Office of Internal Oversight Review

KEY CONCLUSIONS, RECOMMENDATIONS AND OUTCOMES OF A CATEGORICAL USE OF FORCE INCIDENT
Officer-Involved Shooting—2280 South Nellis Boulevard on November 15, 2010

Purpose:

The purpose of this report is to publish key conclusions, recommendations and outcomes of the Las Vegas Metropolitan Police Department's internal review of this incident. There are a variety of actions that can be taken administratively in response to the Department's review of a deadly force incident. The review may reveal that no action is required or determine that additional training is appropriate for all officers in the workforce, or only for the involved officer(s). The review may reveal the need for changes in departmental policies, procedures, or rules. Where departmental rules have been violated, formal discipline may be appropriate. The goal of the review is to improve both individual and the agency's performance.

Synopsis of Event:

On November 15, 2010, at approximately 1032 hours, LVMPD patrol officers responded to PT's Pub at 2280 South Nellis Boulevard to investigate a reported robbery in progress. Arriving officers entered the business and found a male subject, later identified as Benjamin Bowman, holding the female bartender against her will with a knife. Bowman refused commands issued by the officers to drop the knife and release the victim. Bowman stated his intention to kill the bartender. After Bowman made a motion with the knife toward the victim, Officers Kruse, Franco and Zaragoza fired multiple rounds at Bowman, striking him numerous times. Bowman fell to the ground. He was transported to Sunrise Hospital where he was pronounced deceased a short time later.

For a detailed narrative of the incident, please see the District Attorney's decision, reference Benjamin Bowman, Event Number 101115-1591, and the LVMPD Force Investigative Team (FIT) Officer's Report under the same event number.

Outcomes:

The internal review resulted in the following:

1. The Use of Force Review Board determined that the officers' actions were in accordance with Department policy. No policy violations were found.
2. The internal review concluded that the officers' performance was in accordance with Department standardized tactics and training.
3. The internal review found the medical response to be timely and reasonable.
4. The internal review found supervisory response to this incident appropriate.
5. The internal review identified deficiencies in communication between the call taker, police dispatcher and officers involved in the incident. To address this issue, the Communications Bureau was briefed by the Office of Internal Oversight, formally the Organizational Development Bureau, on the deficiencies found in the radio communication.

The Criminal Investigation:

LVMPD FIT conducted the criminal investigation of this incident. Their investigation was submitted to the District Attorney's Office for review. In their examination of the FIT case submission, the District Attorney's Office determined that, "In sum, Officers Kruse, Franco and Zaragoza had the right under Nevada law to use deadly force against the Decedent in defense of Bartender-2 [an employee of the bar]."

Use of Force Review Board:

This matter was heard by the Board on September 1, 2011, and the individual officers who used force were found to be justified and their actions within the scope of Department policy. The Sheriff approved the Board's recommendation.

Below are recommendations made after the Use of Force Review Board and internal review were completed:

1) Tactics and the Use of Force

The internal review of the officers' approach to this incident found Officer Nelson, the first-responding officer, parked away from the entrance of the business and waited for additional officers to arrive. Officer Franco, the second-arriving officer, also parked away from the entrance.

Once Officers Meltzer and Turner, who were the third unit to arrive, had taken a position at the rear of the business to cover the rear exits, entry was made. It was determined the officers' approach was reasonable during this incident.

Officers from two different area commands responded to this incident. Officers Franco, Kruse, Zaragoza, and Nelson entered the bar in a stacked formation. Officer Franco immediately identified Bowman as the suspect, as Officer Kruse did a scan of the dining room area that was just inside of the doorway. Officers Kruse and Franco verbally identified themselves as police and began giving commands to Bowman for him to show his hands and drop the knife. In this review, the commands given did not appear to be conflicting, and clearly identified what the officers wanted Bowman to do. These commands were given prior to any force being used, and Bowman failed to comply with them.

As the officers entered the bar area, they separated from each other, which provided each officer a good angle to confront Bowman and prevent any crossfire situation. In this event, multiple officers successfully worked together as a team in handling a dynamic and volatile situation.

In its final analysis on the use of force, the internal review found the actions of Officers Kruse, Franco and Zaragoza reasonable. Officers Kruse, Franco and Zaragoza responded to a robbery in progress with Bowman holding a knife to the bartender. Officer Kruse heard a female's voice screaming from the inside of the bar, which created exigent circumstances for the officers to enter the bar. Officers were immediately confronted with Bowman standing over the bartender with a knife and saying he was going to kill her. Officers fired their weapons to stop the threat presented to the bartender, striking Bowman several times.

The internal review found the officers' use of force reasonable and their actions to be within standardized tactics and training, and Department policy.

2) Assessment of Medical Response

In the Department's response to this incident, medical was requested when the initial call came into 9-1-1. Officer Kruse immediately requested medical expedite when he notified Dispatch of shots fired. As medical arrived, officers escorted medical to the rear of the bar to prevent the disruption of the crime scene. Bowman was transported to Sunrise Hospital where he was pronounced deceased a short time later.

The internal review found medical response timely and reasonable.

3) Command and Control

In evaluating the supervision, or the command and control, of this incident, it was noted:

Officer Kruse arrived and made contact with Officer Franco at the front entrance. Officer Kruse tried to open the front door but it was locked. Officer Kruse put his ear to the door and heard a female screaming from inside the bar. Officer Kruse advised Officer Franco they needed to make entry into the bar. As Officer Kruse forced the door open to gain entry, Officers Nelson and Zaragoza made entry with them. There was no communication on specific tactics to be used prior to entry.

- Sergeant Carlson, a K-9 supervisor, assigned himself to the call as the officers arrived and prior to the shooting. He was the first supervisor on the scene.
- Sergeant Oaks was heading to the call as the officers were being dispatched and when he heard the shots fired notification, he responded Code 3—red lights and siren.
- Sergeant Oaks arrived on scene within minutes of officers advising of shots fired.
- Sergeant Oaks took control of the scene and began having units secure the crime scene.
- Sergeant Oaks identified the officers involved in the shooting, separated them, and assigned other officers to stay with them.

- Sergeant Robinson arrived on the scene and assisted Sergeant Oaks with the command post.

In its analysis of command and control, the internal review found supervision was reasonable and the officers' actions were within standardized tactics and training, and Department policy.

4) Communication

The internal review identified deficiencies in communication between the call taker, police dispatcher and officers involved in the incident. The initial call was sent to an adjoining area command's dispatcher instead of directly to the dispatcher monitoring the area where the call was taking place. The initial call taker did not complete address verification on the name of the business prior to sending the call to the dispatcher's console. An officer in the field realized the call was actually in the adjoining area command to the north and advised the dispatcher.

The dispatcher from the adjoining area command should have broadcasted the direction to have all the units, who were responding to PT's Pub, switch over to the proper radio channel. This procedure would have avoided information being missed or delayed between two radio channels.

To address this issue, the Communications Bureau was briefed on the deficiencies found in the radio communication. The involved call taker and dispatcher were made aware of the issue.