial contact with Mr. Chasse due to an emergency situation. In fact, Deputy Burton told Detectives that he told Sergeant Nice, just prior to leaving NW 18th/Everett St., "We may be going to go look for that guy (later identified as Mr. Chasse)... 'It was sort of a casual search'... 'We were going to stop him just to chat him up and see what he had to say.'"

- *Based on the above information, the fact that Officer Humphreys and Deputy Burton contacted Mr. Chasse on the street, without advising dispatch of the location and circumstances, is in-consistent with the Training Division's Tactical Doctrine.*

Sergeant Nice observed Officer Humphreys and Deputy Burton stop and contact Mr. Chasse on the street; *he originally had no intention of stopping to assist.* As he drove by *he observed the officers in foot pursuit; he immediately* pulled over and attempted to intercept Mr. Chasse. When the situation became relatively stable, he advised dispatch of the location and circumstances and requested another unit to assist at the scene. The Training Division considers a foot pursuit to be an emergency situation.

- *Due to his close proximity to this foot pursuit, the immediate response and delay in notifying dispatch of the situation by Sergeant Nice, is consistent with the Training Division's Tactical Doctrine.*

- *Initiating the foot pursuit and deploying the knock-down technique, based on the information contained in the case file, is in-consistent with the Training Division's Tactical Doctrine.*

- *The physical techniques applied during the application of the knock-down technique, as described by Officer Humphreys, are consistent with the Training Division's Tactical Doctrine.*

- *Utilizing strikes and kicks to overcome aggressive physical resistance, at close quarters, is consistent with the training Officer Humphreys and Sergeant Nice received during Defensive Tactics instruction; and is consistent with the Training Division's Tactical Doctrine.*

- *The deployment of the Taser by Deputy Burton, in the effort to overcome aggressive physical resistance, is an option that is consistent with the Training Division's Tactical Doctrine.*

- *Officer Weldon's application of the hobble restraint cord is consistent with the training he received when he was certified to carry the hobble by the Training Division.*

- *The techniques used to hobble, carry, secure, observe, and transport Mr. Chasse to MCDC, are consistent with the hobble leg restraint training doctrine taught by the Portland Police Bureau's Training Division.*

- *Providing a two officer transport towards Portland Adventist Hospital, provided Officer Humphreys the ability to constantly monitor Mr. Chasse for changes in behavior and signs of distress. This is consistent with the Training Division's Tactical Doctrine. This afforded the opportunity for Officer Humphreys and Deputy Burton to initiate emergency medical aid procedures quickly when Mr. Chasse's condition deteriorated rapidly.*

RECOMMENDATIONS:

1- Offer the forty (40) hour Crisis Intervention Team (CIT) training to all uniform officers and sergeants in the Portland Police Bureau. *(This has been mandated by the Chief of Police and the Bureau is currently in the process of completing this mandate.)*

2- Revise emergency medical procedures to include the following:

   A. Direct Bureau members to advise EMS personnel of the custody status of the subject, as well as any use of force used against the subject, when EMS is called to the scene.
   B. Direct Bureau members not to sign a medical refusal form on behalf of the subject.
   C. Decide who will have the responsibility of determining the appropriate mode of transporting the subject to the hospital, when medical staff at MCDC refuses to admit him or her for booking.
   D. Direct Bureau Members not to transport a subject who appears to be suffering from excited delirium unless cleared by on-scene EMS.

   These and related issues have been addressed in the new directive, 630.45 Emergency Medical Custody Transports, which became effective on January 30, 2007.

3- In-Service Training:

A. Review person encounter doctrine through scenario-based training; and include the following performance objectives:
    1. Demonstrate effective communication skills.
    2. Demonstrate good defensive tactic skills.
    3. Demonstrate the proper use of force.
    4. Demonstrate proper positioning.
    5. Demonstrate the proper use of cover.

B. Review Directive 1010.20 - Use of Physical Force; through scenario-based training and classroom instruction. The performance objectives should include demonstrating a thorough understanding of the Levels of Resistance which are:

    1. Passive resistance: Actions that do not prevent or attempt to prevent the members attempt to control a subject. Examples include when the subject merely goes limp and/or fails to comply with verbal commands with no other overt signs of physical resistance.

    2. Physical resistance: Actions that prevent or attempt to prevent a member's attempt to control a subject, but do not involve attempts to harm the member. Examples include, but are not limited to, tensing muscles, pulling away, and fleeing.

    3. Aggressive physical resistance: Physical actions of attack or threat of attack, coupled with the ability to carry out the attack, which may cause physical injury. Examples include, but are not limited to striking, kicking, biting, throwing objects capable of causing injury, head butting and taking a fighting stance.

4- Advanced Academy Training:

   A. Introduce Crisis Intervention Team (CIT) training incrementally over time during the Advanced Academy.
   B. Include CIT scenario-based training, during Patrol Tactics instruction interwoven with other disciplines, incrementally over time throughout the Advanced Academy.
   C. Reinforce person encounter doctrine, and applicable statutes and policies related to initiating foot pursuits, through scenario-based training and classroom instruction, incrementally over time throughout the academy session.

5- Develop and disseminate a roll-call video to Bureau members, produced by the Training Division, pertaining to foot pursuits; highlighting the dangers of foot pursuits and the Knock-Down technique.

6- Develop and disseminate a roll call video to Bureau members, produced by the Training Division, discussing the proper application of the Taser when engaged at close quarters with a violent individual.

7- Expand the Training Division's Foot Pursuit Tactical Doctrine when discussing Danger versus Public Safety. Provide additional emphasis outlining factors that should be considered at the onset of a foot pursuit; including the severity of the crime, applicable statutes and policies, ones own knowledge of the subject including physical descriptors (i.e. male or female, size ratio to the member, and muscularity), and the immediate environment.

8- Some of the symptoms displayed by Mr. Chasse, during this incident, were symptoms commonly associated with "excited delirium" and are listed below:

   1) - Violent resistance or physical struggling with officers.
   2) - Incoherent screaming/yelling.
   3) - Subject suddenly goes unconscious after a struggle.
   4) - Talking incoherently.
   5) - Profuse sweating.

   It would be beneficial for members of the Police Bureau, AMR, and the Medical Examiners Office, to attend the National Sudden Death and Excited Delirium Conference, which is presented annually to first responders, investigators, and medical professionals. This would provide continuing opportunity to incorporate up-to-date information, when developing on-going policies and protocols.

205. 10

CITY OF PORTLAND, OREGON

Bureau of Police
Tom Potter, Mayor
Rosanne M. Sizer, Chief of Police
1111 S.W. 2nd Avenue • Portland, OR 97204 • Phone: 503-823-0000 • Fax: 503-823-0342

Integrity • Compassion • Accountability • Respect • Excellence • Service

MEMORANDUM

November 14, 2008

TO: Assistant Chiefs
OAPS Director Stevens

SUBJ: Follow up from Use of Force Board Recommendations on Chasse Case

The Use of Force Board met on October 1 and 2 to consider the in-custody death case of James Chasse. As you are aware, the disposition of the case has been delayed by the surfacing of truthfulness allegations involving Officer Chris Humphreys and Sergeant Kyle Nice. The Internal Affairs Division will investigate the truthfulness allegations when it receives a copy of the booking facility tape that has been processed by a company agreed upon by Mr. Steenson, Deputy Chief Attorney Jim Rice, and the County Counsel's Office.

In the interest of improving the operations of the Portland Police Bureau, I would like to move forward the recommendations for seven of the eight recommendations identified by Lieutenant Dave Famous in the Training Division's analysis of the case. The recommendations are:

1. Crisis Intervention Team training—almost completed.
2. Revise emergency medical procedures—completed through Directive 630.45.
3. In-Service training—review person encounter doctrine through scenarios-based training and Directive 1010.20 through scenario-based and classroom instruction.
4. Advanced Academy training—introduce CIT training, include CIT scenario-based training, and reinforce person encounter doctrine.
5. Develop and disseminate a roll-call video pertaining to foot pursuits, highlighting the dangers of foot pursuits and the knock-down technique to all parties and the community.
6. Expand the Training Division's Foot Pursuit Tactical Doctrine when discussing Danger versus Public Safety. Provide additional emphasis outlining factors that should be considered at the onset of the pursuit, including severity of the crime, applicable statutes and policies, ones own knowledge of the subject including physical descriptors, and the immediate environment.
7. Send members to the National Sudden Death and Excited Delirium Conference—done for the second time.

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In addition, I would like to begin tracking data related to foot pursuits to include when, why, how often, and with what results. Thought should be given to the possibility of altering the data collection form we currently use for vehicle pursuits to determine if it could be used to track both vehicle and foot pursuits.

Office of Accountability and Professional Standards Director Stevens will take the lead in tracking the implementation of these recommendations.

Sincerely,

Rosanne M Sizer

ROSANNE M. SIZER
Chief of Police

c. Mayor Potter, Commissioner Saltzman

PPB Case #06-84962

Recommendations:

1. 40 Hour Crisis Intervention Team (CIT) Training to all Officers and Sergeants.

2. Revise Bureau emergency medical procedures.

3. Review person encounter doctrine through scenario-based training.

4. Introduce Crisis Intervention Team (CIT) training during the Advanced Academy to include CIT scenario-based training and reinforce person encounter doctrine.

5. Develop and disseminate a roll-call video pertaining to foot pursuits, highlighting the dangers of foot pursuits and the knock-down technique to all parties and the community.

6. Expand the Training Division's Foot Pursuit Tactical Doctrine when discussing Danger versus Public Safety. Provide additional emphasis outlining factors that should be considered at the onset of the pursuit, including severity of the crime, applicable statues and policies, ones own knowledge of the subject including physical descriptors, and the immediate environment.

7. Send members to the National Sudden Death and excited Delirium Conference.

8. Begin tracking data related to foot pursuits including reason for foot pursuit, how often, and the end results.

Documentation:

1. 40 Hr CIT Lesson Plan 2007-2008

2. 2009 In-service – City Attorney Civil Updates Powerpoint

3. 2009 In-service Schedule
   2009 In-service – Patrol Tactics – Foot Pursuits Lesson Plan
   2009 In-service – Patrol Tactics – Foot Pursuits Powerpoint
   2009 In-service – Patrol Tactics – Shooting at Vehicles Lesson Plan
   2009 In-service – Patrol Tactics – Shooting at Vehicles Powerpoint

2009 In-service – Defensive Tactics Lesson Plan

4. 2008-1 Advanced Academy Schedule
   2008-1 Advanced Academy CIT Schedule

5. Roll Call Video – Foot Pursuits Lesson Plan December 2009
   Roll Call Video DVD – Foot Pursuits

6. 2008-2 Advanced Academy – Patrol Tactics – Foot Pursuits Lesson Plan
   2009 In-service – Patrol Tactics – Foot Pursuits Lesson Plan
   2009 In-service – Patrol Tactics – Foot Pursuits Powerpoint

7. Roll Call Video – Hobble Review Excited Delirium Lesson Plan July 2007
   Roll Call Video DVD – Hobble Review Excited Delirium
   Tips & Technique – Recommendations for Responses to Excited Delirium Calls 072908
   060001 Sudden Death Excited Delirium Investigations Training Report
   060001 Sudden Death Excited Delirium Investigations Training Roster 111606
   070740 Sudden Death & In-Custody Training Report
   070740 Sudden Death & In-Custody Training Roster 101907
   08059323 Sudden Death, Excited Delirium, & In-Custody Death Conference Report
   08059323 Sudden Death, Excited Delirium, & In-Custody Death Conference Roster 103108
   Roll Call Video – Hobble Review Excited Delirium Lesson Plan July 2009
   Roll Call Video DVD – Hobble Review Excited Delirium
   CIT Certification – Excited Delirium Lesson Plan (part of 40 hr CIT training program)
   CIT Certification – Excited Delirium Powerpoint (part of 40 hr CIT training program)

8. Tips & Techniques – New Pursuit Report 120909
   Special Report on Pursuit Data Collection

Lesson Plan 1: History of the Mental Health System

I. **Course Goals:**

Illustrate how people's experiences with and knowledge of earlier mental health systems and treatment can influence their beliefs and behaviors.

II. **Performance Objectives:**
Upon completion of this class the student will be able to:

1. Describe the historical treatment of the mentally ill and developmentally disabled.
2. Recount the conditions in institutions and society that contributed to the movement to de-institutionalize people with mental illness.
3. Compare the goals of de-institutionalization with the reality of its implementation (including the jail as the new version of the institution).
4. Recognize the effects of the first medications used to treat mental illness.

III. **Methodology**

Class will be taught in lecture format with the use of video to illustrate teaching points.

IV. **Materials, references, and equipment**

1. Projector and screen
2. DVD player
3. Flip charts
4. Colored pens
5. DVD "Snake Pit."

V. **Content**
See below

HISTORY OF THE MENTAL HEALTH SYSTEM

1. 18th century America held beliefs leftover from our European predecessors: the mentally ill were "possessed," to be feared

2. The early 19th century brought an era of "moral treatment," establishing state mental asylums

3. By mid century, changes were occurring in the mental health system: the hospital census had grown and institutional care began to deteriorate and the care of the mentally ill became known as "warehousing"

4. 1949: the National Institute of Mental Health was established

5. Media exposure increased public awareness of deplorable hospital conditions

6. 1950's: discovery of the first major tranquilizers, thorazine being one of the first

7. 1950's and 60's: the national conscience focused on the civil rights movement

8. As social reform responded to deplorable hospital conditions, the movement toward deinstitutionalization began

9. Transfer of hospital patients to the community-based care began and culminated in the Community Mental Health Act of 1963.

10. Ideally clients discharged from institutions would live within family support systems

11. In reality, persons had been "institutionalized": withdrawn, dependent, minimal social skills, years of estrangement from their families/supports; many discharged to nursing homes, single room occupant/low income housing units, and hotels

12. By the end of the 70's, the mentally ill were among the ranks of the homeless

13. The 80's and 90's brought cuts in low income housing, reduction in disability entitlements including the mentally ill, changes in insurance coverage, and a decreased tolerance for persons on the social margins

14. Significant changes in mental health coverage, lack of parity, insufficient reimbursement rates for community providers resulted in an overload of the mental health system

15. The mentally ill became casualties of a well-intended change; unfortunately the criminal justice system and homeless shelters are now frequently the "community partners" in caring for the mentally ill

16. Oregon/Multnomah changes: payor system has changed numerous times over the years; causing service providers to adapt their systems

17. Client's mental health coverage has been cut; they have experienced times when Oregon Health Plan was not taking new patients, or only medical coverage was provided and not mental health

18. Only this January (2007) has Oregon established parity for mental health, finally equalizing insurance coverage for mental illness with medical care

Lesson Plan 2: Current Mental Health System and Services

I. Course Goals:

Identify elements of today's mental health system in Multnomah County. Understand and appreciate the limitations, stresses and strains on the system and how these limitations affect the officer's day to day work.

II. Performance Objectives:

1. Communicate effectively with other professionals by understanding their roles and functions
2. Know how to access "gateway" resources such as Project Respond, Hooper, and the Multnomah County Crisis Line
3. Describe programs within Project Respond
4. Articulate how stigma is a barrier to treatment of individuals with mental illness/developmental disabilities

III. Methodology

Class will be taught in lecture format with brainstorming and discussion sessions. Consumer videos are used throughout the training to highlight the issue of stigma and its effect on individuals suffering from mental illnesses.

IV. Materials, reference and equipment

1. Projector and screen
2. DVD
3. Computer with PowerPoint capability
4. Consumer video(s)

V. Content

See following page

COMMUNICATING WITH THE MENTAL HEALTH SYSTEM:

1) CASE MANAGER:
   a) A person usually working with a clinic who provides assistance with connecting to resources for housing, food stamps, job training, personal care, housekeeping assistance, legal issues, social security entitlements, group supports

   b) They do initial and ongoing mental health assessments

   c) They connect clients with a licensed medical provider (LMP)

   d) They provide therapy/counseling

   e) They frequently have caseloads of more than100 clients

2) COUNSELOR/THERAPIST: Some clients may refer to their case manager as a counselor.

3) MONEY MANAGER/PAYEE: Clients who receive Social Security may be required to have a representative payee who assists the client in paying for rent, groceries, bills, back debt, etc. They generally see their money manager anywhere from once a week to once a month. Clients can also have money management services on a voluntarily basis.

4) LICENSED MEDICAL PROVIDER (LMP): This can be a nurse practitioner, physician assistant, psychiatrist, or a primary care physician; generally clients see their LMP (also called a "prescriber") once or twice a month to once every three months depending on their stability and ability to track appointments.

5) VERITY/VERITY PLUS: This refers to the mental health coverage within the Oregon Health Plan for Multnomah county; a client may say they "have lost their Verity"; this means their medications or clinic visits are not covered. Their case manager can help with reapplication for Verity, but the coverage will be for a limited period of time.

6) CRISIS LINE: A Multnomah County 24 hour crisis line (503-988-4888) available to citizens, consumers/clients, hospitals, police, dispatch.

7) CORE/INTENSIVE CASE MANAGEMENT: A specialty case management service with much smaller caseloads; they respond on scene to crises (sometimes with Project Respond).

8) OUTREACH PROGRAMS: Project Respond (mentally ill homeless), JOIN (homeless camps), Central City Concern, New Avenues for Youth and Yellow Brick Road (youth focus), NARA (Native American focus).

9) SRO: single room occupancy; many of the hotels downtown, some subsidized.

10) HIPAA: A national policy setting standards for security and privacy of health data, standards for electronic data, and protections for health insurance for workers who change or lose their jobs.

11) Personal care assistant: One paid to assist with housekeeping, hygiene, shopping, activities of daily living.

12) PSRB: Psychiatric Security Review Board (see lesson plan # 17)

13) CEP: Community Engagement Program-provides services including housing, case management, psychiatric and medical care, to homeless persons with co-occurring disorders in Multnomah Co.

14) Co-occurring disorders: When a person is experiences two or more ongoing illnesses; could be a mental illness along with substance abuse, or a developmental disorder with substance abuse.

15) Urgent Walk-In Clinic: A service through Cascadia Behavioral Health for individuals seeking urgent mental health services;

   a) Clients are provided with a risk assessment, crisis counseling and recommendations for further treatment.
   b) Primary focus is those who are indigent, OHP eligible or Medicare only and not enrolled in MH services.
   c) Sometimes short term medications are provided.
   d) they are open 7 days/week 7am to 10:30pm.
   e) Clinic is ONLY FOR VOLUNTARY CLIENTS.
   f) If officers are taking client to clinic, they would need to accompany client into clinic waiting room, ask for program manager or clinician, then inform them how their contact with client originated.
   g) Officers are welcomed to call ahead to let clinic know they are coming, or problem solve re: appropriate response; officers can also call Project Respond for consultation or assistance with evaluation.
   h) If a client says he/she is currently seen at another Cascadia clinic, it would be preferable for client to go to their primary clinic if Monday -Friday, 8am-5pm.

16) Community Court: for low-level offenders, non-person to person crimes, misdemeanors and violations only:
   a) Goal is to get them services so they don't re-offend
   b) Could include mental health, drug and alcohol services, economic or educational services
   c) It is voluntary; upon entering the program, client signs agreement for automatic jail sentence if they fail
   d) If officers have questions re: program, contact is Heidi Grant: 988-5090 x24508

17) Medication Scholarship/Patient Assistance Program: Some pharmaceutical companies provide 3-6 month supply of medications to clients who qualify; their prescriber and case manager assist with this process.

Lesson Plan 3: Mental Status Exam

I. Course Goals:

Recognize that mental illness is a brain disorder and comprehend terminology used to describe the signs and symptoms of mental illnesses. Show how imperfections in brain functioning affects people's behavior.

II. Performance Objectives:

Upon completion of this class the student will be able to:

1. Familiarize students with a Mental Status Exam
2. Assess a person's appearance
3. Describe a person's thought process and thought content
4. Describe a person's speech pattern
5. Practice articulation of mental status indicators for report writing purposes

III. Methodology:

Class will be taught in lecture format with the use of PowerPoint, demonstration, video and one activity/game. Videos and activity will be interspersed with lecture material to illustrate different examples of thought processes, speech patterns, movements, insight and judgment.

IV. Materials, references and equipment

1. Projector and screen
2. DVD
3. Computer with PowerPoint
4. Index cards for activity
5. "Cops" videos: "Woman in Shower" and "Street Party"

V. Description of "matching game" Activity:

The activity consists of a matching game where each student receives a card. Written on one set of cards in red ink are statements describing specific mental status indicators. Written on another set of cards in black ink are the clinical names for the mental states.
Example: -"I am the Queen of Wales" paired with "Grandiose Delusion."

VI. Content :

See following page

OVERVIEW OF MENTAL ILLNESS AS A BRAIN DISORDER

1. Not all brain disorders are mental illnesses, but all mental illnesses are brain disorders.

2. The brain regulates our thoughts, feelings, behaviors, and communication.

3. It provides us with a way of testing reality, solving problems.

4. Mental illness can affect all areas of the brain by changing the actual structure of the brain, the chemistry, and electrical impulses.

5. Mental illness is not mental retardation, a split personality, and does not imply a lower IQ.

6. Causes of brain dysfunction can be numerous and chronic or acute:

    - Anatomical abnormality or damage
    - Lack of oxygen / glucose
    - Electrolyte imbalance
    - Neurotransmitter dysregulation
    - Viral
    - Genetic: specific proteins within genetic markers
    - Autoimmune
    - Developmental
    - Substance abuse
    - Nutritional deficits: e.g. omega3 fatty acids

7. Brain disorders and mental illness can be acute or chronic, e.g. psychosis vs. schizophrenia, depressive disorders

8. Mental illness is frequently a long road of remissions and exacerbations, being in and out of treatment, as well as difficulties negotiating a changing mental health system.

FUNCTIONS WHICH CAN BE AFFECTED BY MENTAL ILLNESS

1. Level of attention: e,g. distractable, alert, hypervigilent, somnulent

2. Orientation: person, time, place, situation

3. Emotional reactions; anxious, agitated, apathe tic, fearful
4. Mood: depressed, irritable, labile, euthymic (normal level)
5. Affect: (facial expression) appropriate, restricted, flat, does it fit with mood?
6. Physiological reactions: sleep, appetite, libido
7. Motor activity: may be voluntary or involuntary
    a. Posturing- abnormal, even bizarre positioning
    b. Catatonia- may be immobile, or repetitive activity
    c. Echolalia can occur- senseless repetition of a word or phase just heard
    d. Echopraxia- imitation of movements of another person
    e. Person may need supervision to avoid self harm
    f. Tic-involuntary spasmodic movement
    g. Compulsion- uncontrollable impulse to perform a repetitive act, may be ritualistic, often in response to an anxiety-driven obsession
8. Speech qualities
    a. Rate, rhythm, volume
    b. Pressured- generally rapid, occasionally loud
    c. Poverity of speech- restricted amount
    d. Dysarthria- difficulty articulating due to motor deficit
9. Language- called aphasias
    a. Expressive/motor
    b. Receptive- cannot comprehend meaning of words
    c. Nominal- cannot name objects
    d. Syntactical- cannot arrange words in logical order
10. Memory-function by which information is stored and able to be brought to consciousness
    a. Immediate, short term, and long term (distant)
    b. Amnesia may be organically or emotionally caused

11. Insight- ability of person to understand cause and meaning of a situation

    a. May refer to their illness, benefit of treatment

12. Judgment- ability to correctly assess a situation and respond appropriately to the situation; indicator of person's ability to provide for own safety

13. Thought- the flow of ideas, symbols, and associations which lead toward a reality oriented conclusion. Disturbances in the FORM of thought which can occur in mental illness:

    a. Flight of ideas- shifting of ideas in a slightly connected, continuous manner, can be a play on words

    b. Loosening of association- thoughts shift in an unrelated manner from one idea to another

    c. Incoherence- unable to understand thoughts due to complete disorganization

    d. Word salad- incoherent mixture of words

    e. Neologism-creation of new words

    f. Circumstantial thinking- delay in reaching 'the point'; over-inclusion of details, superfluous ideas

    g. Tangential thinking- thoughts frequently change their course away from the original idea, become non goal-directed

    h. Concrete thinking- literal, limited ability to understand metaphor

    i. Perseveration- persistent responses even after the topic has been changed, continues to return to the same theme or idea

    j. Thought blocking- interrupted or disturbed ability to process information resulting in pauses in flow of thought and ability to respond

    k. Magical thinking- thoughts, words can assume power, many times childlike

14. Thought content/Delusion: beliefs incorrectly inferred from external reality, cannot be corrected by reasoning

    a. Paranoid- being watched, followed

    b. Persecutory- mistreated, harassed

    c. Grandeur- grandiose ideas, special powers

d. Somatic- body related

e. Bizarre- odd mix of delusions

f. Ideas of reference- believe behaviors of others refers to the person, may feel talked about, e.g. the TV speaks only to them, special messages

g. Ideas of influence- beliefs that another person or force controls some aspect of their behavior

h. Thought broadcasting- perceive their thoughts can be heard by others

i. Thought insertion- perceive thoughts are being planted into their mind by others

j. Obsession- pathological persistence of thought or feeling, is irresistible

15. Perceptual disturbance/Hallucination: false sensory perception not associated with a real external stimuli, causes impairment in reality testing

a. Auditory- sounds, voices, vary in quality. May be inside or outside one's head, may be commanding/instructional, frequently negative, may cause one to respond verbally
b. Visual- formed or distorted images
c. Olfactory- frequently foul
d. Gustatory- foul , chemical
e. Tactile- skin, extremity, e.g. skin crawling, phantom sensation
f. Illusion- misinterpretation of real sensory stimuli

Lesson Plan 4: Crisis Communication (Part I)

I. Class goals:

This class provides the foundational concepts for crisis communication. It will familiarize students with the model of the "crisis cycle" and the communication techniques appropriate to various stages of the crisis cycle. The information in this class will be utilized during the entire course in all role plays, scenarios, demonstrations and video reviews.

II. Performance objectives:

Upon completion of this class the student will be able to:

1. Describe the stages of the crisis cycle
2. Identify behaviors that indicate where an individual might be on the crisis cycle
3. Use different communication techniques depending on where an individual is on the crisis cycle
4. Observe signs of escalation and de-escalation in a subject and link these signs to an officer's communication techniques
5. Gain awareness that officers are also on the crisis cycle

III. Methodology

Class will be taught in lecture format (PowerPoint) with brainstorming and discussion sessions interspersed throughout. Class will utilize "COPS" videos to practice skills.

IV. Materials and equipment

1. Projector and screen
2. DVD
3. Computer with PowerPoint
4. "Cops" video: "Backyard Man" (Cops disk 2) & "Woman in Van" (Cops disk 1)

V. Content

Attach power point

Lesson Plan 5: Crisis Communication (Part II)

I. Class goals:

This class will review basic communication theory and apply that theory to crisis interactions.

II. Performance Objectives:

Upon completion of this class students will be able to:

1. Identify 3 basic components of communication:
    i. Sender
    ii. Receiver
    iii. Message
2. Describe various non-verbal methods of communication
3. Understand communication to be an interactive, dynamic and complex process
4. Understand the importance of attending to the emotional content of a message
5. Describe the power of an apology and its application to community policing

III. Methodology

Class will be taught using lecture, videos and discussion

IV. Materials and equipment

1. Projector and screen
2. DVD
3. Computer with power point
4. DVD: "Abbott and Costello", "Jerry Maguire," "Jerry Seinfeld"
5. "Cops" video: "Deaf Woman"

V. Content

(See next page))

COMMUNICATION REVIEW

I. **The importance of communication (and CIT)**
   a. CIT is about communicating effectively with people in crisis. Not just the mentally ill.
   b. Is there a difference between talking and communicating? If so, what is it?
   c. Communicating well is a learned skill.
   d. CIT is not a magic bullet. It is another tool in your tool belt.
   e. CIT gives some additional understanding of the state of mind that people are in when they are motivated by fear and how we might interact with them in this state.
   f. Fear is a dangerous emotion. The more we can lessen someone's fear, the safer YOU will be.

II. **Communication theory review**
   a. Theory review
      i. Most people think of communication as a line.
      ii. But it quickly becomes complicated. *Ex: Say you are home and about to leave for work. You walk through the kitchen and your spouse says: "The trash is full." You keep walking and say, "Why, yes it is." And walk out of the house.*
         1. What is the person REALLY saying? What message are you hearing? What message do you need to respond to? T he words are saying one thing but the contex t gives it a whole other meaning.
         2. In order to communicate effectively we have to **understand the difference between the words and the meaning.** Paying attention to the words but not the meaning can get you into trouble. **Show video "Abbott and Costello."**
         3. Debrief video. Ask class why the communication broke down. Elicit and write on whiteboard what goes into successful communication (options: listening, clarification, frame of reference, assumptions, reacting vs. thinking, slowing down). What EMOTIONS are operating in this scene?

      iii. **Three major components to communication**
         1. (Draw stick figures) Sender-message-receiver. Message is mostly verbal. BUT in addition to an intended verbal message we send lots of unintended messages ALL THE TIME. What are those unintended, non-verbal messages?
            a. Voice, tone, volume, speed, body language- like facial expressions, eyes- personal history and past experiences, personal space, etc
            b. **Students guess % that people pay attention to verbal, tone & volume and body language. Draw pie chart with % verbal (7), tone & volume(38) and body language (55).** (Study with these percentages done in 1981 by Albert Mehrabian out of UCLA. He wrote a book called, "Silent Messages: Implicit Communication of Emotions and Attitudes")
      iv. **Catching the (emotional) message**

1. If we don't catch the emotional message, the message gets amplified! What happens when you talk to a deaf person? You talk louder!
    a. The person escalates until the emotional message is caught. In a relationship, you can have emotional messages that are not caught for years. Leads to divorce.
    b. **Video:** "Jerry McGuire" clip to illustrate escalation of emotions. Kid says "f... you" because Jerry is not paying attention to him.

v. **Power of an apology**
    1. If the message is not caught and the person feels powerless what will they do? Many things, but one thing is they will sue! Modern day form of revenge, retaliation is suing.
        a. Study: Wendy Levinson (2002) studied doctor-patient relationships and found that when doctors apologized for their mistakes, # of malpractice claims decreased.
        b. Study: New York Times article May 18th, 2008 "Doctors say "I'm sorry" before "See you in court." Same finding as Levinson. Johns Hopkins and Stanford trying new approach of admitting fault vs. "deny and defend."
    2. **Movies: Video: Jerry Seinfeld. Customer service example of "revenge."**
    3. **Video: Cops (#1) "Deaf Woman."** Video is broken into two parts. Part !: police take a deaf woman into custody. Part II: Officer talks to deaf woman family member. This is the interesting part of the video. Pause the video to ask questions:
        a. Where is the family member on the crisis cycle?
        b. Is she listening to the officer? Why not? (think crisis cycle)
        c. How is the officer talking to her? (problem-solving)
        d. What is her emotional state? Is he "catching" her emotions?
        e. What does he do well? (Uses her name, nice tone)
        f. Is he giving her correct and good information? (yes)
        g. It is a problem of timing. His good info is wasted on her at this point in the conversation.
        h. When does she start to de-escalate? What helps her de-escalate?
        i. What does officer say that *does* catch her emotionally and reflects her feelings back to her?

Lesson Plan 6: Crisis Communication (Part III)

I. Class Goals

This class builds on previous communication classes and will present additional communication theory and remind students of the importance of listening. Basic communication recommendations for people in crisis will be reviewed and practiced.

II. Performance Objectives

Upon completion of this class students will be able to:

1. Utilize active listening skills
2. Recall questions used to assess an individual's level of crisis
3. Recognize that the officer is always communicating, even if they are not talking, and that they can be easily drawn into a subject's crisis cycle
4. Differentiate between "reacting" and "responding" and being able to articulate the value of each type of response

III. Methodology

Class will be taught using a combination of lecture, video analysis and demonstration.

IV. Materials and equipment

1. Projector and screen
2. DVD
3. Computer with power point
4. DVD: "Dog Day Afternoon" film clip
5. Cops: "Man with Stick"

V. Content

(See following page)

I. Communication is a loop, not a line (PowerPoint slide)
   1. There is no beginning or end to communication
   2. You are always part of that loop because YOU CANNOT NOT COMMUNICATE
   3. People get pulled into these communication loops quickly –this can lead to escalation
   4. Easy to get pulled into someone's bad mood (not other way around)
   5. Non-verbal messages are always present
   6. People react unknowingly and unwittingly to hidden, silent messages

II. React vs. Respond
   1. Verbal Judo concept developed by George Thompson
   2. Elicit from class the difference and write on board
   3. React
      i. The other person is in control
      ii. You are on the defensive
      iii. More instinctive, automatic
      iv. Emotional
      v. They are calling the shots. Their game. Their rules.
      vi. Power struggle (remember the top of the crisis cycle-two year olds love power struggles)
      vii. You can "over react" but not "over respond" (Project Respond not Project React)
      viii. Awareness of your reactions. You can't control your reactions if you don't know you are having them.
   4. Respond
      i. Emotions less engaged
      ii. Detached
      iii. Less likely to be pulled into someone's state
      iv. Realize it is not personal
      v. More chances to control the conversation
      vi. Trying to find mutual communication vs. one up
      vii. More likely to listen in "respond" mode

III. Listening Skills (PowerPoint)
   1. Elicit "How do we know someone is listening to us?"
   2. Opposite of "talking" is "waiting to interrupt"
   3. Techniques for listening:
      i. Emotional labeling
      ii. Paraphrasing
      iii. Reflecting
      iv. Effective Pauses
      v. Minimal encouragers
      vi. Open-ended questions

IV. Making a Connection- (PowerPoint)
   Examples:
   1. I'm here to help you
   2. What's going on today?
   3. Do you feel safe?
   4. What would help you feel safer?

V. Communication Recommendations
    1. Limit input
    2. Slow down
    3. Reduce distraction
    4. Short sentences
    5. Simple language
    6. Repeat yourself (often)
    7. Use people's names to help them focus
    8. Use silence

Lesson Plan 7: Schizophrenia and Other Psychotic Illnesses

I. Class Goals

Students will gain increased knowledge about schizophrenia and other psychotic disorders. Exposure to the signs and symptoms of these disorders will enable students to appreciate the challenges of this disease. Students will be exposed to a risks/reward analysis of medications used to treat these disorders.

II. Performance Objectives

Upon completion of this course the student will be able to:

1. Recognize the symptoms of three types of schizophrenia:
    i. Paranoid
    ii. Disorganized
    iii. Catatonic
2. Articulate the risk factors associated with psychotic disorders
3. Through role play exercises, interview a subject with a psychotic disorder to assess safety to self and others
4. Understand the difference between hallucinations and delusions and the risks associated with each
5. Describe the different conditions that might cause someone to become psychotic
6. Appreciate the need to respond to the behavior and not the diagnosis
7. Practice utilization of outside resources, e.g. Project Respond

III. Methodology

Class will be taught in lecture format with the use of video examples and directed role plays.

IV. Materials and equipment

1. Projector and screen
2. DVD Player
3. Flip Chart and Pens
4. DVD "I'm Still Here- Introduction"

V. Content

See following page

SCHIZOPHRENIA & OTHER PSYCHOTIC ILLNESSES

Psychosis is not necessarily schizophrenia, psychotic symptoms can occur in numerous medical and psychiatric illnesses

Schizophrenia can disturb thinking in its content (delusion), perception (hallucination), and processing (disorganization)

Schizophrenia has both positive and negative symptoms:

- Positive: delusion, hallucinations, paranoia,
- Negative: social withdrawal, flat affect, poverty of speech, decreased motivation

Types of schizophrenia/what presentation you might see:

- Paranoid
- Disorganized
- Catatonic

Person may identify themselves as "having schizophrenia" but unlikely to know type

Other psychotic illnesses:

- Delusional disorder
- Substance induced psychosis
- Medical condition causing psychosis: eg cranial tumors

Schizoaffective disorder: has clinical signs of schizophrenia, manic and depressive episodes; may be bipolar or depressive type

Mood disorder with psychotic features: psychosis occurs as complication of depression which is usually of long duration and with poor prognosis

Suicide among schizophrenia patients:

- Tend to commit suicide during the first years of illness
- Up to 10% of schizophrenics in US commit suicide
- Tend to be younger, male, single, socially isolated
- Most have previous attempts

MEDICATIONS FOR PSYCHOSIS/SCHIZOPHRENIA

Medical Risk - NMS (Fever, ridgid, sweating - medical emergency get paramedics)

Meds work on neurotransmitters, eg dopamine

Development of antipsychotic meds led to deinstitutionalization (thorazine 'discovered' in 1953)

Antipsychotic meds can be used in other disorders; caution in deciding that a person on antipsychotic meds is schizophrenic

Older meds addressed 'positive' symptoms of schizophrenia, did not address the negative: flat affect/vocal quality, apathy, anhedonia, poor attention

Older meds:

- Thorazine, mellaril, navane, trilafon, haldol
- Had profound acute and chronic side effects: eg. dystonias, tartive dyskinesia, cardiac effects, Parkinsons-like symptoms, anti-cholenergic effects

Newer "atypical" antipsychotics:

- clozapine, risperdal, seroquel, zyprexa, abilify, geodon
- less likely to cause side effects of older medications, but have side effects of their own
- Most cause weight gain, elevation in cholesterol, triglyerides; this can lead to metabolic syndrome, type II diabetes and subsequent diabetic complications

Both older and newer antipsychotics can have a severe adverse reaction called neuroleptic malignant syndrome: life threatening high fever, sweating, high blood pressure, increased heart rate, muscle rigidity. It can occur any time during treatment. Clozapine requires frequent blood draws as it can cause a life-threatening blood problem

Other side effects; headache, sleep disturbances, tremors, dry mouth, constipation, dyspepsia, rise in prolactin levels (breast swelling, menstrual irregularity)

Persons have to weigh the risks versus the benefits and should be informed of these by their prescriber, a difficult process when a person is paranoid or thoughts are disorganized

Medication regime may require more medication to treat side effects leading to anticholinergic side effects, such as blurred vision, constipation, difficulty urinating

Medication effects/side effects/ managing of meds presents a significant challenge for a homeless individual. Review of reasons why a person with mental illness may not want meds.

SIDE EFFECTS AND MEDICATIONS USED TO TREAT SIDE EFFECTS:

Neurological/central nervous system:

- Dystonia: muscle stiffness, cramping; generally affects jaw, neck, but could affect other muscles ***Risk-in severe cases airway can close - medical emergency - get paramedics***
- Dyskinesia: referred to tardive dyskinesia: involuntary movements of tonue, jaw, trunk, or extremities; due to medication
- Akathesia: fidgety movements, swings legs, rocking , pacing to relieve restlessness, inability to sit or stand still ***Risk --untreated condition can be intolerable and can result in suicide/attempts***

- Pseudoparkinsonism: tremors caused of neuroleptic medications not from Parkinsons disease affecting the limbs, head, mouth, or tongue; muscle rigidity, decrease in spontaneous facial expression, gestures, speech
- Neuroleptic Malignant Syndrome as described above: 30+% fatal

Medications to treat side effects (may be meds that would treat Parkinsons)
Cogentin (benztropine), Artane, Symmetrel, Akineton, Kemadrin, Benadryl

Other side effects may include allergic responses, skin rashes, cardiac EKG changes, liver changes, specific blood disorders which can be life threatening, endocrine changes such as prolactin.

Lesson Plan 8: Mood/Affective Disorders: Depression and Bipolar

I. Class Goals

Students will gain increased knowledge about mood disorders as a brain disease. Exposure to the signs and symptoms of these disorders will enable students to appreciate the challenges of this disease. Students will be exposed to risks/reward analysis of medications used to treat these disorders.

II. Performance Objectives

Upon completion of this class students will be able to:

1. Recognize the symptoms of depression and mania
2. Articulate the risk factors associated with mood disorders
3. Practice interviewing a subject with a mood disorder to assess safety to self and others
4. Recall that mood disorders may have psychotic features

III. Methodology

Class will be taught using lectures, video examples and directed role plays.

IV. Materials and equipment

1. Projector and screen
2. DVD Player
3. Flip Chart and Pens
4. DVD "The Bridge"- "Chapter 6-Kevin Hines"

V. Content

See following page
PowerPoint "Depression Suicide"

MOOD DISORDERS/AFFECTIVE DISORDERS (General)

Moods fluctuate by nature; when moods interfere with functioning over time, they may become a diagnosed mood disorder

Your observation is one isolated glimpse of their "mood" history

Moods and range of affective expressions are normally in our control; with mood disorders, this control is lost

Mood disorders may be due to medical conditions or substance induced

Neurotransmitters (serotonin, norepinephine, dopamine) are affected in mood disorders; hormones, such as growth hormone, prolactin, may also affect mood

Bias in diagnosis of mood disorders, eg clinicians tend to under diagnose mood disorders in cultural or racial backgrounds different from their own although mood disorders do not differ in racial prevalence

Medical conditions that can significantly affect mood:

- Parkinsons disease/ treatment of Parkinsons disease
- Cardiac disease
- Multiple sclerosis, lupus, i.e. autoimmune diseases
- Strokes
- Postpartum experience
- Cancer/chemotherapy
- Thyroid abnormalities
- Epilepsy
- Treatment with certain medications: blood pressure meds, steroids, prednisone, opiates, anti-inflammatory meds
- Migraines
- Vitamin deficiencies
- AIDS

DEPRESSION

Depression is a common feature of all mental illnesses, regardless of origin

Depression can mimic medical illness and significantly complicates the clinical picture for a person dealing with depression and another acute or chronic medical condition

Seen twice as often in females as in males

Symptoms of depression:

- Persistent sadness, emptiness
- Sleeping too much or too little, early morning wakening
- Change in appetite

- Loss of interest, motivation
- Irritability
- Trouble with concentration, making decisions
- Fatigue, loss of energy
- Physical complaints
- Feelings of guilt, hopelessness, worthlessness
- Thoughts of death, suicide

Diagnosis of depression is made when mania or seasonal pattern is absent

Pre-existing factors may be: personality traits, environmental stressors, cognitive processes, such as learned helplessness, decrease in REM sleep

Seasonal affective disorder: depression associated with seasonal variation of light

Similar to ways sunlight affects seasonal activities of animals, eg hibernation, reproduction

Melatonin, a sleep related hormone, increases production in the dark, so when the days are shorter, the hormone increases

Phototherapy in light boxes, suppress the production of melatonin

MEDICATIONS FOR DEPRESSION

SSRIs: Serotonin Specific Reuptake Inhibitors making more serotonin available in the blood

- Begin to work right away, but take weeks to be effective and need a consistent treatment period of at least 6 months

Side effects of SSRIS:

- Nausea, GI distress
- Headache
- Insomnia
- Diarrhea
- Dizziness
- Tremors
- Ejaculatory dysfunction
- Decreased libido
- Constipation
- Rash
- Serious adverse reactions: suicidality, serotonin syndrome (toxicity)

Serotonin syndrome:

- Caused by too much of the serotonin meds, whether intentional or inadvertently mixed with other medications, eg SSRI with St. Johns wort, MAOI (monoamine oxidase inhibitors) an older form of anti-depressants increases serotonin when mixed with ecstasy(MDMA)

- Often mistaken for a virus, anxiety or worsening psychiatric condition
- Signs: confusion, agitation, headache, shivering, sweating, fever, muscle twitching, jerking, insomnia
- Can look similar to Neuroleptic Malignant Syndrome

SSRIs and similar meds: Prozac, Paxil, Zoloft, Celexa, Lexapro, Luvox, Effexor, Wellbutrin, Remeron- ***Risk - less lethal in overdose than older, tricyclic antidepressants (see below)***

May need other meds to cope with side effects, such as insomnia

Reasons a person may stop meds:
- Side effects
- Feeling better therefore not needing the meds
- lack of insurance and prohibitive cost

Tricyclic antidepressants :
- precede SSRIs, still used today, but sometimes at lower doses and for sleep rather than antidepressant effects

Side effects: sedation, dry mouth, constipation, blurred vision, palpitations
Serious side effects: hypotension, cardiac problems, including heart attack
Might see: amitriptyline, trazodone, desipramine, nortriptylin
Risk - HIGHLY lethal in overdose

BIPOLAR ILLNESS

Equal in men and women, 1% of US population (over 200 million Americans)

High percentage have relatives with depressive disorder of some type

Onset can vary: late 20s to early 30s, also can be diagnosed in children

Many types of bipolar illness which are based on most recent presentation, such as more manic, depressed, or mixed symptoms, severity of symptoms, and whether or not psychosis is present

Symptoms of mania
- Racing thoughts, rapid talking
- Excessive energy
- Decreased need for sleep
- Feeling 'high' euphoric
- Easily irritated
- Exaggerated confidence/grandiose ideas
- Periods of behavior different than usual: change in grooming, obsession with writing, collecting
- Poor judgments: spending sprees, reckless driving

- Unusual sexual drive
- Abuse of drugs
- Provocative, intrusive behaviors
- Denial that anything is wrong

Risks associated with bipolar illness:
High rate of suicide
dehydration
malnutrition
risk of STDs
financial loss
friends
provocative intrusive behaviors increase risk of harm from others
grandiosity may result in lack of judgment and increase risk taking

Manic presentation does not necessarily mean person has bipolar illness; may be substance induced, a medical condition, delirium. This can make bipolar illness difficult to diagnose.

Manic persons are at risk for medical complications, such as dehydration, malnutrition, high risk behaviors causing injuries

Medications to treat bipolar illness can be challenging:
- causes risks on the kidneys and liver
- requires frequent blood level monitoring
- reduces the sense of euphoria

MEDICATIONS FOR BIPOLAR ILLNESS

□ Antidepressants, previously discussed, are used for the depressive phases of bipolar illness

□ LITHIUM: hallmark medication although this may be incompatible with some people

o Side effects: tremors, increased urination, thirst, diarrhea, nausea, vomiting, muscle weakness, weight gain
o Requires lab monitoring of lithium level, kidney and thyroid function
o Lithium may not be effective alone in severe illness
o May require adjunctive medication with its own set of side effects

Risk -- toxicity

□ ANTICONVULSANTS (seizure meds)

o DEPAKOTE (valproic acid): requires lab monitoring, tolerated fairly well
Side effects: tremors, hair loss, weight gain, blood dyscrasias

o TEGRETAL (carbamazepine): requires lab monitoring for liver problems

Side effects: sedation, nausea, blurred vision, ataxia, allergic rash

- o LAMICTAL (lamotrigine): similar side effects, serious adverse reaction of rash

- o GABATRIL, TOPAMAX, TRILEPTAL, NEURONTIN: other meds used for bipolar illness/mood stabilization

- ☐ ATYPICAL ANTIPSYCHOTICS are now approved for treatment of acute mania in bipolar illness:
  - o Zyprexa, Seroquel, Abilify, Geodon,

- ☐ OTHER AGENTS: Clonazepam, clonidine, clozapine, verapamil

Lesson Plan 9: Suicide

I. Class goals

Students will gain increased knowledge about the prevention and intervention associated with a suicidal subject.

II. Performance Objectives

Upon completion of this course the student will be able to:

1. Describe those who are at risk for suicide
2. Describe the risk factors that lead people to suicide
3. Articulate the possible motivations for suicide
4. Recall specific interview questions for a suicidal subject

III. Methodology

Class will use lectures and directed role plays.

IV. Materials and equipment

1. Projector and screen
2. DVD Player
3. Flip Chart and Pens

V. Content

PowerPoint "Depression suicide"

Lesson Plan 10: Anxiety Disorders (general)

I. Class Goals

This class will help students recognize and differentiate anxiety as a normal response to stressful events as opposed to a mental health disorder. Students will be exposed to a risks/reward analysis of medications used to treat these disorders.

II. Performance Objectives

Upon completion of this class students will be able to:

1) Recognize various types of anxiety disorders
2) Describe the difference between normal stress and anxiety as a mental disorder
3) Articulate the risk factors associated with anxiety disorders
4) Practice utilization of outside resources

III. Methodology

Class will be taught in lecture format with the use of video analysis

IV. Materials and equipment

1) Projector and screen
2) DVD Player
3) Flip Chart and Pens

V. Content

(See following page)

ANXIETY DISORDERS

- Anxiety serves us well generally: an alerting signal, warning of impending danger
- threats of bodily harm, pain, punishment
- May be barrier to success
- Effects on bodily functions, social interactions
- Assists in taking steps to lessen the consequence, prevent the threat

Differs from fear in that fear alerts us to known external threats

Two parts of the brain shape our anxiety and fear:

1. Amygdala:
   a. Almond-shaped structure deep in brain, is the go between in the parts of the brain that processes and helps interpret incoming sensory signals; alerts the brain that a threat is present
   b. Appears to store emotional memories
   c. May play a role in specific fears, phobias

2. Hippocampus: also deep in the thalamus, encodes events into memories

Anxiety disorders are THE most common mental illness in America

About 40 million adults; although they occur in children and adolescents as well

Frequently a co-occurring disorder with other conditions, such as addictions disorders, as well as medical conditions, heart disease, Alzheimers, tumors, hyperthyroid

Alcohol use disorders are 3 to 4 times more prevalent in persons with anxiety disorders *Risk - can decrease impulse control and judgment.* ***Very lethal in overdose when combined with medications used to treat anxiety.***

Medications can cause anxiety: antipsychotics (akathesia); thyroid meds, bronchodialators, anticholinergics (cold medicine), hormonal therapy, some anti-hypertensives

Physical response to anxiety:
1. Increased respiration, heart rate, blood pressure
2. Palpitations, sweating, tremors
3. Nausea, diarrhea
4. Urinary frequency, urgency
5. Dizziness, fainting

Becomes pathological, "diagnosable" when it incapacitates one's functioning, and is of duration and frequency

MEDICATIONS FOR ANXIETY DISORDERS

Medications are only one part of treatment; psychotherapy is key

Cognitive behavioral therapy: changes the thinking that supports the anxiety as well as their behavioral reactions to the anxiety

Exposure-based behavioral therapy is used in specific phobias

Anti-anxiety medications: primarily benzodiazepines and generally prescribed for short term;

Side effects of benzos: sedation, ataxia, confusion, with toxicity: respiratory depression

Beta-blockers: routinely used for hypertension, can prevent/reduce the physical symptoms of anxiety, eg. Used before public speaking

Side effects of beta-blockers: dizziness, a slowed heart beat, fatigue, low blood pressure

SSRIs (prozac, paxil, Zoloft, celexa, lexapro, etc) are used particularly with OCD and PTSD

Side effects: gastric distress, nausea, headache, sexual dysfunction and caution of the serotonin syndrome (confusion, sweating, stiffness, increased blood pressure and heart rate)

Lesson Plan 11: PTSD/PTSD & VETS

I. Class Goals

This class will expose students to people at risk for PTSD, signs and symptoms of PTSD, and risk factors associated with PTSD. Special focus will be given to war veterans and PTSD. Students should gain awareness that first responders are especially susceptible for developing this disorder.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Describe signs and symptoms of PTSD
2. Describe who may be at risk for developing PTSD
3. Recall PTSD risk factors specific to war veterans
4. Know how to utilize local resources for vets
5. Recognize that officer has an increased chance of PTSD due to the nature of police work

III. Methodology

Class will utilize a combination of lecture (PowerPoint), video and discussion.

IV. Materials and equipment

1. Projector and screen
2. DVD Player
3. Flip Chart and Pens
4. DVD "Frontline: A Soldier's Heart"

V. Content

See following page

POST-TRAUMATIC STRESS DISORDER

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder. Occurs after a traumatic event. A traumatic event = something horrible and scary that you see or that happens to you. You believe your life or others' lives are in danger.

Anyone who has gone through a life-threatening event can develop PTSD. These events can include:

- Combat or military exposure
- Child sexual or physical abuse
- Terrorist attacks
- Sexual or physical assault
- Serious accidents, such as a car wreck.
- Natural disasters, such as a fire, tornado, hurricane, flood, or earthquake.

How does PTSD develop?

All people with PTSD have lived through a traumatic event that caused them to fear for their lives, see horrible things, and feel helpless. Strong emotions caused by the event create changes in the brain that may result in PTSD.

Most people who go through a traumatic event have some symptoms at the beginning. Yet only some will develop PTSD. It isn't clear why some people develop PTSD and others don't.

Development of PTSD depends on:

- How intense the trauma was or how long it lasted
- If you lost someone you were close to or were hurt
- How close you were to the event
- How strong your reaction was
- How much you felt in control of events
- How much help and support you got after the event

Symptoms of PTSD:

Symptoms of posttraumatic stress disorder (PTSD) can be terrifying. They may disrupt your life and make it hard to continue with your daily activities. It may be hard just to get through the day.

PTSD symptoms usually start soon after the traumatic event, but they may not happen until months or years later. They also may come and go over many years.

PTSD likely if:

- Symptoms last longer than 4 weeks;
- Cause you great distress;
- Interfere with your work or home life.

Four types of symptoms: Re-experiencing, avoidance, numbing, and hyperarousal

PTSD AND VETS

Involved in combat = high potential of exposure to life-threatening experiences

PTSD occurs:

- 30% of Vietnam veterans
- 10% of Gulf War (Desert Storm) veterans
- 6% to 11% of veterans of the Afghanistan war (Enduring Freedom)
- 12% to 20% of veterans of the Iraq war (Iraqi Freedom)

Other factors that may contribute to PTSD and other mental health problems:

- Role in the war
- Politics around the war
- Where the war is fought
- Type of enemy you face

Lesson Plan 12:
Police Officer Holds (POH), Director's Custody Holds,
Emergency Departments, and the
Civil Commitment Process

I. Class Goals

This class will review Police Officer Holds and Director's Custody Holds in Multnomah County. The class will also familiarize officers on emergency room protocols regarding holds. This class will introduce and review the civil commitment process.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Recall the difference between a POH and a Director's Custody Hold
2. Recognize emergency department procedures and protocols
3. Describe the steps in the civil commitment process
4. Articulate the importance of a detailed report for the purposes of a hold

III. Methodology

Class will utilize a flipchart, PowerPoint presentation and deliver the information in lecture format with a question and answer period.

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector/Computer with PowerPoint

V. Content

See following page
See PowerPoints

REQUIREMENTS OF A POLICE OFFICER HOLD (POH)

- Probable cause that the person is a danger to self or others and is in need of immediate care
- Due to mental illness
- POH allows police officer to transport person to the hospital or other appropriate care facility. (In Multnomah County there is no facility that only receives psychiatric patients such as the former Crisis Triage Center).
- 72 hour holds no longer exist and haven't for many years

Putting someone on a hold is a legal decision.

WHO CAN PUT A HOLD ON SOMEONE?

- Police Officer Hold (POH): The POH allows officers to put a **civil** hold on someone who is deemed a danger to self or others. It allows officers to transport the individual to a medical/psychiatric facility for further evaluation.
- Qualified Mental Health Professionals (QMHP) who have undergone training and have been certified by Multnomah County's Mental Health and Addiction Services Division. When a QMHP places a hold on someone they do this under the authority of the county mental health director, hence the term "Director's Hold." ORS states that a person placed on a Director's Hold **shall** be transported by law enforcement to the nearest hold facility.
- Most therapists, psychiatrists, psychologists, and counselors do not have the authority to place a hold on someone.

HOSPITAL EMERGENCY DEPARTMENTS

- Not all hospitals take people on a mental health hold
- All hospitals in our area (save the old Woodland Park) take people on holds
- Hospitals need to be authorized/certified by the state to accept psychiatric patients

WHAT HAPPENS AT THE HOSPITAL?

- The mentally ill person will be evaluated by the emergency department doctor and/or a social worker. The decision to "hold" the person in the ED is made by a doctor in the ED.
- Hospital staff uses the same criteria that police do –danger to self or others due to a mental illness.
- **Or**, a hospital hold can be placed (essentially a continuation of the police officer hold) which means the person stays in the hospital for now.
- If a hospital hold is placed, client is transferred to a hospital unit; this may or may not be at the same hospital where client was taken on the hold. Much depends on bed availability. The person can be held for up to 72 hours at this point.
- **Or**, the hold can be "dropped," meaning the ED doctor determined that the person is no longer a danger to self or others. The person will be discharged from the hospital.

CIVIL COMMITMENT PROCESS

- Once a hospital hold is placed, Multnomah County Mental Health is alerted. An ICP (Involuntary Commitment Program) investigator is assigned from Multnomah County Mental Health. The ICP interviews client and attending staff in the hospital. The ICP also uses previous hospital records, family, friends, caseworkers, police reports etc. to evaluate whether the person meets the "danger to self or others" criteria.
- The ICP can:
    - Continue the hold and set a hearing date for civil commitment
    - Drop the hold (the person gets discharged asap)
    - Let the hold run out (maximum of five business days)

    - The determination to take the person to a civil commitment hearing occurs within 3 business days of the hold.
    - The ICP sets a hearing date for the mentally ill person for no longer than 5 business days from the date the hold was written.
    - The hearing can be set over for an additional week. Practically speaking, this option only occurs if the mentally ill person is participating in treatment (usually taking meds.)
    - The client may also elect to stay in the hospital voluntarily, if agreed upon by medical staff.

Remember: civil commitment is a legal process, not a clinical one. It has been designed as a legal procedure. At times, the logic of the legal process is at odds with the logic of reasonable psychiatric intervention or the wishes of the family, significant others, or treatment providers.

AT THE HEARING

- If the client has a commitment hearing, he/she could be committed for up to 180 days (average commitment is 2-3 weeks).
- **OR** he/she could be released from court
- **OR** he/she could "stipulate" thus voluntarily returning to the hospital
- **OR** he/she could have a "setover" which would send the client back to the hospital until the next week, after which they would return to court to be re-evaluated.
- Present at the hearing are: Two mental health professionals take part in the hearing (usually a psychiatrist and psychologist), in addition to reports from the ICP, witnesses, and a judge who makes the final determination for commitment.

TWO-PARTY PETITION

- A "two-party petition" can be initiated/signed by any two adult members of the community who deem the person in question is unable to meet their basic needs. The "two-party petition" is used for issues of what is called "inability to care" or "deterioration of function." The petitioners must have first hand evidence of the person's lack of ability to care for him or herself. They must also be willing to testify in court.

- The petition is filed at the county's mental health division.
- The person in question remains in the community while the details of the petition are being investigated.
- The investigation is completed within fourteen calendar days.

NOTE:
The term "chronically mentally ill" is defined as followed:

A. Within the previous three years has been committed twice and been placed in a hospital or approved inpatient facility.

AND

B. Is exhibiting symptoms or similar behaviors to those that preceded or led to one or more hospitalizations or inpatient placements.

AND

C. Unless treated will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become as described under either or both subparagraph (A) or (B) of this paragraph.

Lesson Plan 13:
Delirium and Excited Delirium

I. Class Goals

This class outlines the signs and symptoms of delirium and excited delirium. Protocols and procedures for dealing with subjects exhibiting signs of excited delirium will be presented.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Recognize signs and symptoms of delirium
2. Recognize signs and symptoms of excited delirium
3. Describe procedures for dealing with a subject suspected of being in a state of excited delirium
4. Articulate that delirium and excited delirium are **medical emergencies** requiring swift medical intervention

III. Methodology

Class will utilize a flipchart, PowerPoint presentation and discussion.

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector
3. PPB Training Video (March, 2008) if applicable

V. Content

See following page

DELIRIUM

- A *syndrome* and not an ongoing disease

Medical/organic cause:

- Epilepsy/postictal states
- Infection, frequently urinary tract, particularly in older person
- Fluid/electrolyte imbalance, dehydration
- Head trauma
- Stroke
- Medication interaction
- Drug induced
- Alcohol withdrawal
- Extreme hypothermia
- Liver failure
- Kidney failure

Symptoms:

- Perceptual disturbances: visual hallucinations
- Reduced consciousness, unaware of environment
- Highly distractible
- Rambling incoherent speech- may come and go
- Increase or decrease in psychomotor activity
- Disoriented to place, person, and time
- Onset usually sudden, over hours or 2-3 days
- Sleep/wake cycle disturbed
- Immediate memory is impaired

Delirium is a medical emergency

EXCITED DELIRIUM

- See attached PowerPoint
- PPB Training Video (March, 2008) on excited delirium for all Advanced Academy classes starting in 2009.

Lesson Plan 14: Personality Disorders

I. Class Goals

This class will introduce students to the DSM-IV. Specifically, it will underscore the difference between an Axis I and an Axis II disorder. The concept of an Axis II disorder will help students understand why certain behaviors, although maladaptive and potentially dangerous, do not result in a hospital hold. Four personality disorders that officers are most likely to encounter will be discussed.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Articulate the difference between an Axis I and an Axis II mental health disorder.
2. Recognize the specific challenges of interacting with individuals with a personality disorder.
3. Utilize appropriate techniques to most effectively communicate with individuals with a personality disorder.

III. Methodology

This class will utilize a combination of lecture (PowerPoint) and discussion.

Materials and equipment

1. Projector with PowerPoint slides
2. Flipchart with pens

IV. Content

See attached PowerPoint slides

Lesson Plan 15: Psychiatric Security Review Board

I. Class Goals

This class will familiarize students with the function of the P sychiatric Security Review Board (PSRB). Examples of a LEDS PSRB "hit" will be shown so students will be prepared to follow proper procedures should they encounter a PSRB client in need of services.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Recognize a LEDS PSRB "hit" on the MDT
2. Follow appropriate protocols for a PRSB detention order
3. Describe the role of PSRB in the mental health and justice system
4. Articulate the meaning and consequences of being found "guilty except for insanity" (GEI)

III. Methodology

Class will utilize a flipchart, PowerPoint presentation and discussion.

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector
3. Consumer video: "Ashleigh"

V. Content

See PowerPoint

Lesson Plan 16:
"Hearing Voices" Exercise

I. Class Goals

Through this interactive exercise, students will gain an appreciation of the challenges of living with some of the symptoms of schizophrenia.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Identify symptoms of schizophrenia
2. Recognize the challenges of interacting with police officers while experiencing auditory hallucinations
3. Practice communication techniques when interacting with someone who seems "distracted" due to possible psychotic symptoms

III. Methodology

Description of exercise:

Instructors will demonstrate the exercise using volunteers from the class. Then the class will break up into groups of four with the following roles for each of the four participants:

1. "Psychotic" person in the middle of two participants
2. One person on one side of the "psychotic" person
3. One person on the other side of the "psychotic" person
4. One person who interviews the "psychotic" person

Person #1 will sit in a chair. The person needs to remain seated during the exercise. They will listen and try to answer any questions directed at them.

Person #4 will have a list of questions to ask the seated person. He/she will ask familiar ones such as: name, D.O.B., and other, more complicated questions that require higher levels of thinking. This person will stand directly in front of the seated person.

Person #2 and #3 will stand on each side of the seated person, with a "voices" script. They will also get a piece of paper and roll it up into a tube, making a "mini-megaphone." They will then put the tube about 1-2 inches from the seated person's ears and start talking in a low voice. They will talk faster and slower as needed. They can also talk louder and softer as they see fit. If participants are familiar with each other, they can vary the "script" accordingly. Participants switch positions so all class members can experience the challenges of communicating while "hearing voices." The exercise is debriefed afterwards.

Materials and equipment

1. Projector with slides of the two scripts
2. Copies of voices scripts

3. Card stock paper or similar material to create a "megaphone."

IV. Content

PowerPoint of "Scripts"

Lesson Plan 17:
Mental Retardation/Developmental Disabilities

I. Class Goals

This class will familiarize students with the definition of "MRDD." Communication techniques for this population will also be reviewed.

II. Performance Objectives

Upon completion of this class the student will be able to:

1. Define "developmental disabilities" as it is used in Multnomah County
2. Differentiate between people with MRDD issues and people diagnosed with a mental illness
3. Describe appropriate communication techniques for the MRDD population
4. Articulate how interviewing a person with MRDD issues differs from interviewing people outside the MRDD population

III. Methodology

Class will utilize a flipchart, PowerPoint presentation, video and discussion.

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector
3. Video: Dave Dobler

V. Content

See following page

1. Many causes of brain dysfunction
    i. Anatomical abnormality or damage e.g. trauma, tumors, electrocution
    ii. Lack of oxygen/glucose: diabetes, stroke, asphyxiation
    iii. Electrolyte imbalance: dehydration
    iv. Neurotransmitter dysregulation: dopamine (thought organization)
    v. Norephinephrine (fight/flight, focus, alertness)
    vi. Serotonin (mood states)
    vii. Acetylcholine (memory, inhibition)
    viii. GABA (reduces arousal, aggression, anxiety)
    ix. Endorphins (pain, stress response)
    x. Viral
    xi. Genetic
    xii. Autoimmune
    xiii. Substance abuse
    xiv. Nutritional

2. Developmental Disabilities
    i. 220 DD disorders
    ii. Can be genetic, congenital, environmental
    iii. 2% of Multnomah County (approx. 15,000 people)

3. DD differs in cause from mental illness
    i. Childhood diagnosis
    ii. IQ affected
    iii. Lifelong prognosis
    iv. Medications do not change functionality

4. Communication principles and techniques
    i. Patience, patience, patience
    ii. Ask if person has a hearing or other disability
    iii. Ask how accommodation might be made
    iv. Talk clearly and slowly
    v. Repeat yourself if needed
    vi. Offer to have a family member/friend present at the interview
    vii. Understand the person's need to "please"
    viii. Set appropriate boundaries, if needed

40 Hour CIT Curriculum
February 2007-December 2008

Lesson Plan 18: Addictions and Mental Health

I. Class Goals

This class will familiarize students with the physiological and psychological effects of drugs and alcohol. The class will cover the concept of "dual diagnosis" and will outline the unique challenges of treating both substance abuse/dependence and mental illness.

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Articulate the meaning of "dual-diagnosis"
2. Describe the physiological effects of various drugs, including alcohol
3. Appreciate the challenges involved in the process of recovery (i.e. relapse)
4. Familiarize students with addiction resources in the community
5. Recognize the role that officers can play in the recovery process

III. Methodology

Class will utilize a flipchart, discussion, supporting handouts, and video

IV. Materials and equipment

1. Flip Chart and Pens
2. Projector
3. Video: HBO "Addictions" Disk One: The Science of Relapse

V. Content

See handout

CHALLENGING ISSUES IN THE TREATMENT OF MENTAL ILLNESS

There are both internal and external barriers to treatment within the mental health system. We will address both:

Internal Issues:

- On the internal problems, one of the most significant is STIGMA: a labeling process which sets a person apart from others. For the mentally ill, it has severe consequences; it can be the primary reason a person does not seek treatment
- Where does this stigma come from? Fear, assumptions, family teachings, the media, jokes, rigid beliefs, intolerance
- *Activity: Brainstorm stereotypes of people with mental illness on a flip chart*

External systemic issues:

- The media can perpetuate stigma yet can also help overcome the stigma (ex: "Snake Pit" helped bring awareness to psychiatric institutions and their lack of treatment); it can start with individuals, something as simple as not laughing at a joke which stigmatizes someone
- There is a need for mental health providers to include the effects of stigma on the person in their treatment plans
- Of all the "isms" there is not one for discrimination against the mentally ill
- Language matters! For example, "12-34." Understand the need for shorthand in communicating a police call but need to be aware of its effects and the potential for helping to perpetuate the stigma
- Insurance has and continues to be biased against the mentally ill; only in Jan. 2007 has Oregon initiated parity for mental illness (services for mental illness get reimbursed at the same rate as physical illnesses such as heart disease and diabetes
- Cultural factors: Mental illness is viewed differently in different cultures
- Providers may have "compassion fatigue." Caseloads may be unreasonably high
- Empowerment is essential to recovery, yet sometimes clinicians lose sight of hope and the concept of recovery

- ACCESSIBILITY ISSUES:

- Insurance
- Eligibility requirements
- Lack of privacy
- Payor system for providers is constantly changing
- Medication coverage is inconsistent
- Younger persons experiencing the onset of their illness are unlikely to be hospitalized long enough to experience remission of symptoms
- Homelessness offers specific challenges on top of those already mentioned:
    - 1/3 of homeless mentally ill nationwide
    - Shelter requirements i.e. TB card
    - Medications can put one at risk i.e. drowsy, victimization
    - Lack of accessibility due to no housing address, contact info etc
    - Loss of benefits due to symptoms of disorganization
    - Inability to track appointments due to symptoms of disorganization
    - Increased exposure to health problems i.e. dependent positioning

Project Respond

I. Class Goals

This class will outline the various services provided by Project Respond

II. Performance Objectives

Upon completion of the class the student will be able to:

1. Know how to access Project Respond's 24/7 crisis team
2. Recognize Project Respond procedures and protocols
3. Recognize the other programs within Project Respond that might be helpful for following up with subjects
4. Recall under what conditions Project Respond requests police
5. Determine when it is appropriate to call Project Respond

III. Methodology

Class will utilize a flipchart and deliver the information in lecture format with a question and answer period

IV. Materials and Equipment

Flip Chart and pens

V. Content

See following page

PROJECT RESPOND

1. Began in 1993 to provide homeless outreach and crisis response to persons with mental illness in the downtown area; responded to calls from consumers, police, family members, businesses, and social service agencies

2. Today Project Respond is 24/7 , county wide, available through police dispatch and the Multnomah county crisis line; PR carries pagers only accessible through dispatch

3. Services available through Project Respond:

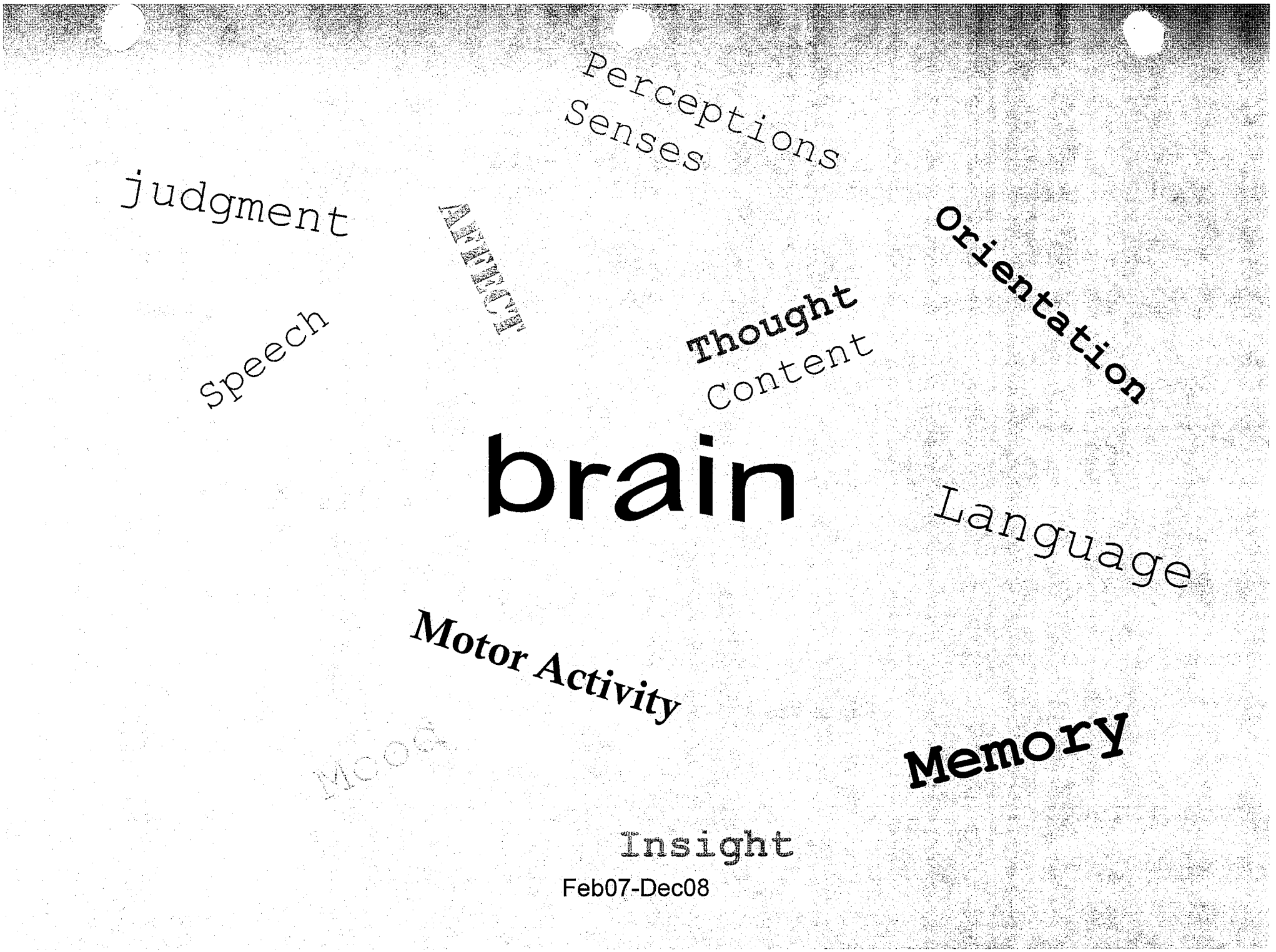
    - On site assistance with crisis, if further evaluation is indicated
    - Follow up engagement visits or welfare checks if officer deems appropriate
    - Outreach to homeless individuals
    - Assist case managers with checking on their clients
    - Implement Directors Custody Holds requesting police for transport to ED
    - Provide community education to community agencies, landlords, security personnel, businesses
    - Assist emergency rooms in connecting persons to resources (those who do not meet hospitalization criteria)
    - Provide welfare checks to residents when requested by landlords (those who may be experiencing symptoms of mental illness)
    - Respond to crisis involving children and families; provide follow up support visits by specialized Child/Family team through PR
    - When culturally specific concerns are present, PR utilizes cultural specialists to address both the clinical and cultural issues and to ensure that the interventions are culturally appropriate; PR has the following cultural specialists:
        i. Eastern European
        ii. African American
        iii. Asian American
        iv. Native American
        v. Hispanic
    - Can provide phone consultation to officers if requested and no PR on site presence indicated

4. IF POLICE REQUESTING PROJECT RESPOND:

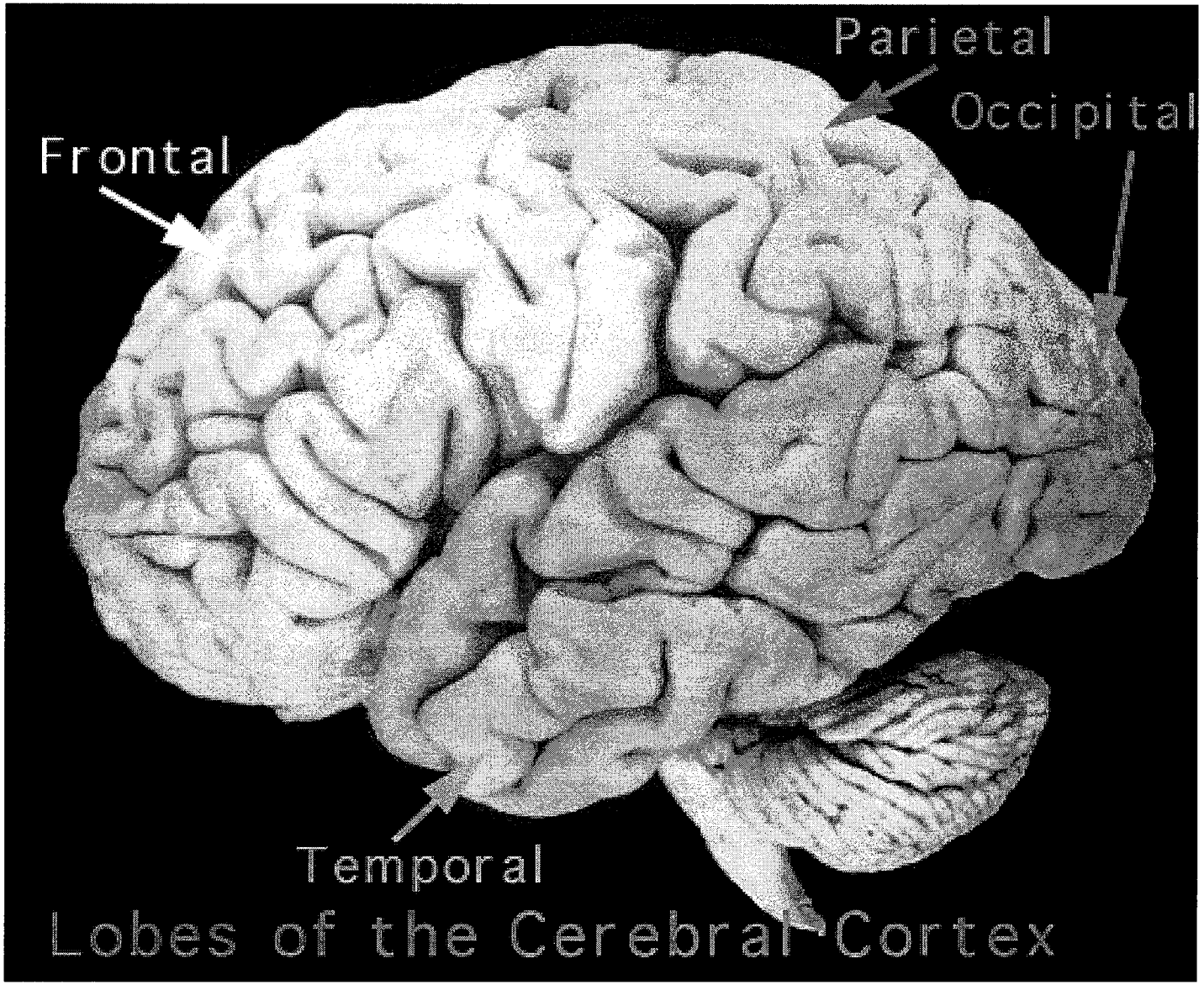
- Page Project Respond through dispatch; if possible, providing information re: subject, DOB if available. This assists PR in potentially obtaining pertinent clinical information.
- Project Respond will provide dispatch with cell phone by which officer can contact PR if needed while PR in route to call
- Upon arrival, PR will consult with officers re: situation, and precede with assistance with subject
- PR may also be called or paged for consultation if no immediate face-to-face intervention is warranted
- Police may also request follow up engagement or welfare check on subject; it is possible that PR will request police to accompany them on this visit if this seems warranted

5. IF PROJECT RESPOND REQUESTING POLICE:

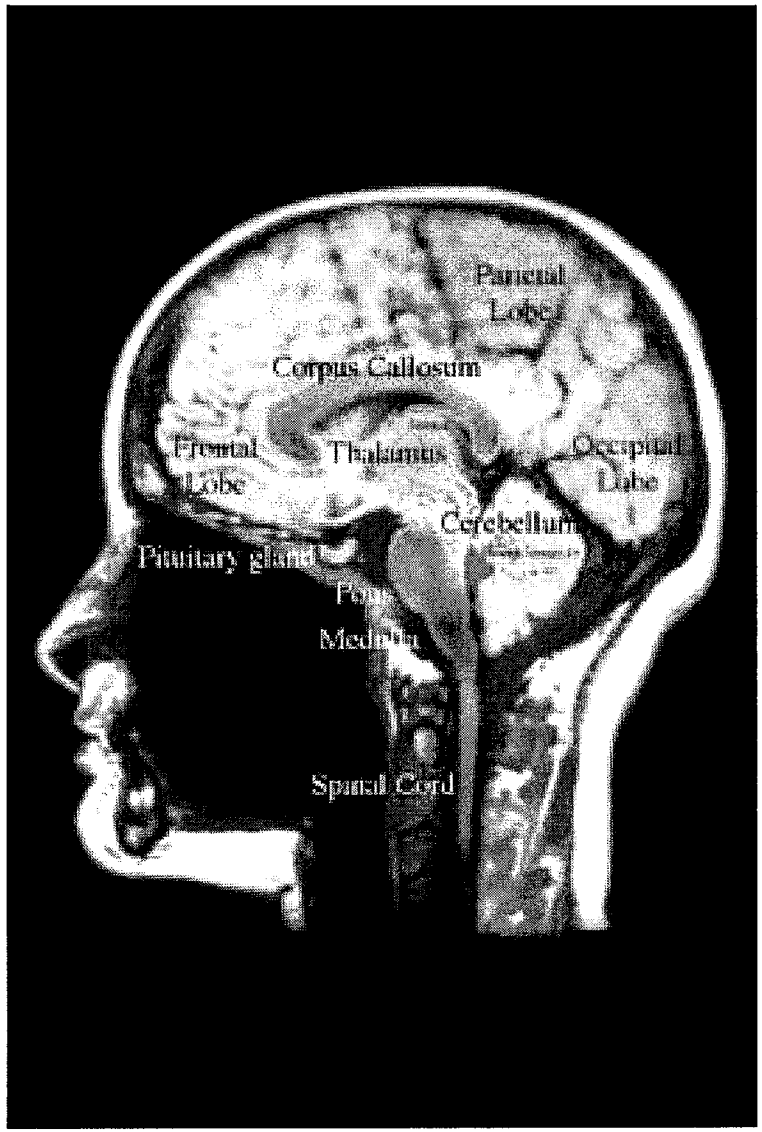
- Project respond will call for police through dispatch providing information re: the reason for assistance and name of client
- If known, PR will provide information re: history of violence, any known weapons, presence of others (or pets) in the environment, and size and presentation of client
- PR will also provide information re: PR whereabouts and cell phone number as PR frequently does not park in front of location
- PR will further brief officers upon their arrival and discuss plan for assessment
- If hold is deemed necessary, PR will request the police transport client to hospital and provide transport officer with Hold form
- Generally, PR accompanies police and client to hospital in order to brief the hospital staff


Perceptions
Senses
judgment
Affect
Orientation
Speech
Thought
Content
brain
Language
Motor Activity
Memory
Mood
Insight

Feb07-Dec08


Parietal
Occipital
Frontal
Temporal
Lobes of the Cerebral Cortex

Feb07-Dec08


Parietal
Lobe
Corpus Callosum
Frontal
Lobe
Thalamus
Occipital
Lobe
Cerebellum
Pituitary gland
Pons
Medulla
Spinal Cord

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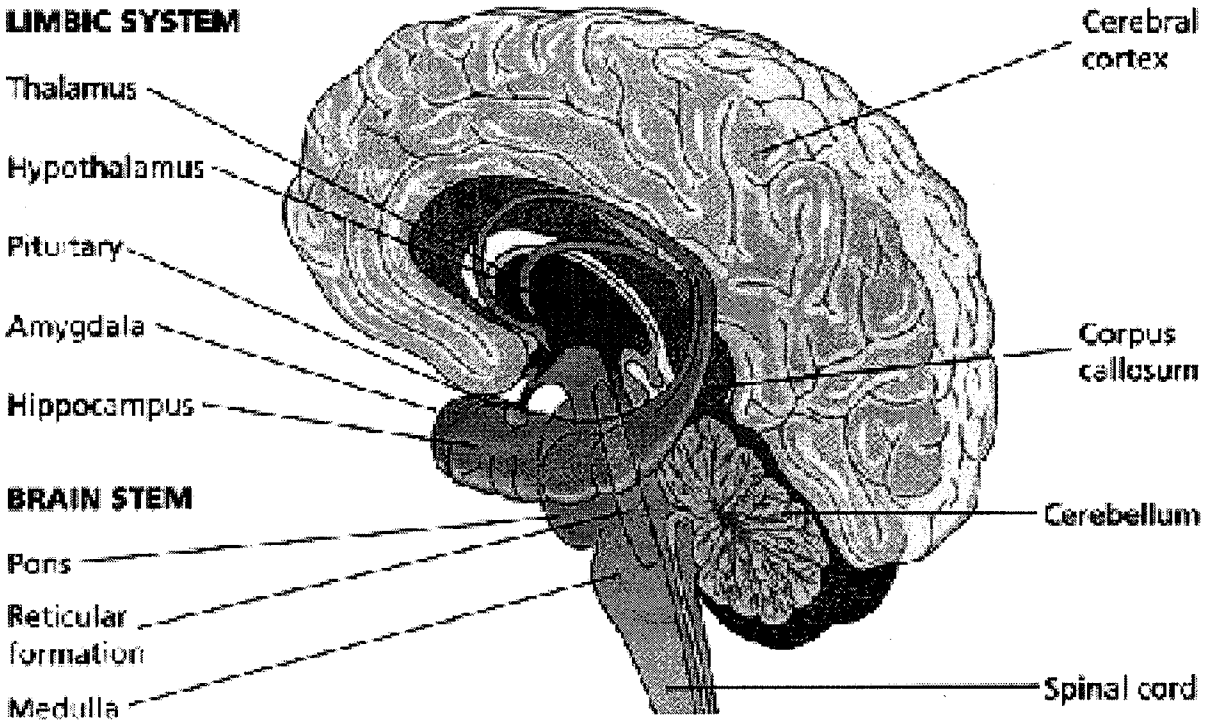
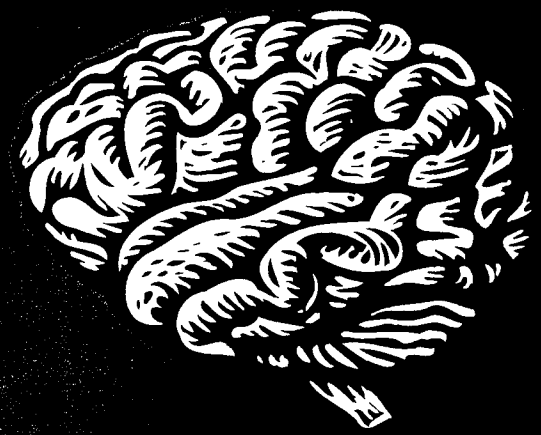

LIMBIC SYSTEM
Thalamus
Hypothalamus
Pituitary
Amygdala
Hippocampus
BRAIN STEM
Pons
Reticular formation
Medulla
Cerebral cortex
Corpus callosum
Cerebellum
Spinal cord

Or…, What's Going On In There?



Components of the MSE

- **General Appearance**
- **Thought Content**
- **Thought Process**
- **Speech**
- **Mood/Affect**
- **Psychosis**
- **Cognition**

General Appearance

- Clothing
  - Appropriate for weather?
  - Appropriate for context?
  - Style?
  - Cleanliness?

General Appearance

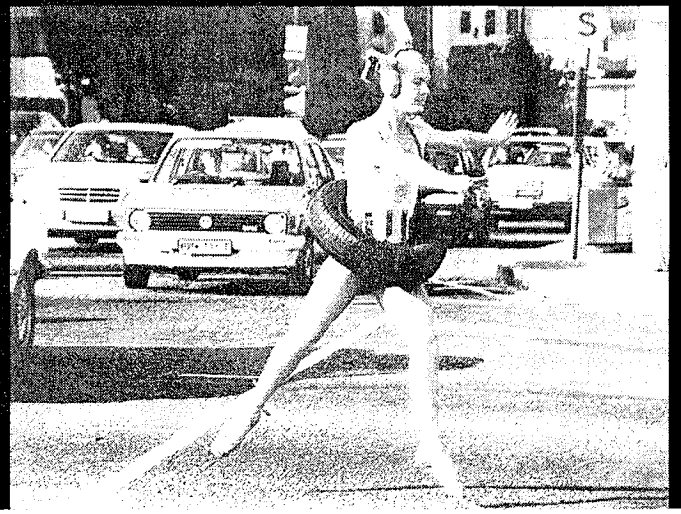
- Hygiene
  - Personal
  - Dental
  - Environmental
  - Clothing

Cognition

- Level of alertness
  - Conscious, sedated, etc.
- Orientation
  - Person
  - Place
  - Time
  - Situation

General Appearance

- Behavior
  - Goal-Directed/Organized?
  - Appropriate for context?
  - Speed?
  - Response from others?
  - Co-operative?



Speech

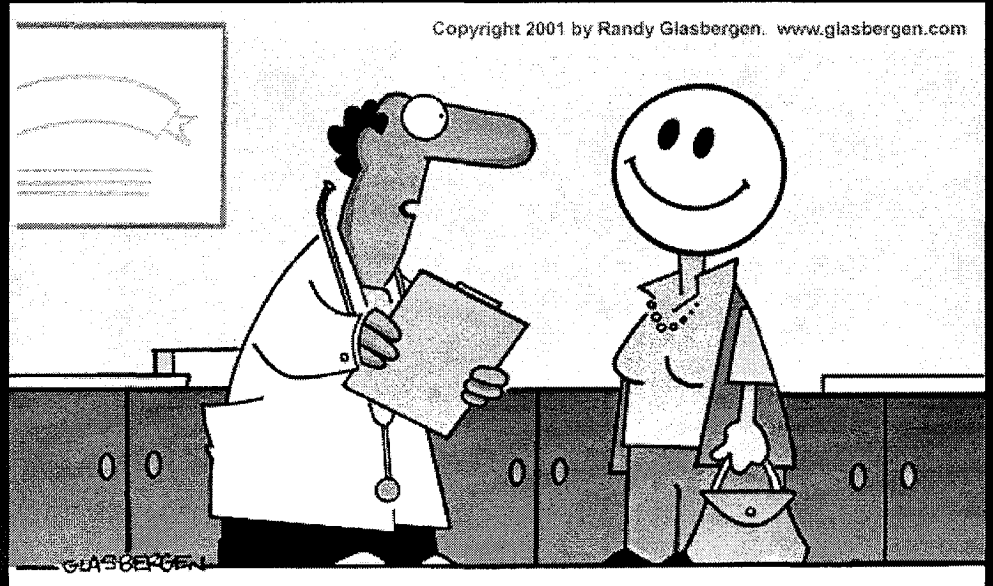
- Speed
- Pressure
- Abnormal Words
  - Nonsense words
  - Neologisms

Mood/Affect

- Mood
  - How the person *says* he/she is feeling)
  - *Subjective* evaluation

Mood/Affect

- Affect
  - How the person *appears* to feel
  - *Objective* evaluation



Thought Content

- ***What*** is the individual saying?
  - Delusions (of persecution, grandeur, conspiracies, etc.)
  - Relevancy to situation
  - Perseveration

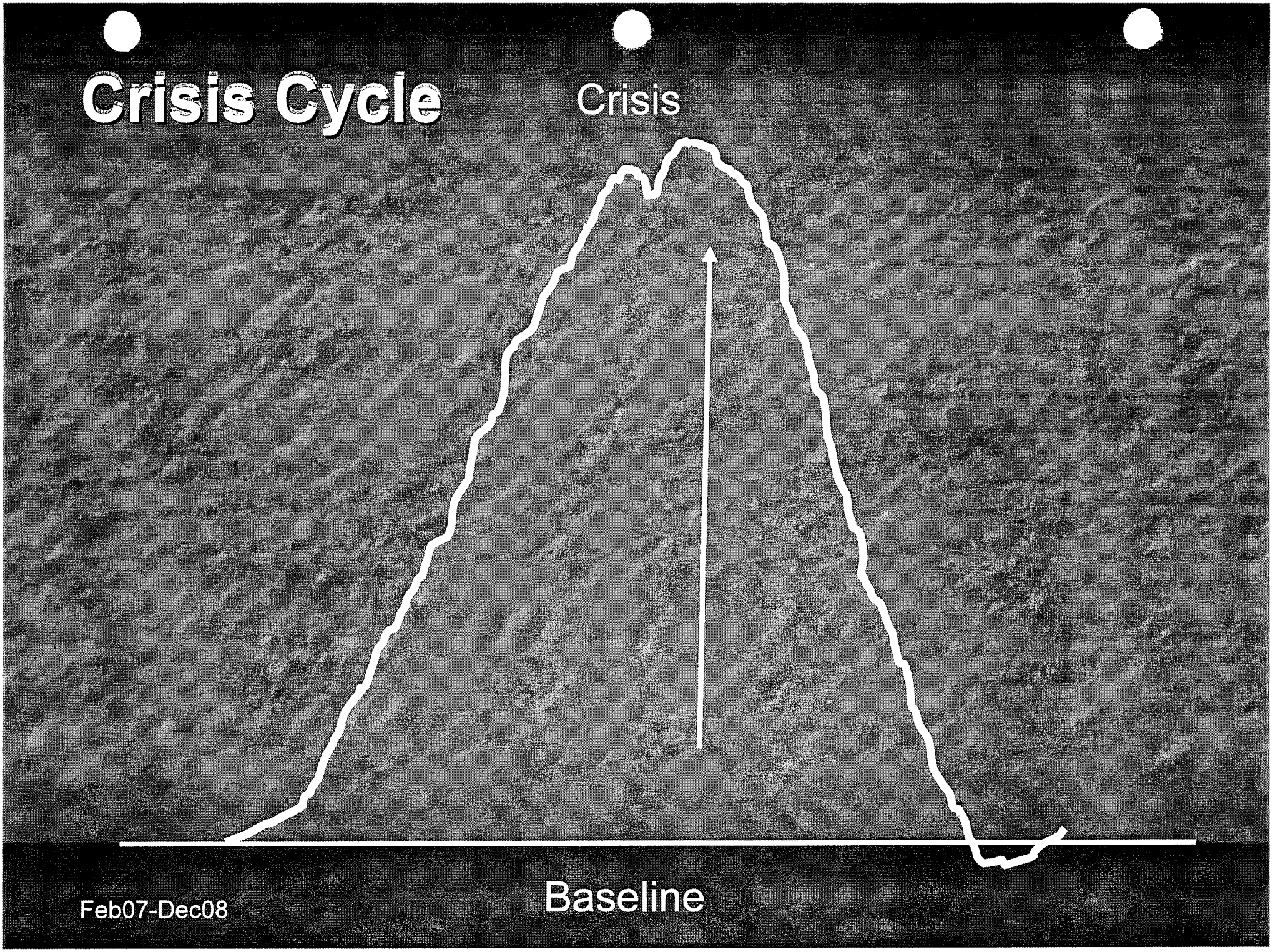
Thought Process

- ***How*** is the individual saying it?
  - Organization (e.g. circumferential, tangential, loose associations, flight of ideas, word salad, etc.)
  - Thought Blocking (i.e. long pauses during talking)
  - Perseveration

Perceptual Disturbance

- Hallucinations
  - Auditory –(hears voices)
  - Visual –(sees things that aren't there)
  - Tactile –(feels things that aren't there)
  - Gustatory –(taste)
  - Olfactory –(smell)
- Responding to internal stimuli

Crisis Cycle



What is a crisis?

Something has happened and it's overwhelmed a person's ability to cope, in that moment, for whatever reason

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Not every mental illness is a crisis;

Not every crisis involves mental illness.

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Mental "Moments"

Mental Moments = No diagnosis but behavior that is far from rational

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Examples of Mental "Moments"

- Road Rage
- Grief
- Traffic Accidents
- Riots
- Frustration/Anger
- Natural disasters

*Where ever people are freaking out and don't respond to normal communication

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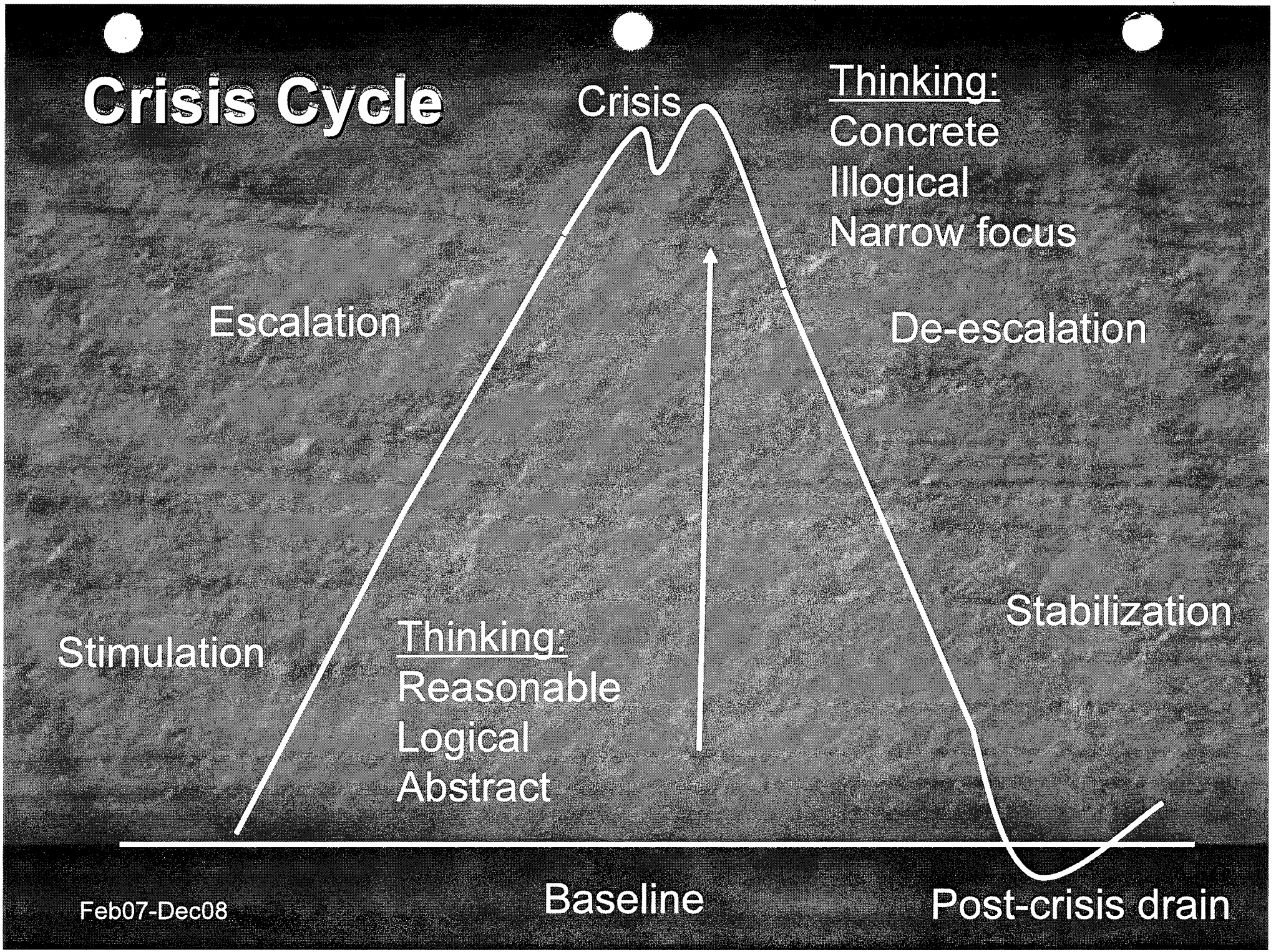
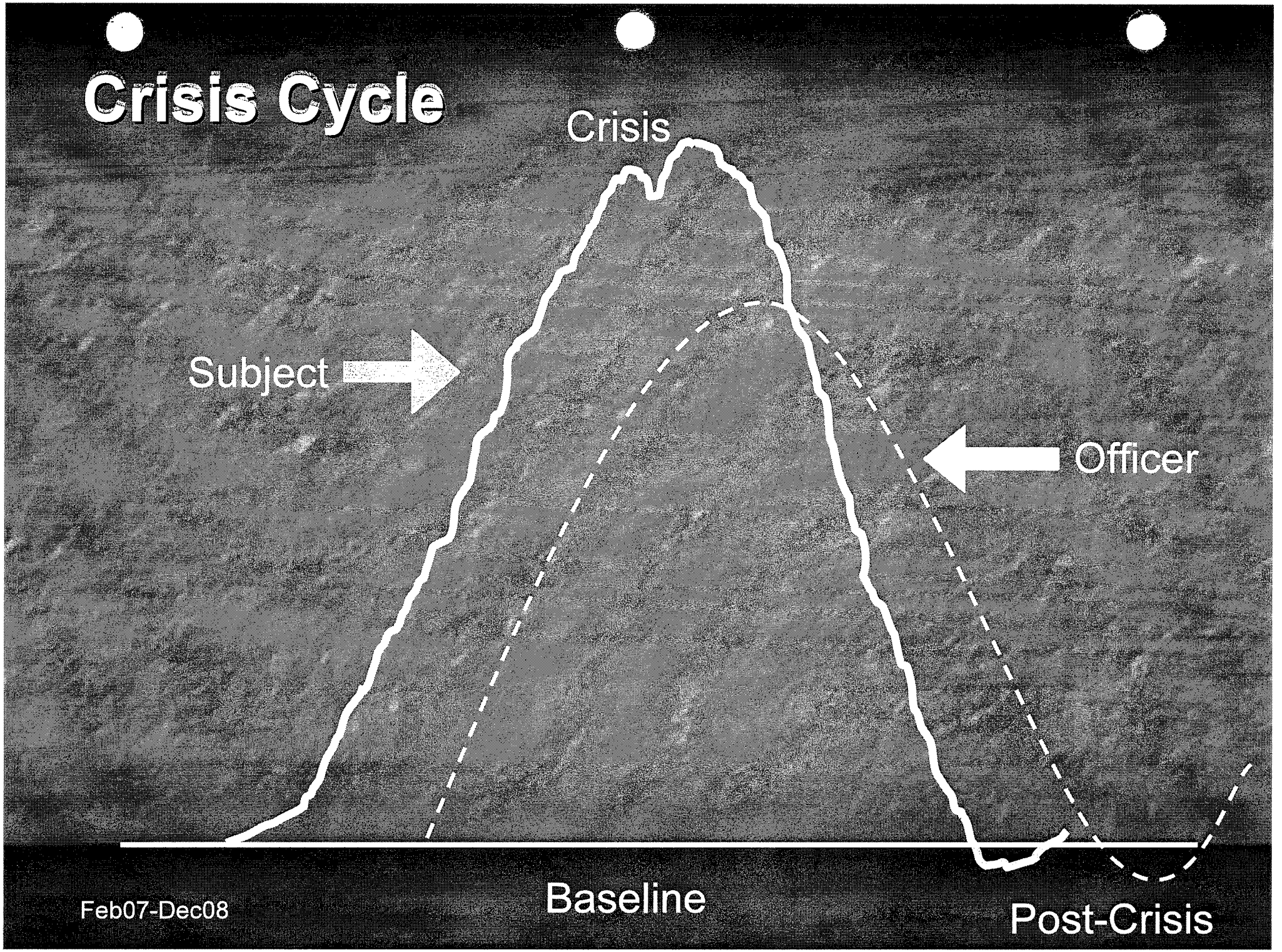

Crisis Cycle
Crisis
Thinking:
Concrete
Illogical
Narrow focus
Escalation
De-escalation
Stabilization
Stimulation
Thinking:
Reasonable
Logical
Abstract
Feb07-Dec08
Baseline
Post-crisis drain


Crisis Cycle
Crisis
Subject
Officer
Baseline
Post-Crisis
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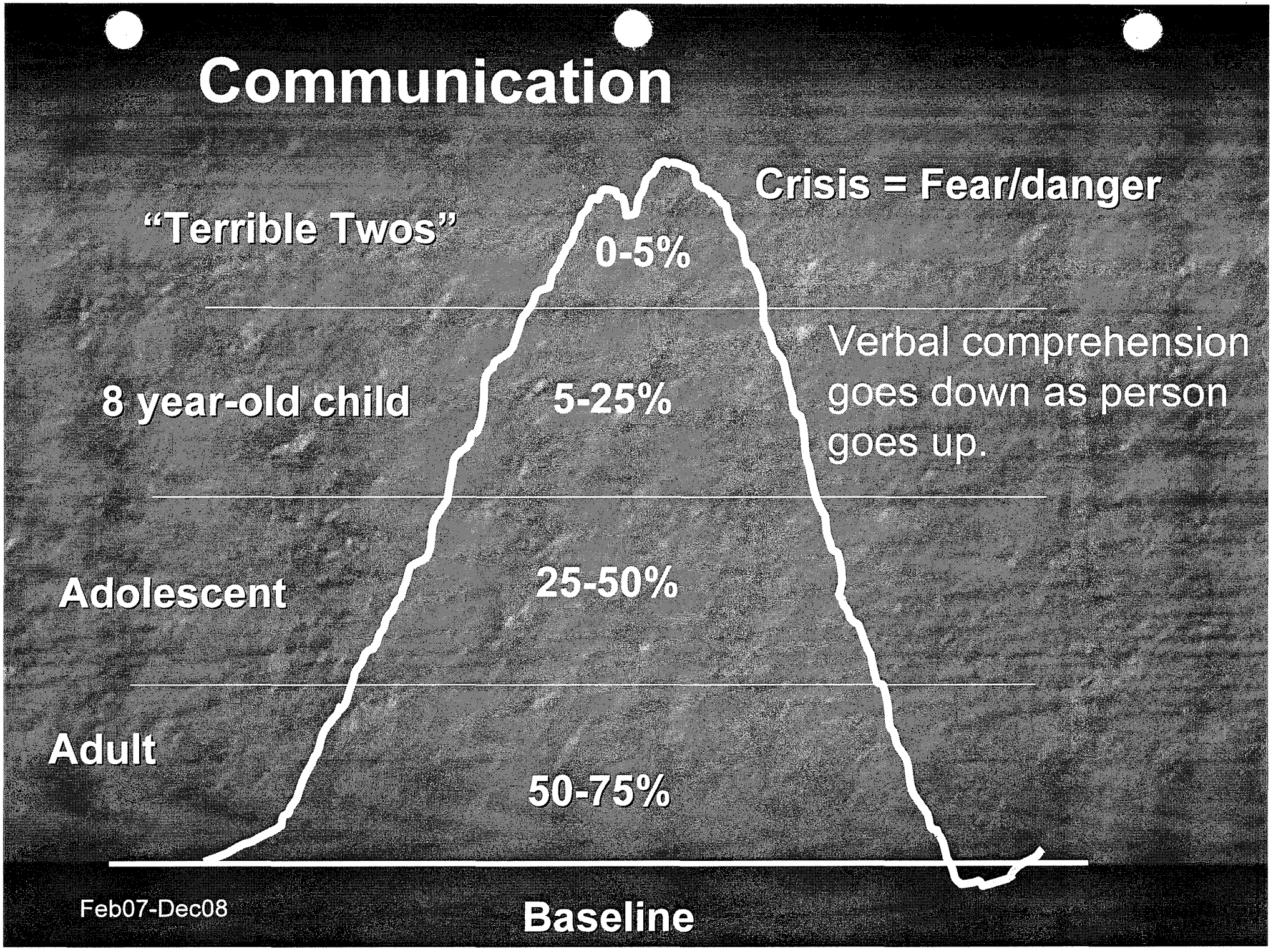
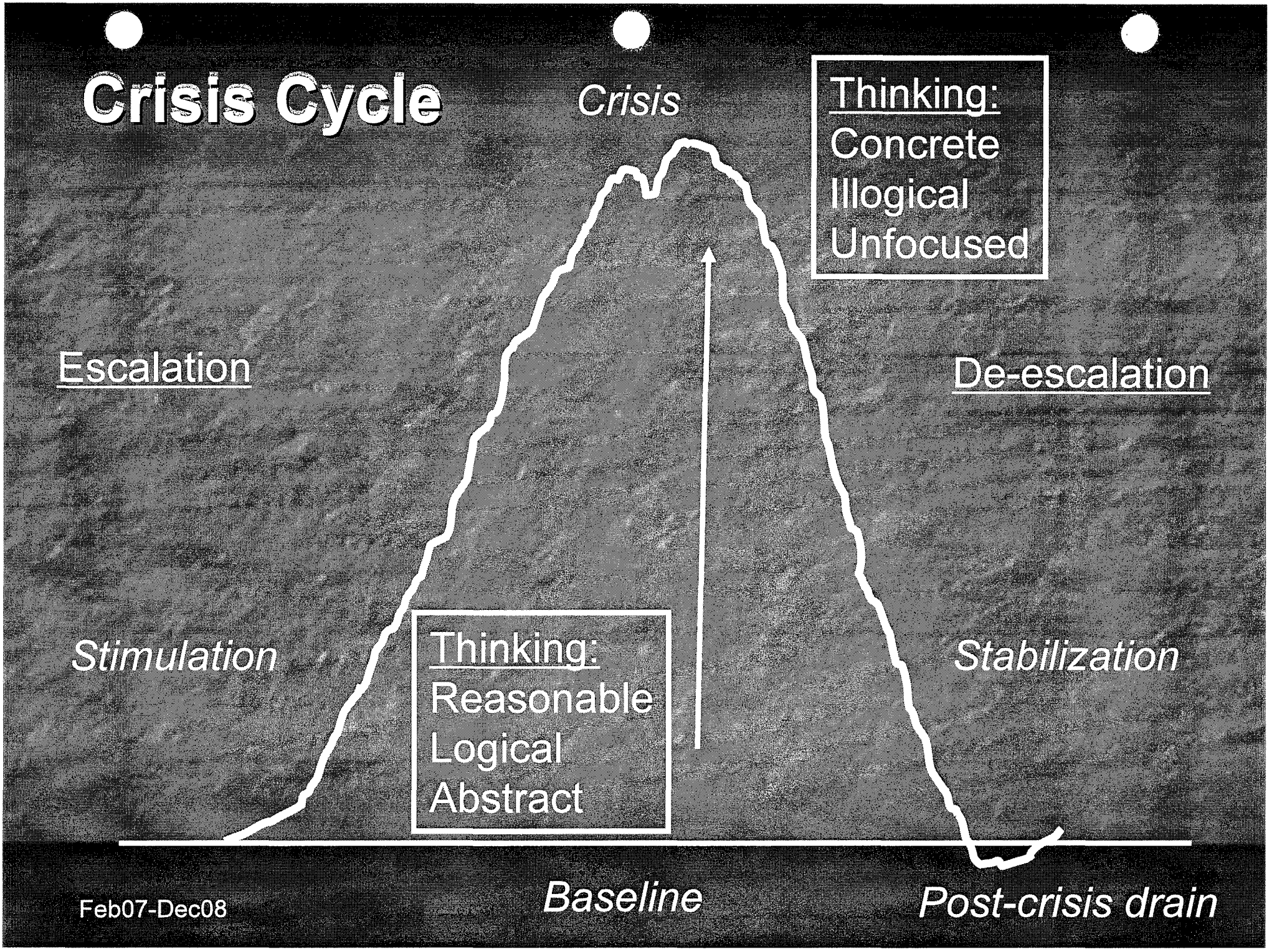
Communication




Crisis Cycle
Crisis
Thinking:
Concrete
Illogical
Unfocused
Escalation
De-escalation
Stimulation
Thinking:
Reasonable
Logical
Abstract
Stabilization
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Baseline
Post-crisis drain

De-Escalation puts people in their comfort zones

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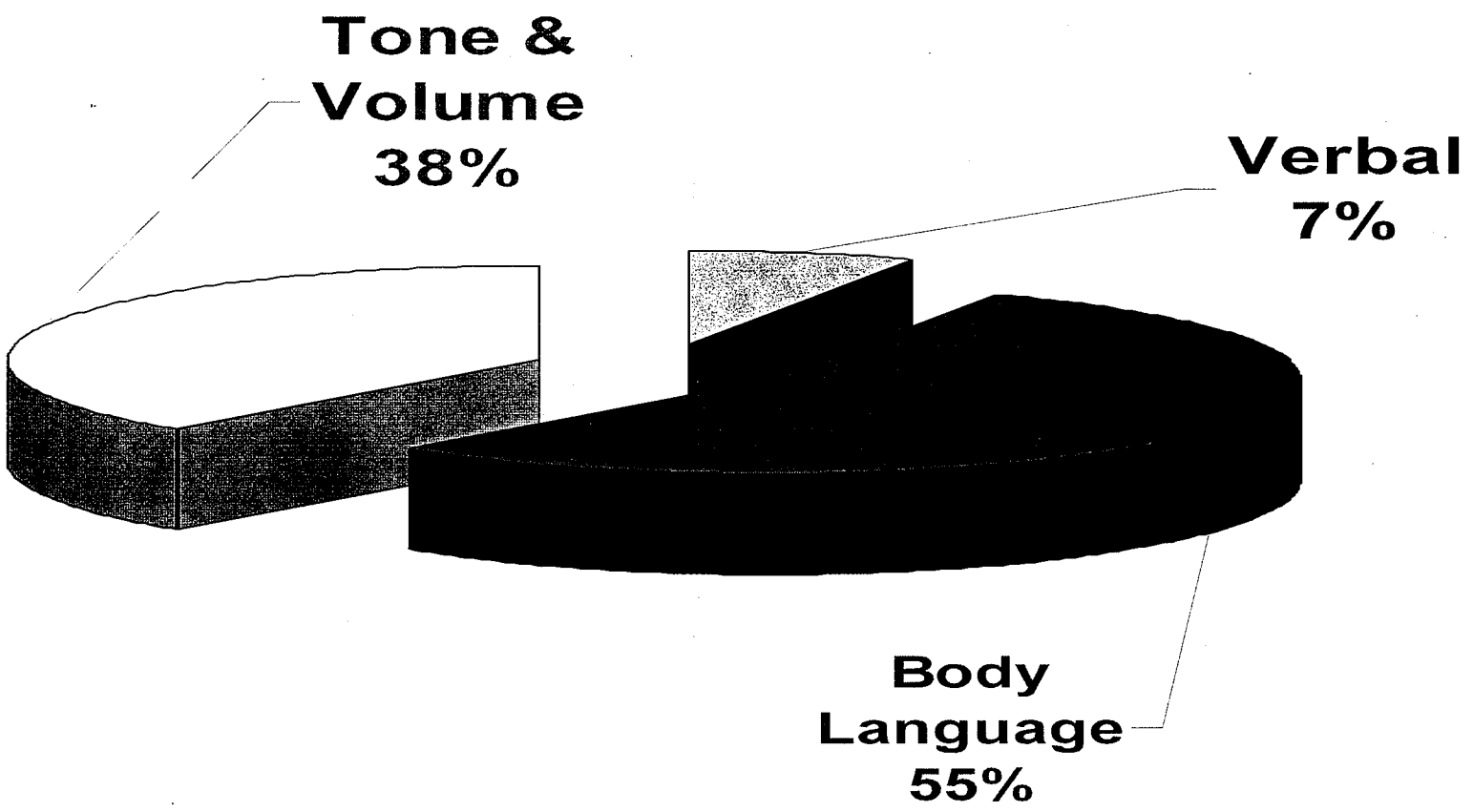
Communication



Communication is a loop... not a line

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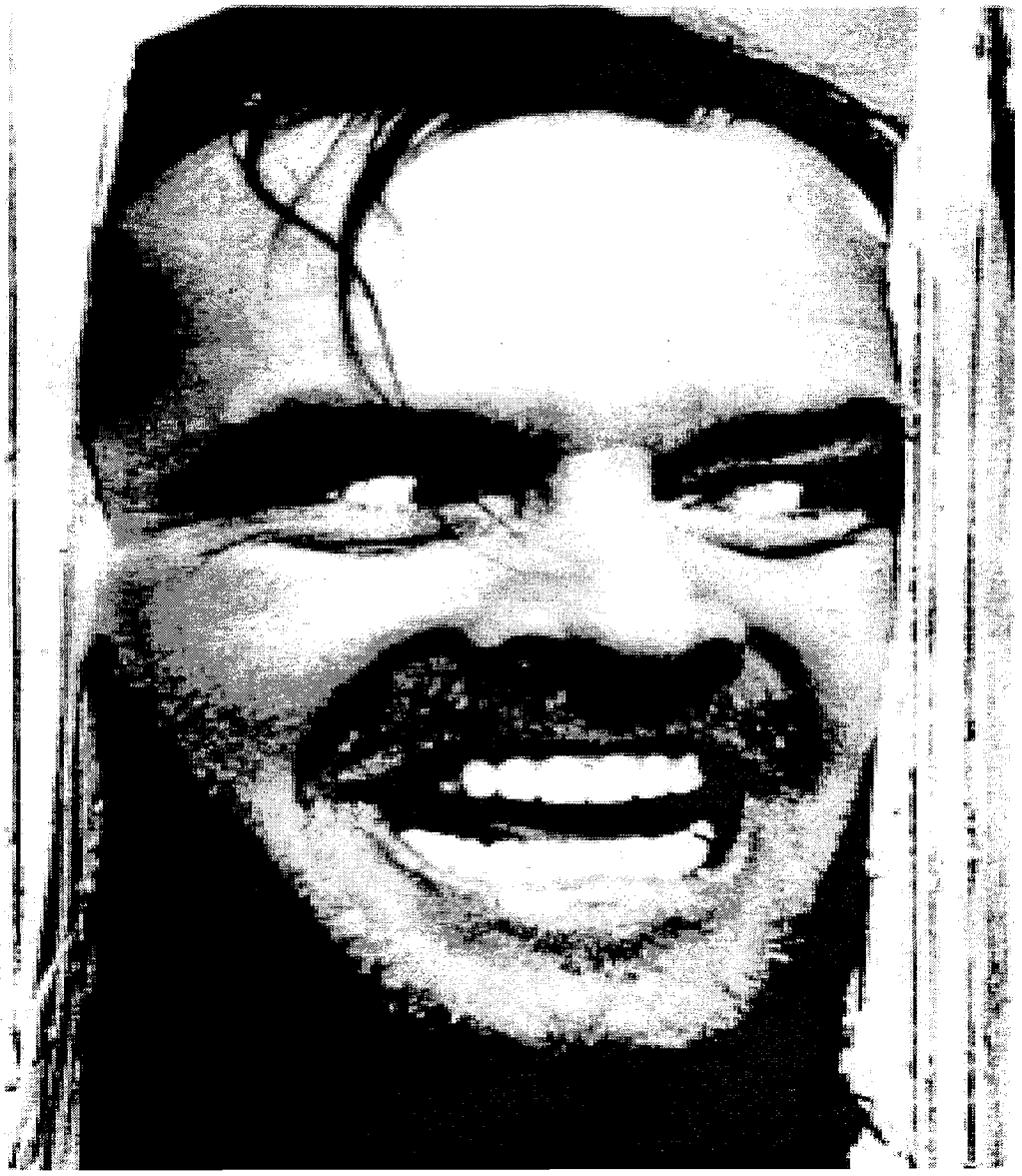
You cannot NOT Communicate



Receiving a signal = Listening

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Communication Recommendations

- Limit input
- Slow down
- Reduce distraction
- Use short sentences
- Simple language
- Repeat yourself
- Use silence

Receiving a message = Listening

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Listening Skills

- Emotional labeling/ Acknowledge emotion
- Paraphrasing
- Reflecting
- Effective Pauses
- Minimal Encouragers
- Open-ended questions

AP Photo by Rick Bowmer

Feb07-Dec08

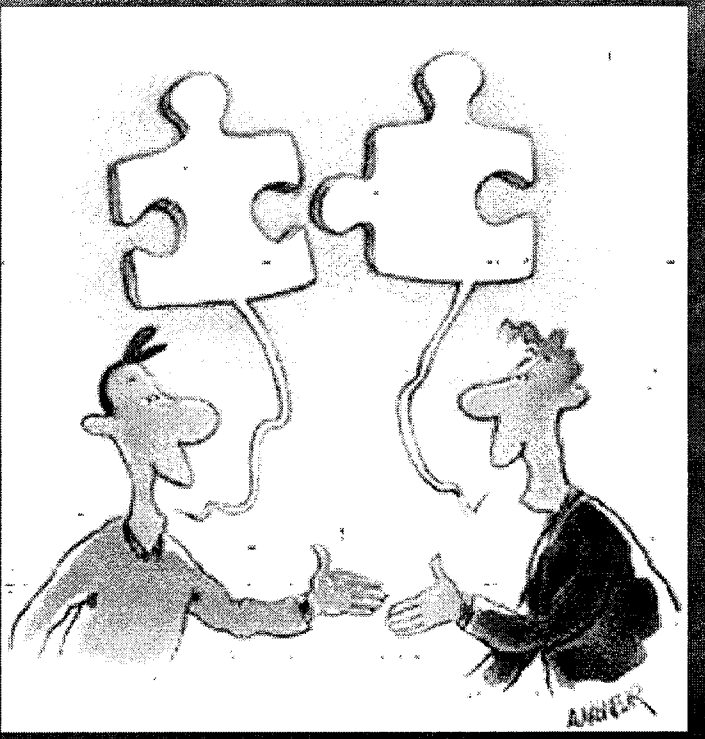
Connect

Emotional labeling **Effective Pauses**

Paraphrasing **Minimal Encouragers**

Reflecting **Open-ended questions**

1. Are you telling me…?
2. Uh huh. Ok. Sure…
3. Did I get it right, that you…
4. What are your plans for today?
5. You seem frustrated
6. < >. I see.
7. How are you feeling?



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Connect

- I'm here to help you.
- What's going on today?
- Do you feel safe?
- What would help you feel safe(r)?

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Connect

- You seem... (name emotion)
- That must be...(name situation)
- It sounds like you...(restate concerns)
- So what you are saying is...
- How can we solve this problem today?

Connect

- I'd like to hear your side...
- Good for you for...
- You deserve that!
- That sucks!

Communication Recommendations

- Are you hearing voices?
- What are they saying?
- Have they said this before?
- Have you ever acted on your voices?
- What helps?

Communication Recommendations

- Don't argue with their reality
- Listen for kernels of truth
- "I believe that you feel rays coming through the ceiling. That sounds terrifying."
- How will you defend yourself?
- How will you recognize the people who are out to get you?

Communication Recommendations

- Limit input
- Slow down
- Reduce distraction
- Use short sentences
- Simple language
- Repeat yourself
- Use silence

Feb07-Dec08

Risk Factors with Psychosis

May have an overlooked medical cause

May not care for basic needs

Disorganized behavior may place person in harm's way, e.g. walk into traffic

May not dress appropriately for weather

Catatonia may further complicate taking into custody

Risk Factors with Delusions

- Assess the dangerousness of the perceived threat; is it specific to a person?
- Increased risk if person has a plan for self-defense, retaliation, preemptive action
- Grandiose delusions can place subject, public or officer in harm's way
- Increased risk with substance abuse
- May cause person not to eat or drink or care for self.

Risk Factors with Hallucinations

- Assess if auditory hallucinations (voices) are giving commands
- Assess dangerousness of command
- Assess person's ability to cope with voices
- Visual hallucinations may direct a person toward harmful actions
- Distraction by hallucination may cause a person to be unaware of situation, placing at further risk

Risks with Medications used to treat Schizophrenia and Bipolar Illness

Tremors

Constipation

Dry Mouth

Parkinson's like signs

Urinary Retention

Cardiac Changes

Weight Gain

Increased Cholesterol

Increased Triglycerides

Diabetes

Diabetic Complications

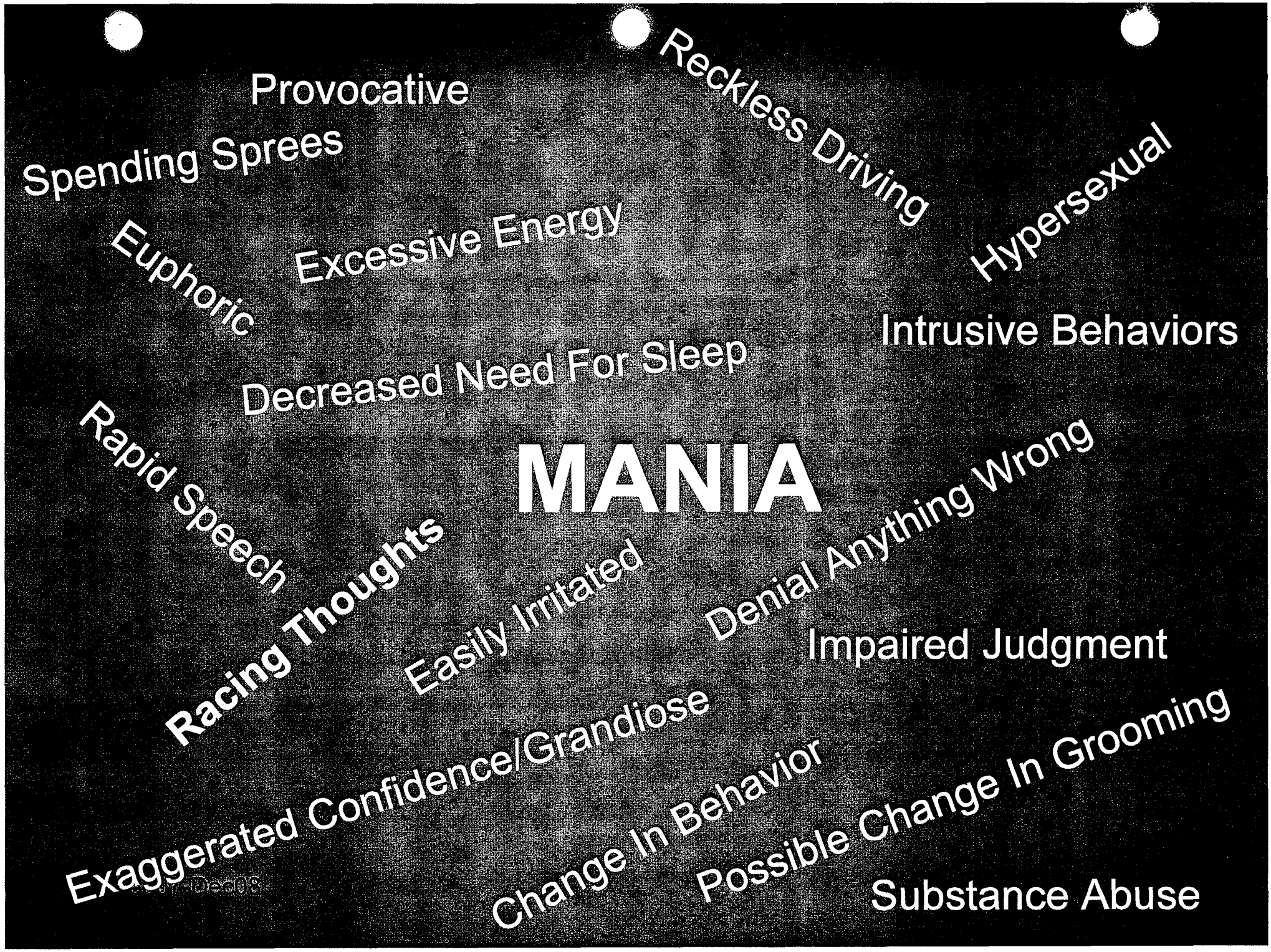
Blood problems

Breast Enlargement

Menstrual Irregularity

A life threatening syndrome

- High Fever
- Increased Blood Pressure
- Increased Heart Rate
- Muscle Rigidity


Provocative
Spending Sprees
Reckless Driving
Hypersexual
Euphoric
Excessive Energy
Intrusive Behaviors
Decreased Need For Sleep
Rapid Speech
MANIA
Racing Thoughts
Denial Anything Wrong
Easily Irritated
Impaired Judgment
Exaggerated Confidence/Grandiose
Change In Behavior
Possible Change In Grooming
Substance Abuse
Dec08

Risk Factors with Mania

- High risk for suicide
- Dehydration, malnutrition
- Reckless driving
- Financial losses
- Sexually transmitted disease
- Provocative behaviors may place in harm's way
- Grandiosity can increase risk taking
- Increased risk with substance abuse

Feb07-Dec08

Depression

- Persistent sadness or emptiness
- Too much/little sleep
- Early morning awakening
- Change in appetite
- Feelings of guilt, hopelessness, worthlessness
- Thoughts of suicide/death
- Loss of interest/motivation
- Irritable
- Trouble with concentration/Decision making
- Fatigue, loss of energy
- Anxiety
- Physical complaints

Feb07-Dec08

Risk Factors With Depression

- Suicide
- Recently starting meds
- Abruptly stopping meds
- Lethal OD with tricyclic meds
- Effects of anorexia, insomnia, immobility
- Lack of motivation/ productivity

Feb07-Dec08

Suicide Risk Factors

- Older, white male
- Recent losses
- Alone, isolated
- Substance abuse
- Firearm in the home
- Childhood abuse
- Family hx of suicide
- Loss of physical health
- Resolve with religious belief

- Pain
- Employment problems
- Impulsivity
- Command hallucinations
- Hopelessness

Feb07-Dec08

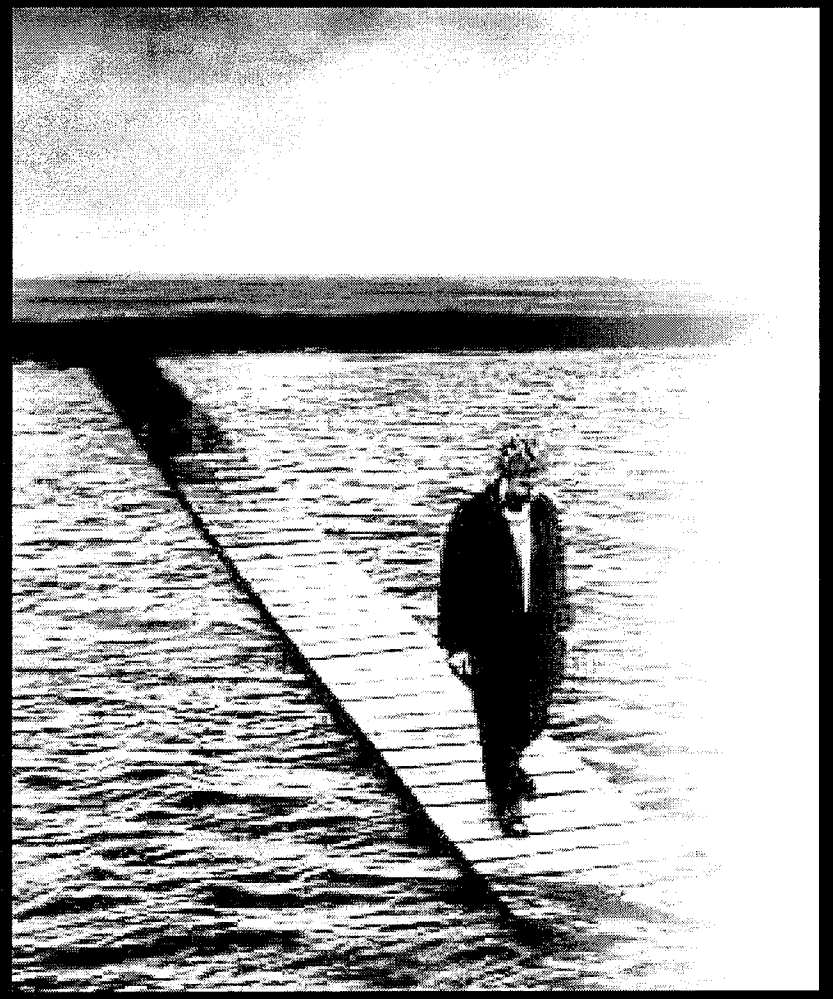
Suicide Risk Assessment

- Thinking about suicide?
- How much?
- Express intent to act?
- Prior attempts?
- How? How many times?
- Cultural concerns?
- Access to planned method?
- Lethality?

Feb07-Dec08

Suicide Risk Assessment

- Religious resolve?
- End life vs relief from pain?
- Social/family support?
- Professional help?
- Currently using drugs or alcohol?
- Medications?
- Future oriented?



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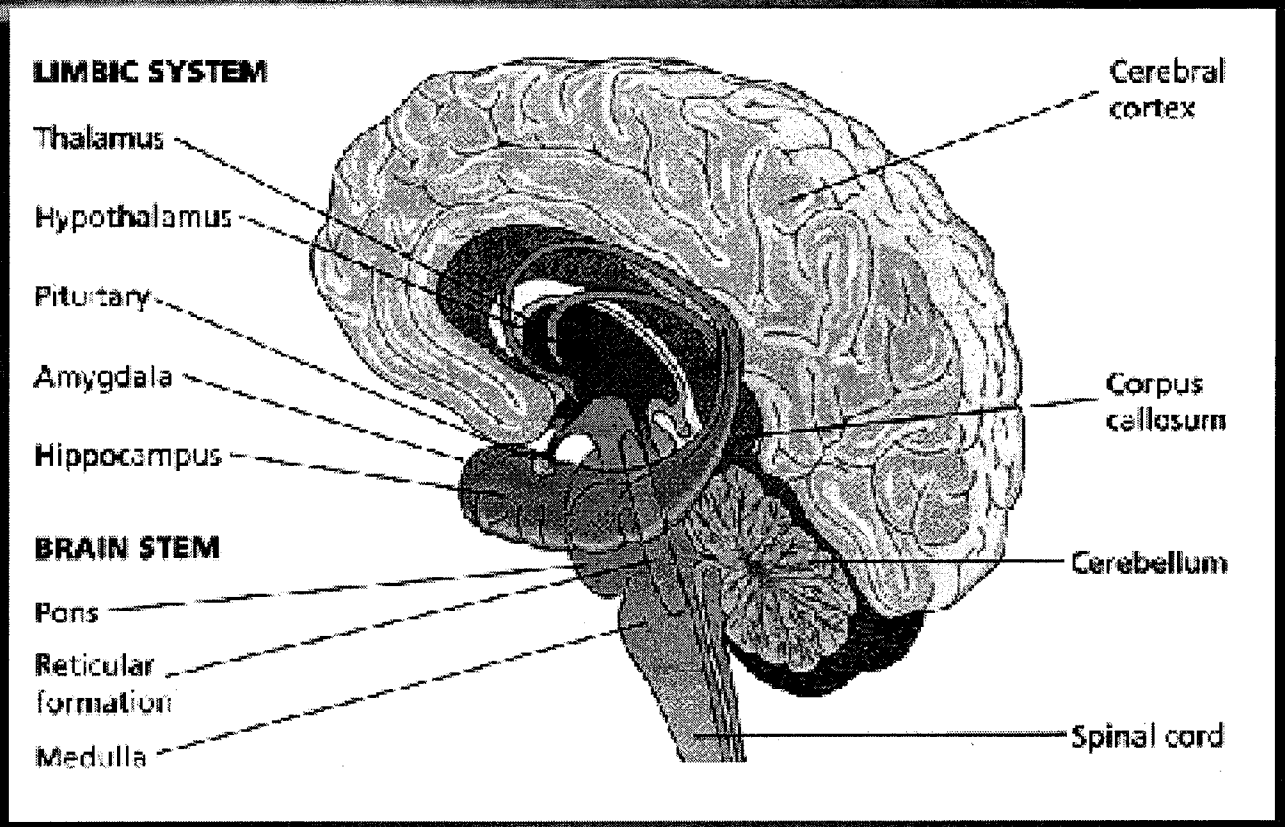
LIMBIC SYSTEM
Thalamus
Hypothalamus
Pituitary
Amygdala
Hippocampus
BRAIN STEM
Pons
Reticular formation
Medulla
Cerebral cortex
Corpus callosum
Cerebellum
Spinal cord

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Post Traumatic Stress Disorder:
Who is at Risk?

- Persons who have experienced and/or witnessed:
  - Sexual assault/abuse
  - Physical/Emotional Trauma
  - Violent Crime
  - Natural Disasters

Post Traumatic Stress Disorder
Who is at Risk? (cont.)

- Immigrants who have fled from cultural persecution
- Experienced or witnessed combat
- Any event in which one could have been killed

Post Traumatic Stress Disorder (PTSD)

Signs/Symptoms

- Emotional numbness, distancing
- Irritability
- Flashbacks: maybe triggered by everyday events
- Nightmares
- Tendency to avoid reminders of event

Post Traumatic Stress Disorder (PTSD)

Signs/Symptoms

- Startle easily
- Sleep disturbances
- Angry outbursts
- May be compounded by depression, substance abuse

PTSD Chemistry

- ↓ Levels of cortisol (hormone which responds to stress)
- ↑ Level of Epinephrine and norepinephrine -- which causes hypervigilance

Mental Health Holds

- Police Officer Hold
- Director Hold
- Two Party Hold

Feb07-Dec08

ORS 426.228

- **Custody; authority of peace officers and other persons; transporting to facility; reports; examination of person.** (1) A peace officer may take into custody a person who the officer has probable cause to believe is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness

Peace Officer Custody for an Allegedly Mentally Ill Person (Civil Custody Report) (850.20)

When taking an allegedly mentally ill person into custody (civil) for a mental health evaluation, members will:

a. Transport the individual to the appropriate secure evaluation facility, or if there is no secure evaluation facility or if the unit is on divert, to the nearest designated hospital emergency department that conducts mental health evaluations.

b. Remain at the facility until a physician determines whether the person will be admitted. If not admitted, the member may arrest the person for an offense, transport the person back to the original custody location or both. In the case where no arrest is made and the person chooses not to return to the location of custody, the person will be released outside the care facility.

c. Complete an Investigation Report and a Civil Custody Report, before leaving the facility.

d. Make copies of both reports. Leave the original Civil Custody Report and a copy of the Investigation Report with the secure evaluation unit or the receiving hospital. Turn in the original Investigation Report along with a copy of the Civil Custody Report to a supervisor before the end of his/her shift.

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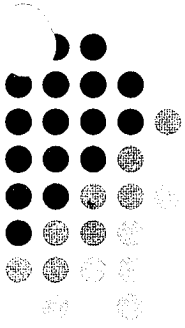
ORS 426.228

- The officer shall prepare a written report and deliver it to the treating physician. The report shall state:
- (a) The reason for custody;
- (b) The date, time and place the person was taken into custody; and
- (c) The name of the community mental health and developmental disabilities program director and a telephone number where the director may be reached at all times.

Police Hold

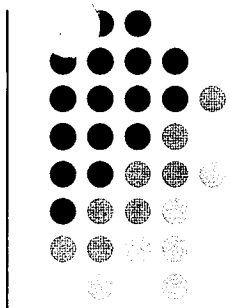
- 72 Hour Hold no longer exists
- Only medical condition that we can force people to get evaluated and possibly treated
- Most therapists, psychiatrics, psychologists, and counselors do not have the authority to place a hold on someone.

ORS 426.228 (Director's Hold)



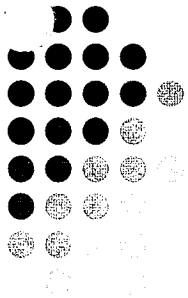
- (2) A peace officer shall take a person into custody when the community mental health and developmental disabilities program director, pursuant to ORS 426.233, notifies the peace officer that the director has probable cause to believe that the person is imminently dangerous to self or to any other person. As directed by the community mental health and developmental disabilities program director, the peace officer shall remove the person to a hospital or nonhospital facility approved by the department. The community mental health and developmental disabilities program director shall prepare a written report that the peace officer shall deliver to the treating physician.

Emergency Department



- Not all hospitals take people on a mental health hold
- All hospitals in our area (save the old Woodland Park) take people on holds
- Hospitals need to be authorized/certified by the state to accept psychiatric patients

Emergency Department

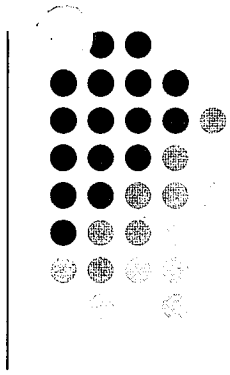


- The mentally ill person will be evaluated by the emergency department doctor and/or a social worker.
- Hospital staff uses the same criteria that police do – imminent danger to self or others due to a mental illness.

Emergency Department

- The hold can be dropped
- A Hospital Hold can be placed (essentially a continuation of the police officer hold)
- Once a Hospital Hold is placed, the hospital contacts County Mental Health and notifies the county investigator – the ICP. The ICP comes out every day, seven days a week, and evaluates the mentally ill person. They use the same criteria as everyone else.

County Mental Health Investigator



- The ICP can:
- Continue the hold
- Drop the hold
- Let the hold run out
- The ICP sets a hearing date for the mentally ill person within 5 business days
- The hearing can be set over for an additional week if the mentally ill person is participating in treatment.

Two Party Hold

- Two adults petition the court
- Unable to meet basic needs

Excited Delirium:

- State of extreme mental and physiological excitement, characterized by extreme agitation, hyperthermia, euphoria, hostility, exceptional strength and endurance without fatigue.

Symptoms:

- Bizarre and violent behavior, most commonly violence towards glass
- Removal of clothing, public nudity (even in cold weather)
- Aggression
- Hyperactivity
- Paranoia

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Symptoms:

- Hallucination
- Incoherent speech or shouting
- Grunting or animal like sounds
- Incredible strength or endurance
- Impervious to pain
- Hyperthermia / Profuse sweating (even in cold weather)

Excited Delirium

- Medical Emergency
- If you think it might be, call medical and get them en route
- There is disagreement in the medical community about what is actually happening physiologically.

IF POSSIBLE….

- Reduce time of struggle, it increases need for oxygen and increased heart rate
- Use Taser
- Hand over to medical as soon as possible
- Person needs medical intervention ASAP

Medical Transport Executive Order

PROCEDURE (630.45)

Transportation of Subjects

Members will not transport subjects who appear to be seriously injured, seriously ill, or unconscious unless an on-scene evaluation by EMS determines the subject is cleared for officer transport. This includes, but is not limited to any subject who:

a. Appears to be suffering from excited delirium. Symptoms may appear as severe agitation, over stimulated or wired appearance, paranoia, disorientation, extreme restlessness, involuntary twitching of small muscles and hallucinations.

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Medical Transport Executive Order

- b. Suffers any seizure prior to (per witness statements or self-proclamation) or during police contact.
- c. Displays respiratory difficulty, including but not limited to, shortness of breath, extreme wheezing, etc.
- d. Displays obvious signs of head trauma or loss of consciousness prior to (per witness statements or self-proclamation) or during police contact.
- **e. Appears to be extremely intoxicated and/or under the influence of drugs in conjunction with any of the above symptoms and has been involved in a prolonged physical altercation.**

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Medical Transport Executive Order

- **Regardless of Location or Situation (630.45)**
- Members will immediately call EMS if they have any concerns or questions regarding a subject's medical status during an incident or custody situation. EMS will respond and evaluate and assess the subject's medical condition.
- Once on-scene, EMS will have the responsibility of determining the appropriate medical treatment and mode of transport for the subject.
- If members transport a subject to jail, EMS will provide the transporting member(s) with a copy of the pre-hospital medical treatment worksheet.

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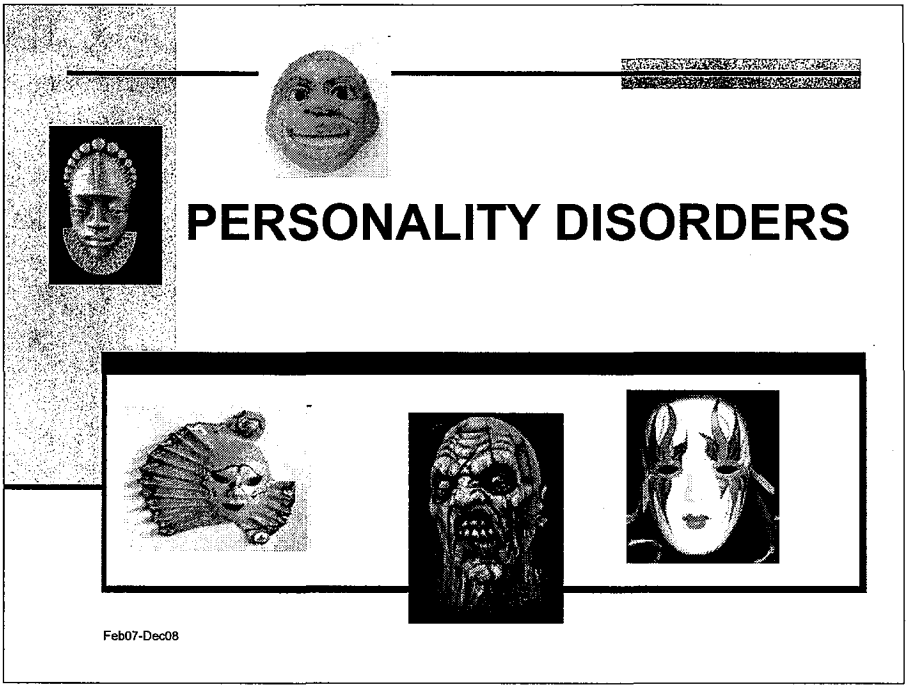
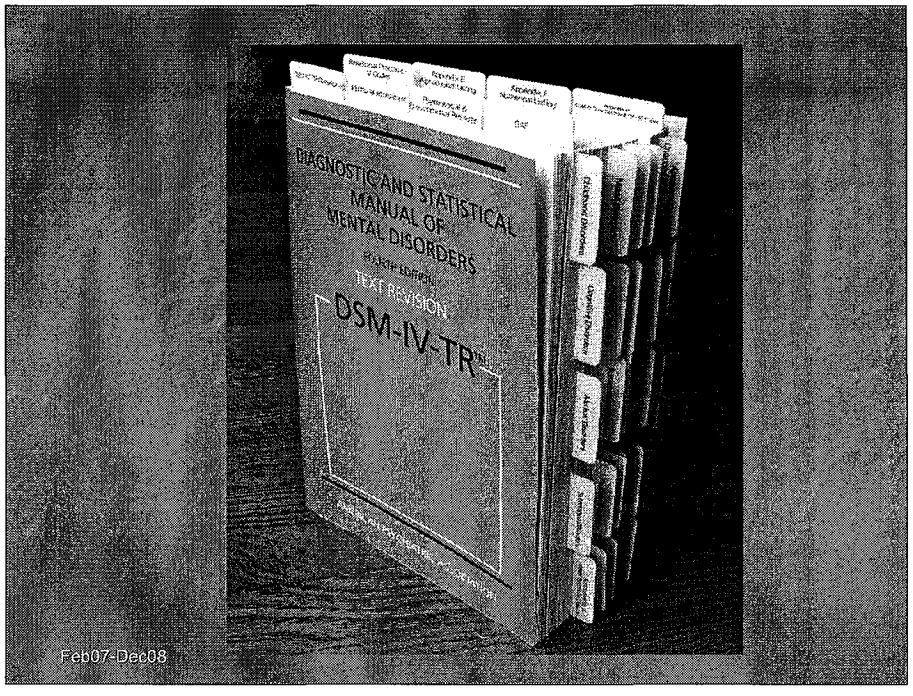
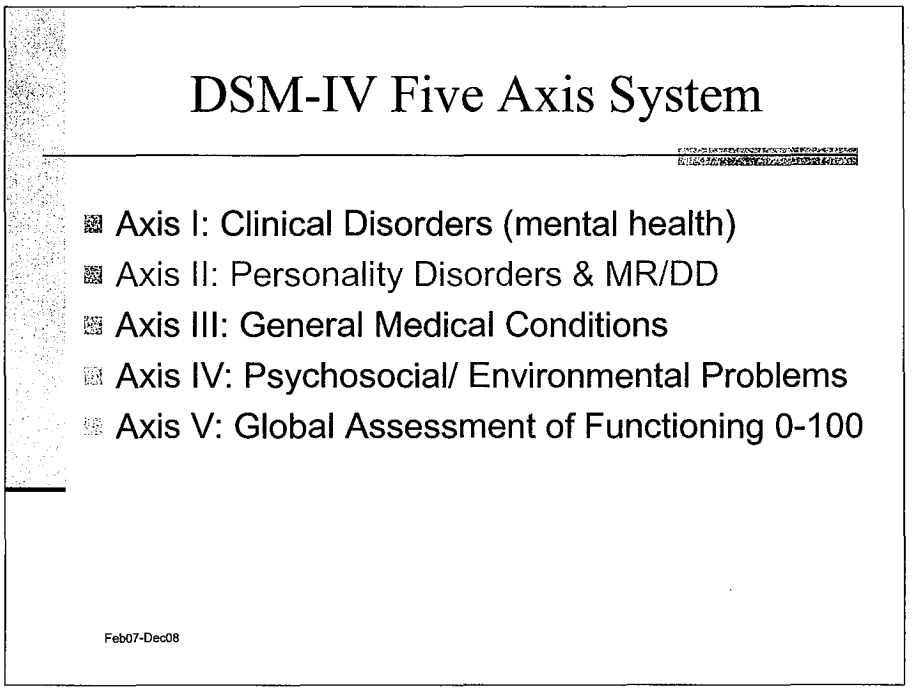


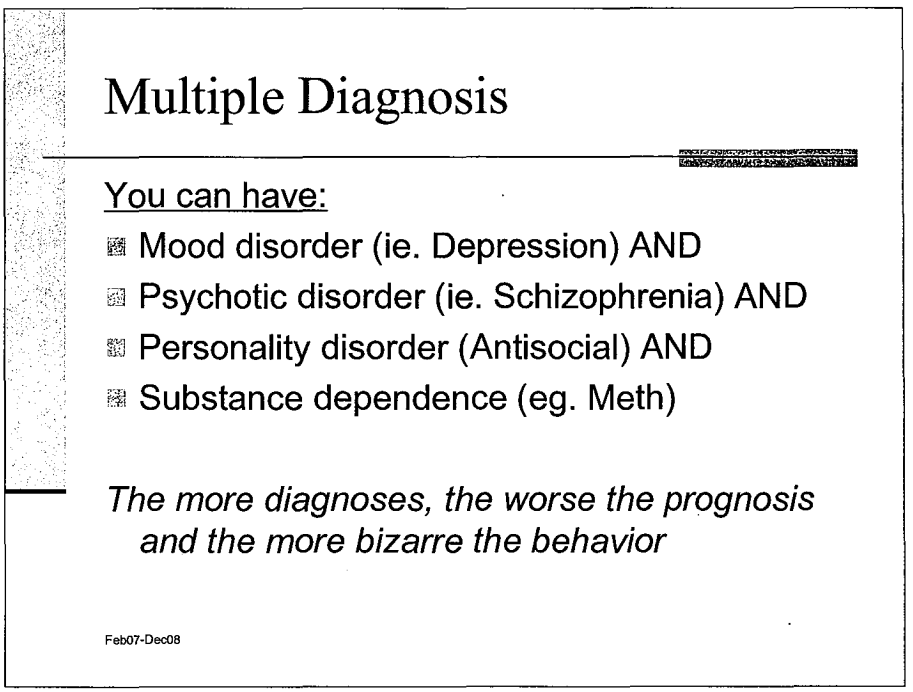
What is a personality? Think about your own personality? How would you describe yourself? Are you one thing? No, you have different personality traits. What kind of traits do you look for in a friend? What are some personality traits that you don't gravitate towards? Before we go into the different personality disorders, let me explain how they fit into the grander scheme of mental health. All week, Kay has been talking about mental illnesses. Schizophrenia etc are MI. PD are NOT mental illnesses, though the person can look very dysfunctional. This is impt. Because often when people don't get held in the hospital, it is because they have a personality disorder and not a mental illness.

PDs-don't respond to meds


DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
TEXT REVISION
DSM-IV-TR
Feb07-Dec08



A person can have an Axis I AND an Axis II diagnosis. (Show the DSM-IV and its divisions). In addition, people can have more than one personality disorders. (Not to be confused with multiple personalities). In the big book they "cluster" the personality disorders, depending on the type of traits people with these disorders exhibit. There are 10 different personality disorders. For the purposes of this class, we will only cover 4. We're going to look at the ones with the highest correlation with criminal bx.



Can you have a personality disorder and a mental illness? Can you have schizophrenia and be antisocial and an alcoholic?

Personality changes may also occur as a result of a medical condition: head trauma, stroke, cerebral tumors, epilepsy, AIDS

Four personality disorders you might encounter in your work:

Borderline

Histrionic

Narcissistic

Antisocial

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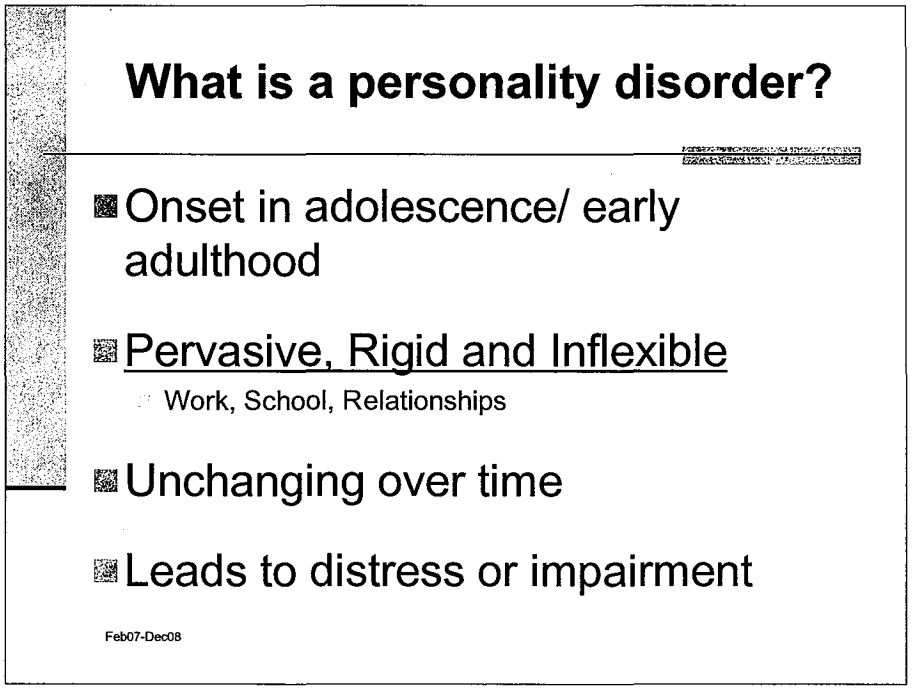
These are the ones we are going to talk about today, in addition to some subcategories.



Onset-you don't dx a personality d/o for the first time when someone is 55 or when someone is a two. Why not? Still developing. Personality is forming. Pervasive means it shows up in different areas of your life. Might be jerk at home but have good relationships at work or in the locker room. Rigid- can't adapt to changing situations. For most of us, say we had been planning to go out to dinner with a friend and that friend calls and needs to cancel at the last minute. We might be mometarily disappointed but then we move on. We don't have a major meltdown because of it. A person who is borderline won't suddenly become mature when the situation demands it. They take their disorder with them like a backpack that you can't take off. Goes where you go. Affects your ability to function in all areas of your life-at home, at work, at the bar, on the playing field.

Balance of attachment: between enmeshment (BPD) and detachment (psychopathic)

Personality Disorders

The development of a personality disorder is a combination of genetics, culture, and environment.

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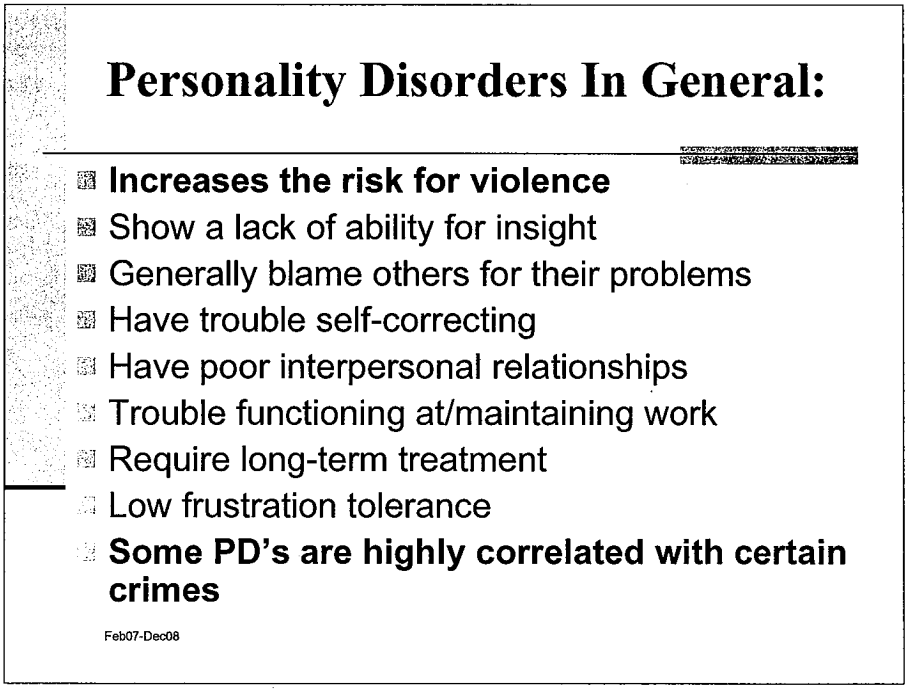


Makes sense re: crime when you look at the list above.

Insight: not the same as the lack of insight with schizo etc. Don't think committing a crime is a bad thing. Don't take responsibility. "victim" of their circumstances.

Trouble self-correcting. Get into a jam, go to jail, but have a hard time doing something different when he/she gets out of jail.

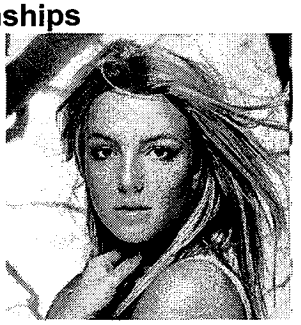
Poor interpersonal relationships-when all you care about is getting your own needs met, makes it hard to have a relationship which involves thinking and feeling outside of yourself, at times. When we are two, that is appropriate, when we are 22, not appropriate.

Low frustration tolerance-again, like the two-year old.

Treatment for PD: meds for the anxiety, depression-SSRI;s also anticonvulsants can reduce impulsive, angry outbursts. Does not affect the traits themselves.

Borderline Personality Disorder
Key word: Needy

- ***Must have at least <u>four</u>:***
  - **Frantic efforts to avoid real or imagined abandonment**
  - **Unstable self image or identity**
  - **Unstable, overly intense relationships**
    - **"Angel or Devil"**
  - **Impulsivity in sex, binge eating, & spending**
  - **Manipulation**
  - **Emotional instability**
  - **Jealousy**
  - ***Recurrent suicidal gestures***



Britney Spears

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Identity diffusion- low self-esteem. Not a well-developed sense of themselves.

DBT-learn coping skills. Frantic efforts to avoid real or imagined abandonment. Can result in fear/anger when, for example, there are unavoidable changes in plans-clinician announcing end of session, panic/fury when someone must cancel or reschedule an appt. Abandonment means they are "bad." Angel vs. devil. Impulsivity in eating, gambling, sex, driving recklessly. Frequent SI. (But 8-10% do complete suicides) and self-mutilation.

Low self-esteem.

Self-Mutilating Behaviors

- Interfering with the healing of wounds
- Hitting self
- Hitting objects
- Burning
- Cutting or scratching

Feb07-Dec08

What kinds of self-mutilating behaviors have you seen?

Cutting kits. Ritualistic.

Why would someone self-mutilate? (next slide)

Reasons for Self-Mutilation:

- To relieve numbness
- To release pent up emotion
- To feel less detached
- To provide a sense of control
- To punish oneself for feeling worthless
- To get a reaction for feeling ignored and misunderstood
- To non-verbally express themselves

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Histrionic
Key word: dramatic

- Constantly seeking attention
- Egotistic
- Overly concerned with how others perceive them
- Excessive emotional displays
- Over reacts to minor stress

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Like your teenager?

Narcissistic

Key word= grandiose

- **Must have *five* of the *nine*:**
  - **Grandiose sense of self-importance**
  - **Interpersonally exploitive, predatory**
  - **Believes he is special**
  - **Preoccupied with fantasies of success, power, brilliance**
  - **Lacks empathy**
  - **Requires excessive admiration**
  - **Envious**
  - **Arrogant**
  - **Hypersensitive to the opinion of others**

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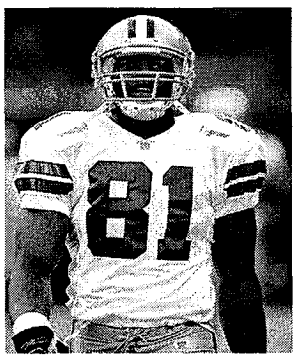
Greek myth: Narcissus- Fell in love with his own reflection and spent his days staring into a reflecting pool.

Enron Execs: CFO Fastow

Narcissistic

- **Main trait**: Grandiosity
- **View of the world**: Theirs
- **View of themselves**: Special
- **View of others**: Their servants
- **Deal with the world by**: Image management
  - E.G. Most world leaders, sports figures



Terrell Owens

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Approach to NPD: emphasize their uniqueness and get them to brag, support their special qualities, and give them the rope (they like to talk). Crimes are exploitive. Cannot view the impact they have on others.

Antisocial Personality Disorder

Key word= callous

- ***Must have at least three:***
  1. Failure to conform to laws or social norms
  2. Deceitfulness
  3. Impulsivity
  4. Reckless disregard for safety of others
  5. Lack of remorse
  6. Irresponsibility
  7. Juvenile delinquency

*used to be called "sociopath"

Feb07-Dec08

Life is unfair. Losers deserve to lose. He had it coming anyway. She shouldn't have worn that see-through blouse.

Antisocial Personality Disorder

- **Main trait:** Exploitation
- **View of world:** Dog eat Dog
- **View of self:** Superior
- **View of others:** Suckers
- **Deal with world:** Opportunism

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The Antisocial Lifestyle

- Self-regulation problems
- Histories of violent crimes
- Non-violent crimes
- Substance use
- Poor employment record
- Irresponsibility in finances/home
- Poor response to probation/parole conditions

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Criminals. Most of the people in jail have this.

Psychopaths

- Two views of the psychopath:
  - **Cold-blooded predator**
  - **Impulsive, charming thug**
- High risk for violence over life span
- 3-4x more likely to reoffend following release

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Blurred distinction between psychopaths and antisocial personality disorder. It is confusing for clinicians and according to one of the most renowned experts on Psychopaths (Robert Hare), also in the DSM-IV.

Examples: John Wayne Gacy-murdered at least 33 young men and buried most of them in crawl space beneath his house.

Ted Bundy: murdered more than two dozen young women in the 70's, going into several states to claim victims

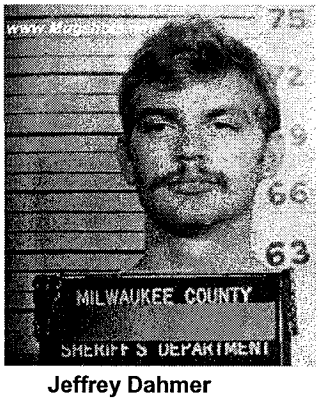
Green River Killer? Dexter?

Violence is more predatory, motivated by identifiable goals, carried out in a calculated manner without an emotional context. Don't tend to commit crimes of passion, such as during DV or extreme arousal.

"madness without delirium", "moral insanity"

Psychopaths

Combination of narcissistic +antisocial:



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Jeffrey Dahmer

Psychopaths score high on factor 1 AND factor 2. Antisocial score high on factor 2 only (impulsivity, stimulation seeking, irresponsibility). Studies found that "group therapy" made things worse for psychopaths. Just learned how to manipulate.

Can be CEO's, politicians, entrepreneurs. Embezzle retirement funds, immoral officials.

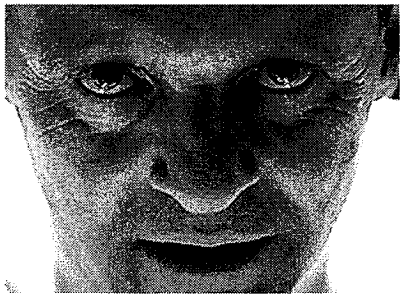
Hare study: countdown timer. At zero "harmless but painful" shock with electorde taped to finger to meas perspiration. Normal people start sweating. Psychopaths didn't sweat. Didn't fear punishment. Quote of psychopathic rapist "They are frightened, right? But, you see, I don't really understand it. I've been frightened myself and it wasn't unpleasant."

Hare study: groups of letters flashed to volunteers. Nonsense and real words. Press a button when they recognized a real word. Hare recorded response time and brain activity. Normal respond faster & display more brain activity when processing emotionally laden words such as "rape" "cancer" than tree. No diff with psychos. Emo language is a second language.

Strategies: think of how much better you will feel/think of the families left behind. But if no guilt or sorrow...appeal to his grandiosity.

Psychopathology

- Narcissistic + antisocial traits
- Lack of remorse
- Superficial charm
- Manipulation
- Shallow emotions
- Irresponsibility
- Uses people as objects
- Grandiosity
- More likely to pose serious threat



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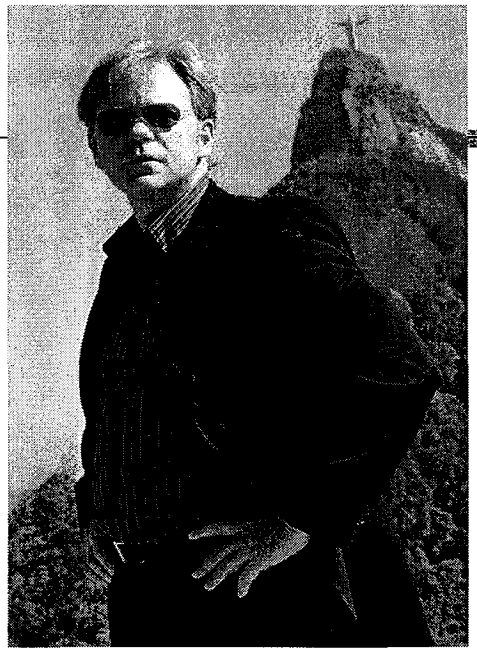

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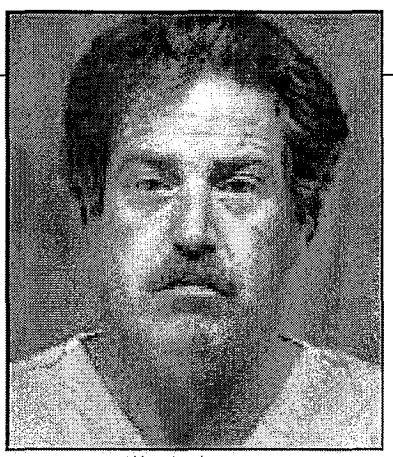

Ward Weaver

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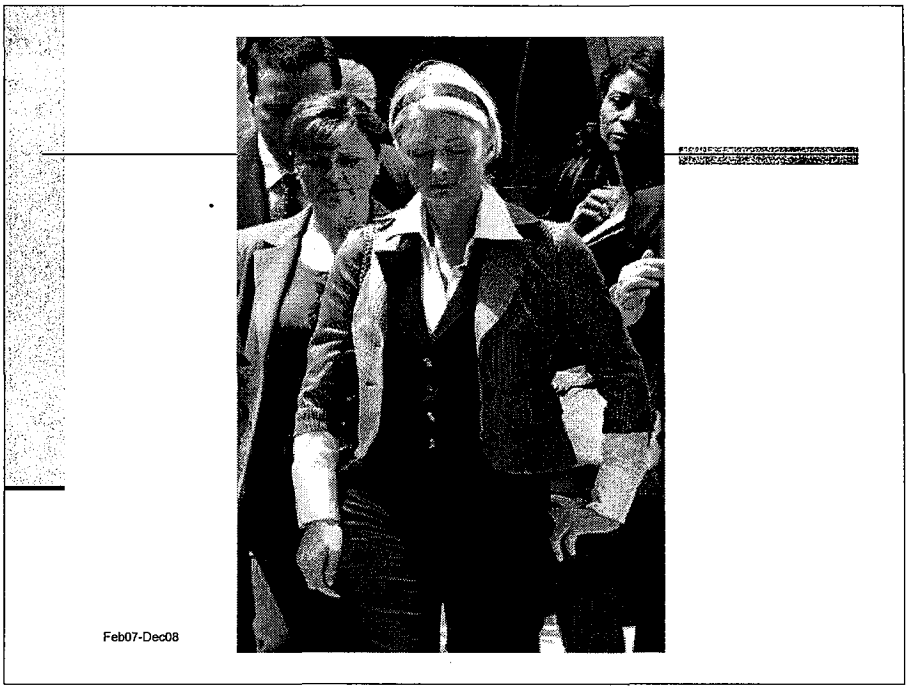
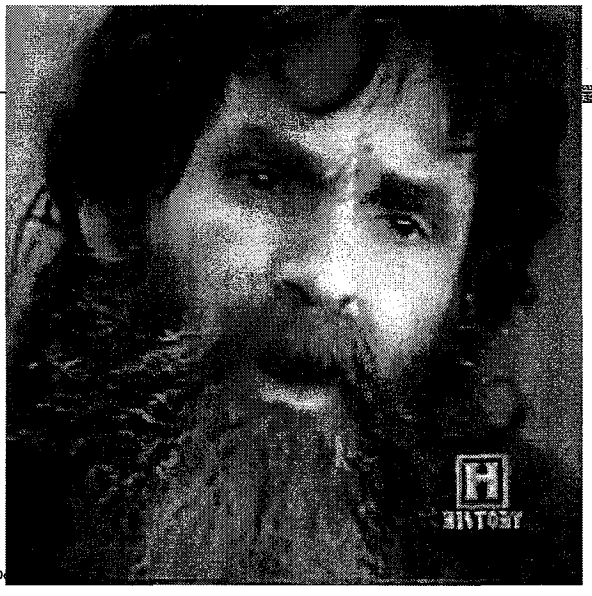


Paris Hilton



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Feb07-Dec08

END

Feb07-Dec08

Where can you get this info?

- Psych reports, review of criminal history and crimes (motivations: predatory, fun, sadistic, reactive)
- YOU keep seeing them over and over

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Highest correlation with criminal behavior

Cluster B:

Antisocial

Narcissistic

Borderline

Histrionic

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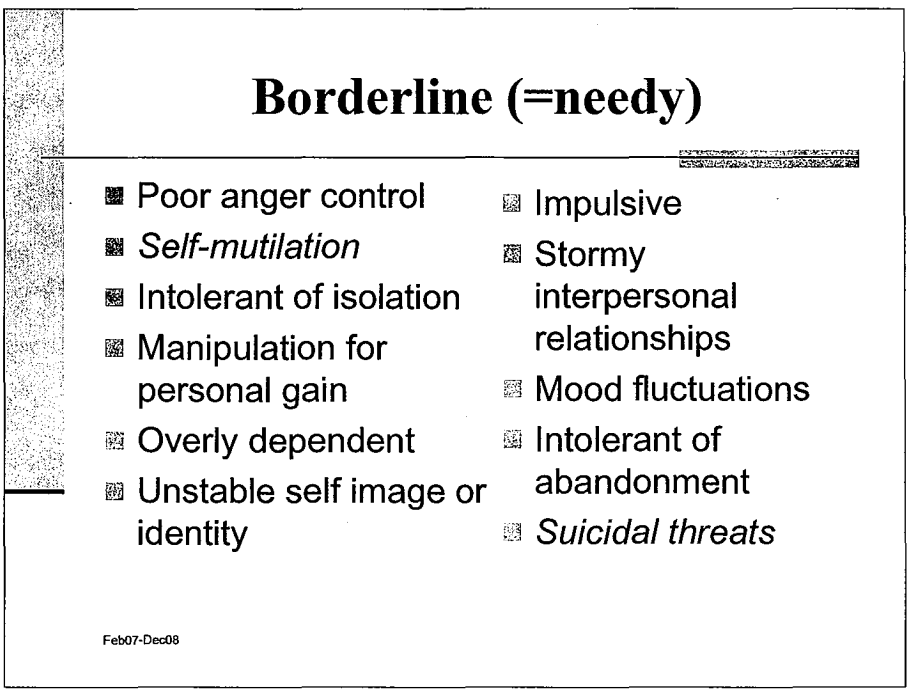
Cluster A: mature or odd (schizoid, etc) Cluster C: anxious and fearful



DBT-learn coping skills. Frantic efforts to avoid real or imagined abandonment. Can result in fear/anger when, for example, there are unavoidable changes in plans-clinician announcing end of session, panic/fury when someone must cancel or reschedule an appt. Abandonment means they are "bad." Angel vs. devil. Impulsivity in eating, gambling, sex, driving recklessly.

Self-Mutilating Behaviors

- Interfering with the healing of wounds
- Hitting self
- Hitting objects
- Burning
- Cutting or scratching

Feb07-Dec08

Reasons for Self-Mutilation:

- To relieve numbness
- To release pent up emotion
- To feel less detached
- To provide a sense of control
- To punish oneself for feeling worthless
- To get a reaction for feeling ignored and misunderstood
- To non-verbally express themselves

Feb07-Dec08

Narcissistic (=grandiose)

- Expects favorable attention from others
- Hypersensitive to the opinion of others
- Masks anger/shame with aloofness
- Fragile self esteem
- Reacts to criticism with extreme humility
- Exaggerated self importance
- Lack of empathy

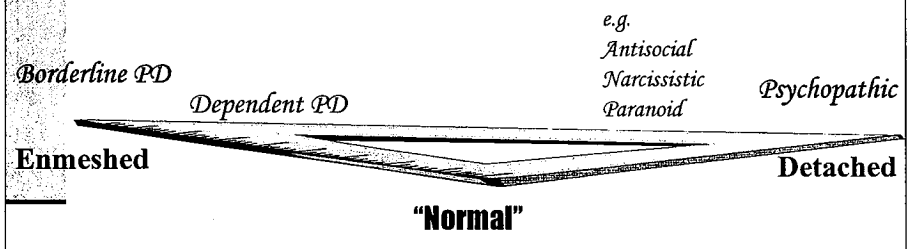
Feb07-Dec08

Borderline

- Poor anger control
- Self mutilation
- Intolerant of isolation
- Manipulation for personal gain
- Overly dependent
- Unstable self image or identity
- Impulsive
- Stormy interpersonal relationships
- Mood fluctuations
- Intolerant of abandonment

Feb07-Dec08

Attachment: "Normal" & Pathological



Feb07-Dec08

Why attachment matters...

- Degree of attachment tells you:
- What to expect from the person
- What risk they pose to you as an officer
- How to approach the person
- How to verbally disarm the person
- How to interact when interviewing/interrogating

Feb07-Dec08

Signs of detachment=Taking

- Exploitation of others (pimping, stealing etc)
- Lack of negative emotions when separating
- Multiple & severe violent acts in love relationships
- Lack of remorse/guilt for harmful behavior
- Cannot describe social emotions (love)

Feb07-Dec08

Signs of over-attachment= Taken care of

- Crisis when separating from person they "care" about ("can't live without them")
- Overly intense relationships
- Fear of abandonment and pathological jealousy
- Use of power and control tactics in an effort to keep the person

Feb07-Dec08

Antisocial (=callous)

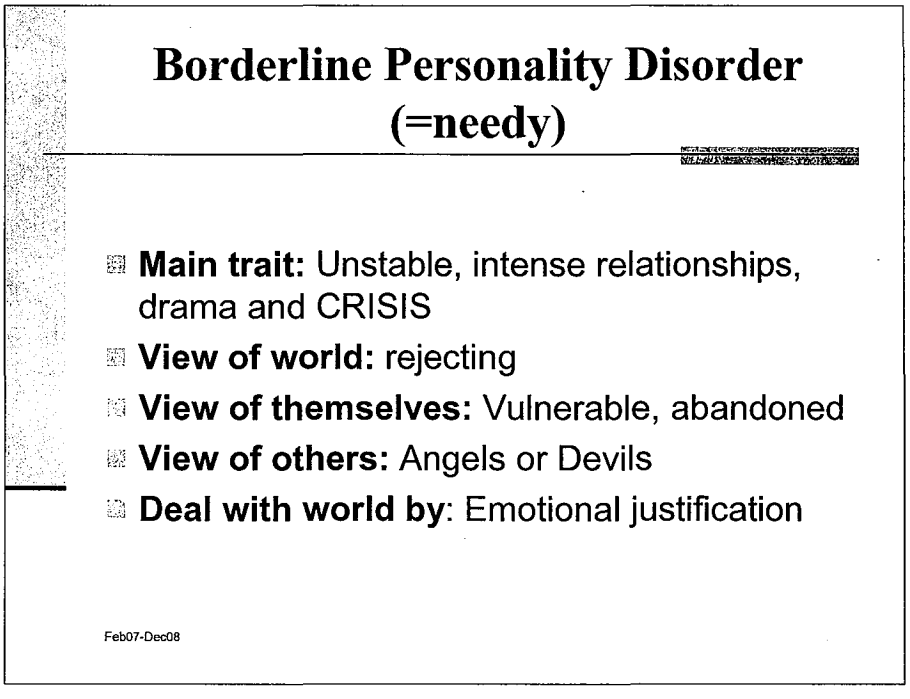
- Aggressive
- Disregard for others safety
- Lack of remorse
- Can be charming
- Does not conform to social norms, rules, or laws
- Manipulative
- Disregard for others safety

Feb07-Dec08

Psychopathy = Two Personality Disorders

- NARCISSISM
  - Superficial Charm
  - Grandiosity
  - Pathological Lying
  - Manipulation
  - Shallow emotions
  - Lack of Guilt
  - Callous/Lack of Remorse
- ANTISOCIAL
  - Need for Stimulation
  - Criminal Versatility
  - Irresponsibility
  - Poor Behavioral Controls
  - Failure to Accept Responsibility
  - Juvenile Delinquency
  - Parole Violations
  - Lack of Plans

Feb07-Dec08



View of the world: we all have a view of how the world works. It is a nice world out there or a mean world? Does the world work for you or against you?

View of themselves: "Vulnerable/abandoned (victim-no taking responsibility for their actions)

Angels or Devils- "splitting" This is a time when PR will not be naïve and compassionate.

Deal with the world by: Emotional justification. It's ok that I get angry with my counselor because she was late.

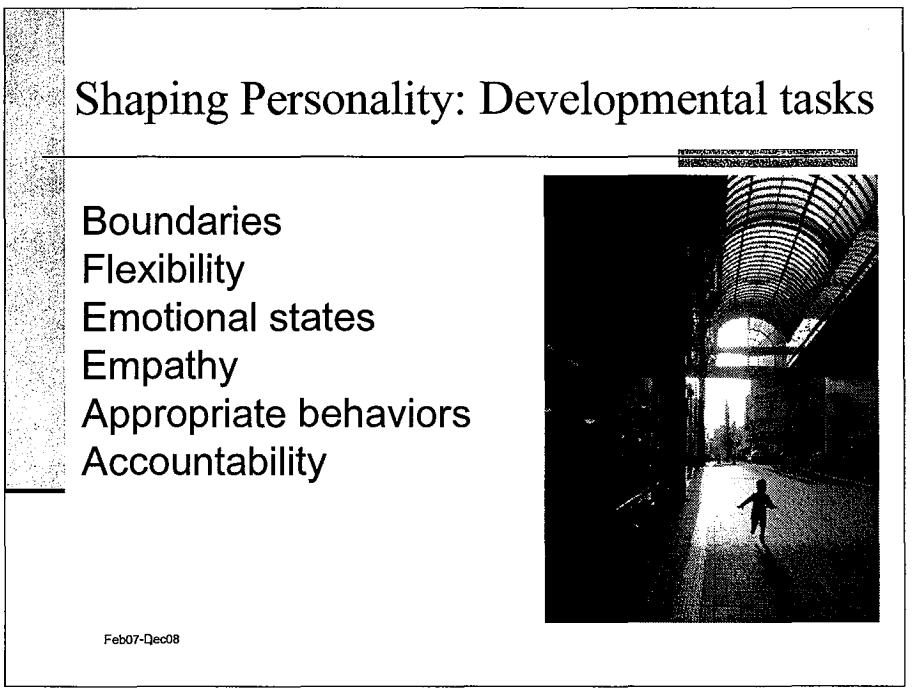
Histrionic (=dramatic)

- **Main trait:** Over-expressiveness
- **View of world:** Impressionistic
- **View of self:** Charming, center of attention
- **View of others:** Admirers
- **Deal with world by:** Performing
- **e.g. Scarlett O'Hara from "Gone with the Wind"**

Feb07-Dec08

View of self=charming, center of attention; View of others=charming; Deal with world by performing

Impressionistic: Monet (garden), based on subjective reactions presented unsystematically. His view of world is as he sees it. Inner drama. There is no system in it. Chaotic. No cohesiveness.



Let's talk about how our personality develops. Many different theories. They are just that, theories. Genetics, culture and environment. Let's talk about the developmental tasks. As we mature we need to learn about boundaries. A baby needs to figure out where it begins and ends. When you are born, you think you are an extension of your mother or primary caretaker. Your mother is not you. She can leave and come back. You are different people. Everyone has a bubble, a boundary to their identity. I am me. You are you. When a child is molested, their boundaries are transgressed. Someone has come into their bubble without permission. Flexibility- we have to learn to adapt to a changing environment. Mom and dad come and go. The environment is not static. (As good as it gets- Jack Nich needs to have silverware a certain way). We have to learn to cope with different emotional states. Tolerate being hungry or thirsty or hot or cold. Empathy- care for others. When you are two, it is all about you. Parallel play. Don't relate. What happens to a person who doesn't develop empathy? Appropriate bx- throw ball in yard not house. Learn rules so later you don't drive drunk etc. How to handle being alone? Can you be alone without being lonely? Become very dependent on others if we can't be alone. OK-development of self-esteem. Always criticized? (not to get too freudian) OR always praised- false sense of self. AccountabilityEvery action has a reaction. Pick up your toys after you play with them. Take responsibility for your actions. Cause and effect. -

PSYCHIATRIC SECURITY REVIEW BOARD

(PSRB)

Feb07-Dec08

Structure of Adult Board:

- 5 member part-time multi-disciplinary
  - psychiatrist
  - psychologist
  - attorney experienced in criminal practice
  - parole/probation officer
  - member of the general public

Psychiatric Security Review Board (PSRB)

- Guilty Except for Insanity
- Sentenced to maximum sentence for crime committed
- Their mental status is reviewed every two years (up to every 6 months upon appeal)

Early Discharge

- A person no longer has a mental disease or defect. (If the disease is in remission but occasionally becomes active, the board will still consider the person to have a mental disease or defect.)
- The mental disease or defect continues but the person no longer presents a danger to others.

Where are they?

- State Hospital Forensics Ward
- Currently 745 people currently under PSRB jurisdiction
- 368 are at the State Hospital
- 377 are on conditional release in community facilities

Feb07-Dec08

Community Facilities

- Secured Residential Treatment (10.5%)
- Residential Treatment Facility (15%)
- Residential Treatment Home (15%)
- Adult Foster Home (16.5%)
- Semi-Independent/Supported Housing (13.5%)
- Intensive Care Management (3%)
- Independent Living (25.5%)
- Other (1%)

Feb07-Dec08

PSRB

- PSRB recidivism rate: 2.2%
- Dept of Corrections recidivism rate: 31.4%
- Small case load for case managers
- Quick to respond and hold people accountable
- PSRB "hit" in LEDS is like a warrant. Person would be transported directly to State Hospital (Salem)

Feb07-Dec08

PSRB EPR HIT

UP0000000000. Aug 08, 2008 14:03:54
BVP OR0340100 20080808 14:01:06 (LEDS)
OR PSYCHIATRIC RV BD
(PRB9)
*NOTIFICATION OF POSSIBLE OFFENDER CONTACT**

QW.OR0340100.NAM/Last, First .DOB/04161960
ORI IS/BEAVERTON POLICE DEPARTMENT (W494)

** POSSIBLE MATCH RETURNED **

EPR OR026035C NAM/Name
1960/07/10 F W 506 160 BRO BRO LNU/W02452 RTP/PCR
MIS/--NOTIFY PRB OF ALL INQUIRIES BY AM MSG--OR CALL LOCAL MENTAL HEALTH
WORKER PATTY AT 503-

Feb07-Dec08

LEDS REVOCATION ORDER

QLW.LNU/W0S4535086
##

LPP0GG40000. Aug 27~
2008 12:46:01
REUR 0664 LEOS
QLW.OR02G035C.LNU/W0S45350B6

NO CRIMINAL WARRANT

PSYCHIATRIC SECURITY REVIEW BOARD ORDER FOR MANDATORY RETURN TO OREGON STATE HOSPITAL. AUTHORITY DRS 1G1.330 ~5)

(BASED ON LNU)
EIP OR02S035C NAMI DOBI
SEX/M RAC/W POB/OR HOT/50? WGT.' 135 EYE/ORN HAI!RED SKNI
OCA/03-1S02 SMT/Se R HND FPC/20070305131052081610
FBI! SIDI SOC!
MNUI

RECORD INFORMAfl0N
DOR/2008/06/23 RTP/PRE
MIS/HIT C0NFIRMATI0N CALL 503-945-2800--TAKE T0 0REG0N
CENTER ST NE, SALEM-0RIGINAL CHARGE ASSAULT r
STATE H0SPITAL 2600

Feb07-Dec08

ORS 161.336 (6)

- The community mental health director, any peace officer…make take a person on conditional release into custody or request that the person be taken into custody, if there is reasonable cause to believe a person is a substantial danger to self/others because of mental disease/defect and is in need of immediate care/custody treatment.

Common Conditions of Release

- Mandatory Mental Health Treatment/Supervision
- Case manager who reports to PSRB about person's status & violations
- Housing Arrangement
- NO drugs/alcohol
- Random drug/alcohol testing
- No firearms
- No driving

Feb07-Dec08

- Jesus believes in you
- Sinner
- Satan will try to get to you but don't fall to his tricks
- I am God and I will set you free
- People will not believe in you
- You come to my kingdom as a God
- You must be cleansed
- You will go go heaven if you kill yourself
- You will overcome if you suffer
- Medications will not cleanse your soul
- Jesus believes in you
- Those who want to help will kill you
- You will suffer
- People will persecute you
- You will suffer

Feb07-Dec08

- You're a bad person
- Everybody hates you
- You should not be allowed to live
- Nobody cares about you
- You should die
- Liar! Liar! Liar!
- You never do anything right
- What makes you think you should go on with your life
- This shows what a jerk you are
- You should die
- You have no real friends
- You are self centered and selfish
- You always fail
- Nothing you do is important
- You're lazy
- You're a worthless person
- Nobody cares

Feb07-Dec08

CIT SCENARIO #2: 16 year old suicidal subject at parent's home

Dispatch

- Officer dispatched to 1234 Cherry Lane
- Officer runs address
- No flags, arrests, wants or other info in PPDS

Summary

Role-Players

16 year old female
Mother
Father

Fact Situation

Profile Role-player: 16 year old girl

You are a typical "16 year old" and you also suffer from bouts of depression. You have been seeing a psychiatrist for the past year. You started seeing her after a friend committed suicide. You are on Prozac but think that "most teenagers are depressed." You have considered suicide in the past, the most recent being last month when you got a hold of your mother's benzos. You think your mother and father (especially mother) is "stupid" and doesn't understand what it means to be a teenager.

Profile Role-player: Mother

You are worried about your daughter and feel you don't have much control over her anymore. You are at odds with her father, who you think is too lax. You are taking anti-anxiety medication. You missed your last dose. Police have the perception that your lack of firm parenting has created this situation.

Profile Role-Player: Father

You try to support the mother but also feel that she is too controlling and should give the daughter more space. You believe she'll "grow out of it" and do not really believe in diagnosing teenagers. You reluctantly admit that perhaps it would be a good idea for your daughter to go to the hospital tonight.

Dynamics

Mother calls police because her daughter grabs a knife after an argument. As mom is calling police, the daughter dumps the knife in the kitchen sink. Mom tells police daughter no longer has the knife *when police ask about it (do not volunteer this info).* Mom tells police as they walk in that her daughter needs to go to the hospital. "Her

psychiatrist told us that when she gets like this again, she should go to the hospital. We don't want to take her in our car because we are afraid she might jump out." Mom goes downstairs (or where ever the daughter's room is in the scenario) but escalates daughter. Police need to separate the parents from the daughter and interview each of them separately. Daughter wants to tell police what jerk her mom is and how she feels like she is "in jail." Father and mother are not on the same page. Daughter admits (after first venting about her ex-boyfriend and her best friend and the stresses of high school) that she has thought about suicide ("doesn't everyone?") as recently as one month ago (by means of mother's benzodiazepines) but has no intention of hurting herself tonight.

Objectives

- Determine location of daughter immediately after entering residence to determine she is safe
- Explain to parents that police are not obligated to take her, despite the psychiatrist's suggestion
- Separate the parents and the teenager
- Consider that father has the most "objectivity" and focus efforts on him
- Explain hold criteria to parents and teenager
- Suicide assessment on daughter (Caution: do not assume that just because the family dynamics are messed up daughter is not legitimately suicidal)
- If hold is placed, explain procedure re: handcuffs; parents need to sign daughter into hospital
- If no hold placed, make a safety plan with parents. Consider returning to home the following day to check.
- Consider f/u phone call to Project Respond for engagement with family to secure resources

Logistics
Need CIT evaluator AND patrol tactics evaluator.

Location

Props

Scenario #2: CIT: Depressed Woman in House

Dispatch

- Officer is dispatched to woman's home-10 Code?
- Dispatch received call from woman's sister in Texas re: subject's suicidal ideation
- Dispatch will respond with "clear" and "no wants or PPDS."

Summary

Role-Players

1 female depressed citizen

Fact Situation

Officers get dispatched to a home to do a welfare check

Specifics

Profile of Role-Player: Depressed Woman

You are a 50-something depressed woman. It is the one year anniversary of your partner's death next week. He was killed in a traffic accident a mile from your house by a drunk teenager who ran a stoplight. You have taken leave from work (line supervisor at UPS) for a few weeks because you have not been feeling well. You have trouble sleeping and have lost your appetite but make yourself eat. You no longer go to your church and have stopped socializing with your friends because they don't understand why you are still grieving after a year. Your sister in Texas called Portland 911 because you had talked to her earlier in the day and said you wanted to be dead. You do not have a good relationship with your sister because she never liked your partner because he was (race/religion-you pick). Your brother lives in Canby and took a gun out of your house a month ago for safekeeping. You grew up in Texas and know about firearms. You have a cup from which you take occasional sips. The cup contains alcohol. You started drinking again about two weeks ago. You are seriously thinking about killing yourself. You have heard that you can attach a hose to your exhaust and kill yourself that way. You tried counseling and some meds (Paxil) right after the accident, but it didn't help and you stopped.

Dynamics

When officers knock on the door and ask to check in with you, you open the door and invite them in with a little hesitation. You talk slowly and somewhat mechanically and take a lot of time between answers. You only "smile" perfunctorily but otherwise do not show any signs of joy or contentment.). You look sad and depressed. After a few questions you tell the officer, "Thank you for coming, but I'm going to be fine." Don't

ask them to leave but just insist that you can deal with this yourself. You do not give them a definitive answer re: suicidality. You are very vague with your answers making statements like, "I don't know how to go on" but never admitting you want to kill yourself. However, you don't deny these thoughts either. You tell the officers your sister in Texas in overreacting and "NOW she decides to care about me. She never cared when I was married to Jim." You admit to sipping alcohol when asked. You do not want to go to the hospital or talk to someone today ("Maybe tomorrow.") You don't want police to call family members or friends. No one "understands what it's like." You are vague about means of suicide but admit that you read on the internet about carbon monoxide poisoning with a car and a garage. You have access to both.

Objectives

- Build rapport- avoid rote questioning
- Patience
- Demonstrate suicide risk assessment knowledge
- Follow up on all leads that could give officers information about her history of depression and suicidality
- LISTEN
- Offer community resources (ie. Project Respond)
- Consider putting a POH on subject

Logistics

Location

Camp Withycombe

Props

Cup with liquid

CIT SCENARIO #3: Jubitz truck stop-Liz Lotts

Dispatch

- BOEC dispatches officers to Jubitz Truck Stop
- No wants or PPDS
- No missing persons

Summary

Role Players
1 female (option-you are pregnant)
(If male- he came to Portland to see a Blazer's game and start a fitness gym)

Fact Situation
Officers are dispatched to Jubitz Truck Stop after a trucker called 911 reporting a "weird lady" who arrived by truck at 2 am. It is currently 6 am. The caller has left and is on his way to Idaho.

Specifics

Profile of Role Player
You are a thirty-something year-old who caught a ride with a trucker from Sparks, Nevada to the Jubitz in Portland. You are dressed in clean flannel pajamas. You are very easy to engage and in fact talk incessantly. You have an attitude, for example, suggesting the officer is a "Type A" who doesn't feel comfortable without a plan when the officer asks what your plans are. You only have a credit card. You came to Portland because you want to go to Nordstorm's to buy "Jimmy Choo" shoes for your upcoming wedding in Nevada. You plan to return to Sparks after you buy your shoes. You have a fiancée there but refuse to give his name or the name of any other family members ("they are sleeping!"). You admit to having taken meds in the past (Depakote) but say they bloat you and you don't want to be bloated for your wedding. You haven't slept and have only eaten a muffin in the last 24 hours. You do not think going from Sparks, NV to Portland with a strange trucker is risky behavior ("he was very nice and even had a bed in the back") and would consider returning to Sparks the same way. You decline to go to the hospital. After some time, you admit she was in a "hospital-slash-spa" before coming to Portland but didn't like it there because it didn't have high-speed internet access. After a lot of talking you admit that you had voluntarily checked yourself into Sparks General Hospital because of feeling "overwhelmed." However, you walked out after a few days. You were not on a hold there.

Dynamics
When police arrive you have no trouble rambling on about your wedding, the anxiety you feel about it and the problems you are having with your soon-to-be mother-in-law etc. Police have a hard time interrupting you, but you do stop and listen to them. You feel they are exaggerating the dangerousness of your situation and just want them to give you a ride to Nordstrom's. You don't give them any family information and only reluctantly

admit to being in a hospital/spa. You are not suicidal or homicidal. You have no coherent plan for food, transportation or anything else. You show extremely bad judgment and have no insight into the potential pitfalls of your plan.

Disposition: Police should strongly consider a hold or at least detaining her until they can get more information.

Objectives

- Stay focused on safety assessment questions despite subject's many tangential thoughts
- Consider whether subject will get "better" without intervention
- Run her as a missing person
- Recognize subject is in a manic state and the symptoms associated with mania
- Use appropriate communication techniques (firm but respectful)
- Keep your cool despite her sarcastic attitude towards you
- Assess her for a hold
- Realize after a few minutes that continuing to reason with subject will not produce results. Questions should be asked to determine her mental status, not to reason with her.

Logistics

Props

Flannel pajamas
Wedding magazine or pictures of wedding dresses
M & M's or other candy that could be used as "wedding favors"

CIT SCENARIO #4: Woman in Bank

Dispatch

- BOEC dispatches officer to US Bank on the corner of NW 23rd and Kearney.

Summary

Role Players
1 man or woman, nicely dressed
Bank manager

Fact Situation

Officers get called to the bank by a bank manager who reports that one of their customers is demanding $30,000 from her bank account. She does not have $30,000 in the bank and is becoming agitated and will not leave.

Specifics

Role Player
Woman: You believe that you have #30,000 in your bank account. In fact, there is only $662 in your account but you don't believe the teller and have been demanding to speak to a manager. However, the manager tells you the same thing and you keep insisting that you want to withdraw money that is rightfully yours.
You tell the officers you are in a hurry to catch a private plane to Barbados where you have been invited to be part of a Texas Hold'Um poker competition. You say you won the competition last year. Your father is a powerful lawyer in LA (worked with Johnny Cochran on the OJ case) and you will call him if the bank doesn't give you your money. You are constantly checking your cell phone and your pager and pacing in the lobby of the bank. You do not take medication ("Why would I take medication? I am not sick.") Your family has wanted to hospitalize you in the past for "doing too much." You are not suicidal/homicidal and have no prior criminal history, warrants or wants.

Bank Manager: You tell police you do not want to trespass your client her but wants her to get help. She has an account at this bank and has been a customer for many years without incident.

Dynamics

When officers show up on the scene, the customer is pacing back and forth in the lobby of the bank. She is nicely dressed and carrying a suitcase. Officers obtain the story from the bank manager and then talk to you. You are convinced about you have $30,000 in an account and are also convinced your uncle owns the Pearl District and can vouch for you. You bristle when officers suggest you might be "manic" and state that you just "have a lot of energy and gets things done." That is why you are ready for a vacation in Barbados and you are in a hurry to get to your private jet. You have a limo service that is picking

you up from the bank and you do not own a car. You belittle the officers and insult their intelligence. You are arrogant and haughty and treat other people like peons. You initially report that you stay at the Benson, but later you admit that you live on the corner of NW Everett and 19th. When asked what you will do if you don't get your money, you hesitate and sputter and posture and then say you will just go to another branch.

Consider having calling Project Respond to do a welfare check on client that evening.

Objectives

- Recognize subject is in a manic state and the symptoms associated with mania
- Risk assessment questions such as "If you don't get your money, what will you do?"
- Maintain composure despite subject's arrogant attitude
- Observe officer safety while engaging subject
- Recognize that subject is delusional and grandiose
- Do not attempt to talk subject out of her delusions
- Assess for substance abuse
- Assess for physical symptoms/risks of mania (e.g. dehydration, sleep, food)
- Assess for POH
- Focus on problem-solving the crisis and not subject's delusions and tangential thoughts

Logistics

Location

Props
Briefcase
Cell phone and/or pager or Blackberry

CIT SCENARIO #1: Person with psychotic symptoms ("Raylyn")

Dispatch

- Officer dispatched in response to call from manager to BOEC
- No wants or hits in PPDS

Summary

Role Players
1 male or female ("Ray" or "Raylyn")
1 male or female apartment manager

Fact Situation
Officers respond to dispatch to check the welfare of a man/woman in the lobby of a downtown SRO (single room occupancy). Subject lives at this facility and has paid the rent.

Specifics

Profile of subject standing in the lobby ("Ray or Raylyn")

You are middle-aged and have been standing in the lobby of this downtown SRO for the past 5 hours. You are initially hesitant to engage with police, giving only short, one-word answers. You have been living at this address for the past year and a half. You are standing in the lobby because it is the only place you think is "safe." After some questioning, you tell police that you believe radioactive rays are coming through the walls and vents in your room. You have been experiencing these "rays" on and off for the past 25 years. Your MO is to move every time they become unbearable. You have seen a caseworker at Cascadia in the past but she is on vacation and you heard that Cascadia was sold. You stopped taking your medication about 4 weeks ago. You do not drink or use drugs. You do not have a coherent plan for dealing with the rays, other than not returning to her room. You can decide whether you are hearing voices or are just paranoid. If officers decide to go to your room they will discover that you have put duct tape on the vents and around the windows.

Profile of manager:

You are a "hands-off" type of manager who does not concern yourself with your residents, other than to collect the rent and make sure the rooms don't get trashed. You report to the officers that this is unusual behavior for the subject. You don't know if the subject has family/friends but seems like a "loner."

Dynamics

When police arrive they briefly talk to the manager who gives limited information and wants the police to "take care of it." The subject has not been threatening but has not

been entirely friendly either. The subject makes limited eye contact and gives brief answers. Police need to spend some time on rapport building before the subject will start to talk about his paranoid delusions involving rays. If police question your firm belief in the rays, you become more agitated. Police will try to get subject to a hospital but he doesn't believe hospitals are helpful. After showing concern for his well-being the subject divulges information regarding his previous services with Cascadia and his belief that Cascadia has been sold and he can no longer go to 12th Ave.

Objectives

- Use rapport-building techniques
- Find the balance between asking about the subject's delusions but not buying into the delusions
- Show awareness of officer safety while communicating concern for subject's situation (fear, inability to go back to his room, food etc.)
- Utilize community resources (ie. Project Respond)
- Focus on mitigating subject's current crisis by asking appropriate medical/mental health related questions
- Assess for POH
- Assess extent of delusion (ie. Does it include contaminated food/water?)
- Educate the manager in a professional manner as to the limits of your authority

Logistics

Location

Props

CIT SCENARIO #2: "Sam"

Dispatch

- BOEC dispatches officer to Borders Bookstore
- Officer will run person for wants
- "Clear" with no "wants or PPDS"

Summary

Role-players
1 homeless male

Fact Situation
A concerned citizen called 911 to report a man who looked like he could use some help. Officers are called to "Borders Bookstore" to check on the man who is wearing multiple layers of clothing, looks to be homeless, and is muttering to himself and circling a bicycle non-stop.

Specifics

Profile of role player
You are a homeless man who is experiencing psychotic symptoms. You are walking in circles around a bicycle because it is "your job." A man, "green hair," asked you to guard the bicycle while he went into the bookstore. He said he would give you a dollar if you guarded his bicycle. You are hearing voices and talking back to your voices. It is difficult for you to focus on the officer and his/her questions and there is a delay in your answers. Your thinking is concrete (Q: Can you give me your name? A: Yes).You voices are absurd and bordering on inappropriate. They are not of a command nature and are not suggesting you harm yourself or others. The voices sometimes make you laugh. You will share what they are saying. When asked where you live you say, "Portland." You can confirm that you ate today at the "Blanchet House" but cannot tell the officer the exact date of the month. You are not on medication and do not have a medical provider or counselor. You do say that you sometimes see "Jim" who gives you cigarettes and coffee.

Dynamics
When officers approach the subject he barely looks up and continues to stay in his own world. Officers need to get his attention several times ("Sir, SIR"). Subject readily engages with officers but has a difficult time staying focused on their questions. He is experiencing psychotic symptoms but can also answer questions regarding his ability to meet his basic needs. Officers assess subject for a hold.

Objectives

- Use communication techniques appropriate for someone who is hearing voices (repetition, use of name, wait longer than "normal," non-threatening)
- Ask risk assessment question to determine the tenure of the voices (command?)
- Ask risk assessment questions – If not X, then what? E.g. "I
- Ask questions to determine subject's ability to care for self
- Show awareness of officer safety while communicating concern for subject's situation
- Utilize community resources (ie. Project Respond's outreach coordinator, Jim)
- Use creative problem-solving (find "green hair" in the bookstore, have owner of the bike paged in the bookstore, call Jim and arrange to have him meet with subject later on in the day)

Logistics

Location

Props
Bicycle
Oversized raincoat
Hat
Crumpled up newspaper for pockets

Civil Law Updates - 2009

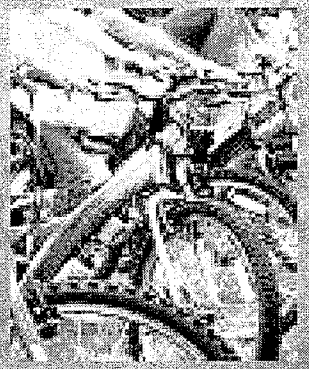
Presented by

Dave Woboril and Ellen Osoinach

Portland City Attorney's Office

Areas of good progress:

- Report writing generally better, and sometimes great
- Interactions with mentally ill and Project Respond
- Force review and internal audit capability
- Avoiding old trap of police-advocated policy and practice and requiring community to become expert and make the tough policy calls – example Toronto
- Relations with bike community



Executive Summary and Introduction

- This Report describes an increasingly excellent police department. Chief Rosanne Sizer and her command staff have worked diligently and in good faith to improve the Portland Police Bureau. To the extent this has meant implementation of the Police Assessment Resource Center recommendations, the Chief has done so effectively and with seriousness of purpose. Importantly, the current administration has built upon PARC's recommendations and developed first-rate new policies. The PPB is indeed in a progressive mode, with an increased capacity for self-critical identification of issues and formulation of solutions. We conclude that the PPB has made substantial progress since we first looked at it in 2002 and 2003.

Complaints Received 2002-2007

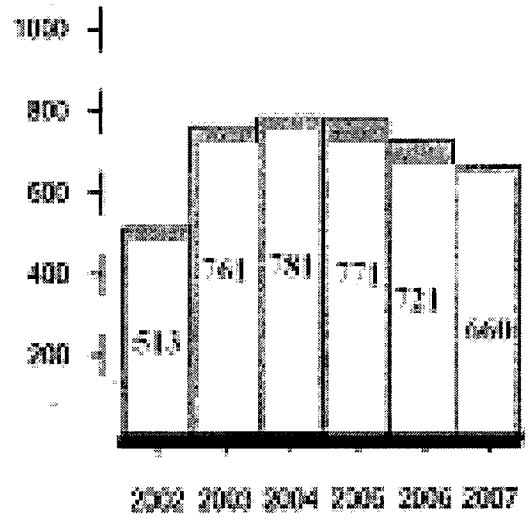


Figure 2.1

IPR opened 660 citizen-initiated complaints in 2007.

IPR closed 593 citizen-initiated complaints in 2007.

Complaints Closed 2002-2007

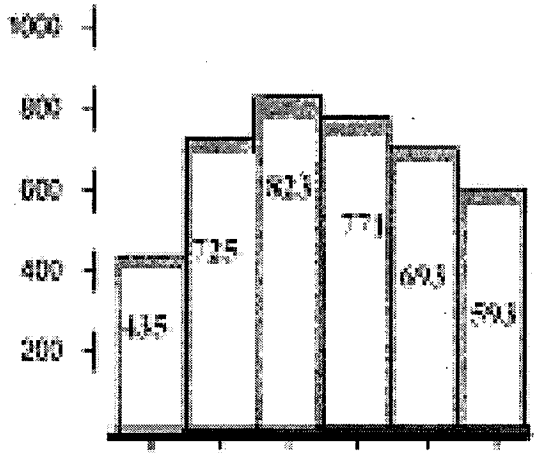


Figure 2.2

The number of citizen complaints per thousand police contacts has declined steadily since 2004 (Table 2.1). Although the number of contacts between citizens and officers (as measured by dispatched and self-initiated calls for service) declined about 5% during the same period, complaints declined by about 15%.

Emergency Medical Custody Transports

The reason for confusion in the past -- Medical people couldn't put custodies into their ambulances without consent to treatment.

The NEW agreement (630.45):

"When a person is in custody and EMS believes the person needs treatment or evaluation at a medical facility, EMS will transport to the hospital regardless of consent to treatment."

If there is an issue about consent to treatment, it will be resolved on the hospital grounds -- not at the door to the ambulance.

A corollary -- no medical transports of custodies in police cars except when necessary in emergencies.

Take No Medical Risks – Call EMS and Sgt. to scene if:

- Seriously ill
- Seriously injured
- Unconscious
- Excited delirium
- Respiratory difficulty
- TASER plus prolonged struggle

– AND –

- Head trauma
- LOC
- Seizure
- Intoxicated / drugged and prolonged struggle

Provide full information and have EMS make the medical call:

- EMS and PPB have agreed that PPB will provide complete information on use of force and patient's symptoms.
- It is EMS' job to determine if a subject needs medical evaluation or treatment at a medical facility.
- By agreement between PPB and EMS, this evaluation is to be independent of the evaluation of consent to treatment.

Officer responsibilities once EMS arrives:

- Announce custody status of subject: civil hold, arrest with charges, etc.
- Describe all use of force or police action that might be related to patient's medical condition.

If EMS determines the patient needs to go to a medical facility:

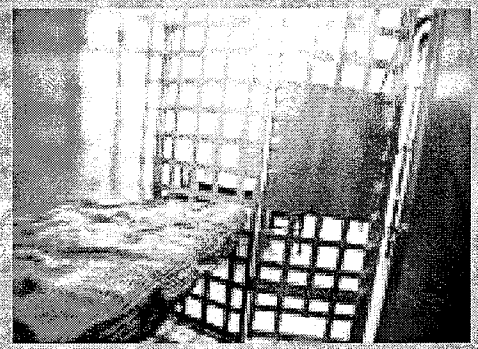
- EMS has agreed to do the transport in an ambulance regardless of consent to treatment.
- If EMS wants an officer to ride in the ambulance, PPB will provide an officer.
- If PPB wants an officer to ride in the ambulance, EMS will accommodate.
- Search rules: properly-limited search incident to arrest for evidence and safety but no inventory. (More on search incident to arrest later.)

If EMS determines the patient does not require treatment or examination at a medical facility:

- Officers may transport to jail
- EMS must provide officers with Pre-hospital Medical Treatment Worksheet
- **EMS will not ask PPB to sign refusal of treatment on behalf of patients. Report to Sergeant if they try to get you to sign any kind of release or refusal.**

At jail:

- Give jail the Pre-hospital Treatment Worksheet and document.
- If jail refuses to accept the prisoner for medical reasons, jail must decide mode of transport to hospital.
- If jail decides EMS transport is appropriate, transport in a police car is out of the question unless an emergency.
- If jail rejects for medical reasons and says police car transport is OK:
- Document the name of the decision maker.
- Call the sergeant and participate in decision on whether to call EMS to MCDC or transport in a police car.



Subjects who are not in custody on a criminal charge who have medical problems:

No authority to do a forced transport unless you place a police hold (i.e.: you determine the person is incompetent and requires mental health or medical treatment).

You must call EMS if you have "concerns about a subject's medical status during an incident or custody situation."

The Medical Catch-All

You must call EMS if you have "concerns" about a subject's medical status during an incident or custody situation."