Office of Internal Oversight Review
Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal
4185 West Tompkins Avenue — August 1, 2017

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 August 1, 2017, at approximately 1415 hours, the Las Vegas Metropolitan Police Department (LVMPD) was involved in a critical incident under LVMPD Event LLV170801002328. The incident occurred near 4185 West Tompkins Avenue, Las Vegas, NV 89103. This address was located within the LVMPD Enterprise Area Command (EAC); sector beat Sam 1 (S1).

The incident was an officer-involved shooting (OIS) and Officer Richard Nelson was the involved officer who discharged his firearm at suspect Miguel Salas, who was armed with a firearm (handgun). Salas was struck one time and was pronounced deceased on-scene by medical units.

Prior to the OIS, Officer Nelson and his partner were dispatched to a suspicious vehicle call. The person reporting the suspicious vehicle told LVMPD Dispatch that he tracked his stolen cell phone to a charcoal colored pickup truck located at 4185 West Tompkins.

Officers Nelson and his partner arrived in the area and located the truck. As they exited their marked patrol vehicle, Officer Nelson approached the driver side of the truck and his partner approached the passenger side. Officer Nelson contacted Salas, who appeared to be asleep in the driver's seat of the truck.

Officer Nelson told Salas not to start his truck and asked him several times to exit the vehicle. Salas ignored numerous verbal commands and refused to exit the truck. As Officer Nelson requested another unit over his radio, Salas reached down inside the truck with his right hand and produced a firearm. Salas discharged his firearm multiple times at Officer Nelson and his partner. Officer Nelson was struck in the upper torso area. Simultaneously, he discharged his firearm, striking Salas in the head.

As additional officers arrived, Officer Nelson was transported to UMC Trauma Hospital where he was treated for his injuries. Arriving officers established containment on Salas' vehicle. After a coordinated approach, it was determined Salas was deceased in his vehicle.

The Criminal Investigation

LVMPD Force Investigation Team (FIT) conducted the criminal investigation of this incident. Fit's investigation was submitted to the District Attorney's Office for review. The District Attorney's Office determined that, "no criminal prosecution of the officer or officers involved in the referenced case is appropriate."

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.

The matter was heard by the UFRB and TRB on August 23, 2018. 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 Richard Nelson

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 a 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.

While Officer Nelson and his partner were en-route to the call, the dispatcher broadcasted on the EAC radio channel "*The person reporting (PR) had just recalled and stated the vehicle was still there and the suspect had a 413A (knife) in one hand and a possible 413 (firearm) in the other hand."*

Upon their arrival and initial contact with Salas, who was uncooperative, Officer Nelson was at the driver's side door talking with Salas. His partner was at the passenger door looking into the vehicle. Officer Nelson nodded to his partner to call for another unit. However, his partner thought Officer Nelson wanted him to come to the driver's side door and assist.

- The administrative review determined the information sharing and the communication between Officer Nelson and his partner were not within standardized LVMPD tactics, training, and policy.

CIRT reviewed audio files of the radio traffic between LVMPD Dispatch and the officers and/or supervisors assigned to the incident and compared the radio traffic to the computer aided dispatch (CAD) document.

- The administrative review determined all radio traffic was within standardized LVMPD tactics, training, and policy.

During the 9-1-1 call, the PR gave a lot of pertinent information that was not documented in CAD by the call-taker.

- The administrative review determined the call screening and processing for the 9-1-1 call was not within standardized LVMPD tactics, training, and policy.

As the OIS took place, a PR called 9-1-1 and spoke with a call-taker. The PR informed the call-taker there was a "cop" shooting at 4205 West Tompkins Avenue. The PR went on to state two Metro police officers are getting shot at and the suspect may be down. The call-taker did not update the call to the extent the PR believed the suspect was down.

- The administrative review determined the call-taker's failure to document in CAD that Salas was down and to keep the caller on the landline was not within standardized LVMPD tactics, training, and policy.

Prior to this call being dispatched to an available patrol unit, a dispatcher had been managing and dispatching resources to another critical incident which involved a child. The dispatcher was working as the EAC dispatcher before, during, and after the OIS.

- The administrative review determined the dispatcher's management of the EAC radio channel, specifically LVMPD event 170801-2328, was within standardized LVMPD tactics, training, and policy.

As a dispatcher assigned Officer Nelson and his partner to the call, she did not immediately broadcast any weapons information about the suspect. Approximately fifteen (15) minutes after being assigned to the event, as Officer Nelson and his partner drove to the call, the dispatcher did broadcast the PR had recalled

and advised the suspect was there and was possibly armed with a firearm. However, Officer Nelson and his partner did not acknowledge the radio traffic.

- The administrative review determined that the failure to initially broadcast the weapons information was 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.

Officer Nelson and his partner received important information pertaining to officer safety. They were en-route for approximately twenty minutes to this call. While en-route, they had conversations ranging from several different topics, but none on how they were going to approach or handle the call.

- The administrative review determined Officer Nelson and his partner's preplanning prior to their arrival and contact with Salas was not within standardized LVMPD tactics, training, and policy.

Salas displayed several indicators of being non-complaint as Officer Nelson and his partner approached. The officers were unable to recognize that it may have been necessary to withdraw to a position that was tactically more secure or allowed them greater distance to consider or deploy a greater variety of force options.

- The administrative review determined Officer Nelson and his partner's approach to Salas' vehicle was not within standardized LVMPD tactics, training, and policy.

After exiting the patrol vehicle, Officer Nelson approached the driver's side door and was the contact officer. His partner was at the passenger door acting as the cover officer. The officers were using teamwork with contact and cover tactics and started communicating with Salas at his vehicle.

Salas was not listening to verbal commands that were being given to exit his vehicle. At one point, both officers started speaking with Salas; i.e., they were not utilizing contact and cover principles wherein only the contact officer speaks.

Officer Nelson's partner walked from the passenger side door to the driver's side door by passing in-front of Salas' vehicle, placing him in the direct line of sight for Salas. He left his position as the cover officer. While both officers were standing in-front of the driver's side door, they presented one target for Salas to confront.

- The administrative review determined the contact and cover used by Officer Nelson and his partner as they contacted Salas at his vehicle prior to their use of force was not within standardized LVMPD tactics, training, and policy.

Officer Nelson and his partner tactically retreated to a place of cover once Salas drew his firearm and started firing; i.e., they did not stay at the driver's side door. Officer Nelson's partner quickly ran in a southeast direction, utilizing a white Mercedes vehicle as cover. Officer Nelson quickly returned fire toward Salas and went to the rear of the patrol vehicle.

While behind cover, knowing he was shot, Officer Nelson performed a speed reload. Officer Nelson stayed behind the cover of his patrol vehicle and was able to reengage and reassess the situation. Officer Nelson was able to broadcast he was shot and communicated with his partner. Both Officers were able to create distance and put themselves in a more secure location.

- The administrative review determined the use of cover and concealment by Officer Nelson and his partner once shots were fired was 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.

When Salas drew his firearm and started firing at officers, Officer Nelson ran south, drew his firearm, and came to a two-handed firing grip as he turned toward Salas to stop the threat.

- The administrative review determined Officer Nelson's drawing of his firearm was within standardized LVMPD tactics, training, and policy.

Officer Nelson was aware of his backdrop. A witness was told to move back and was out of sight when shots were being fired. There was a business at a distance, as well as parked vehicles in the parking lot and the street.

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

When reviewing Officer Nelsons threat assessment, CIRT considered the totality of circumstances he knew at the time he made the decision to use deadly force.

- The administrative review determined Officer Nelson'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.

After the OIS, multiple supervisors to include patrol and SWAT arrived. They worked together to slow the momentum and establish command and control. Multiple resources were used such as K9, SWAT, and the Air Unit. All supervisors worked together and managed multiple scenes to include the OIS, Command Post (CP), and UMC hospital locations.

- The administrative review determined the supervisory response was within standardized LVMPD tactics, training, and policy.

Additional Key Findings, Conclusions, and/or Recommendations

A sergeant quickly made the decision to transport Officer Nelson to the hospital. The sergeant announced over the radio they would be transporting Officer Nelson to University Medical Center (UMC) Trauma and the route they would be taking.

- The administrative review determined the patrol sergeant's decision to transport Officer Nelson to UMC Trauma and the medical response to this incident were within standardized LVMPD tactics, training, and policy.

Vehicle extraction of a non-compliant person training was recommended.

- *As of January 2018, Vehicle Extraction is being implemented and taught at Advanced Officer Skills and Training (AOST).*