Office of Internal Oversight Review
Key Findings, Conclusions and/or Recommendations of an Officer-Involved Shooting: Fatal
18th Street and Sunrise Avenue – December 1, 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 December 1, 2019, at approximately 0745 hours, the Las Vegas Metropolitan Police Department (LVMPD) was involved in a critical incident under LVMPD Event LLV181200001160. The incident occurred near 18th Street and Sunrise Avenue, Las Vegas, Nevada 89101. This address was located within the LVMPD Downtown Area Command (DTAC); sector beat Adam 5 (A5).

The incident was an officer-involved shooting (OIS). Traffic Officer Paul Bruning was the involved officer who discharged his firearm at suspect Demontry Boyd, who was armed with a knife and an Electronic Control Device (ECD). Boyd was struck multiple times and later pronounced deceased.

Prior to the OIS, Officer Bruning conducted a vehicle stop on Boyd for excessive speed. Officer Bruning had projected the vehicle stop at the intersection of 18th Street and Sunrise Avenue. He was unable to give out radio traffic prior to the vehicle stopping due to other radio traffic being broadcast. As Officer Bruning got off his motorcycle, he immediately controlled Boyd's hands by verbally directing Boyd to place them outside the open driver's side window. Prior to approaching Boyd's vehicle, Officer Bruning waited at his motorcycle until he was able to broadcast radio traffic for the vehicle stop.

After approaching Boyd's vehicle, Officer Bruning directed Boyd to turn off his vehicle, take the keys out of the ignition, and exit the vehicle. When Boyd exited the vehicle, Officer Bruning observed a sheath attached to his hip. Officer Bruning advised him not to touch the sheath. Boyd did not comply and reached for the sheath. A physical struggle ensued. Shortly after, Officer Bruning drew and deployed his ECD at Boyd but it was ineffective.

Boyd continued to reach in his pockets and Officer Bruning initiated a second ECD cycle against Boyd. The second cycle appeared not to effect Boyd. While Boyd was on the ground, he crawled toward Officer Bruning making incomprehensible statements. Officer Bruning created distance from Boyd by stepping back and issuing verbal commands. Once Boyd got to the rear of his vehicle, he turned and crawled under the vehicle. Boyd was almost entirely under the vehicle, with just his calves and feet sticking out.

While Boyd was under the vehicle, Officer Bruning broadcast his ECD deployed and requested a Code Red (Emergency Traffic Only). Officer Bruning waited for back up to arrive because he was unable to see Boyd's hands and he had a knife.

Boyd was under the vehicle for approximately 15 seconds and then climbed out from under the vehicle. Officer Bruning attempted to cycle his ECD a third time, not aware the cartridge wires had wrapped around

his left arm, wrist, hand, and leg. As Officer Bruning initiated the third cycle with his ECD, it caused a circuit to form on his body, shocking himself.

Boyd stood up and faced Officer Bruning. Boyd then charged toward Officer Bruning. Boyd continued to utter unknown words as he charged. Boyd pushed Officer Bruning causing him to drop his ECD on the ground. When the ECD fell to the ground, Officer Bruning placed his foot on top of it to prevent Boyd from acquiring it. Boyd continued to advance toward Officer Bruning with the knife on his right hip.

As the struggle continued, Boyd wrapped his arms around Officer Bruning and grabbed onto his duty belt and pulled. This caused Officer Bruning to lose control of his ECD. Boyd bent over and picked up the ECD. When this happened, Officer Bruning was able to draw his firearm.

With his firearm drawn, Officer Bruning gave Boyd verbal commands to stop, including "Don't you dare – Dude I'm going to shoot you." Boyd did not comply and continued to manipulate the ECD. Officer Bruning discharged his firearm, striking Boyd.

Medical was immediately requested, and as additional officers arrived, Boyd was taken into custody. Medical personnel arrived and Boyd was transported to the hospital where he was pronounced 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. 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/or 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 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 July 25, 2019. 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 Paul Bruning

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 officer 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.

A review of the radio traffic and the computer aided dispatch (CAD) document revealed the dispatcher remained calm after the broadcast of "shots fired." The dispatcher confirmed which officers were involved, initiated a Code Red on the channel, and broadcasted the location of the incident. The dispatcher notified the dispatch supervisor who in turn made the proper notifications.

- The administrative review determined all communications personnel performed 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 Bruning projected the vehicle stop, and during the initial contact, controlled Boyd's hands by directing him to place his hands outside the vehicle's window.

- The administrative review determined Officer Bruning's preplanning was within standardized LVMPD tactics, training, and policy.

Officer Bruning had to make an abrupt stop due to Boyd suddenly stopping at the intersection. He parked his motorcycle to the left rear side of Boyd's vehicle before dismounting. Officer Bruning was able to control Boyd's hand and provide the location of the stop to dispatch.

- The administrative review determined Officer Bruning's approach was within standardized LVMPD tactics, training, and policy.

Officer Bruning directed Boyd to turn off his vehicle, take the keys out of the ignition, and exit the vehicle. When Boyd exited his vehicle, he questioned Officer Bruning and did not follow his direction. Boyd had a sheath hanging from his right hip and what could be perceived as a knife in it. When Boyd attempted to retrieve the knife, Officer Bruning went hands on with Boyd.

Additionally, during the incident Officer Bruning gave verbal commands to Boyd, ordering him to stop resisting and to get on the ground. While Boyd crawled toward Officer Bruning, he requested units to assist and was waiting for them to respond before approaching the suspect when Boyd crawled under the vehicle. Finally, Officer Bruning, on several occasions, attempted to separate himself from Boyd to create distance.

- The administrative review determined Officer Bruning's contact and cover 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.

During this incident, it appeared Boyd may have had a knife on his person, and he was not complying with Officer Bruning's verbal commands. Also, Officer Bruning was in a physical struggle with Boyd and had

deployed and cycled his ECD three different times against Boyd. As Boyd was able to acquire and manipulate the ECD, Officer Bruning drew his firearm.

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

During the investigation of the OIS scene, it was determined Officer Bruning discharged his firearm with rounds traveling in a downward direction.

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

Officer Bruning discharged two rounds from his firearm to stop the threat of Boyd, who had a large sheathed knife on his right hip and was in possession of Officer Bruning's ECD. Boyd was manipulating the ECD, possibly attempting to turn it on. Officer Bruning unknowingly had the wires of the ECD wrapped around parts of his body and had already been shocked previously when he deployed the ECD.

- The administrative review determined Officer Bruning'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, the first arriving officer immediately checked with Officer Bruning and confirmed he fired shots. As other officers arrived, he assigned a monitoring officer to stay with him and took control of the scene.

When a sergeant arrived, he assumed control of the scene. He ensured Officer Bruning was separated from the scene and had an assigned monitor officer. The sergeant obtained a Public Safety Statement in a timely manner. A second sergeant arrived on scene, established a Command Post, and assumed the role of Incident Commander.

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

Additional Key Findings, Conclusions and/or Recommendations

Officer Bruning immediately requested medical respond after the OIS to treat Boyd's injuries. Boyd was transported to the hospital where he was pronounced deceased.

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