Office of Internal Oversight Review
Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal
1800 West Charleston Blvd – September 24, 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 September 25, 2017, at approximately 0411 hours, the Las Vegas Metropolitan Police Department (LVMPD) was involved in a critical incident under LVMPD Event LLV170924003824. The incident occurred near the location of 1800 West Charleston Boulevard, Las Vegas, Nevada 89102. This address was located within the LVMPD Bolden Area Command (BAC); sector beat Union 3 (U3).

The incident was an officer-involved shooting (OIS). Officer Thomas Rybacki was the involved officer who discharged his firearm at suspect, Cody O'Bryan, who was armed with an electronic control device (ECD). O'Bryan was struck one time and later pronounced deceased at the hospital.

Prior to the OIS, O'Bryan called 9-1-1 stating he needed medical attention. The LVMPD call-taker notified medical and remained on the line. The LVMPD call-taker and the medical dispatcher attempted to get O'Bryan's location several times, but O'Bryan was intoxicated and rambled incoherently. O'Bryan made comments that "Metro" would come at him with their guns pointed and stated he was armed with a pistol.

The call-taker researched O'Bryan's phone number and found he had called 9-1-1 three days prior, due to being suicidal. The call-taker was able to find an approximate location of O'Bryan within Spring Valley Area Command (SVAC). SVAC officers were assigned and located O'Bryan near the intersection of Charleston Boulevard and Palmhurst Drive.

Shortly after O'Bryan was located, a records check indicated he had a warrant for his arrest. Officer Rybacki arrived on scene and transported O'Bryan to the Clark County Detention Center (CCDC). At CCDC, medical staff refused O'Bryan due to being heavily intoxicated. Officer Rybacki then transported O'Bryan to University Medical Center (UMC). Officer Rybacki was advised O'Bryan would be held at UMC for over four hours. Officer Rybacki determined O'Bryan would need to be booked in absentia. Officer Rybacki left O'Bryan at UMC in the temporary custody of another officer and returned to CCDC to complete the booking in absentia.

At approximately 0240 hours, Officer Rybacki returned to UMC. O'Bryan appeared asleep. Officer Rybacki stayed at the nurse's station for approximately fifty minutes. At 0332 hours, a corrections officer arrived with a bag of supplies, including an ECD.

The correction officer placed the bag of supplies on the floor of O'Bryan's room and secured his left leg to the gurney. The correction officer then returned to CCDC. Later, O'Bryan needed to use the bathroom. While escorting him back to the room, Officer Rybacki realized O'Bryan had soiled his clothing and assisted him into a hospital gown.

Once O'Bryan was changed and re-secured to the gurney, he became verbally aggressive toward Officer Rybacki and indicated several times he wanted to die. Officer Rybacki left the room and closed the door so O'Bryan would not disturb hospital staff. O'Bryan was able to get off the gurney onto the floor and grab the bag of supplies. He rummaged through the bag and pulled out the ECD, placing it on the ground near him.

Officer Rybacki observed O'Bryan on the floor from a monitor at the nurse's station. He then walked into the room and removed the bag, placing it outside the room. Subsequently, a nurse, security officer and Officer Rybacki entered the room to place O'Bryan back onto the gurney, at which time O'Bryan grabbed the ECD pointing it toward the security officer. The security officer ran out of the room and the nurse ducked behind the gurney for protection. Officer Rybacki noticed the threat and moved to the exterior hallway for cover. He removed his gun from the holster and approached the room's entrance. As O'Bryan was pointing the ECD toward him, Officer Rybacki fired one round, striking O'Bryan. A doctor determined O'Bryan to be deceased.

The Criminal Investigation

LVMPD Force Investigation Team (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 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, 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 September 26, 2017. 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 Thomas Rybacki

In this matter, the board found Tactics/Decision-Making: 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.

O'Bryan called 9-1-1 but refused to provide his location. The call-taker was able to find an approximate location and shared that information with the SVAC dispatcher. The dispatcher queued O'Bryan's phone number and recognized O'Bryan had called three days prior. The dispatcher located an approximate location of O'Bryan's phone at West Charleston Boulevard and Palmhurst Drive. Officers responded to the area and located O'Bryan at the location given by the dispatcher. Once O'Bryan was located, the call taker advised medical personnel.

- The administrative review determined the information sharing among the Communications Bureau and Medical Dispatch was within standardized LVMPD tactics, training, and policy.

The audio file of the 9-1-1 call from O'Bryan, audio files of radio traffic between dispatch and the officers and supervisors assigned to this incident were reviewed and compared the radio traffic to the computer aided communication (CAD) document.

- The administrative review determined the 9-1-1 call made by O'Bryan was managed and documented in CAD within standardized LVMPD tactics, training, and policy.

Based on the information provided by the call-takers, the SVAC dispatcher broadcasted appropriate information from the CAD document to the officers on the SVAC radio channel. Based on information given by officers and/or supervisors working this incident, the dispatcher documented the information in the CAD document appropriately.

- The administrative review determined the management of this event by the SVAC dispatcher was within standardized LVMPD tactics, training, and policy.

When a correction officer arrived at UMC to drop off the supply bag, there was no briefing conducted with Officer Rybacki about the contents of the bag nor was there any discussion about the proper chain of custody for the bag.

- The administrative review determined the information sharing between Officer Rybacki and the correction officer was not within standardized LVMPD tactics, training, and policy.

Immediately following the shots fired broadcast by Officer Rybacki, he updated vital information over the SVAC radio channel for responding units.

- The administrative review determined Officer Rybacki's radio traffic, after shots fired was broadcasted, was 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.

Once Officer Rybacki returned to UMC, after booking O'Bryan in absentia, he left O'Bryan unattended for approximately 50 minutes. Officer Rybacki did not place himself in a position that allowed him to have a clear view of the door and the inmate.

When the supply bag was dropped off, Officer Rybacki believed he was not responsible for the bag; however, he was aware of the contents of the bag and did not take into consideration the proximity of the bag to O'Bryan. When O'Bryan became verbally aggressive toward Officer Rybacki, Officer Rybacki left the room and closed the door for approximately one minute and 45 seconds. During that time, O'Bryan was able to retrieve the ECD from the bag and hide it from Officer Rybacki

- The administrative review determined Officer Rybacki's actions were not within standardized LVMPD tactics, training, and policy.

As Officer Rybacki entered the room to place O'Bryan back on the gurney, he saw O'Bryan pointing the ECD toward the security officer. Officer Rybacki retreated out of the room and used the doorway as cover. He drew his firearm and used a technique known as "cutting the pie" to safely get a visual on O'Bryan.

- The administrative review determined Officer Rybacki's use of cover and concealment 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.

At the time Officer Rybacki drew his firearm, O'Bryan was armed with an ECD pointing it at the security officer as he ran out of the room. When Officer Rybacki approached the room's entrance, O'Bryan pointed the ECD at him.

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

When Officer Rybacki fired, he was facing O'Bryan who was seated in an upright position with his back resting on the wall. Officer Rybacki's backdrop was a wall with no other people near O'Bryan.

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

At the time deadly force was used, O'Bryan had pointed the ECD at the security officer running out of the room, the nurse was trapped in the room, and O'Bryan pointed the ECD at Officer Rybacki when he approached the room's entrance.

- The administrative review determined Officer Rybacki'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.

As a sergeant was advised of the event, he immediately responded to the hospital. Two watch commanders were also assigned to the event. A detective unit responded to assist in the preliminary investigation. All supervisors worked together and managed the scene of the OIS and established command post. One sergeant obtained the public safety statement from Officer Rybacki.

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

Additional Key Findings, Conclusions and/or Recommendations

After the OIS, a UMC doctor arrived, checked O'Bryan for a pulse and pronounced him deceased.

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