Office of Internal Oversight Review
Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal
2451 North Rainbow Boulevard – December 12, 2011

Purpose

The purpose of this report is to publish key findings, conclusions, and/or recommendations of the Las Vegas Metropolitan Police Department's (LVMPD) internal review of this incident. A variety of actions can be taken administratively in response to the Department's review of a deadly force incident. The review may reveal no action is required or determine 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 Department 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 Department performance.

Synopsis of Event

On December 12, 2011, at approximately 0057 hours, the LVMPD was involved in a critical incident under LVMPD Event LLV111211004156. The incident occurred in the Alondra Condominium complex at 2451 North Rainbow Boulevard, Las Vegas, Nevada 89108. This address was located within the LVMPD Northwest Area Command (NWAC); sector beat Victor 6 (V6).

The incident was an officer-involved shooting (OIS) and Officer Jesus Arevalo was the involved officer who discharged his firearm (rifle) at suspect Stanley Gibson, who was barricaded inside his vehicle. Gibson was struck multiple times while inside his vehicle and was later pronounced deceased on-scene.

Prior to the OIS, on December 11, 2011, at approximately 2322 hours, a person reporting (PR) called 9-1-1 from her residence at 2451 North Rainbow Boulevard. The PR reported two black males were kicking the front door to her apartment and turning the doorknob. She then stated the males did not enter her apartment and left in a large white Cadillac, which she last saw driving toward the front of the apartment complex. The PR described the males as being approximately 30 years old but could not provide any further description. The PR was unaware if the subjects were armed with any weapons. At approximately 2327 hours, a female officer arrived and contacted the PR. At approximately 2349 hours, a male officer arrived at the PR's apartment.

On December 12, 2011, at approximately 0017 hours, the female officer stepped out of the PR's apartment and observed a white Cadillac parked in a parking space in front of the PR's building and it was still running. The officer broadcast this information, over the radio, and the vehicle matched the description of her suspect's vehicle. The officer then requested the assistance of additional officers.

As the two officers waited for additional resources, the male officer positioned his LVMPD marked patrol vehicle behind the Cadillac, about a car length away. Both officers positioned themselves behind the patrol vehicle's driver and passenger doors and began to order the occupant(s) to turn the car off and exit the vehicle. The officers were unable to identify the race or gender of the subject(s) due to the dark tinted windows. The driver and sole occupant of the Cadillac (later identified as Stanley Gibson) refused to obey the officers' commands. Instead, he placed his vehicle in reverse and backed out of the parking space.

At approximately 0024 hours, as Gibson backed out of the parking stall, the rear of his Cadillac contacted the front of the LVMPD marked patrol vehicle. The female officer shouted over the radio, advising the vehicle was backing up and ramming them. Gibson then placed his vehicle in drive, and as he prepared to move forward, two additional officers arrived. One of the officers positioned his LVMPD marked patrol vehicle up to the right front wheel well of the Cadillac. This placed his right front "buddy

bumper" into the right front wheel well of Gibson's vehicle; pinning the Cadillac between the two LVMPD marked patrol vehicles.

At approximately 0026 hours, information was broadcast, over the radio, that more officers were needed because Gibson had rammed a police car, was spinning the tires of his Cadillac, and had barricaded himself inside the car.

At approximately 0027 hours, a sergeant arrived at the scene and witnessed Gibson revving his engine and spinning the rear tires of his Cadillac, while pinned in by the two LVMPD marked patrol vehicles. With Gibson not complying to the officers' commands to turn his vehicle off and exit, the sergeant and a senior officer developed a plan to extract Gibson from his vehicle.

The plan designed was to approach the Cadillac from the rear, fire a low lethality beanbag round through the rear window, then under lethal cover approach the rear window and spray Oleoresin Capsicum (OC) spray into the passenger compartment, through the broken rear window. The OC spray would force Gibson out of the vehicle where he could be taken into custody. Additionally, LVMPD K9 was in the area should Gibson exit his vehicle and run away from officers.

At approximately 0043 hours, a lieutenant assigned as the LVMPD watch commander (WC) arrived and was briefed on the plan to extract Gibson from the Cadillac. The extraction/arrest team consisted of the sergeant who would use the OC spray, an officer assigned to the low-lethal shotgun (LLSG) who would shoot a beanbag round through the rear window, a lethal cover officer (shotgun), a "hands-on" officer, and Officer Arevalo who would also provide additional lethal cover with his rifle. While the supervisors communicated with each other and coordinated resources, Gibson remained inside his car and continued to not obey the officers repeated commands to turn the vehicle off and exit the car.

At approximately 0051 hours, during a period where Gibson was not spinning his tires, the extraction/arrest team maneuvered toward the rear of the Cadillac to initiate their plan. However, the WC decided against the extraction plan due to a crossfire situation. It was determined officers would continue to use the public address (PA) system (from an LVMPD marked patrol vehicle) to communicate with Gibson, while the WC contacted the Special Weapons and Tactics (SWAT) section.

With the extraction plan canceled, the team moved away from Gibson's vehicle. Initially, they repositioned themselves near the WC, by a dumpster enclosure that provided cover and concealment. However, with the extraction plan canceled, the arrest team began to disperse from each other. The LLSG officer stayed near the WC, while Officer Arevalo moved to the east side of the dumpster enclosure. Officer Arevalo positioned himself behind a vehicle in the first parking stall next to the dumpster.

At approximately 0056 hours, Gibson started his car, revved the engine, placed it in reverse, and spun his right rear tire. Thirty-six seconds later, the WC broadcast over the radio "alright units we're moving in, shoot." The WC directed the LLSG officer to discharge a bean bag round at the window of the Cadillac. The officer's beanbag round impacted the right rear passenger door window of the Cadillac and "punched" a small hole in the passenger side rear window.

The result of that beanbag round was a hole approximately three inches in diameter in the passenger side rear window. The beanbag round also shattered the tempered glass of the front passenger side

window, which did not fall out due to the window tint. The shot fired caused officers to perceive they were being fired upon, but in fact was the LLSG application used to shoot out the Cadillac's window. Approximately one second after the beanbag round, Officer Arevalo discharged seven (7) rounds from his rifle at the Cadillac.

All of Officer Arevalo's shots passed through the right front passenger door and window. Gibson was also struck as he sat in the driver's seat. After Officer Arevalo discharged his rifle, the WC and officers approached the Cadillac and extracted Gibson from the vehicle. Las Vegas Fire Department (LVFD) Paramedics who were on scene, responded, and pronounced Gibson deceased at the scene.

During the preliminary criminal investigation, it was learned Gibson was not armed with a firearm and did not possess a weapon. Additionally, it was learned Gibson had a history of mental health issues. Since 2010, numerous events involving LVMPD, Department of Veteran Affairs, Nevada Gaming Control, and AMR Ambulance documented contact with Gibson. Within fourteen months, Gibson had numerous contacts with law enforcement for disorderly-type crimes. He was Legal 2000'd three times.

For this critical incident, LVMPD officers did not recognize Gibson as a person in crisis. However, officers continually attempted to engage Gibson via the PA system, but he never responded. Thus, officers at the scene of this incident were never able to establish a dialogue with Gibson. In prior contacts with Gibson, officers readily identified his mental health issues and appropriately ensured he was committed via Legal 2000 to the mental health system currently in place.

During the administrative investigation, it was learned a pattern of "cascading errors" occurred in several areas; specifically command and control (both formal and informal). The errors were a series of small mistakes, some overlooked or ignored, combined, and compounded with larger ones, accumulating in the tragic shooting of an unarmed man who was in a mental crisis. Not one single act, either by omission or commission, can point directly to the outcome; it was a sequence of mistakes. Though some of the mistakes were more significant than others, there was more than one contributing factor in the failure to avert the use of deadly force against Gibson.

The Criminal Investigation

The LVMPD Force Investigation Team (FIT) conducted the criminal investigation of this incident. The investigation was submitted to the District Attorney's Office for review. The District Attorney's Office determined that, *"Based upon the review of the available materials and application of Nevada law to the known facts and circumstances, it has been determined that the actions of Officer Arevalo, while tragic, were not criminal. The law in Nevada clearly states that homicides which are justifiable or excusable are not punishable. A homicide which is determined to be justifiable shall be 'fully acquitted and discharged.' NRS 200.190. As there is no factual or legal basis upon which to charge the officers, and unless new circumstances come to light which contradict the factual foundation upon which this decision is made, no charges will be forthcoming."*

For additional information related to the investigation of this incident, please refer to the LVMPD's FIT Report and the Clark County District Attorney's Legal Analysis Report.

LVMPD Administrative Review and Critical Incident Review Process

It is the policy of this Department to provide LVMPD and the community with a thorough review of incidents wherein deadly force was used by Department members. The Critical Incident Review Process (CIRP) includes the participation of citizen board members who reside within the LVMPD jurisdiction, who are not personally affiliated with the Department, who are not related to any of its members, and who have not had prior law enforcement experience.

The CIRP is comprised of two related boards whose sole purpose is to conduct comprehensive administrative review of the tactics utilized by involved Department members as well as decision-making, Department policy, training, supervision, and the use of deadly force.

The Use of Force Review Board (UFRB) consists of commissioned and citizen members. The Critical Incident Review Team (CIRT) presents the facts related to the use of deadly force. The board issues findings regarding the actions of Department members who used, directly ordered, or directly influenced the use of deadly force, whether such force resulted in death or serious injury. The UFRB may choose from one of four findings after hearing the presentation of facts from CIRT. The findings are Administrative Approval, Tactics/Decision-Making, Policy/Training Failure, or Administrative Disapproval.

The Tactical Review Board (TRB) reviews CIRT conclusions. The TRB can validate, overturn, or modify the conclusions regarding the actions of Department members.

The matter was heard by the UFRB and TRB on May 15, 2013. Below are the key findings, conclusions, and/or recommendations from the CIRP determined by the UFRB and TRB members and approved by the Sheriff.

Use of Force Review Board

UFRB: Officer Jesus Arevalo

The UFRB acknowledges that the incident resulting in the tragic death of Stanley Gibson was fraught with errors relating to leadership, decision-making, tactics, and command and control. The failure of senior leadership on scene to take basic steps to establish command and control, to develop and execute sound tactical plans, to follow LVMPD policy and procedure, or to fully and clearly communicate intentions and instructions added confusion to an already stressful and chaotic incident. In short, the absence of effective leadership helped create the conditions under which various actions and related stimuli were likely to be misinterpreted by on-scene personnel.

The board's finding was Tactics/Decision-Making. Tactics/Decision-Making is defined as: this finding considers under the circumstances, objectively reasonable force was used based on the information available to the Department member at the time. However, it acknowledges even though the use of deadly force was within policy, the actions of the Department member worked to limit alternatives that may have otherwise been available to the Department member. A different approach or overall response by the Department member may have lessened the need for the Department member to employ deadly force and potentially changed the outcome of the incident.

Tactical Review Board

Communication

Communication can be verbal or non-verbal. It includes electronic transmission or in-person. A review of these recordings can provide valuable evidence of the circumstances surrounding a particular event.

The information given and received between the dispatcher and officers is recorded in CAD. The dispatcher alerts officers by radio of the nature of the call and other important information as received from the call-taker. The computer records the time a dispatcher takes an action and links it to the incident and the unit records for later review.

- The administrative review determined multiple times throughout this incident that communication between officers and supervisors was not within standardized LVMPD tactics, training, and policy.

- The administrative review determined the two biggest contributing factors in the cascading errors were the WC's decision to direct the low lethality deployment and Officer Arevalo's decision to shoot. The primary underlying cause that ran through the chain of events was a lack of communication which was not within standardized LVMPD tactics, training, and policy.

The WC injected himself into a technical aspect of first-line supervision. He hurried and failed to adequately communicate his intent to other officers at the scene. The WC did not address the possibility of sympathetic fire in the application of the LLSG through adequate communication prior to breaching the window.

- The administrative review determined the WC lacked good judgment in directing tactics for this event and his decisions were not within standardized LVMPD tactics, training, and policy.

De-escalation

Policing requires that, at times, an officer must exercise control of a violent or resisting subject to make an arrest or to protect the officer, other officers, or members of the community from risk of harm. Clearly, not every potential violent confrontation can be de-escalated, but officers do have the ability to impact the direction and the outcome of many situations based on their decision-making and the tactics they choose to employ. As a strategy to diminish the likelihood and the severity of force, officers will attempt to de-escalate confrontations.

During the officers' initial contact, they faced an unknown risk due to the information received reference the driver being involved in felony crimes.

- The administrative review determined the officers' initial contact was within standardized LVMPD tactics, training, and policy.

The supervisors' decision to use the LLSG was a complex, flawed plan—it was not safety-conscious when dealing with an incident where a person is suspected of being armed or otherwise dangerous. As an outcome, the tactic promised to compress distance and time—both of which are contrary to slowing down the action.

The one beanbag round—which was fired—tore open as it passed through the Cadillac's window. Lead pellets from the beanbag were dispersed in the interior of the vehicle while the beanbag lodged underneath the headrest of the front passenger seat. The lead pellets had the possibility of striking Gibson in the face. LVMPD policy reads: *"During non-deadly force incidents, members should avoid striking suspects on the head, neck, sternum, spine, groin, or kidneys."*

- The administrative review determined the supervisors' decision to use the LLSG to breach a window is not a trained tactic for patrol officers and was not within standardized LVMPD tactics, training, and policy.

Use of Force

It is the policy of this Department that officers hold the highest regard for the dignity and liberty of all persons and place minimal reliance upon the use of force. The Department respects the sanctity of every human life, and the application of deadly force is a measure to be employed in the most extreme circumstances where lesser means of force have failed or could not be reasonably considered.

The Department seeks to manage use of force beyond the *Graham v. Connor* (1989) standard and its minimum requirements by establishing further parameters for the application of force and to offer explicit direction to officers. Sound judgment, the appropriate exercise of discretion, and the adherence to Department policy will always be the foundation of officer decision-making in the broad range of possible use of force situations.

Officers will only use a level of force that is objectively reasonable to bring an incident or persons under control and to safely accomplish a lawful purpose. An officer's use of force must balance against the level of resistance exhibited by the subject. The level of force administered by an officer must be carefully controlled and should not be more than objectively reasonable to overcome the physical harm threatened.

In a confrontation, an officer will continuously reassess their response and adjust any use of force accordingly based upon the level of resistance encountered. Failure to reassess each application of force can lead to a violation of law and/or policy. The use of force by an officer must be within Department policy, which may be more restrictive than the law.

Due to inadequate communication and a lack of situational awareness, Officer Arevalo did not use readily available cover. At the conclusion of the administrative investigation, it was found that Officer Arevalo was unable to achieve target isolation or target identification before he fired his weapon seven times through the tinted passenger window. Officer Arevalo did not use good judgment in selecting his position and he acted outside of training when he chose not to maximize cover as he perceived a threat.

Subject matter experts (SMEs) found Officer Arevalo's aiming of his rifle, prior to the shooting, was not necessary since sufficient lethal coverage was already in place based upon the tactical situation. There were other officers, better positioned than Officer Arevalo, to see Gibson and determine if he was a verifiable threat.

There were distracting environmental conditions (such as the noise, smoke, and flying rubber debris) prior to the shooting. SMEs found Officer Arevalo had a reasonable alternative of ducking down behind cover to take the time to obtain a better threat assessment prior to shooting Gibson.

SMEs found Officer Arevalo rushed a decision to shoot because of his poor positioning. It is notable that several other officers providing lethal coverage did not discharge their weapons. Officer Arevalo discharged his rifle into the Cadillac, through a heavily tinted window, at an unknown threat not readily identified.

- The administrative review determined Officer Arevalo's threat assessment and use of deadly force was not within standardized LVMPD tactics, training, and policy.

Incident Management

Supervisors will possess a thorough knowledge of tactics and ensure that officers under their supervision perform to a standard, in accordance with LVMPD policy and training. The prospect of a favorable outcome is often enhanced when supervisors become involved in the management of the overall response to a potentially violent encounter by coordinating officers' tactical actions.

Supervisors will acknowledge and respond to incidents in a timely manner when officer use of reportable force is probable. Supervisors will also manage the deployment of resources and equipment. In dynamic and highly charged incidents, supervisors will provide clear direction and communication to officers regarding their positioning and roles. Upon observing substandard officer approaches or flaws in tactical decisions, the supervisor will promptly act to correct any deficiencies.

In reviewing supervisory response for this event, poor tactical decisions (from approving, to supervising, to direct application) endangered officers and others. SMEs found the WC and the on-scene patrol sergeant should have communicated and coordinated with each other and done the following to slow the momentum, to avert a use of deadly force: Maintain the perimeter; Establish a command post (CP); Recognize the risk of the flawed plan in using the LLSG as a breach tool; Recognize the application of OC spray was discouraged by existing LVMPD policy; Develop contingency plans such as maintaining an arrest team; Maintain proper command and control of the incident (not become tactically involved); Direct that intelligence be gathered on Gibson; and manage the critical incident as a barricaded subject.

- The administrative review determined the management of this incident by the WC and a patrol sergeant was not within standardized LVMPD tactics, training, and policy.

Additional Key Findings, Conclusions, and/or Recommendations

- Opportunities were missed to intercept a crisis with Gibson. However, LVMPD is only one of numerous medical, governmental, and social agencies tasked with dealing with mental health issues in the community. After this OIS, Crisis Intervention Team (CIT) started a process for re-certification. A block of instruction is also delivered at the new sergeant and lieutenant schools.

- SMEs agreed the use of the LLSG as a breach tool is not a tactic trained to department patrol officers. CIRT contacted Portland, Denver, Seattle, Phoenix, and Los Angeles police departments about discharging the low lethality beanbag round through glass. From the Phoenix Police Department's Use of Force Policy, the following was documented on the use of the low lethality shotgun: *"Stun-bag CTS Super Sock rounds should not be fired through mediums, such as glass or chain link fences because the bag might tear and lead shot might be released."*

This language was added to the LVMPD's Use of Force Policy under the low lethality shotgun. At the time of this incident, there was no policy language prohibiting this use. The current language is not prohibitive but clarifies that this should be a tactical consideration if the munition is used as a breaching tool.

- At the time of this incident, LVMPD did not track Legal 2000s to identify people in crisis or attempt any follow-up interventions unless someone was brought to the attention of the CIT unit. CIT liaisons at each area command review CIT after-action reports and forward any concerns to the CIT office for follow-up. After this OIS, LVMPD Records started a protocol to track subjects who have been Legal 2000'd multiple times.

- In December of 2011, Sheriff Douglas Gillespie contacted the Department of Justice in Washington DC for their assistance. LVMPD partnered with the Community Oriented Policing Services (COPS) Office, which is a branch of the Department of Justice. As a result, LVMPD had an independent investigation conducted into its use of force policies and procedures.

- In February 2012, Sheriff Douglas Gillespie created LVMPD's Office of Internal Oversight to provide a continual review process for all issues surrounding the use of deadly force by police officers. In the years since 2012, the bureau has evolved into what is now the Internal Oversight and Constitutional Policing Bureau (IOCP). The IOCP consists of three sections: Critical Incident Review Team (CIRT), Force Investigation Team (FIT) and Office of Internal Oversight (OIO), all of which perform a critical role in the process first outlined by Sheriff Douglas Gillespie. As an agency that places the highest value on human life, LVMPD is committed to reducing the number of deadly force incidents by its officers and providing more public accountability and transparency in all areas related to the responsibilities of its police officers and the use of deadly force.

- LVMPD recognized the need for improvement in the use of deadly force. An extensive review of the Use of Force Policy began in February 2012. LVMPD communicated with the local chapters of the ACLU and NAACP on recommended changes and improvements to LVMPD's Use of Force procedures. LVMPD completed the review and implementation of the recommendations/changes in May 2012, conducted extensive training for LVMPD personnel, and announced the updated policy to the public in July 2012.

- In November 2012, the COPS Office completed the assessment and included 75 reforms and recommendations for improvement to LVMPD. In May 2014, a final assessment report was released to document LVMPD's progress toward reforming policies and practices. The report demonstrated LVMPD's continued work to address the public safety needs and concerns of the community.

- On February 28, 2013, the Police Fatality Public Fact-Finding Review (PFPFFR) was held for this incident. When a police-involved death occurs, and the prosecutor preliminarily determines that no criminal prosecution of the officer or officers involved is appropriate, the prosecutor shall call for a PFPFFR. A presiding officer and an ombudsman shall be selected by the County Manager or his designee from lists approved by the Board of Commissioners, and the presiding officer shall pick a date and location for the review. The location shall be in the County Commission chambers, or other similar public facility capable of seating members of the public who wish to observe the review (Clark County Code Ordinance, Chapter 2.14).