Independent Review and Analysis of the Officer-Involved Shooting Death of Jacob Macduff

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What is done cannot be undone, but at least one can keep it from happening again.

- Anne Frank

Introduction

On January 6, 2021, Jacob Macduff was shot and killed by then Tigard Police Officer Gabriel Maldonado. Following Mr. Macduff's death, the City of Tigard agreed to pay Macduff's estate $3,800,000.00 to address all claims arising from the Tigard Police Department's ("TPD") use of deadly force. One of the terms of the settlement agreement was that the family could commission, at their expense, an independent critical incident review and analysis. Pursuant to those terms, the review would include the post-incident steps taken by the City of Tigard about any improvements and reform related to its policing policies, procedures, and training. The parties further agreed that Michael Gennaco of OIR Group[1] would conduct the independent critical incident review and analysis and prepare a written report setting out findings and recommendations. This report is intended to be responsive to that expectation as set out in the settlement agreement.

The focus of this review was the investigation of the event conducted by the Washington County Major Crimes team and the subsequent administrative review conducted by the Tigard Police Department's Use of Force Review Board. The goal of the project was to assess the objectivity and thoroughness of fact collection and the rigor of the subsequent internal review of involved officers' actions.

In furtherance of that goal, this writer reviewed the evidence that was assembled during the Washington County Major Crimes team investigation. The timeliness and effectiveness of the process were considered, as was the extent to which current County protocols provided for evidence collection that was sufficient to the task of properly evaluating the involved officers' tactics and decision-making.

The review also examined TPD's incident review materials and protocols to learn whether those systems properly facilitated the ability of the Department to ensure appropriate accountability, learn from the critical event, and adjust its practices to strengthen future performance. Finally, and based on an evaluation of the attributes and limitations in the

[1] Since 2001, Michael Gennaco of OIR Group has worked with government entities in a variety of contexts related to independent outside review of law enforcement, from investigation to monitoring to systems evaluation. As part of OIR Group's oversight responsibilities for numerous jurisdictions, Mr. Gennaco has reviewed hundreds of officer-involved shootings and devised recommendations to improve attendant investigative and review practices.

current model, this writer devised recommendations to further improve relevant TPD policies, practices, and protocols – thereby promoting not only appropriate accountability but also the identification and dissemination of beneficial "lessons learned."

Based on this review, this writer found that there were significant gaps in the Washington County Major Crimes investigation into the fatal officer-involved shooting of Jacob Macduff. The report accordingly includes responsive recommendations. This writer suggests that TPD (as a member of the interagency team) communicate these observations to partner agencies so that potential improvements can be adopted for the future.

Moreover, because the focus of the Major Crimes Team investigation is limited to the use of deadly force, other issues critical to TPD – such as the use of force by one officer preceding the shooting, their tactics and decision-making during the event, and crime scene maintenance – fall to the Department to consider and address when such incidents occur. The Major Crimes Team's structurally narrow focus means that it is even more imperative that TPD collect the facts necessary to perform the wide-ranging analysis that is warranted by these incidents.

To TPD's credit, during its internal review of the incident (which was delegated per policy to its Use of Force Review Board), it identified training issues for consideration. And to its credit, the Review Board's recommendation to develop training on how best to address barricaded subjects in a vehicle and how to use less lethal munitions in that circumstance resulted in two robust trainings that addressed several issues present in the Macduff shooting. However, there was no apparent debriefing (or any other specific corrective action) of the on-scene officers relating to the decision-making in this incident. And, as indicated in this report, the Review Board did not apparently identify, discuss, or assess other relevant issues, such as the actual on-scene decision-making of the officers and sergeant and their failure to consider that Mr. Macduff was likely experiencing a mental health crisis during the encounter.

To reiterate, the responsive training interventions that TPD did devise were praiseworthy as far as they went. However, this report also identifies significant additional issues that could and should have been the focus for the Use of Force Review Board. The remaining gaps in the investigative and review process undermine both the substantive legitimacy and the lasting value of the Department's internal outcomes. In short, they create skepticism as whether sufficient accountability, learning or remediation followed from the Macduff shooting. Therefore, this report also identifies additional remedial actions that *should* have sprung from TPD's internal review process, and it devises recommendations to improve both the investigative and review process when future deadly force incidents occur.

It is important to note that the current investigative and review structures have the *capability* both to develop a thorough and objective factual record and to utilize that record

for a robust, constructive review. However, this writer's assessment finds that the initial investigation by the multi-agency team had significant deficiencies. And while the training initiatives by the Department were commendable, TPD fell short of producing the sort of accountability, learning and remediation that an agency should demand of those entrusted with these critical functions.

Coming out of the litigation, representatives of Mr. Macduff's estate required that significant changes in policy, training and equipment be made to provide better guidance to officers on de-escalation, ensure a rapid deployment of body-worn cameras (an initiative that had languished), and otherwise reduce the likelihood of future deadly force incidents under similar circumstances. This report provides a description of those initiatives as well.

This report, then, has both substantive and procedural observations about the underlying incident and TPD's ultimate responses to it. This writer is hopeful that TPD and City leadership consider this analysis and recommendations in the constructive, forward-looking spirit with which they are issued. An objective and thorough collection of the facts of a serious incident is indispensable for an effective review process. And an effective review process allows for accountability, learning, and course correction. When both elements are in place, the result is an effective feedback loop that better prepares that agency for similar future challenges, enhances officer and subject safety, and potentially reduces incidences of deadly force. This report is intent on further developing a framework within which TPD can achieve each of these vital objectives.

Methodology

As stated above, Jacob Macduff's mother agreed to a settlement of the claim she had filed on behalf of his estate in response to his death. As part of the settlement agreement, the City of Tigard agreed to pay $3,800,000.00. In addition, the City delineated a list of changes to policies, procedures or training that were the result of, related to or influenced by the incident resulting in the death of Jacob Macduff. (This will be discussed later in this report.) As part of the agreement, the City agreed to provide all documents related to the incident and agreed that Ms. Macduff could commission an independent critical incident review and analysis. The parties agreed that OIR Group (in the person of Michael Gennaco) would conduct this independent review. Pursuant to the agreement, Ms. Macduff commissioned an independent review by OIR Group.

This writer began the assignment by reviewing the investigative file. This writer reviewed reports, photographs, statements, and the interviews of witnesses and involved officers. This writer also reviewed current relevant policies of TPD and investigative protocols of the Major Crimes Team. Unfortunately, as detailed below, because the grand jury proceedings conducted by the Oregon Department of Justice were not made public, this writer was not able to learn the breadth and extent of the witnesses presented and the testimony provided in that proceeding. Finally, this writer had an opportunity to speak with representatives of the Police Department, including the Chief, to have a better understanding of field practice and an update on structural reforms undertaken by the City. We received excellent cooperation through this process and appreciated the responsiveness and candor exercised by TPD's command staff.

Factual Summary

In the days prior to the date of the officer-involved shooting, TPD officers had responded to five calls for service at the apartment where Jacob Macduff was residing. He was living with his former girlfriend and the calls for service dealt with domestic disputes between the two. On the date of the shooting, TPD Officers Gabriel Stone and Kaci Mace responded to calls from neighbors reporting that they had heard banging on walls in the apartment.

When the officers arrived at the apartment, they encountered the female roommate, a work friend of hers, the roommate's sister (who lived in a nearby apartment), and a maintenance man for the apartment complex. The four advised the officers about the previous actions of Mr. Macduff, and the officers were able to observe damage to the walls caused by Macduff. The girlfriend advised that Mr. Macduff had confronted her and "chest bumped"

her, told her that the situation was going to be a Romeo and Juliet scenario, and said that Macduff had told her that he would "skin her alive". During the discussion, the officers were advised that during the prior calls for help, previous officers who had responded had refused to take any action against Macduff, indicating that they were reluctant to "poke the bear."

While talking with the four, Officer Stone was handed a cell phone and talked with Macduff's mother, who was living in Southern California. The mother said that she hoped that Macduff could be placed on a mental health hold so that he could receive treatment.

After talking with the individuals, the two officers went downstairs with the maintenance man who showed them where Macduff parked his truck. The officers saw that Macduff was in the truck and approached him. They asked him to roll down his windows and speak to him, but Mr. Macduff was largely non-responsive. Due to the non-responsiveness of Mr. Macduff, Officer Stone radioed for backup.

Officers Gabriel Maldonado, Nathaniel Will, Brent Mastrich, Brian Orth, and Sergeant Caleb Phillips all eventually responded to the parking garage. Officer Will placed his patrol car behind Mr. Macduff's truck so that he would not be able to drive away. Officer Mastrich placed spike strips behind the back wheels of the truck for the same purpose.

When Officer Will arrived, he was given the responsibility of attempting to talk with Mr. Macduff due to his training and experience as a crisis negotiator. Initially, Officer Will tried to talk to Macduff through the closed passenger window, but eventually Officer Mace returned to the apartment and obtained Macduff's cell phone number. Officer Will called Macduff and the two engaged in two phone calls that together lasted approximately an hour. During the encounter, Macduff declined to exit the vehicle despite Officer Will's repeated entreaties, but he continued to converse with Officer Will. Towards the end of the conversation, Officer Will advised Macduff he was under arrest and needed to surrender.

The other officers on scene milled around the area as the incident progressed. Eventually, Officers Maldonado and Stone were positioned at the driver's side, shining a flashlight into the interior of the truck. Officer Mace was positioned behind those two officers, and Officer Mastrich was positioned towards the front of the truck, holding a less lethal shotgun that contained bean bag rounds. Sergeant Phillips was positioned behind a van that was parked adjacent to the truck on the driver's side.

An extraction plan of sorts was discussed in which Officer Maldonado would use a glass punch to take out the driver's side window, ideally allowing Officer Stone to then unlock the door and pull Macduff out through the door or window. Officer Mace would be behind the two officers with a Taser. Officer Mastrich later asserted that he was to use less lethal munitions should Macduff "go mobile" or if a need arose, but other officers professed not

to know of his assigned role. Similarly, Officer Will was unclear of his own role should there be a decision to forcibly extract Macduff. Sergeant Phillips later acknowledged that such a plan had been discussed, but said he was not prepared to execute it as long as Macduff was talking with Officer Will, which he continued to do.

Officer Maldonado told investigators that at some point he received a signal to proceed with the extraction plan from Officer Will and/or Sergeant Phillips (which neither of them later corroborated). He accordingly deployed a window punch tool on the driver's window. The punch shattered the glass, but the window film tint held the window in place until Officer Maldonado used his fist to push the glass in. At that point, Officer Mastrich said he saw MacDuff lean further into the vehicle and feared he was attempting to access a weapon. He then delivered three bean bag rounds to the windshield of the truck to "distract" Macduff; this produced two holes in the glass.

Officer Stone then attempted to open the driver's door, but it remained locked. Officer Maldonado reported that he then saw Macduff holding a knife in his right hand and yelled, "knife." Officer Maldonado reported that he saw Officer Stone still attempting to open the door, placing him the closest and most at risk to Macduff.

Officer Maldonado then drew his handgun while yelling at Macduff to drop the knife. Officer Maldonado said that Macduff did not comply, at which time he fired five rounds at Macduff, who was now leaning away from him and further into the truck as if trying to access something. One hour and fourteen minutes had elapsed since officers had first located Macduff in his vehicle.

After the less lethal rounds were fired, Officers Stone, Mace, Will and Mastrich all moved away from the truck. Officer Maldonado, however, remained at the driver's door and continued to yell at Macduff to drop the knife. A full *eighteen seconds* after his initial volley, Officer Maldonado fired additional rounds at Macduff while continuing to yell at him to drop the knife. Officer Mastrich grabbed Officer Maldonado by the vest and pulled him away from the driver's side door and toward cover.

After the shooting, on-scene officers discussed how to re-engage with Mr. Macduff to provide emergency aid. Sergeant Philips ran to his car, which was parked at the front of the complex, to retrieve a ballistic shield and drove it back to the scene. The shield was used for cover and officers pulled Macduff from the vehicle through the passenger side front door of the truck. Officers began to perform first aid until paramedics, who had been staged nearby, responded, and took over rescue operations. Despite those efforts, Mr. Macduff was pronounced deceased at the scene. A bloodstained open folding knife was later found behind the center console of the truck. None of the other officers reported seeing a knife.

Per County protocols, the Washington County Major Crimes team took over the initial investigation of the incident. Upon completion of the investigative report, the Washington County District Attorney requested the Attorney General review the investigation and make the determination regarding criminal responsibility. In his communication to the Attorney General, the District Attorney wrote that "your review of the evidence and application of [new state law] HB 4301 to that evidence will provide the independent evaluation I believe is necessary, given the concerns I have developed regarding this incident". The Attorney General agreed to conduct the criminal review of the incident and an assistant attorney general was designated as a special district attorney for Washington County. The Attorney General convened a grand jury to review the incident. Following that presentation, the Attorney General announced that the grand jury had declined to charge Officer Maldonado for his shooting of Mr. Macduff.

Following the grand jury proceedings, the Tigard Police Department convened a Use of Force Review Board to consider administrative implications surrounding the shooting. The Review Board determined the shooting and the use of less lethal munitions to be consistent with TPD policy. As set out in further detail below, the Review Board identified training issues for consideration.

Investigative Issues

As indicated above, the investigation of officer-involved shootings in Washington County is conducted by the County's Major Crimes Team, a collaborative unit drawn from police agencies and the Sheriff's Office within the county. Per protocol, the agency who employs the officer involved in the deadly force incident does not play an active role in the initial investigation. The role of lead investigator into the Macduff shooting was assigned to a Beaverton Police Detective.

The initial investigation of officer-involved shootings that occur in Washington County is conducted in accord with the County's Use of Deadly Physical Force by Police Officers Plan. That plan, however, was last revised over fourteen years ago and provides almost no guidance on how the investigation is to be conducted, when interviews of involved and witness officers are to be undertaken, and how and when information can be shared with the agency who employs the involved officers. Perhaps because of this lack of detail, a review of the investigative file revealed protocols that are inconsistent with best practices and significant gaps in the resultant Major Crimes Team investigation into Macduff's death.

Truncated Scope of Washington County Major Crimes Investigation

The Washington County Major Crimes investigation focused virtually exclusively on the shooting. However, each preceding instance of tactical decision-making and force by the officers set in motion the sequence of events that eventually resulted in the tragic outcome of this incident. It is incumbent upon any effective investigation of an incident such as this to explore the rationale for—and influence of – the various and interrelated decisions and force deployments by each participating officer. As detailed below, there were questions about the events leading up to the use of deadly force that were not explicitly addressed. Those included:

- Confronting the on-scene officers with external evidence that Macduff *was* experiencing a mental health crisis;
- Sergeant Phillips' failure to advise all on scene officers of the tactical plan for extracting Macduff from the truck;
- Officer Mastrich' apparent unilateral decision to direct less lethal beanbags at the windshield of the truck;

- Officer Maldonado's decision to punch out the window before receiving clear approval from his sergeant and before effectively communicating his intentions to his fellow officers; and
- Officer Maldonado's decision to remain at the side of the vehicle and deliver additional rounds at Macduff eighteen seconds after the first volley instead of moving away from the vehicle as all the other officers did.

Moreover, the Major Crimes investigation failed to focus on the earlier calls for service involving Macduff. According to accounts by Macduff's roommate (and others), there had been five calls for service into Macduff's behavior and actions in the days leading up to the deadly force incident that provided further evidence of the mental health issues confronting Jacob Macduff. And significantly, the prior calls for service were handled without any need to use force or arrest Mr. Macduff. While the investigators were made aware of these prior calls for service by the civilian witnesses they interviewed, the reports of those earlier calls did not make their way into the investigative file.[2]

RECOMMENDATION ONE: TPD should advocate for a modification of Major Crimes deadly force investigative protocols to ensure a broad scope of initial fact collection, including a full exploration of any tactical decision-making, efforts at warnings and de-escalation, and other options preceding the use of deadly force.

Failure to Segregate Involved Officer and Witness Officer

The investigative reports reveal that, after the shooting, Officer Maldonado was directed to sit in a patrol car and appropriately relieved of other scene responsibilities. However, shortly thereafter, Sergeant Phillips directed Officer Will to go sit with Officer Maldonado in the patrol car.

Basic officer-involved shooting protocols require segregation of involved and witness police officers from each other. This is so the individual recollection of events is not contaminated by exposure to others' accounts. The need for such a practice is especially acute in the officer-involved shooting context because of concern that involved police personnel will either intentionally or inadvertently influence each other's later description

[2] When Officers Stone and Mace first arrived at the apartment, Macduff's roommate expressed unhappiness about the prior calls for service not resulting in an arrest or any other action. Another issue not explored by the investigation or review was the degree to which officers' insistence on arresting Macduff was influenced by the roommate's stated dissatisfaction with the way the prior calls for service had been handled. Sergeant Phillips did say that he decided that apprehension was necessary because the calls for service showed an escalation of behavior, and the victim was afraid.

of events. For that reason, all progressive police agencies have policies requiring that involved and witness officers are immediately segregated and chaperoned by an uninvolved officer until a "pure" statement can be obtained. The direction of Sergeant Phillips to have Officer Will (a witness) sit with the shooting officer was in direct contravention of those best practices and the underlying philosophy behind them. It was unclear from the record how long the two officers were together and what they discussed during the time they were together. The investigative report also does not disclose when and how Officer Maldonado was eventually removed from the scene.

The decision by the on-scene sergeant to have the involved and witness officer sit together with no direction had a serious impact on the integrity of the investigation, and it is not clear that this issue was pursued, addressed, or even considered as part of the Major Crimes team efforts. Nor did TPD's internal Review Board address this violation of basic investigative protocols through issue-spotting or remedial action during the Department's administrative process.

Basic investigative practices require segregation of witnesses and involved officers prior to formal interviews. TPD apparently has no such protocols and needs to adopt them to ensure that involved personnel do not share information about the event prior to being interviewed. And the Major Crimes Team should adopt protocols to address a situation in which this basic investigative protocol is violated.

> **RECOMMENDATION TWO: TPD should refine its written protocols requiring that supervisors ensure segregation of involved officers and witnesses to deadly force incidents.**
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> **RECOMMENDATION THREE: When the Major Crimes Team learns that involved officers and witness officers have not been properly sequestered, it should document any efforts at amelioration and should include questions about any relevant discussions when interviewing impacted officers.**

Inordinate Delay in Interviewing the Involved Officers

The Washington County Major Crimes team did not interview the shooter and witness officers to this incident until three days after it occurred. This practice is inconsistent with basic investigative principles of effective and objective fact collection.

It is critical for detectives conducting an officer-involved shooting investigation to learn immediately about the shooting and witness officers' actions, decision-making, and observations. Accordingly, obtaining a "same shift" statement is essential to any effective

officer-involved shooting investigation. This is true because of the inherent value of a "pure" statement that is contemporaneous and untainted by subsequent input. Obviously, the three-day passage of time before the shooter and witness officers were interviewed prevented the Major Crimes team from obtaining a pure and contemporaneous statement. Moreover, such delays are so contrary to normal investigative protocols that they fuel the perception among many segments of the community that "police investigating police" provide their colleagues with advantageous treatment not extended to members of the public.[3]

Special rules such as these only serve to reinforce skepticism about the rigor and objectivity of such investigations. The investigative process in Washington County must provide for more timely interviews of officers involved in a shooting. Until it does so, much of the public that County law enforcement serves will quite reasonably lack confidence in its approach or outcomes.

Agencies that routinely delay interviews of involved personnel have reportedly done so under the supposition that recollection is improved over time. However, the proponents of the delayed approach are largely limited to either police associations or those who regularly defend police in officer-involved shootings, and objective research has debunked this notion. See, for example, "What Should Happen After an Officer-Involved Shooting? Memory Concerns in Police Reporting Procedures," Journal of Applied Research in Memory and Cognition, 5 (2016) 246–251, Rebecca Hofstein Grady, Brendon J. Butler, and Elizabeth F. Loftus.

We understand that, as one participant in an interagency group, TPD has a voice but not the final authority in how the protocols are developed. Accordingly, we urge TPD to exercise that voice in getting the protocols modified to align with best investigative practices. And if the Major Crimes Team insists on delaying the criminal interview for multiple days, there is no prohibition to TPD's conducting an administrative interview[4] of the involved and witness officers before the end of the officer's shift.[5] For that reason, unless and until the Major Crimes Team interview protocol is modified to be consistent

[3] As a cogent illustration of another negative consequence of delaying witness and involved officer interviews for three days, investigators did telephonically interview Macduff's mother the day after the incident but had to repeatedly advise her that they were not yet clear on what occurred because they had yet to talk to the witness and involved officers.

[4] While the criminal investigation into an officer-involved shooting addresses the legality of an officer's use of deadly force, an agency's administrative review relates to issues of compliance with internal policy. As discussed below, it ideally also takes a holistic look at operational issues that potentially merit a broader agency response.

[5] We recognize that exceptions to the "same shift" timeline may be necessary in the rare case of an officer having been hospitalized and seriously injured. That was not the case here.

with best investigative standards, we recommend that TPD administratively interview involved and witness officers involved in shootings prior to end of shift.

RECOMMENDATION FOUR: TPD should work with its County partners to modify the Major Crimes Team protocols, so that "same shift" interviews of officers involved in deadly force incidents occur.

RECOMMENDATION FIVE: Unless and until the Major Crimes Team protocols are appropriately modified, TPD should conduct administrative interviews of involved officers prior to the end of shift.

Failure to Include On-Scene Officer Diagrams in the Final Investigative Report

To the investigators' credit, during the interviews with the on-scene officers, they were asked to provide a sketch diagram of the incident scene, with Mr. Macduff's truck, the adjacent van, and other reference points of the parking area included. The officers were then asked to mark the positions of the officers and their direction of movement prior to and during the shooting sequence. Particularly in this case, where the positioning and movement of officers was critical to an understanding of the tactical decision-making of on-scene TPD personnel, it was an important investigative technique to have each officer document where he and other officers were positioned at critical times of the event.

Unfortunately, while the diagrams were created, they were not included in the investigative file provided to TPD. It is incumbent upon the Major Crimes Team to ensure that all such materials are included in the investigative file so that reviewers of officer decision-making can be informed by them. The fact that this did not happen here was a significant gap in the investigative materials collected.

Moreover, since the diagrams were not included in the investigative file, they were not available for the Review Board. As a second check, TPD should revise its protocols to assign a member of the Review Board to check for completeness of the investigative file.

RECOMMENDATION SIX: The Major Crimes Team investigators should ensure that investigative materials developed during its investigation are included in the investigation file.

RECOMMENDATION SEVEN: One member of TPD's Review Board should be tasked with ensuring that the investigative file of the incident is complete, and all referenced materials are accounted for.

Failure to Interview TPD Officer Who Initially Responded to the Scene

As detailed above, Officer Orth initially responded to the scene and was part of TPD's response to the barricaded vehicle situation for several minutes. Because Officer Orth's shift had ended, he asked Sergeant Phillips if he could leave the scene and was allowed to do so prior to the shooting. However, Officer Orth *was* on scene for relevant portions of the encounter, and his observations quite relevant to learning about how he and his fellow officers handled the situation.

Though Officer Orth did prepare a terse supplemental police report, such an account can never substitute for a full investigative interview with a witness officer. The failure to interview Officer Orth caused a significant gap in fact collection by the Major Crimes Team.

> **RECOMMENDATION EIGHT: Washington County Major Crimes protocols should be modified to ensure that any officer who responds to a location in which a use of deadly force eventually occurs is interviewed about the officer's actions and observations.**

Investigators' Failure to Challenge Officers' Response that they Did Not Believe that Mr. Macduff was in a Mental Health Crisis When They Encountered Him

When interviewed by Major Crimes Teams investigators, all on-scene officers disavowed having any impression that Mr. Macduff was going through a mental health crisis when they encountered him in his truck in the parking lot of the apartment complex. However, the evidence collected during the investigation showed persuasively that Mr. Macduff was in fact having mental health issues at the time that he was in his truck. First, responding officers were specifically advised that Macduff had repeatedly banged his head on the apartment walls. Additionally, when Officer Stone talked with Macduff's mother, she had advised him that she wanted him committed for psychiatric observation due to his history of mental health issues. Macduff's former girlfriend's sister reported how days previously Macduff had repeatedly harassed her young child for no rational reason. And Macduff's former girlfriend told Officer Stone that Macduff was not allowed to come to her workplace because he had acted "crazy" there.

When officers first sighted Macduff in the truck, based on their reporting, he was non-responsive to their repeated instructions, had his fingers peculiarly fashioned, and was extremely deliberate in his movements. Officer Maldonado told investigators specifically that Macduff was "doing these weird things over and over and over again." Officer Mace specifically noted Macduff's "rigid body language". When Officer Will began to speak with him, he asked the officer to refer to him as "Macfluff". Officer Will told investigators that Macduff talked in slow methodical speech and used words that did not make sense. Officer Maldonado said that Macduff pretended to talk when he was in the truck. And when Sergeant Phillips again spoke with Macduff's mother, she reiterated his history of mental illness. However, the Major Crimes Team investigators failed to question on-scene officers as to their conclusions that Macduff was not in the kind of mental health crisis that warranted different decision-making.

RECOMMENDATION NINE: The Washington County Major Crimes Team should question witness and involved officers about any conclusions that are in apparent conflict with external evidence.

Negative Consequences of Assigning the Initial Investigation to Outside Agencies

Oregon law requires that the initial investigation of deadly force incidents be assigned to an outside agency. While the intent of the law is to increase separation between the shooter officer and the investigative body and presumably increase objectivity, that separation does have negative consequences for the flow of information. In practice, there is little communication between what the investigators are learning and the leadership of the agency for which the involved officer is employed. As a result, critical decisions such as what to do with the involved officer while the investigation is pending must be made without any real knowledge of what that investigation is uncovering. In fact, we were advised that TPD had no real knowledge of what the Major Crimes investigation had revealed until it received a copy of the investigative report after the Attorney General had concluded its grand jury investigation, several months after the incident.

While having the initial investigation handled by another investigative entity does mean that the agency employing the officer will not determine the breadth and depth of the investigation, it should not mean that the agency's leadership be kept in the dark about facts of the investigation as they are being developed. The Washington County Major Crimes Team practice should be modified to provide sufficient and timely information to the impacted agency so that it can take any appropriate action during the pendency of that investigation.

RECOMMENDATION TEN: The Washington County Major Crimes Team protocols should be amended so that the involved officer's agency has sufficient and timely information about what the investigation is revealing.

Attorney General's Grand Jury Presentation Lacked Transparency

The District Attorney of Washington County advised that because he "had issues" with the incident and considering the new state statute governing use of force, he decided to refer the matter to the Attorney General for review. We were advised that the District Attorney was particularly concerned with the significant gap between Officer Maldonado's first volley of shots and the final volley of shots directed at Jacob Macduff, but apparently there was no detailed documentation of the District Attorney's rationale for referring the case.

The Attorney General initiated a grand jury investigation into the matter, which may have been the first time a grand jury was convened in Washington County into a deadly force incident. Upon conclusion of the process, the Attorney General announced in a one-page press release that the grand jury had decided not to file charges against Officer Maldonado; there were scant further details provided. In fact, the publicly released summary of the facts consisted of a single paragraph. The press release further advised that the grand jury had been advised on the new police use of deadly force law and that the grand jury had heard from first-hand witnesses describing what happened at the scene.

There was no move by the Attorney General, TPD, or any other governmental entity to supplement this concise announcement by releasing the grand jury testimony for public review. As a result, the public had no ability to know who testified, what they said, or the breadth of questioning they faced. Instead, the public's understanding of the grand jury proceedings was entirely reliant on the conclusory remarks in the Attorney General's press release.

This approach is in marked contrast to nearby Multnomah County's longstanding tradition of routinely petitioning for release of grand jury materials in a police-involved shooting so that the public can learn the identity, extent of questions, and testimony of witnesses who appeared before the grand jury. It is disappointing that this practice – and the commitment to transparency it reflects – was not undertaken by corresponding entities in Washington County.

We were informed that the Review Board was delayed as the City Attorney for Tigard requested transcripts of the Grand Jury and was advised that there were no transcripts but that a TPD employee would be authorized to listen to the recordings of the proceedings. And according to the TPD Review Board report, a TPD supervisor was afforded the opportunity to listen to the recorded testimony of the grand jury witnesses as part of the

administrative inquiry into the shooting, but he only reported that the testimony of witnesses was "consistent" with their interviews.

This cursory account also does little to provide insight into the nature of the grand jury inquiry, the robustness of any inquiry, and what the specific issues that were or were not addressed. Nor was this reviewer afforded the opportunity to make such an assessment; the grand jury proceedings remain sealed. On a going forward basis, governmental entities in Oregon (including the Attorney General, the District Attorney, and TPD) should all be cognizant of the public's interest in transparency about deadly force incidents and should regularly move for any release of grand jury testimony once the proceedings have been concluded.[6]

> **RECOMMENDATION ELEVEN: Considering the critical interest of public transparency in Washington County, entities who either convene a grand jury investigation into a police-involved deadly force incident and/or whose personnel are the subject of the investigation should move to unseal the testimony of witnesses upon the conclusion of the proceedings.**

Deadly Force Review Issues

TPD's Failure to Conduct an Administrative Investigation

Progressive police agencies recognize that there is a need to conduct an administrative investigation into any deadly force incident to fully address issues of accountability. Moreover, those agencies also recognize that an internal investigation will provide additional salient facts with which to identify training and policy issues. A robust internal investigation will involve, at a minimum, interviewing witness and involved officers to inquire of tactics, force options deployed, the consideration of de-escalation, and other decision making. Such a process facilitates not only individual performance analysis but also the identification of learning opportunities and other adjustments that could enhance the handling of future critical events.

Current TPD policy allows for the Department to conduct a separate administrative investigation. It also provides the Use of Force Review Board with the option of sending the case back for more investigation. Best practices, however, require such an investigation as a matter of course. This is primarily because the focus of a criminal review is inevitably narrower than the full range of potentially significant performance and

[6] To the degree that transcripts were not prepared during the grand jury proceedings, it would be preferable to prepare and then release such transcripts, rather than the actual recordings of the proceedings.

operational issues that such an incident encompasses. Moreover, because a criminal investigation is solely focused on whether the officer who used deadly force broke the law, additional issues of policy compliance, tactics, officer decision-making and departmental learning from the incident are often not addressed during that initial fact collection process.[7]

The Macduff matter is one for which such a full-fledged review was particularly warranted. The incident featured several different officers and a supervisor who were dealing with Mr. MacDuff for over an hour, and there were several critical inflection points that warranted administrative consideration. Areas that were not the focus of the Major Crimes investigation included the following:

- The performance of Sergeant Phillips in managing the scene;
- The officers' assessment of whether Mr. Macduff was in a mental health crisis;
- TPD's efforts to negotiate with Mr. Macduff; and
- The tactics of on-scene officers.

Moreover, as detailed throughout this report, there were numerous inconsistencies between the on-scene officers' observations, particularly regarding who (if anyone) gave approval to Officer Maldonado to begin the tactical operation and to Officer Mastrich for his use of the less lethal munitions.[8] While dynamic situations can result in observations and recollections that are divergent but nonetheless equally sincere, additional administrative interviews would have provided more clarity on these and other significant issues.

However, despite policy that allows for and anticipates administrative investigations, TPD chose to conduct no further inquiry whatsoever of the involved officer, the on-scene sergeant, and the other on-scene officers. The failure of TPD to conduct any administrative interviews with its personnel resulted in a serious deficiency of information with which to evaluate the performance of each of its involved officers and improve the agency's response to future events.

RECOMMENDATION TWELVE: As a matter of course in a critical incident review, TPD should conduct administrative interviews of witness and involved

[7] The Oregon Department of Justice's press release announcing the conclusion of its investigation specifically noted that "the grand jury's role was solely to determine whether the involved officers' conduct warranted criminal charges; questions regarding matters that are civil or administrative in nature were beyond the scope of the investigation and the grand jury's review."

[8] One explanation for the divergent accounts from the officers is that the same Major Crimes Team investigators did not interview all six of the on-scene officers. As a result, the investigative teams did not all explore the same precise terrain in their questioning, and they were not privy to the accounts of each officer as they moved forward with the investigation. Potential opportunities for clarification were thus lost.

officers to gain insight regarding tactics, decision-making, and other performance issues including the role of tactics, communication, planning, and de-escalation techniques in the response.

Other Limitations in TPD's Administrative Review Process

Overview of Process and Findings

Pursuant to its current policy, TPD convened a Use of Force Review Board to evaluate the incident. That policy restricts TPD into determining only whether the use of force was within or outside of policy. Other potential policy violations or performance issues are outside the province of the Review Board. Progressive police agencies have realized that the jurisdiction of the Review Board should not be so limited. As a result, those Boards regularly opine regarding tactical decision-making, supervisory issues, and other performance issues as part of their holistic review. However, TPD's Review Board was expressly limited by policy to a decision on the propriety of the uses of force and to identifying training opportunities.

The Review Board was facilitated by a commander of TPD who wrote the documentation memorializing the proceedings. The Review Board members included a supervisory firearms instructor, a non-administrative supervisor, a division management representative, a peer officer representative, and an outside law enforcement representative. To its credit, TPD provided each Review Board member prior access to the investigative file so that each could be well versed in what the investigation had revealed. The Review Board was also provided with relevant TPD policies and an investigative summary of the incident. The Review Board presentation and discussion took approximately six hours.

The Review Board produced a report for the Chief that began with a summary of the incident and a description of the proceedings. The memorandum then reported that as to Officer Mastrich, the Board unanimously found that his use of the bean bag shot gun was within policy. The memorandum reported that there was no consensus on whether the use of the beanbag shotgun was a use of force, with four of the five members opining that it was not a use of force since its intended use was to distract Macduff. The commander opined that the discharge of the beanbag shotgun in any circumstance is a use of force, even when used as a distraction. The commander further recommended that current policy be revised to clarify that any discharge of a weapon is considered a use of force and reviewed by a supervisor or the Review Board.[9]

[9] Although not documented in the Review Board materials, we were advised that a Commander of TPD reviewed current policy and determined that the policy was clear and that the discharge of the bean bag shotgun ***was*** a use of force under that policy. However, the "clarity" conclusion is

The memorandum reported that all five members of the Review Board found that Officer Maldonado's use of a firearm was within policy. No further explication was provided for the finding.

A separate memorandum was prepared identifying training recommendations. In addition to the above, those included the following:

- Audio microphones associated with the in-vehicle camera system at the time were not used;
- The photographs taken of the involved and on-scene officers after the incident by the Major Crimes Team were not comprehensive;
- Regarding the bean bag shotgun, a better targeting area, such as the body of the vehicle, might be preferable to windows, to minimize the potential for inadvertent penetration;[10]
- The positioning of arresting officers – including focus on the passenger side of vehicle – and the use of other available tools merited scrutiny;
- The designated negotiator should be separated from decision-making as to use of force, but should be kept apprised of plans; and
- A trained crisis negotiator should be used when available.

Inclusion of Peer Member on Use of Force Review Board Not Consistent with TPD's Accountability System

Current policy provides for the inclusion of a peer member on the Review Board. This protocol raises several concerns, most of which arise from the opportunity of this representative to vote on the outcome of the review.

TPD's accountability system in all other areas involves recommendations and determinations about whether officer conduct is within or outside of policy to be made by supervisors and ultimately the Chief of Police. Yet under current policy, a non-supervisory peer officer is given a vote about the propriety of the use of deadly force – perhaps the most critical determination a law enforcement organization can make. The inclusion of a peer officer on the Review Board is inconsistent with TPD's accountability structure and principles of progressive policing.

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undermined by the fact that four of the five members of the Review Board found that Officer Mastrich' firing of the less lethal shot gun was ***not*** a use of force as they understood TPD's use of force policy.

[10] We were advised that this point was also included in the training for less lethal impact munitions as distraction devices.

RECOMMENDATION THIRTEEN: TPD should modify its policy to eliminate the peer officer as a voting member of the Use of Force Review Board.

Lack of Sufficient Documentation of Review Board Deliberations

The Review Board memorandum provided no insight whatsoever into the analysis that caused the Board to conclude that Officer Mastrich's use of force and Officer Maldonado's use of deadly force comported with TPD policy. No facts are cited in support of those conclusions, and the eighteen factors that TPD's use of force policy requires a body to consider in determining the reasonableness of the force are neither identified nor overtly applied to the case. In short, the board's written conclusion is not supported by facts or analysis and is accordingly not helpful in explaining – or justifying –the decision that was reached.

In sum, the Use of Force Review Board memorandum provided no real insight for the Chief of Police into why the Board came to its conclusion on the propriety of both less lethal and deadly force. More guidance and greater expectations should be set out in writing regarding documentation of Review Board deliberations.

RECOMMENDATION FOURTEEN: TPD should modify its protocols to require a designated member of the Review Board to prepare a detailed written analysis of any findings regarding the use of force.

Review Board's Responsibilities Too Narrowly Scoped

As set out above, current TPD policy restricts the scope of the Review Board to determine whether the use of force was within policy and identifying any training opportunities. These are critical functions. But as a *limit* to the Review Board's responsibilities, that scope is too narrow. For the organization to fully learn from the incident and ensure that it is better prepared to address future similar challenges, the after-action review should not so restrict the Board. Rather, the Review Board should explore the incident through multi-faceted prisms including tactics and other decision-making. Oftentimes, sub-optimal tactics can increase the likelihood that deadly force will be used; accordingly, the Review Board should make a separate finding on whether the tactics and other elements of performance were consistent with training and policy.

In addition, any deadly force review should also consider whether the on-scene supervision met Departmental expectations. Finally, the Review Board should be tasked with

reviewing how effective post-incident emergency aid and scene management was. This holistic approach has been adopted by progressive police agencies to ensure that potential accountability and remediation occurs in a robust, multi-faceted way.

> **RECOMMENDATION FIFTEEN: TPD should set out in writing minimal expectations for documentation of its Use of Force Review Board deliberations, including requirements that each use of force assessment go beyond the mere question of the appropriateness of the force and related training opportunities to encompass the following:**
>
> - **Tactical and other decision-making;**
> - **Supervision; and**
> - **Post-incident emergency aid and scene management.**

Lack of an Effective Mechanism for Implementation and Follow Through

As noted above, a number of items were identified as training issues. But little guidance was provided as to what training regimen would appropriately address those issues. While, as detailed below, many of these issues did result in the development of robust and valuable training, it is unclear what became of others of the recommendations. For example, as detailed above, there was interest in clarifying policy that the use of less lethal munitions, even as distraction devices, should be considered a use of force, yet there is no documentation as to what became of this recommendation.[11] As another illustration, there is no documentation regarding whether the identified concern about the quality of the photographing of the involved officers was ever forwarded to the Major Crimes Team.

TPD's current deadly force review process has no ability to ensure implementation and follow through of any recommendations advanced by the use of force review. The Review Board process provides no structure for developing an "action plan" regarding training issues and assigning the development of a training curriculum designed to address the identified issues. There is also no mechanism for ensuring that any assignments – and their subsequent fulfillment – are reported back to the leadership of the organization. Simply put, there is no formal mechanism under current protocols to ensure implementation for even the most worthwhile of ideas.

Without subsequent action, the most insightful identification of issues and potential solutions is of no lasting benefit to a law enforcement organization. Someone must chart a

[11] As noted above, we were advised that a TPD commander determined that there was no need for clarification of policy regarding whether this was a use of force, but this was not documented in the Review Board file.

path forward and ensure that the talk results in improvement. Unless there is a mechanism for ensuring that constructive suggestions are turned into action, some of those ideas are destined to die on the vine. In this case, there appears to have been attention placed on transforming the majority of the recommendations into "deliverables;" this is commendable. But others lacked similar evidence of meaningful follow-through.[12]

Accordingly, we recommend that TPD's General Orders be modified as follows:

> Upon the conclusion of the Review Board meeting, and conditioned on their approval by the Chief, the Chair will designate to a specified attendee the responsibility of implementing any recommended actions or identified training needs, along with a time certain for completion of the task.
>
> The Chair (or a designate with command authority) will be personally responsible to ensure that the assigned measures are completed in both an effective and a timely manner.

RECOMMENDATION SIXTEEN: TPD should devise explicit protocols to ensure that any accepted recommendations or identified training issues emerging from the Use of Force Review Board (and endorsed by the Chief) are implemented by:

- **Assigning the responsibility of implementation or development of training domains to specific TPD personnel.**
- **Delegating to an TPD command staff member the responsibility of ensuring effective and timely implementation.**

No Documentation of Formal Feedback of Review Board Findings to Involved Personnel

In addition to developing training to identify issues identified that could improve a law enforcement agency's response to future similar challenges, it is also critical that involved personnel receive the insight of the Review Board's assessment of the case through targeted debriefing. However, there is no documentation in the Review Board materials that the on-scene officers received formal feedback regarding their performance. A fact-

[12] We were advised that the task of follow through was assigned to the Board chair, that meetings were held to ensure follow through, to brief the trainers on the incident, and how best to incorporate the issues into training. While as we say elsewhere we did find the training that resulted commendable, it would have been helpful to document the assignment of tasks and the follow up meetings. It is also helpful to write protocols with these express expectations to ensure that there will be robust follow up with future Review Boards.

specific debrief with each involved officer allows the pursuit of identified training issues in an individualized way.

There is significant value to the process of providing information to involved personnel regarding specific issues considered and addressed by the Use of Force Review Board. To ensure this important feedback loop, we suggest that policy be revised so that one Board member is assigned to provide an objective, unvarnished debriefing to involved personnel at the end of the process. In that same forum, the involved individuals could share their own perspective on the investigative and review process, as well as suggestions for improved future performance and readiness.

We were advised that in this case, the Chair of the Review Board met with each involved member with the exception of Officer Maldonado who was no longer with the Department. TPD should be commended for taking this important step. However, there was no documentation of the meetings or what was conveyed during the meetings. To ensure that such a process occurs, and that appropriate documentation of the briefings are prepared, we recommend consideration of the following additional language:

> The Chair will also designate to a specified attendee the responsibility of meeting with involved members and providing both a complete debriefing of issues raised during the Review Board process and an opportunity for members to provide their insights and perspectives.
>
> The Chair (or designee with command authority) will be personally responsible for ensuring that this step occurs in a timely manner.
>
> **RECOMMENDATION SEVENTEEN: TPD should expressly incorporate a debriefing phase into its Use of Force Review Board process that would provide involved officers with a forum for hearing the board's findings and analysis as well as an opportunity for the officer to share his or her own perspective.**

Training Instruction Provided by TPD

To the Department's credit, two significant training initiatives emanated from TPD's review of the incident involving the use of less lethal munitions as a distraction device and on dealing with a subject who is barricaded in a vehicle. We were provided with copies of the PowerPoint presentations for both trainings.

Use of Less Lethal: PowerPoint

In a March 2022 training presentation entitled "Less Lethal Impact Munitions as Distraction Devices," the stated goal was "to understand the limitations and department guidelines on using less lethal impact munitions as distraction devices." The slide presentation specifically instructs officers:

> Do not use [Less Lethal Impact Munitions] on glass. They will be ineffective in breaking glass as well as create higher levels of risk than may be intended or allowable.
>
> Unless otherwise justified, do not aim the [Less Lethal Impact Munition] toward or near a person when being used solely as a distraction device.

The training presentation instructs officers who use less lethal munitions on a vehicle as a distraction device to aim for parts of the vehicle that will not likely be penetrated. The presentation further advises contacting a TPD tactical team member if there is consideration of using less lethal munitions as a distraction device. Significantly, the training instructs officers to ensure that all personnel on scene understand the role of the less lethal munition in the operation and the intended target area/backdrop.

It is apparent that the instruction on use of less lethal was directly responsive to issues presented in the Macduff shooting and was a beneficial by-product of the review process. It illustrates the ways in which thoughtful scrutiny of major events can provide a basis for future improvement.

The presentation also implicitly reflects the agency's recognition of shortcomings in the specific approach to the less lethal munition that was taken by Officer Mastrich. And the instruction to consult with a tactical team member and to coordinate and communicate with others on scene spoke to the failure of Officer Mastrich to apparently do either.

However, while the training presentation was an effective critique of the use of less lethal munitions by Officer Mastrich in the Macduff shooting, as discussed above, the Review Board report itself contains no such direct disapproval. Moreover, as noted above, there was no documentation of the debriefing or

counseling (or any other intervention) of Officer Mastrich's use of the less lethal munitions in this case. As noted above, individualized accountability and remediation should accompany forward-looking initiatives that benefit the Department as a whole. Both have value.

Finally, one of the limitations of training as a remedial option is that it is evanescent and subject to variables that can limit its lasting influence. This is as opposed to policy, which of course is relatively permanent.

> **RECOMMENDATION EIGHTEEN: TPD's Review Board's final written report should set out any critique of officer decision-making as a support for any recommended training initiatives.**
>
> **RECOMMENDATION NINETEEN: TPD should ensure that officers who performed inconsistently with Departmental expectations are remediated through either targeted debriefing, counseling, or some other formalized remediation and that the remedial steps are documented.**

Barricaded Subject in Vehicle: Power Point Presentation

As a result of this incident, a training power point presentation was developed entitled "Barricaded Subjects in Vehicles" with the following course goals:

- Understand the legal requirements for de-escalation
- Know the leadership roles
- Understand tactical options
- Know the negotiator role
- Understand the difference between a dynamic and static event

The training included a refresher on the new state law focusing on expectations that de-escalation techniques will be used prior to using force when feasible.

The slide presentation expressly includes concepts that were not evident in the Macduff shooting:

- Police initiated actions on a barricaded suspect should be done with approval and direction from supervisors
- Sometimes disengaging will be the best course of action
- CONTINUALLY ASSESS – Just because we started something doesn't mean we can't leave
- Someone must be in charge, and it must be clear who that is

- Be aware of crossfire
- Designated negotiator needs a second officer to act as a liaison between incident commander and the negotiator
- Record conversation when possible
- Negotiator should give the suspect instructions for surrendering and coordinate with the arrest team
- Information to gather: Mental health factors
- The need for an escape path
- The arrest team and leadership should make a plan. The plan should be approved by the incident commander

As with the training on the use of less lethal, while the training provided helpful reinforcements of tactical decision-making, the report of the Review Board did not include a written critique of the tactical missteps present in the Macduff shooting. Nor was there any documentation of any direct intervention such as targeted debriefing or counseling regarding the Board's concerns about the team's performance. And none of the important concepts relating to addressing a barricaded vehicle situation were incorporated into Departmental policy. All these remediations should have occurred and been documented.

RECOMMENDATION TWENTY: TPD should incorporate into policy major concepts addressed in its training relating to barricaded subjects in vehicles.

Other Internal Reforms Emanating from Macduff Shooting

In the settlement agreement, the City set out several changes to policies, procedures, and training that were the result of, related to, or influenced by the incident resulting in the death of Jacob Macduff. They included:

- Decision to employ the Use of Force Review Board as the process for the review of the deadly force incident;
- Drone program developed as an option to assist with vehicle barricaded subjects;

- Use of Force policy amended to add specific and clear language on de-escalation and verbal warnings, with a scenario-based training component;[13]
- Deployment, implementation, and training related to body worn cameras and dash cameras;[14]
- TPD supervisors sent to "train the trainer" de-escalation training and de-escalation component added to all use of force training;
- De-escalation posters placed in strategic locations in TPD building;
- TPD joined with three cities to create and fund the "South Cities Mental Health Response Team (MHRT)" to increase availability of MHRT and clinicians;
- Scenario based de-escalation training provided; and
- Police Legitimacy and Procedural Justice training

These policy, training, and equipment reforms are commendable and will leave TPD members better prepared to address future similar challenges. The type of attention that TPD placed on interventions designed to address issues identified in the Macduff shooting is consistent with the progressive concept of learning and improving from a careful review of critical incidents.

As stated earlier, a shortcoming to these thoughtful and robust interventions is that TPD did not produce any written critique of officer decision-making nor direct intervention with the involved officers that could have served as a foundation and support for these significant reforms. But to the extent that TPD did address some but by no means all of the areas that called out for improvement in this incident, it deserves a measure of credit.

[13] Specifically, the revisions to the use of force policy added an "Alternative Tactics- De-escalation" section instructing officers to use non-violent strategies and techniques to reduce the need for force, and a requirement that verbal warnings be provided prior to using physical force, if reasonable to do so, and with provision of a reasonable opportunity to comply. This is consistent with new state standards discussed below.

[14] TPD had dash cameras with the ability to sync up audio at the time of the Macduff shooting, but the equipment had aged with questionable functionality – so much so that officers were specifically advised that they did not need to carry or activate the audio microphones.

Issues Not Addressed by Review Board

Failure of Review Board to Address New State Law Requirements of De-escalation and Verbal Warnings

In a 2020 Special Session of the Oregon State Legislature, House Bill 4301 was passed and signed by the Governor. The requirements of HB 4301 went into effect on January 1, 2021, just six days before the Macduff shooting. The law made substantial changes into how uses of force by police in Oregon are to be governed. Significantly, Section 7(3) of HB 4301 required that:

> Prior to using physical force upon another person, if the peace officer has a reasonable opportunity to do so, the peace officer shall:
>
> (a) Consider alternatives such as verbal de-escalation, waiting or using other available and techniques if reasonable, safe, and feasible; and
>
> (b) Give a verbal warning to the person that physical force may be used and provide the person with a reasonable opportunity to comply.

In anticipation of the new law, in 2020 TPD provided training to its officers on its new requirements, including de-escalation and verbal warning and its policies were realigned.[15]

While the negotiation between Jacob Macduff and Officer Will was the key feature of the responding officers' deployment of de-escalation techniques, there was no evidence that prior to using force, (including the less lethal and lethal rounds fired by Officers Mastrich and Maldonado respectively) that Macduff was advised that physical force was about to be used in order to provide him an opportunity to comply. Nor was there any indication from on-scene officers that there was an exigency that prevented such verbal warnings from being made.[16]

Because, as detailed elsewhere, the grand jury proceedings conducted by the Office of the Attorney General remained sealed, it is unknown to what degree the new law requirements, including the need to use de-escalation techniques and provide verbal warnings, were addressed with the involved officer and the officer witnesses.

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[15] To TPD's credit, policies were again updated after the officer-involved shooting to provide further clarity on the law's expectations.

[16] Officer Will advised Macduff that he was going to be arrested and physically extracted from the vehicle if he did not exit voluntarily but neither Officer Maldonado nor Officer Mastrich warned Macduff prior to their uses of force.

Regarding TPD's Use of Force review, there is no indicia in the Board report that the new verbal warning requirements were considered or applied to the facts of the case. As a result, the fact that no verbal warnings were provided by on-scene officers prior to the application of force, in potential contravention of Oregon law, was not considered by TPD in evaluating the conduct of Officers Maldonado and Mastrich. This failure to consider the new law requirements in TPD's deadly force review was a significant gap in the Department's analysis.

> **RECOMMENDATION TWENTY-ONE: In assessing deadly force incidents, TPD should expressly consider Oregon state law de-escalation and verbal warning requirements to determine whether its members performed consistent with state law and policy.**

Review Board's Failure to Consider Evidence that Mr. Macduff Was in a Mental Health Crisis and the Implications for the Involved Officers' Response

As detailed above, there was overwhelming evidence that Mr. Macduff was going through a mental health crisis when officers encountered him in his truck. First, when they arrived at the apartment, Officers Stone and Mace were specifically advised that Macduff had repeatedly banged his head on the apartment walls – not an action generally connected with rational behavior. And the indicia continued from there, including various inputs from family members and friends and several observably unstable elements to Macduff's statements, demeanor, and physical actions.

Yet despite all these indicators of mental health issues, the Review Board chose instead to accept the officers' accounts that they did not even consider Jacob Macduff to have been experiencing a mental health crisis during their time of engagement and opined that the circumstance was not a mental health call.

Of course, the failure of the officers to recognize the signs indicating that Macduff was in the middle of a mental health crisis had serious implications for how the event concluded. For example, had there been recognition of this fact, the Washington County Mental Health Response Team (MHRT) could have been contacted to assist with the call. With clinicians involved in the response, the situation may well have been resolved short of the tragic outcome that ended the event and the life of Jacob Macduff.

The investigation also did not pursue whether the MHRT would have been available to respond. One reason that this avenue of inquiry was not fully pursued at the time of the incident or considered by the Review Board was the fact that Officer Will was a trained

crisis negotiator, which may have lessened the perceived need to engage the MHRT. However, there would have been no downside to calling the Team to respond had they been available to do so. The investigation and review should have explored the team's availability and whether the its range of functions could have helped better resolve the situation.

Review Board's Failure to Identify and/or Document the Tactical Deficiencies of the On-Scene Officers

The Review Board failed to set out in its report the numerous tactical deficiencies of the on-scene officers and sergeant. Each of the following merited further analysis.

Failure to Fully Discuss and Communicate a Tactical Plan, Resulting in a Poorly Coordinated and "Chaotic" Tactical Response.

Prior to the shooting, the on-scene officers had positioned themselves around the truck. Officer Will was on the passenger side talking with Macduff from the window area and then over the phone. Officer Mastrich was at the front of the truck. Officers Stone and Mace were on the driver's side of the truck while Sergeant Phillips was further back from the truck, behind the van.

There had apparently been some discussion of a plan if negotiations proved unsuccessful: Officers Maldonado and Stone would pull Macduff from the truck, with Officer Mace armed with a Taser should Macduff become aggressive. However, existing evidence indicates that the Sergeant and other officers were in no way prepared to take such action at the specific point that Officer Maldonado moved to break the driver's side window.

This is evident from the statements of the on-scene officers. As noted above, Sergeant Phillips told investigators that he was in no rush, and so long as Officer Will and the subject were talking, he was not going to take action to extract him. Sergeant Phillips described Macduff as not aggressive, did not feel the need to escalate, and thought that Officer Will was getting somewhere with him.[17] At some point, however, Sergeant Phillips said that he observed Officer Maldonado nod as if he were going to break the window, but he told Maldonado "No" since Officer Will and the subject were still talking. Sergeant Phillips said that several minutes later Officer Maldonado then used a punch tool to break the window but he did not say that he had given the go ahead to do so.[18]

[17] In contrast and in possible conflict with Sergeant Phillips' statement, Officer Will said he told Macduff during the end of the conversation that his sergeant wanted to move this along.

[18] In contrast, Officer Maldonado told investigators that he advised Sergeant Phillips that they were going to go ahead. Officer Maldonado said he made sure everybody was ready to go and they said

Similarly, Officer Will said he had no forewarning that Officer Maldonado was going to move to punch out the window when he did.[19] Officer Mace told investigators that Officer Will was still on the phone with Macduff when Officer Maldonado decided to punch out the window.

Once Officer Maldonado moved to punch out the window, Officer Mastrich delivered rounds from this less lethal shotgun into the windshield of the truck.[20] Officer Mastrich said that the plan was for him to watch Macduff in case he made any "furtive" movements or dove towards the center console or passenger seat area. According to Officer Mastrich, if Macduff did that, he was supposed to fire a couple of rounds of less lethal munitions through the windshield to deter or stop him from doing what he was doing. Sometimes, officers are required to react instinctively to volatile events; but when there is time, as here, to develop a coordinated tactical plan, one should be devised with everyone knowing each other's role.[21]

Because there was no coordinated tactical plan, on-scene officers were at a severe disadvantage when Officer Maldonado decided to begin the tactical operation and Officer Mastrich followed with delivery of less-lethal rounds to the windshield of the truck. Officer Mace summed up the situation as "chaotic" and was not sure who had fired when she heard the first bang and then a series of pops. Despite the clear lack of coordination reflected in both the officer's accounts and their actions as they unfolded in the incident,

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they were. Officer Maldonado did not mention initially being told "no" by Sergeant Phillips when he had wanted to break the window earlier. Officer Stone told investigators that Officer Will gave Officer Maldonado the nod to go, because Macduff was not going to open the door. Officer Stone said Sergeant Phillips then told Officer Maldonado to "hold up." Officer Stone said Officer Maldonado looked back at him and said he (presumably Sergeant Phillips) had given Officer Maldonado the okay to go forward, in apparent conflict with Sergeant Phillips' version of events.

[19] Officer Mastrich also told investigators he saw Officer Will make a gesture, and he saw Officer Maldonado then break the window and sweep away the glass and try and reach into the window.

[20] As another illustration of the poorly concocted "plan", Officer Maldonado told investigators he did not know what Officer Mastrich' role was to be should the team move to extract Macduff from the vehicle. He further commented that the vehicles were so close together that it was not feasible to use a less lethal shotgun in that area. Officer Maldonado also said that officers were not supposed to use less lethal munitions unless they were more than ten feet away. Officer Maldonado said there was not enough time and space to move in a less lethal shotgun and use it effectively.

[21] The Review Board did note that the tactical plan devised by the on-scene sergeant and officers failed to designate an officer as lethal cover – a shortcoming that should have been addressed. The Board also noted that the use of less-lethal munitions by Officer Mastrich was not authorized in the way that it was deployed but devised no remediation to the officer.

the Review Board did not delve into an analysis of this dynamic and its influence on the outcome.

Failure to assess Officer Mastrich' use of less lethal munitions.

Officer Mastrich's introduction of the less lethal munitions in this manner was of no assistance in extracting Mr. Macduff, and in fact rather significantly detracted from the operation. Officer Mastrich admitted to investigators that the defects in the windshield caused by the less lethal rounds subsequently compromised his ability to see into the truck. Officer Mastrich' completely unannounced deployment of less lethal munitions left other officers (and likely Mr. Macduff) confused about what was occurring, where the munitions were coming from, whether they were less lethal bean bags or bullets, and whether Macduff or other officers were responsible for the sounds of munitions fire. For example, Officer Maldonado said that he interpreted Officer Mastrich' firing of the less lethal munitions as bullets being fired by officers to his left with no real idea who was shooting. Officer Maldonado also told investigators that he suffered temporary hearing loss due to the beanbag shotgun going off nearby. And Officer Stone believed that the pop he heard was the firing of a Taser.

Failure to Consider Potential Crossfire Situation

Sergeant Phillips said that he advised the officers during the incident to watch out for potential crossfire based on their positioning. Nonetheless, when Officer Maldonado initiated the punching out of the window and then began delivering rounds at Macduff, Officer Will had been at the passenger side of the truck, creating a potential crossfire situation. Fortunately, Officer Will was able to move to the front of the truck and out of the line of fire, but the original positioning of the officers created a real potential for officers to be struck by each other's fire. However, the Review Board did not consider this issue during its deliberations.

No Apparent Discussion or Written Analysis by Review Board of Failure of Officer Maldonado to Move to a Position of Safety Rather Than Delivering the Final Volley of Rounds

Officer Mace said that when she heard the first bang (later learned to be the less-lethal rounds delivered by Officer Mastrich) she and Officer Stone backed up from their position at the driver's side of the truck and moved to the back of the van for cover. Officer Will said that he moved away from the side of the truck and up to the front of the vehicle.[22]

[22] Officer Will said as he moved to the front of the truck, he saw Macduff with a gun, but did not advise his fellow officers of this observation. No gun was recovered from Macduff or the truck, and Officer's Will's stated perception was incorrect. Still, officers are trained to provide warnings

Sergeant Phillips said that he moved farther back behind the adjacent van. And Officer Mastrich also moved away from the truck. It was only Officer Maldonado who maintained his position at the driver's door pillar, even after he said he observed Macduff with a knife.

As detailed above, the evidence was that Officer Maldonado delivered an initial volley of five rounds and a second volley of three more rounds. Between the two volleys, besides continuing to scream at Macduff repeatedly to drop the knife, he did nothing to increase his safety by creating distance, as did all the other on-scene officers. Instead, Officer Maldonado stayed in his vulnerable position for another *eighteen seconds*, and then, when Macduff did not (or could not) comply with his instructions to drop the knife, he delivered additional rounds as Macduff was facing away from him.[23] Unlike a person with a firearm, a barricaded subject armed with a knife inside a truck would have presented no significant threat to Officer Maldonado had he created distance and searched for cover like the other officers.[24] In fact, Officer Maldonado told investigators that after the firing stopped, he moved away from his location only after Officer Mastrich grabbed his vest and pulled him back from the truck.

Constitutional law recognizes the sometimes "split-second" decisions that need to be made regarding use of deadly force and provides some leeway to those decisions. However, this case was not of this nature. Officer Maldonado had more than ample time to re-evaluate the threat between the two volleys and had other tactical options (consistent with principles of de-escalation) that he did not consider – most obviously moving away from the driver's side of the truck. And importantly, at no time did Macduff make any movement of aggression to any of the officers: even under Officer Maldonado's version of events, the

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to their colleagues in such a situation. The Review Board did not mention this in their closing memorandum.

[23] This is particularly critical as Officer Maldonado advised investigators that it was one of the last few shots he fired that finally hit Macduff, suggesting that Macduff may have survived the incident had Officer Maldonado not resumed firing after pausing for eighteen seconds. The forensic evidence suggests that more of the rounds fired by Officer Maldonado (if not all) struck Macduff than Officer Maldonado believed. Regardless and obviously, the fewer rounds fired by an officer, the more likely an individual might survive.

[24] Officer Maldonado told investigators that he had nowhere to go after the delivery of the less lethal rounds. Yet Officers Stone and Mace were right next to him when Officer Mastrich deployed the bean bags, and they were able to successfully move to the back of the van for cover. And once Officer Maldonado stopped firing, Officer Mastrich was able to pull Officer Maldonado to a position of cover.

only threat presented was a man who was armed with a knife locked inside his own vehicle.[25]

Because the Review Board did not prepare any detailed written analysis of its discussions and deliberations, we must assume that it determined that it found that Officer Maldonado reasonably believed he was in fear for his life when he first decided to use deadly force. However, as detailed above, the Review Board's determination did not articulate whether Oregon's new law requiring warnings prior to the use of deadly force and Officer Maldonado's failure to provide any such warnings changed that calculus. Moreover, it is not apparent whether the Board's ultimate finding that the deadly force was reasonable reflected a consideration of other concerning factors, including the eighteen second gap between volleys, Officer Maldonado's failure to reassess during that gap, failure to seek other tactical options such as creating distance, and resumption of firing (again without giving warnings)

> **RECOMMENDATION TWENTY-TWO: The Review Board's protocols should be modified so that relevant tactical issues are identified, and a document is prepared opining whether the tactics were consistent with training and Department expectations.**

Failure of Review Board to Produce an Analysis Relating to the Legitimacy of the Use of Deadly Force

As noted above, TPD's current use of force policy sets out eighteen factors that are to be considered in adjudging the propriety of any use of force. The Review Board did not produce a written document discussing any of these factors; nor did it prepare any written analysis regarding the bases for its conclusion that Officer Maldonado's use of deadly force was within policy. As a result, there is no written documentation regarding whether the Review Board considered the following in its determination:

- Whether Officer Maldonado unilaterally began the tactical operation by punching out the window without the sergeant's authorization;
- Whether Macduff, even if armed with a knife, presented a sufficient threat to justify the use of deadly force, considering he was still seated inside a locked vehicle and had no obvious way to harm officers;

[25] Attorneys for Macduff strenuously dispute Officer Maldonado's assertion that he saw Macduff armed or reaching for a knife. The Major Crimes investigation did not conduct any forensic or biomechanical examination to learn how likely the observation asserted by Officer Maldonado was supported by the physical evidence. However, even if Officer Maldonado's assertion is accurate, he acknowledges that during his firing sequence he observed no movement by Macduff that could be characterized as aggressing himself or other on-scene officers.

- Whether Officer Stone or any other officer was in sufficient harm's way to justify the use of deadly force, considering all of them were able to move away from the truck and further eliminate any threat presented by Macduff;
- Whether Officer Maldonado could have also moved away from the truck and behind cover rather than resorting to deadly force;
- Whether Officer Maldonado's failure to provide warnings and consider de-escalation maneuvers such as creating distance was consistent with new Oregon state law requirements;
- Whether, after the first volley, Officer Maldonado should have moved away from the vehicle, rather than remain in a position of vulnerability and eventually fire additional rounds after an eighteen second gap; and
- Whether, after the first volley, Officer Maldonado adequately reassessed the threat level the posed by Macduff eighteen seconds later.

Considering the serious challenges raised by each of these issues, a "bottom line" determination by the Review Board that was unsupported by any written factual analysis is particularly unsatisfying.

Failure to Note the Unrecorded Conversation Between Mr. Macduff and Officer Will

During the investigation, Officer Will was asked if he recorded the telephone call between Mr. Macduff and him and he said that he did not have the capability to do so. Generally, those assigned to crisis negotiation can record conversations between themselves and subjects. A record of such conversations can be invaluable in evaluating the contact, identifying strategies that went well, and critiquing those that could have been better. The fact that the conversation was not recorded is a significant information gap and prevents such after-action review. While there is no mention of this information vacuum in the Review Board's report, the introduction of body worn cameras now provides all TPD personnel with the capability of recording such conversations and policy that mandates recording such interactions.

Use of Force Review Board's Failure to Consider Performance History of Involved Officers

Progressive review boards routinely consider the prior performance history of involved officers to determine whether there were prior common issues similar to any identified tactical decisions coming out of the shooting review. For example, if there was information in prior force incidents that an officer had

failed to coordinate and communicate a tactical plan, it would be helpful to identify those issues so that a more robust intervention could be devised. Similarly, if prior incidents show similar issues relating to on-scene supervision, it might suggest a need for a more intense remedial program for that supervisor.

There is no evidence that the TPD Review Board considered this information in its review of this incident. On a forward going basis, TPD should devise protocols to ensure that this type of review occurs.

RECOMMENDATION TWENTY-THREE: TPD should revise its use of force review board protocols to ensure that past performance of involved officers is considered as part of the review process.

Use of Force Review Board's Failure to Clarify Whether TPD Policy Mandated an Arrest of Mr. Macduff

Based on the officers' statements, there was apparent confusion as to whether, under the circumstances presented, they were mandated to arrest Mr. Macduff. Some said that they were required to arrest him under Oregon's domestic harassment statutes, while others suggested the decision to arrest was discretionary.[26] In addition to resolving confusion about the current state of the law and/or TPD policy, it was important in evaluating the officers' decision to push forward with a more aggressive response to know whether the law required them to apprehend Macduff that evening.

In fact, Officer Will reported that he temporarily interrupted his conversation with Macduff to talk with Sergeant Phillips about whether they were intent on arresting him that evening or whether walking away was an option. While Sergeant Phillips told Officer Will that leaving without an arrest was not an option, he did not cite any mandatory arrest provision of Oregon law or TPD

[26] For example, Officer Stone told investigators that Tigard takes domestic harassment a little more seriously than other departments. He said that approximately 5-6 years ago, a retired Tigard Lieutenant made domestic harassment a mandatory arrest for Tigard officers, but that mandate has since relaxed.

policy as a basis for that determination, instead focusing his concern on the potential well-being of the roommate.

It was incumbent on the Review Board to provide clarity on this legal issue. Such analysis would not only better assess the potential options that responding officers had in dealing with Mr. Macduff that evening but would also ensure that a productive consideration of this question would help shape future decision-making for all officers. The failure to develop remediation for this aspect of the event was a significant shortcoming of the Board's review.

RECOMMENDATION TWENTY-FOUR: TPD's Use of Force Review Board should ensure that any identified confusion about current policy be addressed for future reference.

Review Board's Failure to Identify Proficient Tactical Decision-Making

A suitably comprehensive review of a critical incident will also identify aspects of the police response that were consistent with best tactics and Departmental expectations, both to affirm the past performance and enhance future performance through reinforcement. For example, the decision of on-scene officers to position a patrol car behind the truck to prevent Macduff from driving away and endangering officers, followed by the positioning of stop sticks under his rear tires, is the type of thoughtful decision-making that should be identified and reported back to the involved officers in an after-action debriefing. Similarly, the subsequent decision-making of Sergeant Phillips to reposition the patrol car even closer to Macduff's truck was also worthy of identification and comment (although ideally the sergeant would have delegated that task to one of the on-scene officers so that he could continue to maintain overall command and management of the scene).

There were other decisions that were also worthy of positive feedback, including the decision to send an officer back to the apartment to learn whether another set of keys could be retrieved and to obtain Mr. Macduff's cell phone number. Despite the lack of success in obtaining another key, the retrieval of the cell phone number allowed for more effective communication between Officer Will and Macduff and should have been identified as a commendable decision. To

incentivize thoughtful tactical decision-making and export those decisions to the entire department, it is incumbent that the review process identify these decisions and have a mechanism for providing feedback to Department members.

RECOMMENDATION TWENTY-FIVE: TPD should ensure that its internal review process identifies thoughtful tactics and decision-making and provides feedback to both involved officers and all Department members for future reference.

The Review Board's Failure to Consider Alternative Resources That Were Available to On-Scene Officers to De-escalate the Situation

The investigation revealed that Sergeant Phillips talked to Macduff's mother over the phone, who indicated that she wanted to speak with Macduff to try to talk him into complying with the officers' instructions. According to Ms. Macduff, the police did contact her during the standoff with her son and asked her to speak with him – which she agreed to do. Ms. Macduff said that after being placed on hold, she was disconnected. Ms. Macduff reported that her next contact with police was several hours later, when she was advised telephonically that they had shot and killed her son.

During its interview with Sergeant Phillips, the Major Crimes Team did not ask the sergeant about why the expected call involving Macduff's mother did not ultimately occur. And the Review Board did not apparently consider this missed opportunity in its analysis of the shooting incident.

In addition, the apartment's maintenance supervisor (who had developed a friendly relationship with Macduff and had successfully reasoned with him in the past) offered to talk with him while he was in the truck, but Sergeant Phillips had dismissed the idea as too dangerous, since the person would have had to be placed close to the vehicle. However, once communication was occurring by cell phone between Macduff and Officer Will, the safety concerns were significantly diminished, and the maintenance supervisor could have had a telephone conversation with Macduff in a position of safety. Yet Sergeant

Phillips declined to exercise that option, discarding an approach that could have been fruitful. The Sergeant was not asked about this option during his interview, nor was it apparently considered by the Review Board.[27]

The Review Board also did not apparently consider the role of Sergeant Phillips in supervising the on-scene officers (particularly the failure to devise an effective tactical plan even though there was close to an hour to do so) or whether he sufficiently considered other available resources that might have resolved the situation without resorting to deadly force. There is no mention of the sergeant's decisions in the written report and no critique of them. In this case, the sergeant's role was critical in evaluating the incident's progression and tragic outcome. It was a serious shortcoming that the Review Board chose not to examine the on-scene supervisor's decisions with an eye toward accountability and improvement.

> **RECOMMENDATION TWENTY-SIX: Where relevant, TPD should critically review and evaluate the nature and quality of on-scene supervision as part of its administrative review of an officer-involved shooting.**

No Consideration by the Review Board of Relocating the Adjacent Van

When officers encountered Macduff in his truck, there was a van parked in a stall adjacent to the driver's side. While, as detailed elsewhere, the van was used at times as a position of cover by some of the officers both before and after the shooting, officers articulated it as an obstacle for maneuvering near the driver's door of the truck. In fact, some of the on-scene officers including Officer Maldonado cited the closeness of the van as a basis for the officers having a difficult time in repositioning and getting to cover once the shooting sequence began.

Yet during the extended encounter between Macduff and the officers, no apparent thought was given toward relocating the van to allow for greater room

[27] These areas of inquiry that were not pursued by the criminal investigation could and should have been pursued during a subsequent administrative interview of the sergeant.

to maneuver. Because the maintenance man was nearby, officers could have asked him to identify the owner of the van and see whether keys could be retrieved so that the van could be moved back and away from the truck driver's door. It would then have made any extraction plan more facile and less fraught for the officers. Yet neither the on-scene officers nor the Review Board identified this option during the encounter and subsequent review respectively.[28]

Failure to Consider Sergeant Phillips Initial Positioning of His Patrol Car

After Officer Maldonado was pulled back from the truck, Sergeant Phillips and other on-scene officers determined the next steps that led to the eventual extraction of Macduff from the truck. Sergeant Phillips said that because he had parked his car a distance from the scene, he had to run to his car to retrieve the ballistic shield; he then drove his car closer to the scene. It would have been preferable if this had occurred at an earlier point in the encounter when it would have increased the officers' resources and tactical options. This issue was not identified by the Review Board and thus no remedial action was taken to address the issue.

> **RECOMMENDATION TWENTY-SEVEN: When there is extended time to consider improving positioning, planning, and relocation of assets, officers should be taught to identify ways in which the scene can be improved to increase the likelihood of a favorable outcome.**

> **RECOMMENDATION TWENTY-EIGHT: TPD should instruct its supervisors that during a barricaded vehicle situation, they should consider having any potential equipment (such as a ballistic shield) at the ready.**

[28] The Review Board did note that officers could have considered repositioning their tactical team to the passenger side of the vehicle where they would have had more room to maneuver.

Additional Issues/Concerns

Poor Inter-Agency Communication Regarding the Status of the Investigation

At the time of the shooting, Officer Maldonado had applied for a lateral transfer to the Port of Portland Police Department. Immediately following the shooting, Officer Maldonado was placed on leave pending the investigation but was returned to active duty on March 23, 2021. Officer Maldonado resigned from the Tigard Police Department on April 15, 2021, and began employment with the Port of Portland on April 19, 2021. On April 27, 2021, a media report indicated that Officer Maldonado had started with a new Department while still under criminal investigation.

In May 2021, the Port of Portland reported that Officer Maldonado was not eligible for employment after it learned that he was under active investigation from the Macduff shooting. The Port of Portland indicated that the status of the investigation was not brought to light during its hiring process and said that if it had known that the Washington County investigation was open, it would not have offered Maldonado the position. The Port of Portland then separated Officer Maldonado from employment.

It is unclear what precisely caused the breakdown of communications between Tigard PD and the Port of Portland regarding the status of the investigation. Certainly, there was confusion about whether Officer Maldonado had been cleared, as evidenced by internal contemporary documentation by Port of Portland officials that indicated that they were advised by Tigard PD that a grand jury would not be convened by the District Attorney. To this day, there is debate between the two jurisdictions about precisely what information Tigard PD provided the Port of Portland.

Some of the confusion may stem from the fact that, as discussed elsewhere, TPD was itself essentially shut out of any information about the status of the proceedings during the pendency of the criminal investigation and review. Thus, since Tigard Police personnel were not “in the loop” about the investigation and

review process as it was unfolding, they were poorly situated to advise the Port of Portland on the status of those proceedings. Recognizing this, the better approach would have been to refer the Port of Portland's inquiries regarding the status of the investigation either to the Major Crimes Team or the District Attorney.

RECOMMENDATION TWENTY-NINE: Washington County's officer-involved shooting protocols should advise its members that all inquiries about the status of the investigation and review should be referred to the Major Crimes Team or the District Attorney.

No Formal Follow Up Regarding Officer Maldonado's Hiring Circumstances

As a result of the Port of Portland releasing background materials relating to Officer Maldonado's hiring circumstances, media reports were able to write that for nine years prior to his start in Tigard, he applied twice to the Oregon State Police, failing the physical once and withdrawing because of a physical ailment. He also applied and failed the Portland Police Bureau oral boards and the written test with Beaverton. He also unsuccessfully applied twice with the Clackamas County Sheriff's Office, failing the written test the first time and the interview the second.

Officer Maldonado also applied for a Code Enforcement Officer position in Lake Oswego but was not selected. Maldonado interviewed with the Gresham Police Department but was not selected after it was discovered he had failed to disclose a juvenile curfew violation. And in August 2019, after about 13 years as a Tigard police officer, Maldonado failed the background investigation for a position with the University of Oregon Police Department.

Most significantly, the Port of Portland records revealed that when Maldonado was hired by Tigard in 2006, the investigator at the time recommended not hiring him. Apparently, the investigator relied on Gresham records that indicated that it had identified four instances where Maldonado either lied or omitted significant events in his statements. Despite the background investigator's recommendation, Tigard made the decision to hire Maldonado.

After this information was made public, at some point Tigard command staff reviewed the earlier background information and advised that the nature of the false or omitted information that Gresham had identified was not apparent from the records. Regardless, there was seemingly no concerted effort by TPD to re-evaluate the initial hiring decision.

Though the passage of fifteen years arguably lessened its present relevance, an evaluation of that earlier process would nonetheless be useful in assessing whether earlier standards had been met and whether updated controls and safeguards were warranted. For example, it appears that more documentation could and should have been sought from Gresham to learn the nature of the falsities and omissions so that a more informed choice about whether to hire could be made. And if that was the consensus, Tigard could then have reviewed current hiring protocols to learn whether a more rigorous investigation into specifics should be required whenever an applicant is reported to have made a false statement with other agencies. This type of holistic review is what is demanded whenever a critical incident occurs.[29]

RECOMMENDATION THIRTY: With this case as a reference point, TPD should evaluate the thoroughness and sufficiency of its current practices regarding the background investigation of applicants.

Late Condolences to Macduff's Surviving Family

The parents' loss of a loved one is devastating under any circumstances, and a sudden death at the hands of police carries additional traumatic implications. Progressive leaders of police agencies recognize this and are increasingly offering expressions of sympathy, both private and public, to surviving family members for their loss.

In this case, and to her credit, the Chief of TPD did eventually reach out to Macduff's mother by sending a personal note to express condolences. However, it was nearly a year after the event before she did so. In the note, the Chief referenced that there were "various

[29] We were advised that TPD did review the background investigation as well as the past hiring decision. While this is commendable, our suggestion focuses on whether the background investigation conducted then was sufficiently probing and more importantly, whether current TPD background investigative protocols do provide sufficient information to make hiring decisions. We have also been advised that TPD leadership is involved in a working group developing statewide background standards.

processes" and other people involved in "handling things," implying that she was not in a position earlier to offer such regrets.

It is true that the inherent dynamics of an officer-involved death have created barriers to such communication in the past. Sometimes, the specter of litigation is used as a further rationale for this failure to extend sympathies. However, the progressive approach is to recognize that an expression of human empathy transcends the allegiances and tensions that naturally arise from such incidents. And to express regret for the loss of a family member does not equate to an acknowledgement of fault or liability.

The City and Chief of TPD should reconsider the approach in future officer-involved shooting circumstances.

> **RECOMMENDATION THIRTY-ONE: In the immediate aftermath of a fatal officer-involved shooting, the Chief of Police should reach out to surviving family members and offer condolences for the loss.**

Conclusion

The police-involved death of a person in crisis, is inherently a matter of significant public interest. Along with our feelings of sympathy and concern, there are questions: what happened, could it realistically have been avoided, will people be accountable, and will appropriate changes ensue?

The death of Jacob Macduff implicates all these responses. The family's struggle to contend with Macduff's mental health issues surely has resonance for countless families who fear for the well-being of troubled relatives. Law enforcement's role in this dynamic is itself the subject of tremendous scrutiny and reconsideration.

All of this is to say that a legitimate, meaningful investigative and review process is never more crucial than in the aftermath of such an event. The use of deadly force is rightly scrutinized for its legal justifications – a process that occurred here, if imperfectly in ways that this report discusses above. However, given the applicable legal standards and the latitude that the system gives to officers when they assert a threat to themselves or others, it is very unusual for officers to face prosecution – apparently, even under the new legal requirements set out in Oregon law and discussed above. An actual conviction is even rarer.

Because of this, and the "bottom line," either/or nature of the criminal process, the more comprehensive evaluations of critical incidents such as Macduff's death can – and must –

occur administratively. The most effective law enforcement agencies, therefore, are those that recognize that such events demand the most rigorous levels of review.

There are two components to this – both equally important. One relates to accountability: a clear-eyed determination as to whether and how involved officers met the standards of the agency in terms of policy, tactics, training, and other performance variables. Agencies should not be reticent about acting in those instances when officer conduct is egregious enough to warrant termination of the officer's employment. And measures should be deployed to correct lesser individual deficiencies and to reinforce the agency's standards and expectations. While formal discipline is one vehicle for this, training, counseling, or other remedial measures also exist to address substandard performance.

The second component to robust internal review is systemic. It involves a holistic examination of every aspect of the agency's response to look for strengths that it wishes to highlight and shortcomings that it wishes to improve upon. The potential benefits of such a process for enhancing department-wide future performance are what makes this exercise so worthwhile.

There are traditional obstacles to this in some law enforcement cultures. They include a reluctance to second-guess and an inclination to support officers who have been involved in deadly force incidents. But many progressive police organizations have moved beyond this paradigm. They have come to see the importance of the process as outweighing those other considerations. And they have framed it as a constructive reckoning with the very real challenges of modern policing.

OIR Group appreciates the opportunity to contribute to that dynamic in Tigard through this report. Our hope is that it provides the family of Jacob Macduff with some consolation in the form of a careful evaluation and answers to some of the lingering questions it may have. We also hope, though, that it will be embraced by the Police Department as an opportunity to revisit some of its own protocols and improve upon them in the future. If Tigard officers are better equipped to confront future situations without resorting to the use of deadly force, then the family's interest in this review will have been validated in the best of ways.