

INTRODUCTION AND OVERVIEW

In order to ensure transparency in the investigation and review of critical incidents (officer-involved shootings and in-custody deaths) involving the Denver Police and Sheriff Departments, the Independent Monitor submits this quarterly report regarding the status of investigations into these incidents and decisions made by the Departments regarding officer conduct.

As a general overview, it should be noted that timeliness of investigations is essential to ensuring the integrity of internal affairs processes. Timely investigations are important to employees who have a right to expect finality in the disciplinary process. Timely investigations also ensure that employees are held accountable for misconduct and that the imposition of discipline can have a positive effect on future performance. Timely investigations also assist City managers in sending a message to the public that the Denver Police and Sheriff Departments can, in fact, do police themselves and ensure the credibility of the administrative and disciplinary processes.

It must be acknowledged, however, that in some unusual cases, it will take longer to complete an investigation than the goals established by the Department and the Monitor's Office. The OIM has, in fact, established a goal that the Police and Sheriff Departments resolve critical incident investigations within six months of the incident.

As with all officer-involved shootings and in-custody deaths, the Denver Police Department (DPD) is initially charged with conducting a criminal investigation to determine whether any person should be held criminally liable for the death or serious bodily injury of any person killed or injured as the result of a law enforcement action. Thus, the DPD's Homicide Bureau immediately responds to investigate all critical incidents. Homicide detectives spend considerable time and effort to interview all witnesses and involved officers and to obtain appropriate reports from all involved parties. Only after the criminal investigation is complete, can the administrative investigation and review process begin.



Special accolades should be given to the Denver District Attorney's Office which has recognized the need for a timely evaluation of these criminal investigations to ensure that the administrative review process can begin as soon as possible in appropriate cases.

DENVER POLICE DEPARTMENT

Officer-Involved Shooting and In-Custody Death Investigation and Review Protocol:

In all cases where a Denver police officer intentionally discharges his or her firearm at a person, or where a person dies in police custody, the incident is automatically investigated by the Homicide Unit of the Denver Police Department under the supervision of the Denver District Attorney's Office (if a person is injured or killed as the result of the incident). The investigation is actively monitored by the Office of the Independent Monitor. The District Attorney's Office and the Monitor's Office are both notified as part of the critical incident roll-out protocol. The District Attorney's Office is primarily concerned with determining whether the involved officer(s) committed any violation of the criminal law; the Monitor's Office is primarily concerned with potential violations of Department rules and policies.

Once the District Attorney has made a filing decision (usually in the form of a public "shoot letter"), the Homicide reports are submitted to the Internal Affairs Bureau for its review and handling. The Monitor's Office confers with Internal Affairs to determine if further investigation is necessary from an administrative perspective. If no further investigation is necessary, the case is then submitted to a Use-of-Force Board (consisting of the Department's four Division Chiefs and two civilian volunteers and chaired by the Commander of Internal Affairs) to determine whether any policy violations occurred. The Monitor's Office is present during all Use-of-Force Board proceedings and deliberations.

If the Use-of-Force Board finds that the officers' actions were in compliance with Department policy ("in-policy"), the case is forwarded to the Chief of Police to make a recommendation to the Manager of Safety who is the ultimate decision-maker. The Independent Monitor is present during the Use-of-Force Board deliberations.



If the Use-of-Force Board finds that the officers' actions were in violation of any Department policy ("out-of-policy"), the Use-of-Force Board then makes a disciplinary recommendation to the Chief of Police. If the disciplinary recommendation is anything more than a reprimand, the officer has the opportunity to request a hearing before a Disciplinary Review Board (DRB) (consisting of 3 citizen volunteers, 1 peer officer, 1 supervisory officer and 1 command officer). The Independent Monitor is present during the DRB proceedings and deliberations.

After deliberating, the DRB makes its own disciplinary recommendations to the Chief of Police. The officer is then given the opportunity to provide any mitigating statements to the Chief of Police at a "Chief's Hearing." The Independent Monitor makes his disciplinary recommendations to the Chief of Police at that time and both the Chief's recommendation and that of the Monitor are forwarded to the Manager of Safety for his consideration. The Manager of Safety is the ultimate decision maker as to whether the officers' actions were "in-policy" or "out-of-policy" and what the appropriate level of discipline should be.

After the issuance of the Manager's final order, the Independent Monitor reports to the public on all disciplinary orders issued by the Manager of Safety, on a quarterly basis and in an Annual Report which is released by March 15th of each year.

Officer-Involved Shooting Cases Pending Administrative Review as of the end of the 4th Quarter, 2007:

- April 4, 2007 shooting. 1 officer fired 1 shot at a suspect threatening the officer with a moving vehicle – the suspect was injured and later arrested. A District Attorney shooting letter was issued on May 7, 2006 (See, denverda.org/News_Release/Decision_Letters). Case pending review by the Manager of Safety.
- November 12, 2007 shooting. 1 officer fired 1 shot at a suspect who attempted to flee a traffic stop and then assaulted the officer – the suspect was injured and arrested. A District Attorney shooting letter was issued on December 28, 2007 (See, denverda.org/News_Release/Decision_Letters). Case pending Administrative Review and a Use-of-Force Review Board.



- November 14, 2007 shooting. 2 officers fired multiple shots at an armed robbery suspect who was in the process of brandishing a shotgun and threatening customers at a restaurant – the suspect was injured and arrested. Case pending District Attorney review.
- December 19, 2007 shooting. 1 officer fired multiple shots after a foot pursuit – the suspect was killed. Case pending District Attorney review.

Officer-Involved Shooting Cases Administratively Closed in the 4th Quarter 2007:

- March 29, 2007 shooting. 1 officer fired 2 shots at a suspect wielding a replica firearm – the suspect was injured and later arrested. A District Attorney shooting letter was issued on April 30, 2007 (See, [denverda.org/News_Release / Decision_Letters](http://denverda.org/News_Release/Decision_Letters)).

The shooting itself was determined to be “in-policy” as the shooting officer was faced with a suspect who brandished what appeared to be a firearm at the officer in an attempt to escape arrest. The suspect denied being armed, but acknowledged access to a replica firearm which matched the description of the firearm provided by the officer.

The shooting officer and his partner, however, failed to call out the shooting to dispatch and delayed in reporting the shooting to their supervisor. The officers' actions were publicly criticized by the District Attorney in his “Shoot Letter.”

The Manager of Safety imposed a two-day suspension on the shooting officer for failing to adequately communicate with his partner to ensure that the shooting had been called out. The Monitor notes that the officer should have recognized that no cover officers were responding while the officer and his partner searched for the suspect who had escaped from the immediate scene. However, the Monitor recognizes, as a factor in mitigation, the officer had lost his radio during the foot pursuit and he could have reasonably assumed that his partner had called out the foot pursuit and the shooting. Even so, the officer should have communicated with his partner to ensure that his partner had advised dispatch of the incident. The Monitor believes that the two-day suspension was within the range of disciplinary sanctions



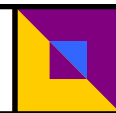
that could reasonably have been imposed, however, the Monitor also believes that a five-day suspension would have been more appropriate.

The Manager of Safety imposed a 30-day suspension on the shooting officer's partner for failing to immediately notify dispatch of the shooting and endangering other officers, themselves and the public through inappropriate tactics.

Although the Monitor understands and respects the Manager's decision, the Monitor disagrees with the disciplinary decision as to this officer. The Monitor believes that a 60-day suspension was warranted, given all of the circumstances. Specifically, the Monitor believes that more significant discipline needed to be imposed, in part, because the officer made a misleading statement to the dispatcher when he reported that he and his partner were investigating a one car collision (the suspect had crashed his car before the initiation of the foot pursuit) even after shots had been fired by his partner. Even after informing his supervisor that an officer-involved shooting had taken place, the officer failed to notify his supervisor that the suspect was at-large and likely wounded.

The Department's policy that officer-involved shootings are immediately called out to dispatch is an important one. It helps ensure that the scene is quickly contained and that the subsequent investigation and review process has integrity. It also ensures that nearby officers are aware of any danger that a fugitive may present to themselves and the community at-large. It provides a level of safety for the involved officers that adequate cover arrives quickly and that dispatch is aware of their location and whether they are in any danger. Finally, it ensures that a wounded suspect will be located as soon as possible so that appropriate medical attention can be provided. As such, a violation of this policy was, and needs to be, considered a serious breach of conduct.

In this case, the Monitor believes the officer tried to ensure that this deadly force incident would be handled by officers from within his own special unit. (The officer's actions, in this regard, were thwarted by his supervisor who, as appropriate, made the necessary call out as soon as he was advised that an officer involved shooting had taken place.) The officer was deceptive in his communication with dispatch, incomplete in his communication with his supervisor and, as such, put



numerous lives in danger. In addition, his actions had a negative impact on the integrity of a well-thought out and long-standing officer-involved shooting investigation protocol. Finally, but for the suspect's admission that he had access to a replica-type weapon, the department would have been faced with a situation where the officer's false statement to dispatch could have caused credibility issues that would have raised serious questions about the legitimacy of the shooting. For these reasons, the Monitor believes that more severe discipline was warranted.

It should be noted that the Manager of Safety discussed the basis for his decision in this case with the Monitor and took the Monitor's opinions and recommendations into consideration when making his decisions.

In-Custody Death Cases Pending Administrative Review as of the end of the 4th Quarter 2007:

- Fatal Traffic Collision. A passenger died after the vehicle in which he was traveling was struck by a police car traveling Code-10 (lights and sirens). Pending Traffic Investigations Bureau (TIB) Investigation and District Attorney review.
- In Custody Death. A suspect died after being taken into custody using take-down and control holds. Pending Autopsy Report & review by Internal Affairs.

In-Custody Death Cases Administratively Closed in the 4th Quarter 2007:

- In-Custody Death. A suspect died after being taken into custody. Force included use of a Taser, baton strikes and take-down and control holds. No District Attorney letter was issued. Administratively resolved as "Exonerated." The Monitor concurred with the Department's decision to find the use-of-force as "in policy."

This use-of-force was publicly criticized by the family of the decedent, who alleged that the decedent was walking his dog at night and was accosted by police officers for no reason. The Monitor supports the Department's finding in this case based, in part, on 911 calls which established that the decedent was attacking and destroying



neighbors' property and yelling incoherently. The investigation revealed that the officers' Use-of-Force was in response to the decedent's attacking one officer's vehicle and aggressively approaching another officer in order to stop the officer from getting out of his patrol car.

Per all officer accounts, the decedent engaged in aggressive behavior that warranted the use of a Taser. Upon arrival, officers confronted the decedent, who was running down the street, at 3:00 a.m., wearing only shorts and covered with blood. When confronted by officers, the decedent failed to respond to any commands, and ran around yelling: "Oh my God, Jesus." After the Taser proved ineffective (after four attempts), officers used take-down techniques and baton strikes in an attempt to place the decedent under arrest.

After the decedent was taken into custody, he began to suffer cardiac arrest and the officers administered CPR. He was resuscitated but later died at the hospital at 4:15 a.m.

The autopsy report was unable to provide an explanation for the decedent's death.

The investigation revealed that the decedent had a prior incident, when he was 18-years-old, wherein he overdosed on drugs, "freaked out" and thought that, if he hit lights, he would "go to Jesus." In this case, the decedent was reported to have broken out numerous light bulbs in the neighborhood while screaming: "Jesus, Oh my Lord, Jesus" over and over again.

Given that the Denver Police Department policy on use of the Taser restricts its use to "active aggression" and is one of the more restrictive in the nation, and that an audit of the Department's deadly force policy (which will include an evaluation of the use of the Taser) is pending, no policy changes were recommended.

DENVER SHERIFF'S DEPARTMENT

In-Custody Death Investigation and Review Protocol:

In all cases where a person dies while in the custody of the Denver Sheriff Department, the incident is automatically investigated by the Homicide Unit of the



Denver Police Department. The investigation is actively monitored by the Office of the Independent Monitor. The Sheriff's Internal Affairs Bureau and the Monitor's Office are notified as part of the critical incident roll-out protocol. If the in-custody death were determined to have been as the result of conduct of a sworn officer, the District Attorney's Office is notified in order to respond to the scene and supervise the criminal investigation. The District Attorney is primarily concerned with determining whether the involved officer(s) committed any violation of the criminal law; the Monitor's Office is primarily concerned with potential violations of Department rules and policies.

Once the District Attorney has made a filing decision (in those cases where an officer is alleged to have caused a death), the Homicide reports are submitted to the Internal Affairs Bureau for its review and handling. In addition, the Sheriff's Internal Affairs Bureau will usually conduct its own parallel administrative investigation of the incident. The Monitor's Office works with Internal Affairs to ensure that the investigation is thorough and complete. Once the investigation is deemed complete, it is submitted to the appropriate Division Chief for review and findings.

If the Division Chief finds that the officers' actions were in compliance with Department policy ("in-policy"), the case is forwarded to the Director of Corrections to make a recommendation to the Manager of Safety, who is the ultimate decision maker. The Independent Monitor reviews the Division Chief's findings and makes his own recommendations to the Director and the Manager as well.

If the Division Chief or the Director finds that the officers' actions were in violation of any Department policy ("out-of-policy"), the case is referred to the Director for a "Pre-Disciplinary Hearing." That hearing is conducted by the Department's three Division Chiefs and is chaired by the Director of Corrections. The Independent Monitor observes the hearing and the deliberations of the Command Staff. At that hearing, the involved deputy(s) have the ability to present his or her side of the story and any mitigating factors that might exist. After hearing from the involved deputy(s), the Independent Monitor makes his disciplinary recommendations to the Director and both the Director's recommendation and that of the Monitor are forwarded to the Manager of Safety for his consideration. The Manager of Safety is



the ultimate decision-maker as to whether the deputy(s) actions were “in-policy” or “out-of-policy” and what the appropriate level of discipline should be.

After the issuance of the Manager’s final order, the Independent Monitor reports to the public on all disciplinary orders issued by the Manager of Safety on a quarterly basis and in his Annual Report which is released by March 15th of each year.

Sheriff In-Custody Death Cases Pending Administrative Review as of the end of the 4th Quarter 2007:

- In-Custody Death. An inmate committed suicide in the County Jail. Pending further investigation and Pre-disciplinary hearing relating to a possible failure to conduct adequate rounds.
- In Custody Death. An inmate committed suicide in the County Jail. Pending administrative investigation by Internal Affairs.

Sheriff In-Custody Death Cases Administratively Closed in the 4th Quarter 2007:

- In-Custody Death. An inmate died at the City Jail after suffering injuries from a DUI related traffic collision. The inmate was examined and released by the Denver Health Emergency Room to the custody of the Sheriff’s Department within four hours of the collision. The inmate was incarcerated in the City Jail for 19 hours before she became unresponsive and paramedics were called. Discipline Administered by Manager of Safety.

An internal affairs investigation was automatically initiated as a result of the in-custody death. During the course of that investigation, video records were reviewed for the entire period of the inmate’s incarceration. The video records disclosed that some deputies failed to conduct some rounds as documented. (Deputy Sheriffs conduct “rounds” to check on the safety and security of the facility and all of its inmates on a regular basis. Deputies walk by and observe each occupied cell to ensure that there are no obvious serious issues of concern that need to be addressed.) The discipline that was imposed was for the failure to conduct and the inappropriate documentation of those missed rounds. The Monitor agreed with the Department’s



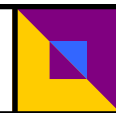
disciplinary actions based upon the conclusion that the involved deputies' misconduct did not result in the death of the inmate. Specifically, the rounds that were missed occurred before the inmate was brought to be evaluated by medical staff. Because there was evidence that deputies reported on the inmate's condition to the medical staff and because deputies are trained not to substitute their judgment for that of the medical staff, the deputies could not be held responsible for the inmate's death.

As a result of this investigation, a deputy was suspended for a period of three days for documenting but failing to conduct two rounds and for failing to notify nursing staff of the need to immediately examine the inmate upon her arrival at the City Jail. The Monitor agrees with the Manager's disciplinary decision as to this deputy. Specifically, the Monitor believes that the failure to provide immediate access to the nursing staff did not result in the death of the inmate as she was, in fact, seen by medical staff more than 15 hours before she became unresponsive. Otherwise, more serious discipline would have been warranted.

A second deputy was also suspended for a period of three days for documenting but failing to conduct one round. The Monitor believed that, due to the deputy's prior disciplinary history, a five-day suspension was more appropriate.

A third deputy resigned from her position with the Sheriff's Department before discipline was imposed in this case. The Monitor's Office believed that the Deputy should have been terminated for documenting and failing to conduct four rounds and for lying to internal affairs. A violation of the policy requiring deputies to be truthful to internal affairs warrants severe disciplinary sanctions. The integrity of Internal Affairs investigations should be considered sacrosanct and a deputy who fails to accept responsibility for his or her actions by making false statements to internal affairs should realize that termination is a reasonable response on the part of the Department.

A fourth deputy was issued a "cautionary letter" as the result of the finding that the deputy documented but failed to complete two rounds. This letter was issued instead of discipline being imposed. The Monitor's Office does not agree with the Department's failure to impose discipline on this deputy, but understands that there



were mitigating factors that made that decision not unreasonable.

Finally, the Department issued a “cautionary letter” to a supervisor who may have failed to adequately supervise the deputies who failed to conduct their rounds. The OIM agreed that a cautionary letter needed to be issued to the supervisor to document the issue and to remind the supervisor of the need to be cognizant of his supervisory duties while conducting rounds in the jail.

Timeliness Issues:

Although discipline was not imposed in this case until almost two years after the inmate’s death, it must be noted that the Sheriff’s Department conducted a thorough and complete investigation into the incident and that the delays in the investigation were an unfortunate but necessary result of the need to ensure that the investigation and its results were fair, complete and appropriate. In addition, substantial time delays were attributable to factors outside the control of the Sheriff Department.

In this case, it took the Department more than 21 months to complete its investigation and impose a final disciplinary order. Thus, the Department has suffered public criticism for the lack of a timely investigation. Public allegations were made that the Department was covering up misconduct and failing to hold its employees accountable. As the months passed, it became difficult for the Department to try to explain to the media and other interested persons why the case was still “under investigation” or “under review” without further explanation.

The criminal investigation in this case was not completed until almost seven months after the death of the inmate. It was only then that the District Attorney concluded that no criminal charges could be filed against any of the involved Sheriff personnel. At that time, the investigation was transferred to the Sheriff Department Internal Affairs Bureau for an administrative investigation into the conduct of Sheriff Department employees. The Sheriff’s Internal Affairs investigation included additional interviews with deputies, specifically addressing the administrative concerns not usually addressed during a criminal investigation.

The internal affairs investigator was forced to work around the time schedules of



attorneys, union representatives, witnesses and the involved employees. One of the primary factors that delayed the handling of the administrative investigation, however, was not the interviews, but the refusal of Denver Health Medical Center personnel to cooperate in the investigation.

Medical staff testimony about the conduct and statements of the involved deputies would have provided insightful information as to the conduct of the deputies in this case. As such, in an attempt to ensure a thorough and complete investigation, the Monitor's Office contacted Denver Health, the City Attorney's Office and the Mayor's Office, in order to obtain cooperation from the nurses. By the end of 2006, however, Denver Health made it clear that the nurses would not cooperate in the investigation. Because the nurses are employees of Denver Health and not the Sheriff Department, the Sheriff Department could not compel their cooperation in any way. As such, the actions of the nurses and their impact on the deputies actions had to be evaluated based only on the information available from the involved deputies, inmates and videotapes.

The Sheriff IAB investigation was completed by the end of 2006, but the extensive write-up of the investigation was not completed until the end of March 2007. The write-up included transcriptions of the interviews, summaries of witness statements, timelines and an evaluation of many hours of video feed from seven different cameras. An internal affairs investigator worked on the case investigation, on almost a full-time basis, for many months.

After the investigation was complete, by the end of March 2007, the Independent Monitor's Office reviewed all of the documentation and engaged in an extensive and lengthy discussion regarding the investigation. The Monitor's Office believed this to be an important investigation that warranted thorough documentation. As such, any time delays associated with completing the investigation and its write-up was considered to be acceptable.

It also took the Division Chief some time to complete his review of the extensive investigation. At that point, pre-disciplinary letters needed to be prepared by the Department and reviewed by the City Attorney's Office and the Monitor's Office. After the completion and service of the pre-disciplinary letters on the involved



deputies, Pre-Disciplinary hearings were set up for the nearest available dates, taking into consideration requests from representing counsel and vacations of command staff who were charged with conducting the hearings.

The final disciplinary orders in this case were delayed due to additional internal complaints brought against the deputy who eventually resigned. All the cases against that deputy were going to be considered along with the misconduct allegations made in this case. In addition, it was concluded that all discipline related to this case should be handed down at the same time.

The final pre-disciplinary hearing relating to the deputy who resigned was scheduled for mid-November, 2007. The deputy resigned the day the hearing was scheduled to take place. The Manager of Safety imposed his discipline shortly thereafter.

Policy & Technology Issues:

There were substantial policy and technology issues that were identified as the result of this case investigation. See “Policy Issues” section of this report, *infra*.

Denver Sheriff Department Technology Concerns:

The City Jail uses a video recording system within the City Jail to ensure safety and hold inmates and staff accountable for their actions. As the result of conducting and monitoring numerous investigations, the Sheriff Department and the Monitor’s Office noted significant problems relating to the videotape system. Specifically, in one case, there were significant gaps in the video footage from numerous video cameras throughout the period of the inmate’s incarceration.

In that case, the Monitor’s Office was convinced that the lost footage was not the result of any deliberate tampering, contrary to public statements made by representatives of the vendor that installed and administered the system. In fact, the Sheriff investigation includes a statement from the vendor explicitly noting that “no deliberate or incidental indication of tampering that would result in the loss of recorded video” was noted in that specific case. The vendor also noted that the technology was not “flawless” and “an error rate [of] typically less than 1% should be expected.”



As a result of the system's failures, the investigation was unable to conclusively establish when and where rounds were conducted. Department command staff concluded that in order to conduct an uninterrupted round, a deputy would need, at minimum, 31 seconds to walk through his or her area of responsibility and check each cell. As such, anytime there was a skip in the video that exceeded 31 seconds during the 30 minute period in which a round could have been conducted, the Department concluded it could not prove that the involved deputy did not conduct the documented round. As such, the Department gave the benefit of the doubt to any deputy who might possibly have conducted a round during these periods of time.

In another internal investigation, a Jail supervisor reviewed the hard drive of the video surveillance system. When internal affairs attempted to retrieve the data for their investigation, that portion of the video was missing, along with various other portions of the video for that day.

The Sheriff Department attributed the video system issues to ongoing hardware and software failures that include hard disk drives, motherboards, drive controller cards, software failures and hard disk drive docking bay failures. The Sheriff Department reports that they have moved away from local DVR's (Digital Video Recorders) and have phased out the current vendor. The Department is looking to solve the any continuing problems with the assistance of the City's Technology Services Department and will be using another software vendor and enterprise SAN (Storage Area Network) storage to resolve the current issues. A test platform is currently being utilized within the Denver Police Department and the Sheriff expects to migrate to this system by the end of the 2007.

POLICY RECOMMENDATIONS (DSD):

As a result of an in-custody death investigation, the Monitor's Office made several policy recommendations:

First, the Monitor's Office recommended that deputies be required to note the exact time of each round, instead of simply documenting that rounds were conducted every half hour on the hour. It was also recommended that only the deputy who conducted a round be permitted to document that action in the appropriate log. The



Independent Monitor believed such procedural changes would ensure more reliability in the completion of the logs.

In lieu of accepting this recommendation, the Department contracted for new technology which would ensure that rounds are being conducted. Specifically, the Department contracted for a “wand” system which requires deputies to pick up a wand from their duty station, walk to the far end of their area of responsibility and swipe the wand against a sensor which would document the exact time of the round.

This system would require a deputy to walk up and down his or her corridor of responsibility in order to get credit for conducting a round. As such, the inventory log sheets would no longer be necessary. As of November 9, 2007, the wand system was put into use in both the City and County Jails.

Second, the Monitor’s Office recommended that the Department seek immediate upgrades to the City Jail’s video recording system in order to avoid the skips in the video that made it impossible to prove or disprove misconduct on the part of seven additional deputies. As indicated above, necessary system improvements should already be in place.

Third, the Monitor’s Office recommended that the Denver Health contract be amended to ensure the cooperation of nurses in any in-custody death investigation in which they are percipient witnesses. During the course of the year, the Monitor’s Office met with the City Attorney’s Office and Denver Health representatives. An agreement was reached, whereby nurses will provide written answers to questions in future investigations where there are concerns regarding possible liability. The Monitor’s Office hopes that this agreement will ensure more complete and thorough investigations in the future.



MANAGER OF SAFETY

Cases Administratively Resolved

- April 20, 2006 shooting. 1 shooting officer; 1 shot fired at a suspect threatening the officer with a moving vehicle – suspect killed. District Attorney shooting letter issued on May 5, 2006 (See, [denverda.org/News_Release / Decision_Letters](http://denverda.org/News_Release/Decision_Letters)). (For more information, see OIM 2006 Annual Report at Chapter 6, pages 10-11). The Monitor concurs with the Use-of-Force Board decision to find the shooting “in-policy.” Administratively resolved by the Use-of-Force Board on November 29, 2006. Manager of Safety Report issued on December 31, 2007. No further action required.
- June 25, 2006 Special Weapons & Tactics (SWAT) shooting. 2 shooting officers; 17 shots fired at a suspect who had wounded 2 and killed 1 civilian and wounded a police officer – suspect killed. (For more information, see OIM 2006 Annual Report at Chapter 6, pages 11-12). District Attorney shooting letter issued on June 29, 2006 (See, denverda.org/News_Release/Decision_Letters). The Monitor concurs with the Use-of-Force Board decision to find shooting “in-policy.” Administratively resolved by the Use-of-Force Board on February 15, 2007. Manager of Safety Report issued on December 31, 2007. No further action required.