

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**3899 Almondwood Drive – July 29, 2014**

**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. 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 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 July 29, 2014, at approximately 0645 hours, the Las Vegas Metropolitan Police Department (LVMPD) was involved in a critical incident under LVMPD Event LLV140729000659. The incident occurred near 3899 Almondwood Drive, Las Vegas, NV 89120. This address was located within the LVMPD, Southeast Area Command (SEAC); sector beat King Four (K4).

The incident was an officer-involved shooting (OIS) and Officers William Moore and Ryan Rotta were the involved officers who discharged their firearms at suspect Cody Winters, who was armed with a firearm (handgun). Winters was struck multiple times and later pronounced deceased on-scene by paramedics.

Prior to the OIS, LVMPD Dispatch Center received a 9-1-1 call from 3930 Autumn Street. The person reporting (PR) stated his father was on top of an intruder. Additional information included there were two intruders in the residence and the father had been shot.

Responding officers arrived, encountered a female, and learned the suspects were a white male adult and a black female adult, later identified as Cody Winters and Natasha Jackson. Officers entered the residence and found the female's husband suffering from a gunshot wound.

Winters attempted to enter a residence located at 3919 Almondwood Drive. He was met by the homeowner who turned him away. Winters then went to 3909 Almondwood Drive and met up with Jackson. As additional officers arrived, Winters and Jackson made entry into 3909 Almondwood Drive by breaking a window in the front of the house.

Officer William Moore arrived on scene and contacted a responding sergeant. Officer Moore was directed to cover the rear of the residence. Officer Moore entered the rear yard of 3920 Autumn Street and was met by another officer. While officers contained the rear perimeter, Winters went to the rear of the residence. Officer Moore issued Winters verbal commands to surrender but Winters ignored the commands. Officer Moore and another officer, concerned that Winters knew their location, moved to the southeast corner of the residence at 3909 Almondwood Drive.

As Officer Moore was in the process of moving to a new position, Winters exited the rear of the residence and pointed a handgun at him. Officer Moore fired his rifle; however, he missed Winters. Officer Moore and the other officer moved to a new position.

Jackson, who officers initially believed was Winters' hostage, exited the house and went to Officer Moore and the other officer. Once the officers realized she had not been a hostage, the other officer took her into custody. While this occurred, Winters fled westbound, made entry into the residence at 3899 Almondwood

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**3899 Almondwood Drive – July 29, 2014**

Drive and shot a female in the residence. Next, Winters took control of the female, forcing her to exit the front of the house with him. As they exited the house, the female became limp and fell to the ground. Winters, who was still armed with a handgun, was standing over the victim and yelled he was going to kill her.

At this time, Officer Rotta discharged his rifle, striking Winters who immediately fell to the ground. Soon after, a sergeant on-scene formed an arrest team, took Winters into custody, and assisted in rescuing the female.

The male and female who had been shot were taken to area hospitals but later died because of their injuries. Winters was pronounced deceased at the scene by paramedics. A semi-automatic handgun was found in proximity to Winters.

### **The Criminal Investigation**

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 on 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 the officers were reasonable and legally justified."

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

### **LVMPD Administrative Review and Critical Incident Review Process**

It is the policy of this Department to provide both the 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 (2) 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 both 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 (1) of four (4) 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.

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**3899 Almondwood Drive – July 29, 2014**

The matter was heard by the UFRB and TRB on September 10, 2015. 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: Officers Moore and Rotta**

The Board's finding was Administrative Approval. Administrative Approval is defined as: "objectively reasonable force was used under the circumstances, based on the information available to the officers at the time." This finding acknowledges that the use of force was justified and within Department policy.

### **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 radio traffic was compared to the computer aided dispatch (CAD) document managed by communications. Communications properly broadcast and documented CAD information from officers and supervisors who advised and/or requested information throughout the incident.

- The administrative review determined all Communications employees performed within standardized LVMPD tactics, training, and policy.
- The administrative review determined the radio traffic by officers and supervisors was within standardized LVMPD tactics, training, and policy. Radio clarity issues existed; however, they were directly related to the Desert Sky Radio System and had no direct impact on the incident outcome.

#### **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 this incident, officer Moore and another officer changed their locations several times. The officers communicated between themselves and used sound principles of contact and cover.

- The administrative review determined Officer Moore and another officer's use of contact and cover were within standardized LVMPD tactics, training, and policy.

While Winters was inside the residence at 3909 Almondwood Drive, Officer Rotta took a position of cover and concealment at 3908 Almondwood Drive behind a Ford F-150. Officer Rotta was able to cover the front of both 3909 and 3899 Almondwood Drive from this location. Ultimately, this was the position from which Officer Rotta discharged his firearm.

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**3899 Almondwood Drive – July 29, 2014**

- The administrative review determined Officer Rotta's use of cover and concealment were within standardized LVMPD tactics, training, and policy.

**Use of Deadly 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 U.S. Constitution.

Knowing Winters was armed with a firearm and that he shot at least one person, Officers Moore and Rotta drew their firearms upon arrival.

- The administrative review determined Officers Moore and Rotta deploying their rifles was within standardized LVMPD tactics, training, and policy.

Officer Moore's backdrop was a cinder block wall.

- The administrative review determined Officer Moore's assessment of backdrop, target identification, and isolation were within standardized LVMPD tactics, training, and policy.

Officer Rotta's backdrop was a porch area and a wall.

- The administrative review determined Officer Rotta's assessment of backdrop, target identification, and isolation were within standardized LVMPD tactics, training, and policy.

Officer Moore was moving from one position to another after Winters identified his original location. Radio updates were given that Winters had shot a person. Officer Moore was in the back of the residence when Winters exited holding a firearm. Winters then pointed the firearm at Officer Moore.

**Office of Internal Oversight Review**  
**Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal**  
**3899 Almondwood Drive – July 29, 2014**

- The administrative review determined Officer Moore’s threat assessment was within standardized LVMPD tactics, training, and policy.

Officer Rotta was in a position of cover and concealment when Winters came to the front door of the residence with a firearm in his hand. A victim, whom Winters had shot, was lying at his feet. At this time, it was known Winters had pointed a firearm at Officer Moore and that he previously shot other people. While holding a firearm in his hand, Winters yelled that he was going to kill the victim he was standing over.

- The administrative review determined Officer Rotta’s threat assessment was 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.

A patrol sergeant arrived and immediately provided direction to on-scene officers. The sergeant sent an additional officer to assist Officer Moore as his spotter. The sergeant provided critical updates to Dispatch and officers. When Winters went down, the sergeant formed an arrest team to take him into custody and rescue the victim.

- The administrative review determined a patrol sergeant took action to ensure the safety of the responding officers. The patrol sergeant’s performance was within standardized LVMPD tactics, training, and policy.

**Additional Key Findings, Conclusions, and/or Recommendations**

Officers requested medical assistance and had ambulances staged in the area.

- The administrative review determined the medical response for this incident was within standardized LVMPD tactics, training, and policy.