Office of Internal Oversight Review
Key Findings, Conclusions, and/or Recommendations of an Officer-Involved Shooting: Fatal
11600 block of Elcadore Street – January 26, 2018

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 January 26, 2018, at approximately 0247 hours, the Las Vegas Metropolitan Police Department (LVMPD) was involved in a critical incident under LVMPD Event LLV180126000438. The incident occurred near the location of the 11600 block of Elcadore Street Las Vegas, Nevada 89183. This address was located within the LVMPD South Central Area Command (SCAC); sector beat Ida 4 (I4).

The incident was an Officer-Involved Shooting (OIS). Officers Celina Cruz and Anthony Raymond were the involved officers who discharged their firearms at suspect Axell Vivas, who was armed with a revolver. Vivas was struck multiple times and later pronounced deceased.

Prior to the OIS, LVMPD Dispatch received a 9-1-1 call from a 16-year old minor reporting his mother had been shot. The minor identified Vivas, his mother's husband, as the suspect and advised Vivas was armed with a firearm. Patrol officers from South SCAC responded to the residence under LVMPD Event number LLV180126000020.

Upon arrival, officers established a perimeter around the residence and requested the minor exit with his siblings. After they exited, officers made entry and located the victim in the master bedroom with multiple apparent gunshot wounds. Medical personnel were requested to the scene where the victim was declared deceased. It was discovered Vivas fled the residence in a white 2005 Chrysler Sebring bearing Tennessee license plate Y0488A. This information was broadcast via the radio.

During the initial investigation, it was learned the minor heard multiple gunshots from the master bedroom. As he entered the room, he observed Vivas holding a firearm and the victim on the bedroom floor with several gunshot wounds. Vivas reloaded his firearm and left the bedroom as the minor called 9-1-1. The minor also advised dispatch Vivas wanted to suicide by cop.

Patrol officers and patrol detectives canvassed the area to locate Vivas after he was identified as the homicide suspect. Officers were aware of the suspect's description, vehicle description, that he was armed with a firearm, and wanted to suicide by cop.

At approximately 0238 hours, Detectives located a possible suspect vehicle at 11636 Elcadore Street. Detectives communicated over the SCAC radio channel they had possibly located Vivas' vehicle and requested a marked unit to their location. The dispatcher requested the Air Unit and a K9 unit to be in route to assist.

Officer Cruz arrived and deployed her shotgun. Officer Raymond arrived and deployed his rifle. Officer Raymond approached taking a position of cover behind a detective's vehicle and then transitioned to a patrol vehicle for cover. Officer Raymond activated his bi-pod switch and set up on the hood of the vehicle, which was approximately 83 feet southwest of Vivas. He placed one leg of the bi-pod on the hood of the vehicle and the other on the windshield. Vivas was behind the Chrysler Sebring using it as cover.

At approximately 0246 hours, Vivas was behind the Sebring's driver side door. As a detective communicated with Vivas to drop his firearm, Vivas held the firearm in a one-handed firing grip and pointed it over the Sebring's hood towards officers. Officer Raymond fired one round at Vivas.

Officer Raymond reassessed as Vivas ducked down and stood back up after the shot was fired. Vivas continued to point his firearm at officers and Officer Raymond fired rounds 2-9 at Vivas to stop the threat. Vivas ducked back down again and then came back up and continued to point his firearm at officers. Office Raymond discharged rounds 10-11 at Vivas and reassessed, as Vivas fell to the ground behind the Chrysler Sebring.

As Officer Raymond engaged Vivas, Officer Cruz also saw Vivas pointing his firearm in the direction of herself and other officers. Officer Cruz fired one round from her shotgun and saw Vivas drop behind the Chrysler Sebring. Officer Cruz then saw Vivas come back up and point his firearm at her and she fired another round. Officer Cruz saw Vivas drop back down and come back up again pointing the firearm and she fired her final third round at him from her shotgun.

After Vivas fell to the ground, officers formulated a plan to approach Vivas and took him into custody. Medical personnel arrived shortly after Vivas was taken into custody and pronounced him 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 no criminal prosecution of the officer or officers involved in the referenced case was 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 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 December 12, 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: Officers Celina Cruz and Anthony Raymond

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.

Communications properly broadcast and documented computer aided dispatch (CAD) information from officers and supervisors who advised and/or requested information throughout the incident.

- The administrative review determined the OIS incident managed and documented by a dispatcher was within standardized LVMPD tactics, training, and policy.

As the incident progressed, the dispatcher provided real time information she received from responding units. When the dispatcher received the information reference the suspect vehicle being located, she relayed the information on the SCAC radio channel.

- The administrative review determined the officer safety information broadcast by a dispatcher was within standardized LVMPD tactics, training, and policy.

Two detectives located Vivas' vehicle and immediately broadcasted this information over SCAC radio channel and asked for a marked patrol unit; however, they did not provide any additional information on Vivas' location for responding units.

- The administrative review determined two detectives did not update arriving units and directed them as needed. The detectives' communications 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.

When the detectives attempted to locate Vivas' vehicle, they did not conduct any preplanning. Once the detectives located the vehicle, they did not formulate a plan. When the lieutenant and a marked patrol unit arrived, the detectives advised them they were unsure if Vivas was in the vehicle. They also did not gather any additional resources nor set up containment prior to illuminating Vivas' vehicle.

- The administrative review determined the preplanning of the two detectives and a lieutenant was not within standardized LVMPD tactics, training, and policy.

When the detectives were traveling north on Elcadore Street, they located Vivas' vehicle and immediately stopped in the middle of the street. The detectives did not want to drive past Vivas' vehicle because they were unsure of his whereabouts and believed it would be an unnecessary risk to drive in front of an armed homicide suspect.

- The administrative review determined the detectives' initial approach to Vivas' vehicle was within standardized LVMPD tactics, training, and policy.

When Vivas exited his vehicle, one detective assumed the role of contact while the other detective and the lieutenant assumed the role of cover.

- The administrative review determined the contact and cover tactics used and adjusted by the two detectives and a lieutenant during the initial contact with Vivas was within standardized LVMPD tactics, training, and policy.

One detective initially took a position of cover on the passenger's side of his vehicle near the front door to issue verbal commands as the contact officer. The detective believed, based on the distance and angle to Vivas for the type of firearm Vivas was armed with, that this was enough cover. While the detective was communicating with Vivas, the detective began to move forward ending up in front of the windshield standing almost straight up thereby exposing his body's entire upper half to Vivas.

- The administrative review determined the detective's cover and concealment was not within standardized LVMPD tactics, training, and policy.

A responding officer arrived at the incident and parked approximately ten to fifteen yards behind the detectives and lieutenant. When he arrived, the officer observed the detectives and lieutenant stacked on the detective's vehicle. The officer exited his vehicle taking a position of cover on the passenger side of his vehicle. The officer stayed in this position as Officer Cruz advanced past him to the detective's vehicle. The officer continued to maintain this position as Officer Raymond also advanced past him towards lieutenant's vehicle.

- The administrative review determined the approach of the officer who took a position of cover at the passenger side of his vehicle, while Officers Cruz and Raymond advanced past him, was not within standardized LVMPD tactics, training, and policy.

Officer Raymond took a position of cover behind the engine block of the lieutenant's vehicle. He utilized the hood of the vehicle as a platform to fire from and maintained this cover throughout the encounter. Officer Cruz took a position of cover at the rear of the detective vehicle. She also utilized this position as a platform to fire from. She maintained this position of cover until she joined the arrest team.

- The administrative review determined Officers Raymond and Cruz's 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.

When Officer Cruz arrived and deployed her shotgun, Vivas was in possession of a firearm.

- The administrative review determined Officer Cruz' deployment of her shotgun when she exited her patrol vehicle and saw Vivas in possession of a firearm was within standardized LVMPD tactics, training, and policy.

When Officer Raymond arrived and deployed his rifle, Vivas was in possession of a firearm; however, he failed to announce the deployment over the radio.

- The administrative review determined Officer Raymond's deployment of his rifle when he exited his patrol vehicle and saw Vivas in possession of a firearm was within standardized LVMPD tactics, training, and policy; however, not announcing the deployment over the radio was not within standardized LVMPD tactics, training, and policy.

When Officer Cruz arrived, Vivas was behind his Chrysler Sebring as cover. Officer Cruz' backdrop was a block wall, trees, and a house.

- The administrative review determined Officer Cruz isolated and identified her target and was aware of her backdrop. Her actions were within standardized LVMPD tactics, training, and policy.

When Officer Raymond arrived, Vivas was behind his Chrysler Sebring as cover. Officer Raymond's backdrop was a brick wall and a two-story house.

- The administrative review determined Officer Raymond isolated and identified his target and was aware of his backdrop. His actions were within standardized LVMPD tactics, training, and policy.

At the time of the OIS, Vivas was in possession of a firearm and had pointed it at officers.

- The administrative review determined Officers Cruz and Raymond'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.

In evaluating the supervision of this incident, a lieutenant responded immediately to the scene when detectives announced they located Vivas' vehicle. The lieutenant was the first supervisor and marked patrol unit on scene. He took a role as a cover officer instead of assuming command and control of the incident.

- The administrative review determined the lieutenant did not manage the incident within standardized LVMPD tactics, training, and policy.

A responding sergeant assembled an arrest team and established the command post. An additional lieutenant responded and took command and control of the scene.

- The administrative review determined the other responding supervisors managed the post OIS incident within standardized LVMPD tactics, training, and policy.

Additional Key Findings, Conclusions and/or Recommendations

Medical personnel arrived shortly after Vivas was taken into custody. He was evaluated on scene and pronounced deceased.

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

A lieutenant did not activate his BWC when he was assigned to the incident and activated it after the OIS.

- The administrative review determined the lieutenant was not within standardized tactics, training, and policy.