

Report of the Tucson Sentinel Event Review Board (SERB)  
on the Deaths in Custody of  
Mr. Damien Alvarado and Mr. Carlos Adrian Ingram-Lopez

September 18, 2020

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## Executive Summary

This report summarizes issues identified by the Tucson Sentinel Event Review Board (“the SERB”) in its 2020 review of the deaths of Mr. Damien Alvarado and Mr. Carlos Adrian Ingram-Lopez while in the custody of the Tucson Police Department (“TPD” or “the Department”), as well as the failure of TPD to notify the community of the in-custody death of Mr. Carlos Adrian Ingram-Lopez in a timely fashion.

The deaths of Damien Alvarado and Carlos Adrian Ingram-Lopez are two of five in-custody deaths over the past decade (one in 2010, two in 2012, and the recent two) that involved some use of restraints imposed by the Tucson Police Department. TPD leadership believes that any death in custody is a tragedy that should be carefully reviewed and understood, and improvements to procedures implemented to reduce the chance that any such event can happen in the future.

The SERB is a multi-stakeholder group, including representatives from TPD, the Tucson Fire Department and its Emergency Medical Services (“TFD” or “EMS”), the Public Safety Communications Department, staff from the offices of the Mayor and Councilmembers, the Community Police Advisory Review Board (“CPARB”), and a diverse array of community participants, including experts in critical care, the care of individuals with mental or behavioral health issues, and experts in cultural literacy and racial justice.

Assisting the SERB were John Hollway, Executive Director of the Quattrone Center for the Fair Administration of Justice from the University of Pennsylvania Carey Law School (“Quattrone Center”) and Michael Scott, Clinical Professor and Director of the Center for Problem-Oriented Policing at the Watts College of Public Service and Community Solutions at Arizona State University. Mr. Hollway and Mr. Scott are experts in the conduct of sentinel event reviews.

Mr. Hollway and Mr. Scott guided the SERB in a process to identify the acts, omissions, management, institutional, social, and environmental conditions that resulted in the deaths of two Tucson community members while in the custody of the TPD in early 2020, and further why the TPD failed to disclose one of the deaths to the community in a timely fashion. In doing so, the SERB sought to help the TPD, the stakeholder group, and the larger Tucson community learn from these events and make recommendations that will prevent future tragedies like these.

The SERB identified 32 contributing factors and conditions leading to the two deaths. From these, the Quattrone Center and the Center for Problem-Oriented Policing worked with the stakeholder group to propose 53 recommendations for modifications to policies, procedures, supervision, and the environment in which our first responders are making decisions that we feel will provide substantial improvements to ensuring the safety of the Tucson community, including both the people of Tucson and officers and EMS in the TPD and TFD.

The SERB was not formed to judge whether any specific participants in these events were “blameworthy” or “liable.” That is for other existing reviews, including the TPD administrative review and the County Attorney’s review of these cases for possible criminal conduct, and was outside the scope of our analysis. We recognize, however, that participating in events leading to a death in custody does not mean that one acted in ways that are inappropriate or deserving of blame or punishment. For example, an officer’s engagement with a suspect who presents a

legitimate danger to himself or others contributes to the outcome of that interaction, but if the officer's actions are appropriate and within protocol, he or she is not blameworthy even if the eventual outcome is undesired.

While individual actors – including not only on-the-scene police officers, but others who were involved such as 911 operators, EMTs and paramedics, witnesses, etc. – acted in ways that contributed to the undesired outcomes, the SERB viewed these tragedies as system failures, rather than failures for which individuals should be *solely* held responsible. No single actor or factor itself was sufficient to cause the deaths of Mr. Alvarado or Mr. Ingram-Lopez. Each death resulted from a cascade of contributing factors, some caused by individuals and others caused by the environment in which those individuals were acting, which increased the likelihood of these undesired outcomes. We sought to identify and address all these contributing factors in order to prevent other such tragedies in the future.

Our first responders have chosen careers that leave little margin for error in responding to high-stress, high-stakes, rapidly changing environments where people's lives are at stake. The reality is that errors will occur in all human activities despite our best efforts. However, it is the obligation of the leadership, managers, and supervisors in these organizations to anticipate the unexpected and to put our first responders in positions that maximize their ability to obtain desired outcomes.

The SERB has no disciplinary authority, and our review was not intended to impose discipline on any individuals who acted inappropriately. We note the ongoing administrative and criminal investigations occurring in the aftermath of Mr. Alvarado's and Mr. Ingram-Lopez's deaths.

Sentinel Event Reviews occur in parallel to these investigations. Both the criminal and the administrative investigations apply backward-looking accountability, evaluating the officer's potential individual criminal culpability for his/her past actions and evaluating whether the officer has violated any departmental policies, protocols or codes of conduct that might subject the officer to official discipline.<sup>1</sup> By contrast, the SERB sought to understand what factors contributed to the bad outcome and focused on *forward-looking accountability* – the obligation to learn from this tragedy and try to prevent similar outcomes in the future. Because the investigations have different objectives, they do not duplicate efforts. The key question driving our recommendations was "If this recommendation had been in place at the time of the deaths of Mr. Alvarado or Mr. Ingram-Lopez, would either man be alive today?" This is not typically a question asked in the criminal or administrative contexts.

The members of the SERB want to recognize the difficult work that the members of the Tucson Police Department and Tucson Fire Department do every day in the service of our community. The members of our Police and Fire Departments have dedicated their careers to working in dangerous and challenging environments and are often forced to make difficult decisions with incomplete and changing information under circumstances where peoples' lives are at stake. While the SERB identified many opportunities for improvement, we also noted the

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<sup>1</sup> The SERB did discuss techniques for identifying whether officers in these incidents had acted in ways that warranted disciplinary action, additional training, or other types of assistance. For more on this topic, see the discussion of "just culture" in Appendix C. below.

professionalism of TPD and TFD personnel, including a willingness of their leadership to self-scrutinize, accept responsibility for actions, and make improvements going forward. This cannot be understated, and we thank them for their openness in this process.

## Participants and Methodology

The Tucson Police Department incorporated feedback from the community to create the SERB as a diverse multi-stakeholder group to carefully review the events leading up to two deaths in police custody. The SERB was informed by an earlier internal TPD process called the Critical Incident Review Board; the transition to the SERB process took on additional external guidance and moderation.

The SERB was composed of both community members as well as staff from the agencies that participated in the events leading up to the deaths (e.g., the dispatch and response team answering 911 calls within the Public Safety Communications Department (“PSCD”), TPD, and Emergency Medical Services within TFD). The SERB was designed to allow for robust discussion of the various aspects of the cases – TFD’s, PSCD’s and TPD’s handling of calls for assistance made by members of the Tucson community, understanding the various complications presented by the cases (law enforcement, cultural/racial, clinical and mental health, among others), and to provide an ability to understand not just what the officers responding to these calls did, but *why* they acted the way they did. In this way, the SERB sought to intervene upstream of the deaths themselves to help prevent these situations from happening in the first place or allowing for different results should TPD, PSCD, and TFD personnel find themselves in similar situations in the future.

The Tucson Police Department was fully transparent in the SERB process and shared an extraordinary amount of information with us. This included extensive body-worn camera (BWC) video footage and unredacted criminal and administrative interviews and other documentation of both events.<sup>2</sup> While we were unable to meet with the participants in these events<sup>3</sup>, the audio recordings and transcripts of the administrative interviews, conducted in close proximity to the events by experienced TPD investigators to identify whether police directives or protocols had been followed properly, were an excellent substitute. Potential limitations of our recommendations include that we did not interview the participants and because the interviews reflect the mindset of the participants after the event had concluded in an undesired outcome.

The members of the SERB are listed in Appendix B. We met four (4) times, each a full-day session held at TPD. Meetings were moderated by Jose A. Vazquez, Esq., a Tucson attorney specializing in immigration issues, and TPD Lieutenant Monica Prieto. Guidance on sentinel event reviews, including discussion about contributing factors and recommendations, was

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<sup>2</sup> Pursuant to the U.S. Supreme Court’s ruling in *Garrity v. New Jersey* (1967), police officers under investigation of wrongdoing can be compelled to provide statements about their actions to police administrators, but they are protected by the Fifth Amendment in the same fashion as all citizens from being compelled to incriminate themselves in criminal investigations. Any statements given in the administrative investigation cannot be used in the criminal investigation unless the officer waives his or her right against self-incrimination. In accordance with these rules, TPD immediately initiated administrative reviews of both of the cases reviewed by the SERB and also referred the cases to the Pima County Attorney’s Office for its independent decision on whether to pursue criminal charges against the officers involved.

<sup>3</sup> Due to ongoing investigations into the incidents, the SERB was unable to speak directly with the officers involved. In addition, three of the officers involved had resigned from the TPD rather than going through the process of being terminated due to their actions.

provided by John Hollway from the Quattrone Center at the University of Pennsylvania Carey Law School and Michael Scott from the Center for Problem-Oriented Policing at Arizona State University.

The members of the SERB value all human life. We acknowledge the history of the policing of communities of color at a national and local level and the associated historical trauma caused by systemic racism, evidenced by instances of police violence. This is not to accuse any individual TPD, PSCD, or TFD representative of being explicitly racist, but to point out that they are acting within structures that reflect a racist history. In this context, we agreed to make an assumption of the presence of systemic racism rather than debate its existence. Because of the trauma caused by two in-custody deaths and the controversy in the aftermath surrounding the handling of the deaths, members of the SERB felt it was important to step outside the norm in issuing these reports by adding this statement. A diverse cross section of community sectors was represented on the SERB with membership from TPD, subject matter experts, community leaders, and representation from the impacted communities of color.

This was a difficult and necessary process. The complexities and challenges are attributed to capturing the urgency of current events compounded by the pain and justified mistrust of law enforcement by communities of color.

To take meaningful steps towards healing and building trust, members of the SERB led conversations about the role of race and equity in the context of the sentinel event review.<sup>4</sup> Members took part in self assessments on cultural proficiency and learned from subject matter experts.<sup>5</sup> Doing so strengthened the capacity of the board to make actionable recommendations to the police department. Additional such conversations between TPD, TFD, PSCD, and the community will enhance our community's progress on these important issues.

The SERB membership will work with these departments to collectively monitor and ensure that the final SERB recommendations are implemented to the extent possible.

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<sup>4</sup> See Appendix G for "An Introduction to Equity Work" PowerPoint slides presented by a SERB member as part of these conversations.

<sup>5</sup> See Appendix H for results from the cultural proficiency self-assessment taken by SERB members.

## Chronology and Fact Patterns

### In-Custody Death of Mr. Damien Alvarado, March 22, 2020

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On March 22, 2020, at approximately 1715 hours,<sup>6</sup> Damien Alvarado (the “decedent”), a 29-year-old male, fled on foot after being involved in a serious hit and run crash at East Prince Road and North Campbell Avenue. The decedent matched the description of a suspect in a shooting that had occurred nearby a short time earlier. Two witnesses at the scene of the crash (a 42-year-old man and his 18-year-old son) saw the decedent flee into the neighborhood. They followed him and located him in the rear of a parking lot at 1990 E. Prince Rd. The father stayed with the decedent as he sent his son to get the police.

The father was speaking with the decedent when the first TPD officer arrived at the scene, at approximately 1740 hours.<sup>7</sup> Upon the appearance of the TPD officer, the decedent attempted to flee by climbing over a wall at the back of the parking lot. The father attempted to physically stop the decedent’s departure by grabbing hold of his legs and was joined by his son and the TPD officer. After a brief struggle, the three adult men fell to the ground. The decedent violently resisted arrest and dislodged a magazine from the officer’s duty belt. The TPD officer was able to separate himself and the decedent from the father and son. The officer attempted to subdue the decedent through multiple ways, beginning with physical restraint, then escalating to fist strikes. The officer deployed his Taser twice, but it had no noticeable effect on the decedent other than the decedent’s statement, “Stop tasing me, bro.” The officer later described the encounter as one of the worst fights he’d been in.

The father who had been assisting the officer, exhausted by the exertion, dropped out of the struggle and started vomiting or dry-heaving due to exhaustion. The fight continued as two more TPD officers arrived. Even with three TPD officers trying to restrain the decedent, the subject was able to fight and push himself up into a hands-and-knees position. The decedent refused to submit to arrest or go down to the ground, and his strength and violence was such that these three officers were unable to immediately place him into handcuffs. He continued to push the officers off him, and repeatedly tried to stand up.

A fourth TPD officer, who had run from the crash scene to the fight location, joined in the struggle to take the decedent into custody. The first officer, noticing that the father had disengaged and seemed to be vomiting, got on the radio and requested TFD EMS to respond and to check on the two witnesses first, then attend to the suspect, while continuing to try to subdue the decedent, who continued to fight and refused to submit his arm so he could be handcuffed.

After almost five minutes of fighting, the officers were finally able to handcuff the decedent as additional TPD officers arrived on the scene. Even while handcuffed, the decedent continued to resist, trying to buck the officers off of him. One of the officers can be heard saying “Don’t

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<sup>6</sup> Times are given in 24-hour time.

<sup>7</sup> The body-worn camera footage of this incident can be found at [https://www.youtube.com/watch?v=Dn5K5FqphL8&feature=youtu.be&has\\_verified=1](https://www.youtube.com/watch?v=Dn5K5FqphL8&feature=youtu.be&has_verified=1). Please note that this video contains graphic content.



f\*\*\*\*\*g bite me, man!” to the decedent.

One of the TPD officers, a defensive tactics specialist, told the others of the need to place the decedent on his side as soon as it was practical. The officers used a Total Appendage Restraint Procedure (“TARP”) restraint tool on the decedent, which simultaneously secured the decedent’s arms and legs with belting and cuffs, connecting the handcuffs fastened behind the decedent’s back to a hobble restraint device that secures the ankles. The officers turned the decedent on his side into what is known as the “recovery position.” TPD officers also placed a “spit sock” over the decedent’s head. A spit sock is a translucent bag that can be placed over an individual’s head to prevent spittle, blood, or other fluids from getting on officers. The device is designed to allow the individual wearing it to see through it and be seen by officers, without constricting the individual’s airway.

Throughout this time, the decedent was yelling such things as “Don’t touch me! Get away! I don’t like this!” One officer encouraged the decedent to breathe as the decedent continued to yell, while another used his feet to support the decedent’s head to ensure that he did not roll back onto his stomach, a position known to contribute to difficulty breathing while individuals are in restraints.

While the TPD officers waited for EMS to respond, they continued speaking with the decedent. When the suspect said he couldn’t breathe, one officer replied to him, “You can breathe just fine. Shut your f\*\*\*\*\*g mouth.” Another officer said, “You can breathe just fine.” The decedent called the officers “devils” and could clearly be heard breathing.

The officers continued to monitor the decedent, and mentioned the need to “TARP him properly,” referring to the fact that the device was hastily applied during the struggle. The officers did not deem this viable given the decedent’s continued resistance, though they did relax the handcuffs to make them fit properly as they were initially too tight. One of the officers requested a supervisor for the Taser and TARP deployment, as required by department policy, and advised they had restrained the decedent. The decedent continued to claim he couldn’t breathe, and officers again replied, “You’re talking. You can breathe just fine.”

TFD EMS personnel arrived and offered to evaluate the father and son, who declined medical assessments. They then turned to evaluate the decedent. EMS personnel also applied a second spit sock of a slightly different design. At approximately 1755 hours, TFD EMS asked the decedent if he had any injuries and the decedent said he did not. TFD EMS personnel took the decedent’s vital signs, which were elevated but not beyond levels that would have been expected for an individual who had just been in a physical altercation. The medics reported some difficulty obtaining all vital signs in strict accordance with recommended practice due to the decedent’s struggling.

At approximately 1805 hours, the TFD EMS personnel began to leave, with the decedent being maintained in the recovery position (on his side) by TPD officers who discussed taking the decedent to jail. At approximately 1807, as the TFD EMS personnel neared the other side of the parking area, TPD officers noted that the decedent was unresponsive and called for EMS to return (which happened within approximately 60 seconds). In the meantime, a TPD officer began compression-only CPR on the decedent. TFD returned and, after the restraints were removed from the decedent (which took about 98 seconds), took over the attempts to revive the

decedent, and the decedent left in an ambulance at 1811. Efforts to revive him were unsuccessful.

The officers who had subdued the decedent remarked upon the decedent's "superhuman" strength and speculated that drug use might have fueled his resistance. The autopsy completed by the Office of the Medical Examiner (OME) ascribed the cause of death to "sudden cardiac arrest in the setting of acute methamphetamine intoxication and restraint with dilated cardiomyopathy as a significant contributing condition."<sup>8</sup>

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<sup>8</sup> Cardiomyopathy is a disease of the heart muscle that makes it more difficult for the heart to pump blood. <https://www.mayoclinic.org/diseases-conditions/cardiomyopathy/symptoms-causes/syc-20370709>.

## In-Custody Death of Mr. Carlos Adrian Ingram-Lopez, April 21, 2020

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On April 21, 2020, at approximately 0114 hours, officers from TPD Operations Division East were dispatched to 2111 S. Doral concerning a call labeled “unknown trouble” by the 911 call-taker. The decedent, according to the caller, was drunk and nude; yelling could be heard in the background throughout the call and the caller’s ability to speak to and respond to the call-taker’s questions was interrupted periodically by the caller’s attempts to speak to the decedent and to get out of the house, which she said the decedent was preventing her from doing.

The caller was the grandmother of the decedent and was a native Spanish speaker who spoke to the call-taker in a combination of Spanish and broken English. The 911 operator did not speak Spanish and seemed to have difficulty understanding the grandmother at multiple points on the phone call, at times even when the grandmother spoke in English. While there was a Spanish-speaking operator on duty at the time, that operator was actively engaged in another call and was unable to assist. In addition, the call-taker had the option to place the caller on hold and connect to a “language line” that provides real-time translation, but because the essential information necessary to dispatch officers to the scene was obtained, the language line was not deemed necessary, a decision later supported by supervisors. While the grandmother stated six times during the call that drugs were responsible for the decedent’s erratic and unpredictable behavior, this information was not explicitly communicated to the responding police officers by the dispatch operator. The grandmother also mentioned that her grandson had come to stay with her because his wife would not let him stay at her house.

While en route to the location, responding TPD officers were provided updated information regarding the incident by dispatchers. Through an “open line” that allowed them to hear some of the dialogue between the caller and her grandson, the 911 operator was successful in keeping the caller on the line for over 11 minutes. During that time, the operator attempted to gather additional information, and made 14 inquiries about what was going on in the house. The language barrier prevented clear communication and the dispatcher did not ask additional specific questions that might have helped responding officers assess the potential risks of the situation, such as whether other occupants were in the house, whether weapons were in the house, or specifics about the nature of the decedent’s behavior and whether he was being violent towards others. The dispatcher did run the decedent’s name through existing records and notified the responding officers that the decedent had a “stop and arrest” order outstanding for a recently reported domestic violence incident.

Three TPD officers, including one Lead Police Officer (“LPO”), arrived at the scene at approximately 0120 hours.<sup>9</sup> They immediately approached the house together. As they did, an older woman came out from a gated courtyard into the front yard to meet them, and the officers glimpsed another person retreating from them and entering a separate garage next to the house through a side door. (The front garage door was closed and did not offer an available entrance or exit.)

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<sup>9</sup> The body-worn camera footage of this incident can be found <https://www.youtube.com/watch?v=kYrxl7o2yHc>. Please note that this video contains graphic content.

The officers ran past the woman (the grandmother who had placed the 911 call) and within seconds had entered the garage, a one-car garage with a red Ford Mustang parked inside. The decedent was nude and standing on the far side of the car from the side door, near the front door of the garage. Officers entered aggressively with commands to "get on the ground," which the decedent immediately did while saying "I'm sorry!"

Despite the fact that the man was nude and had lain down on the ground, the three officers, reportedly concerned about the close quarters and aware that the man was large, used their body weight to restrain him. They stated that he was resistant to their efforts to put him in handcuffs with his hands behind his back. The handcuffing process lasted approximately one minute, with the TPD officers using only control-hold techniques. No weapons were recorded as having been used. The limited space available in the garage and the decedent's large size, however, made handcuffing difficult. Ultimately, two sets of handcuffs were used, with one set on each wrist and the two sets interlocking behind decedent's back.

The decedent never verbally or physically threatened the officers but continued to move his body about while being held on the garage floor. The officers continued to use physical restraint to hold the decedent down and still. One officer used his knees and hand(s) against the decedent's upper back to control and hold the decedent's torso to the garage floor, while another officer used his body weight and hands to control the decedent's legs.

Throughout the incident the decedent repeatedly asked for water<sup>10</sup> and at one point advised, "Oh s\*\*t; I can't breathe." One officer disengaged from the situation to speak with the caller/grandmother, and to try to open the front garage door to allow the officers more room to maneuver. He also conducted a search of Mr. Ingram-Lopez's property and the bedroom in which he was staying that revealed an indeterminate white powder in his bathroom that was later collected for testing.

While still holding the decedent down on his stomach, the remaining two officers requested that an emergency blanket be provided. One of the officers explained later that this was done so that when the garage door was opened, the man's nudity would not be visible to anyone who happened to be outside and to prevent the decedent's bodily fluids from contacting the officers.

Upon manually opening the roll-up garage door, an officer gave directions to move a police vehicle closer to the garage entrance. The officers intended to lay the decedent down in the backseat during the transport to jail. This first vehicle was outfitted with two (2) separate bucket seats in the back. The officers decided this was not the best option to lay someone down in and requested a vehicle with bench seats. While they waited for the appropriate police vehicle, the officers, who wore latex gloves throughout, placed two emergency blankets over the decedent's body, one over his torso and one covering his head. In addition to the emergency blankets, a spit sock was placed on the decedent's head after the decedent began making coughing or gurgling sounds, like clearing his throat/airway, according to the accounts of the officers involved.

Approximately thirteen minutes after TPD's initial arrival on the scene, a supervising sergeant

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<sup>10</sup> The decedent requested water no fewer than 21 times while being restrained on the floor of the garage.

arrived at the scene. The sergeant observed two officers continuing to restrain the decedent, who was lying on his stomach. One officer had his knee on the decedent's back, while the other continued to hold the decedent's legs. The decedent was not moving or making any sounds. A short time later, an additional Officer took over physical control from the LPO and asked the officers, "shouldn't we have him in the recovery position (positioning a subject on their side)."

As officers repositioned the decedent, they observed that he was unresponsive to voice commands and appeared to be unconscious. The TFD was requested for medical assistance. According to the LPO's BWC, there is a one-minute interval between the last time the decedent was heard making a vocalization and the first time the sergeant inquires whether the decedent is breathing. After another 30 seconds, during which the officers try to get the decedent to respond to shouts and shaking, they radioed for EMS. At this time, the decedent had been in a prone position, handcuffed behind his back, with officers intermittently applying pressure to his torso and legs for approximately twelve minutes.

Numerous medical interventions were applied by the officers prior to TFD arrival, including administering two doses of Naloxone (Narcan) along with compression-only CPR. Mr. Ingram-Lopez was declared deceased at 0206 hours.

## OPS Investigation and Public Notification

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At approximately 0300 on April 21, immediately following the in-custody death of Mr. Carlos Adrian Ingram-Lopez, the TPD Office of Professional Standards (OPS) began an investigation into the events culminating in the death. The officers involved in the incident exercised their right to remain silent in the criminal investigation, and two sergeants in OPS conducted administrative interviews of the officer participants the following day.<sup>11</sup>

Prior to conducting the interviews, the two sergeants – one a three-year veteran of OPS, the other a relatively new addition to the team – reviewed the BWC footage available from the incident. All the officers had kept their BWCs recording throughout the incident. Both Sergeants were deeply disturbed by the events in the videos, with one later calling it “one of the worst videos I’ve ever seen.”

Due to COVID-19, investigative staff were put on alternating work schedules to minimize COVID-19 exposure to entire units. Thus, there was reduced interaction among members of OPS, who typically analyze such videos as a group. What interaction occurred was often done via video conference, specifically Slack, Zoom and Microsoft Teams (“MS Teams”). The comfort level that officers had with these technologies varied. In addition, the assistant chief who oversaw OPS was also assisting with coordinating the TPD response to COVID-19, and his added responsibilities were in conflict with regular scheduled meetings of the OPS office. As a result, the unit’s lieutenant, who had been the head of OPS for one year, was operating with greater management responsibility and less oversight than she had prior to the outbreak.

Despite these challenges, the lieutenant was in regular contact with both subordinates (the sergeants who were leading the OPS investigation into Mr. Ingram-Lopez’s death), and her superior (the assistant chief). The OPS sergeants’ and lieutenant’s initial appraisal of the events lacked consensus. The case sergeant and lieutenant felt the case investigation had issues with operational momentum, lack of incident command, care of Mr. Ingram-Lopez (failure to place him in a recovery position sooner), and inexperienced personnel. In the initial stages of the investigation, both the sergeant and the lieutenant felt that the facts of the investigation highlighted re-training opportunities, and that further discipline might not be necessary pending further review of the incident. The secondary case sergeant agreed the personnel would need re-training but also felt strongly that the personnel’s actions would also result in General Order violations that merited strong discipline.

The lieutenant reported to the assistant chief late on the morning of April 21 that she interpreted the officers’ actions as mere training violations that could be remedied with additional training. She reiterated this view after watching the BWC footage. She also mentioned that the presence of a white powder at the scene suggested to her that the decedent had ingested a drug and was not of sound mind during the events in question.

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<sup>11</sup> As described in the introduction, officers have a constitutional right not to respond to questions that could be used against them in a criminal proceeding but must answer administrative review questions asked by others within TPD. The administrative interviews may not be used in a criminal proceeding. The invocation of the right against self-incrimination is not an admission of guilt or misconduct.

On April 23, 2020, the lieutenant briefed the chief of police and members of his Executive Leadership Team (ELT) on the Ingram-Lopez case. The lieutenant did not invite the sergeants leading the investigation to participate in this meeting, expressing her opinion that she could adequately recount the facts of the case. The meeting was held on MS Teams, and at the time, the lieutenant was using her department cell phone to participate in the meeting. Both because of her perception of the incident's severity and because of the challenge of showing a video on Teams using her phone (agency training on the new software was ongoing, and she had not received the training yet), the lieutenant described the events leading up to the death verbally but did not show any of the BWC footage of the incident during the meeting.

The lieutenant had previously indicated to the lead sergeant that she did not plan to show the video to the ELT. The sergeant was not comfortable with this decision, but as a new member of OPS (<1-year tenure) and because he and the lieutenant were not physically in the office together, the sergeant decided not to further question his superior's decision. The sergeant did discuss the matter with a peer, who agreed with his assessment but reminded him that "it's [the lieutenant's] call."

After the April 23, 2020 ELT briefing, the officers involved in the events leading to the decedent's death were returned to regular duty, and the TPD administrative investigation remained paused to await both the results of an autopsy conducted on the decedent and the results of the criminal investigation.<sup>12</sup>

On May 25, 2020, George Floyd was killed while in the custody of Minneapolis police officers. Many people around the nation and in Tucson reacted to his death with large-scale protests calling for police reform and an end to systemic racism in policing. Tucson specifically experienced several nights of protest in the days and weeks following (and protests persist as of this writing).

On June 11, 2020, the autopsy report was received from the OME. It ascribed the cause of death to "sudden cardiac arrest in the setting of acute cocaine intoxication and physical restraint with cardiac left ventricular hypertrophy as a significant contributing condition."<sup>13</sup> The manner of death was undetermined.

A criminal briefing of the case closure<sup>14</sup> was held on June 12, 2020 with the deputy chief and two assistant chiefs. The briefing elevated the case profile and expedited the administrative case update for the chief of police. On June 15, 2020, the assistant chief scheduled a second briefing to discuss the case with the chief of police. The assistant chief held a pre-briefing with OPS staff, including the lieutenant and the investigating sergeants, during which he watched the BWC for the first time.

Several hours later, the Field Services Bureau chief, deputy chief and chief of police were briefed, and they too watched the BWC video for the first time. The ELT unanimously expressed

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<sup>12</sup> As of this writing, the criminal investigation is ongoing.

<sup>13</sup> Left ventricular hypertrophy is enlargement and thickening (hypertrophy) of the walls of your heart's main pumping chamber (left ventricle). <https://www.mayoclinic.org/diseases-conditions/left-ventricular-hypertrophy/symptoms-causes/syc-20374314>.

<sup>14</sup> This is a standard step in the case prior to its delivery to the County Attorney's Office.

alarm at the events in the video, and they took immediate action. The officers involved in the event were placed on administrative leave by the chief of police after the briefing concluded, and three of the six officers investigated would formally submit their resignations on June 18, 2020.

The OPS investigation of the in-custody death was re-assigned to staff outside OPS for completion. All OPS staff involved in the investigation, including the assistant chief, became themselves focus of a new internal investigation into these matters, and were removed from the internal investigation of the Ingram-Lopez case pending a decision from the chief of police on how the internal review into the OPS handling of the case would be resolved. The new investigative team began its portion of the investigation on June 16, 2020 and on June 23, 2020, the investigative findings were submitted to the chief of police for review.

On June 24, 2020, the chief of police met with the family of the decedent just prior to a scheduled press conference to release case information to the community. During the press conference the chief stated that the department had taken steps to make sure that, going forward, any in-custody death will immediately be brought to the public's attention. The chief further announced a new policy, effective immediately, that requires at least two chiefs to review BWC video from any in-custody deaths within 48 hours of the event. The chief offered to resign his position while discussing both the death and the failure of the TPD to promptly notify the community of the investigation and related BWC video. The chief's offer to resign was ultimately declined by the city manager. That same day, the lieutenant who had been in charge of OPS was re-assigned to a temporary assignment pending resolution of the ongoing investigation.

On June 26, 2020, the chief sent the mayor and city council an email furthering his commitment to city leadership that the agency would have two chiefs review footage from all in-custody deaths within 48 hours and also an updated agency policy to release BWC video within 72 hours (barring legal considerations).

On June 28, 2020, the ELT placed a captain to lead the OPS in addition to the existing lieutenant role, providing additional supervisory oversight and enabling the lieutenant more time to supervise investigations. An interim captain and lieutenant were assigned to OPS.

On July 28, 2020, the investigative findings of the case were finalized, and presented to the chief of police. The review resulted in significant discipline for both the OPS lieutenant and assistant chief (the final discipline cannot be discussed pending the officers' service and contractually provided grievance period).



## Contributing Factors and Recommendations

### Summary

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The SERB evaluated these cases as if there were three sentinel events: (1) the in-custody death of Mr. Alvarado; (2) the in-custody death of Mr. Ingram-Lopez; and (3) the failure of TPD to disclose the death of Mr. Ingram-Lopez in an appropriate fashion to the Tucson public. We reviewed each of these events separately to identify the various factors that contributed to their occurrence and strove to propose recommendations that will prevent their recurrence in the future.

While there are many ways in which the Alvarado and Ingram-Lopez cases differ, there are many ways in which they are similar:

- Each case involves the response of multiple TPD officers to an emergency call placed by a member of the community to the Tucson Public Safety Communications Department by calling 911. In these cases, a call-taker receives information from an individual who calls 911. The call-taker relays that information to a dispatcher, who provides the responding police officers with information about the incident. Both PSCD employees are essential to helping the responding officers in planning their approach to the call.
- In each of these cases, TPD officers were responding to calls in which a Latino male is the principal suspect, raising concerns among some members of the SERB that implicit racial bias and systemic racism might have influenced the response by TPD officers, PSCD personnel, or TFD EMS throughout each event.
- Both events involved male suspects who had recently ingested stimulants – methamphetamine in the case of Mr. Alvarado, and cocaine in the case of Mr. Ingram-Lopez – though the officers were only aware of the potential intoxication in advance in the case of Mr. Ingram-Lopez. These stimulants had an impact on the behavior of the decedents and increased their risk of cardiac arrest.
- Both cases involved an individual who had an outstanding warrant for his arrest on domestic violence charges, though again this was not known to the responding officers in Mr. Alvarado's case at the time of his detainment.
- In both cases, the responding officers had taken appropriate training classes in areas pertinent to these incidents, including: de-escalation, respiratory distress, restraint, use of force, and risk factors for excited delirium.<sup>15</sup> In addition, at least one TPD officer active in each incident was trained and certified as an Emergency Medical Technician (EMT).
- Finally, both cases occurred after the COVID-19 pandemic arrived in Tucson; in this environment, officers were reasonably concerned about infection via bodily fluids and respiration of others in close physical proximity. While understanding that members of TPD and TFD would want to protect themselves and others from the potential transmission of bodily fluids – particularly during the COVID-19 pandemic - members of the SERB also found it interesting that a spit sock was used in both cases.

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<sup>15</sup> For a more detailed definition of excited delirium, see below p. 24

Given the overlap in these cases, many of the contributing factors and recommendations made by the SERB applied to both cases, and we set them forth below. We provide a visual representation of how the various factors contributed to the tragedies in the “fishbone” diagrams below.

### In-Custody Death of Mr. Alvarado – Contributing Factors

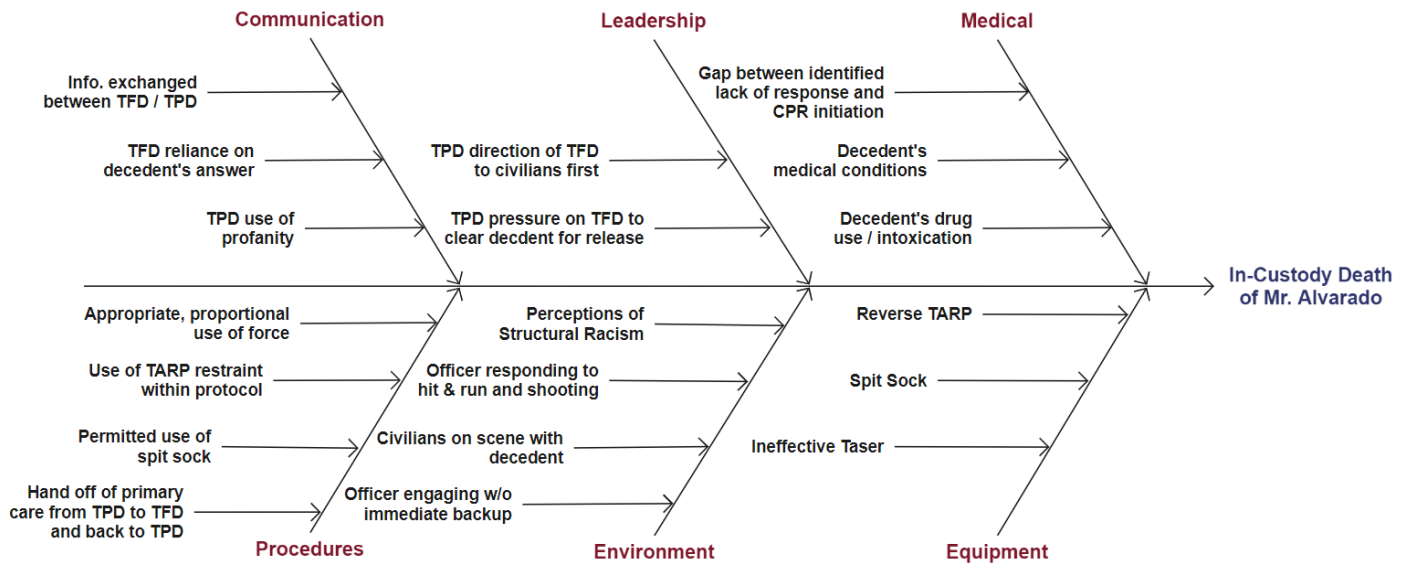


Figure 1. "Fishbone" Diagram: Contributing Factors in Alvarado Case

### In-Custody Death of Mr. Ingram-Lopez – Contributing Factors

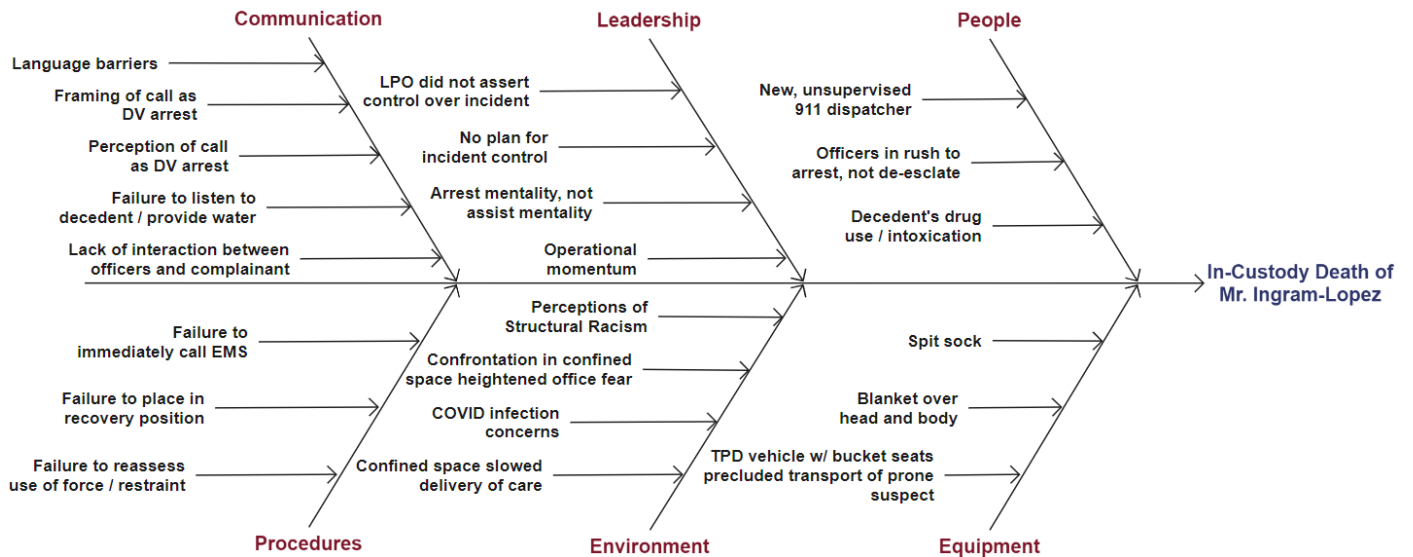


Figure 2. "Fishbone" Diagram: Contributing Factors in Ingram-Lopez Case

## Failure to Notify – Contributing Factors

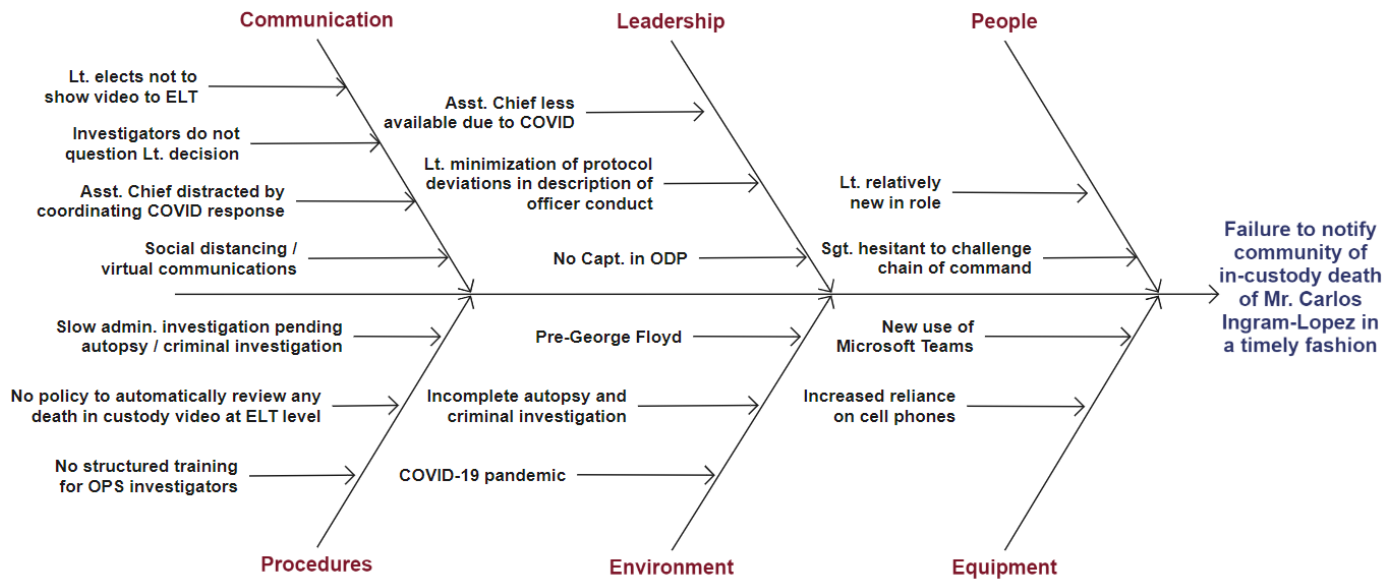


Figure 3. "Fishbone" Diagram: Contributing Factors for Failure to Release Ingram-Lopez Video

## Section A: Contributing Factors: Approaching the Scene

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This section addresses the contributing factors and recommendations relevant to actions taken prior to the initiation of engagement between TPD officers and Mr. Alvarado and Mr. Ingram-Lopez.

Emergency dispatch and 911 operators have a significant role in how TPD officers respond to engagements with complainants, witnesses, suspects, victims, and bystanders. They provide most of the information that officers use to plan their approach to the interaction. In the Alvarado case, dispatchers informed the responding officers that the individual could be connected to a shooting and that community members were engaging with him after he had fled the scene of a hit-and-run. This information was instrumental in the officer's deliberate decision to engage as rapidly as possible and without immediate backup. Given the specific geography of the area where the encounter with Alvarado occurred, there was no way for the first officer on the scene to avoid being seen in his approach. Upon the officer's arrival, the decedent attempted to flee, setting next steps in motion.

In the Ingram-Lopez case, the dispatcher's ability to provide a complete picture of events to the responding officers was significantly limited by the call-taker's inability to understand spoken Spanish or to transfer the call to someone who could translate. The inability of a PSCD call-taker to effectively communicate with a Spanish-speaker, and of the dispatch office to ensure that a Spanish speaker was available to take the call is problematic given the substantial Spanish-speaking population in Tucson.<sup>16</sup> While there may be benign explanations for these challenges, such errors underscore community observations of systemic racism and should be immediately addressed.<sup>17</sup>

While the grandmother repeatedly told the call-taker in both Spanish and broken English that her grandson was "on drugs" and had "no clothes," this precise information was not conveyed to the responding officers. Instead, they were advised that the grandson might be "10-41," which is defined as being "drunk."<sup>18</sup> This signal code might not have conveyed an accurate picture of the situation to the officers. Even if it had been understood by TPD officers to mean "intoxicated" more broadly, had officers known the combination of factors—that the grandson was naked; likely high on drugs; acting paranoid, delusional, and in a highly agitated manner, they might well have identified this call as having an increased health risk to the individual, and responded more cautiously than they did.<sup>19</sup> The call-taker was unable to gather specifics on what precisely was causing the caller to need assistance and thus could not determine if only

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<sup>16</sup> According to the 2018 Census, nearly 30% of Tucson residents speak Spanish.

<https://data.census.gov/cedsci/table?tid=ACSST5Y2018.S1601&g=1600000US477000>

<sup>17</sup> It was mentioned during our meetings that increasing the number of Spanish speakers at PSCD would require increased funding. The SERB is not in a position to be able to judge how public money should be spent or what additional funding is necessary. We limit ourselves to pointing out that if Mr. Ingram-Lopez's grandmother had reached a Spanish-speaking call-taker, the outcome of his interaction with TPD might have been dramatically improved.

<sup>18</sup> <https://www.tucsonaz.gov/police/radio-codes>

<sup>19</sup> Consider, for example, the difference between the operator reporting the situation as "10-41" as opposed to "10-41 and naked" and how that might change the approach by a TPD officer.

*police* assistance was needed or if medical and/or psychiatric assistance would also be warranted. This, coupled with an outstanding domestic violence arrest order for the decedent, gave officers a very particularized view of the situation upon arrival.

The inability of the call-taker, who had been on the job for three months, to effectively communicate with the grandmother led the dispatcher to classify the call as “unknown trouble” as opposed to something that more precisely communicated that this was a domestic dispute involving a person in a drug-induced and highly agitated state of mind. Furthermore, her communication of the outstanding DV warrant<sup>20</sup> in Mr. Ingram-Lopez’s name without providing additional information about *this* instance – other occupants, the existence (or lack thereof) of weapons, or the use of violence – may have colored the impressions of the responding officers, whose focus appeared to be arresting a wanted man rather than de-escalating a confrontation with a man having a drug-induced mental health crisis. This does not absolve the officers involved from the expectation to independently evaluate the situation upon arriving at the scene, leading to the realization that this was a person exhibiting signs of mental and/or physical distress (i.e., no clothes, delusional, etc.). It may explain, at least in part, why their initial mindset prioritized apprehension instead of medical care for Mr. Ingram-Lopez. TPD training on dealing with persons in states of excited delirium and other situations in which subjects’ medical condition is at issue makes clear that criminal arrest considerations should be secondary to medical considerations.

#### *A Note on Implicit Bias*

Community participants in the SERB expressed concern that implicit bias could have contributed to the speed with which TPD officers moved to impose control over the situation, and their willingness to use physical force rather than a more measured approach, particularly in the Ingram-Lopez case. By its very definition, implicit bias is not something that exists in the conscious thoughts of an individual, and therefore it is impossible to prove conclusively. At the same time, recent studies<sup>21</sup> indicate that gathering additional specifics can transform a call of “suspicious activity” that may trigger implicit biases, into a better understood situation that helps police respond more appropriately.

How might this be reflected in a dispatcher’s response to a 911 call? Each of the officers’ administrative interviews reflected their awareness of the DV warrant in the Ingram-Lopez incident, and its prominence in their mind as they approached the scene. The chart below shows the different questions that a call-taker is trained to ask if the situation is classified as “unknown trouble” rather than “domestic violence.” It is important to note the challenges of gathering detailed information in the midst of an emergency call, including high emotions, time pressure, lack of awareness of certain factors by the caller, and other issues, and also important to note that the 911 operator in this case kept the grandmother on the line for quite a while and

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<sup>20</sup> The Board recognized that the PSCD operator would be negligent not to inform responding officers that an arrest warrant existed, and that the burden will remain with the officers to decide what is most important once they arrive.

<sup>21</sup> See, e.g., Gillooly, Jessica W. "How 911 callers and call-takers impact police encounters with the public: The case of the Henry Louis Gates Jr. arrest." *Criminology & Public Policy* (2020), <https://doi.org/10.1111/1745-9133.12508>.

continued probing for information, both useful actions. When looking for opportunities for improvement, we can consider the additional information that could have been provided to the TPD officers responding to the grandmother's 911 call if the call-taker had been prompted to ask the questions in the column on the right, and how it might have allowed officers to confidently approach the scene more slowly and calmly without safety concerns.<sup>22</sup>

	Unknown Trouble	DV/Fights
911 Calls	Level 2 911-UNKTRB- Unknown Trouble	Level 1 DV-WEAPONS- DV Weapons Involved FIGHT-WEAPONS- Fight Weapons Involved
Call Text	<ul style="list-style-type: none"> <li>What was heard?</li> <li>Any indications of trouble or distress?</li> </ul>	<ul style="list-style-type: none"> <li>What is happening (physical/verbal?)</li> <li>Are there any weapons involved? If so, what is being used?</li> <li>How many people involved?</li> <li>What is the relationship of the involved parties?</li> <li>Suspect description/behavior</li> <li>Victim description/behavior</li> <li>Is there a court order in place?</li> <li>Children present?</li> <li>Where is it happening? (Inside/Outside/Vehicle?)</li> <li>If in a vehicle, what's the vehicle description?</li> <li>What direction of travel if GOA?</li> <li>Are there any injuries?</li> <li>Is medical attention needed?</li> <li>How long ago did the event occur?</li> </ul>
Pre-Arrival	<ul style="list-style-type: none"> <li>Stay on the line if you're hearing arguing, fighting, signs of a struggle/distress.</li> </ul>	<ul style="list-style-type: none"> <li>Advise caller to separate themselves from the situation, if not the victim.</li> <li>Stay on the line with caller if the situation is active.</li> <li>Secure any potentially aggressive pets.</li> <li>Check history and premise information.</li> <li>Call back with any updates/changes.</li> <li>Secure weapons when officer(s) arrive.</li> </ul>
Short Report	<ul style="list-style-type: none"> <li>Who is the reporting party and how are they related to the incident?</li> <li>What are they reporting?</li> <li>Where did the incident take place?</li> <li>When did the incident occur?</li> <li>Any weapons?</li> <li>Any injuries?</li> </ul>	<ul style="list-style-type: none"> <li>Who is the reporting party and how are they related to the incident?</li> <li>What are they reporting?</li> <li>Where did the incident take place?</li> <li>When did the incident occur?</li> <li>Any weapons?</li> <li>Any injuries?</li> </ul>

Of course, it is necessary and important for dispatchers to notify police of existing warrants for a

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<sup>22</sup> This would not solve the language barrier that existed in this incident, but it seems likely that it would result in supplying officers with more information prior to entering a situation, if not a complete picture.

suspect's arrest, and of factors that might impact officer safety. In this case, however, the dispatcher informed the officers only of the DV warrant; since the case was labeled "unknown trouble," additional questions were not asked that might have served as a counterweight to de-escalate the initial officer response upon arriving at the scene.

A real-world example of the use of additional clarifying questions to combat implicit bias was identified by Stanford psychologist Jennifer Eberhard and deployed by the consumer task-sharing and notification app NextDoor. Additional information is set forth in Appendix F.

The officers then further contributed to the escalation of the event by failing to pause and coordinate an approach to Mr. Ingram-Lopez and his grandmother. The failure of the officers to engage with Mr. Ingram-Lopez's grandmother, who initiated the 911 call and who came out of her house to meet the officers, was viewed by many members of the SERB as an example of implicit anti-Latina bias. This included the officers running past her without acknowledgement at the outset of the incident, not providing the water she brought to Mr. Ingram-Lopez, and their conduct towards her throughout the incident. Interacting with the grandmother, who was both the homeowner and the most knowledgeable person on the scene about what was happening, would have required only a few seconds to remind the officers of their primary purpose – secure the scene and return normalcy before deciding what administrative, custodial, or medical care acts were needed – before engaging with the grandmother or the decedent. It also would have clarified the LPO role and created clear lines of responsibility for overseeing the interaction for all of the responding officers. In its absence, the officers were acting with the belief that they could figure out those responsibilities as the situation unfolded, creating confusion and inattention due to the lack of clear leadership.

Such immediate and reflexive sweeps into action are known to police as "operational momentum," and in this case led to officers rushing into the garage to aggressively restrain Mr. Ingram-Lopez rather than talking to the grandmother, assessing the situation, and trying to persuade Mr. Ingram-Lopez to come out of the garage into a larger space where the three officers could address the situation more calmly. By rushing into the garage, the officers created a situation in which they were forced to confront Mr. Ingram-Lopez in close quarters, which heightened their sense of danger, both because of Mr. Ingram-Lopez's size and (initially) due to fears that he was going into the garage to obtain a weapon while out of the officers' sight. This sudden and aggressive response by officers and their rush to immediately take him to the ground and restrain him likewise seems to have elevated Mr. Ingram-Lopez's fear that something harmful was happening to him, rather than that people were there to help him.



## Section A: Contributing Factors and Recommendations

- A - 1 **CONTRIBUTING FACTOR:** Inability of 911 call-taker to effectively communicate with caller due to language barrier.

**RECOMMENDATION:** Ensure all 911 call-takers speak conversational Spanish, or at least have Spanish interpretation instantly available within PSCD. Additionally, establish an advanced language line to serve the large populations of foreign-language speakers in Tucson.<sup>23</sup>

*Implementation: PSCD*

**RECOMMENDATION:** In the event that the call-taker and the caller have a language barrier, provide multiple language translation cards to assist the dispatcher in asking yes/no questions to gather additional useful information.

*Implementation: PSCD*

- A - 2 **CONTRIBUTING FACTOR:** Lack of gathering information from caller during 911 call and lack of transmitting information to responding officers, including:
- Information about other individuals and/or weapons at the scene of the incident.
  - Information regarding the drug-induced state of the subject of the call.

**RECOMMENDATION:** Review communication procedures and develop a more robust list of questions for operators to ask callers. Specifically:

- Solicit specific information about weapons, violence, other occupants in home, etc. in “Unknown trouble” 911 calls to guide officers on perceived threat/safety level of situation.
- Ensure drug ingestion/use questions are asked on most calls and that information is relayed to officers.
- Include information on what signs and/or circumstances warrant launching Crisis Intervention Team (“CIT”) personnel with enhanced training in mental or behavioral health situations. Train all PSCD call-takers in recognizing and communicating potential mental or behavioral health issues to responders.<sup>24</sup>
- Document a list of support resources that dispatchers can consult and outsource calls to other than TPD.

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<sup>23</sup> Spanish speakers on staff is both the most predictable need and the need that might have contributed to a better outcome in the Ingram-Lopez case. Members of the SERB pointed out, however, that other languages would also be helpful given the demographics and diversity of Tucson.

<sup>24</sup> The SERB membership was composed mostly of non-clinical personnel and did not want to be overly prescriptive on what exactly such training should include. One suggestion was additional training on pathognomic words and phrases – that is, words that are sufficiently associated with specific conditions that they are clinical “flags.” An example of this is when a patient says he or she has “the worst headache of my life,” clinicians are trained to treat the individual for a brain hemorrhage until proven otherwise. “Naked and agitated” suggests drug use, and thus an increase in risk factors for excited delirium. Educating police on such words and phrases can provide a useful shorthand that improves health outcomes in police interactions with community members.

- Collaborate among these resources and TPD for cases where both social services and safety issues are involved.
- This an area that requires further discussion and elaboration and may take form through an expansion of TFD's TC3 program or through the Community Safety Pilot Program currently being discussed by Mayor & Council, to name a few ideas.

*Implementation: PSCD, TPD, TFD, and potentially several other City of Tucson Departments and community agencies*

- A - 3** **CONTRIBUTING FACTOR:** Failure of call-taker to identify the Ingram-Lopez call as a behavioral health crisis rather than a law enforcement emergency.

**RECOMMENDATION:** Encourage and publicize the use of 520-622-6000, a crisis line<sup>25</sup> for the community to use to request for immediate non-law enforcement government service, including non-violent mental health or drug-induced interactions.

*Implementation: Tucson & Pima County Government Officials<sup>26</sup>*

**RECOMMENDATION:** When possible given COVID-19, return to the practice of having crisis center call staff, including individuals with mental and behavioral health training, be co-located in the same physical space, to enable real-time consultation and triage of clinical and/or law enforcement personnel to community requests for assistance.

*Implementation: PSCD*

- A - 4** **CONTRIBUTING FACTOR:** Dispatch's framing of the call, including information shared with responding officers and communication of outstanding DV arrest warrant, contributed to the officers' approach to the Ingram-Lopez call as one of arresting a criminal, rather than helping a community member in the midst of a drug-induced psychosis.

**RECOMMENDATION:** Increase live supervision in PSCD over call-takers. The supervisor hearing the interaction can then help to ensure proper resources are dispatched.

*Implementation: PSCD*

**RECOMMENDATION:** Ensure that all call-takers are trained in an interdisciplinary fashion, to include the law enforcement training that TPD call-takers previously received as well as the "medical" or other additional training that TFD call-takers previously received.

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<sup>25</sup> The Community-Wide Crisis Line is available for Pima County residents 24 hours a day, 7 days a week, including holidays. The federal government also recently approved 9-8-8 as a nationwide mental health 3-digit number, and various agencies within Tucson and elsewhere are working to implement this in an effective way.

<sup>26</sup> For example, the "Subzero Pilot" is a joint effort with local mental health crisis providers to place trained clinicians in the City of Tucson Public Safety Communications center (physically or virtually as circumstances require). Those clinicians will intercept non-violent mental health calls prior to the point of dispatch in order to immediately connect with the person in crisis. The clinician can provide crisis counseling telephonically and/or dispatch a crisis mobile team composed of two clinicians instead of police. This interface will augment the 520-622-6000 crisis line and the eventual national adoption of 9-8-8.

*Implementation: PSCD*

**RECOMMENDATION:** If there is an open line, or the caller is still on the phone with PSCD personnel, remind TPD officers that they can ask the dispatcher to gather additional information from the caller. Officers should take initiative in gathering information they need prior to entering the situation.

*Implementation: PSCD/TPD*

- A - 5 **CONTRIBUTING FACTOR:** Failure of responding officers to pre-plan response to incident and establish clear incident command and responsibilities.

**RECOMMENDATION:** Ensure that either the Lead Police Officer, the primary dispatched or the first arriving officer establishes operational control prior to engagement with the community and implements a plan of engagement on each response to a community member request for help. An intentional, and higher level of communication is needed when multiple personnel are responding to an incident.

*Implementation: TPD*

**RECOMMENDATION:** Focus Incident Control plans on defusing the immediate situation and restoring calm so that reasoned decisions can be made about further need for custodial control.

*Implementation: TPD*

## Section B: Engagement and Placement of Restraints

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In each incident, officers charged aggressively into the situation. It is important to note that this does not mean the officers always acted thoughtlessly. In the Alvarado case, the officer carefully considered the risk that the decedent would flee, the fact that there were intervening witnesses who could have gotten hurt, and the possibility that the decedent had participated in an immediately preceding shooting and thus might have been armed. In the Ingram-Lopez case, officers were primed to charge in because of the framing from dispatch (namely that the decedent had a DV warrant and the categorization of the call as “unknown trouble”), and a lack of incident control, oversight, and management contributed to an aggressive entry into the grandmother’s home.

In both cases, the decision to go “hands on” escalated the situations. In the Alvarado case, this led to a (probably unavoidable) fight between officers and the decedent. In the Ingram-Lopez case, this led officers to engage in close quarters, creating added risk to everyone involved. The officers’ misinterpretation that Ingram-Lopez was resisting arrest, and their failure to take pressure off of his chest and transition him to a “recovery” position, were compounded by the cramped environment which they chose to engage in.

In the Alvarado case, officers had to fight to subdue the decedent. Their use of profanity, intended to psychologically shock the decedent into compliance, clearly did not have the desired effect and likely only exacerbated the situation by elevating the officers’ own stress levels and perhaps the decedent’s as well.

In the Ingram-Lopez case, operational momentum contributed to officers deviating from relevant training, ignoring important aspects of the situation, and failing to reassess use of force levels. Officers who seemed focused on apprehension and detention chose to rapidly engage the decedent in a cramped garage and immediately began to subdue the decedent, taking him to the ground without asking any questions or further assessing the situation. The decedent was initially compliant but became passively resistant<sup>27</sup> once the officers grabbed him.

The officers’ handling of the situation in the Ingram-Lopez case remained consistent with what they were initially primed for, and did not evolve with the situation, as it should have. While in control of the situation, the officers made few attempts to de-escalate the situation (aside from periodic commands to “calm down” in both Spanish and English). They did not provide any care for the decedent’s physical condition, including ignoring his repeated requests for water (even after the decedent’s grandmother provided the officers with water to give to the decedent). Most concerning, the officers only placed the decedent in a “recovery” position after they realized that he had lost consciousness.

In both cases, the use of spit socks may have increased the decedent’s anxiety and contributed to the undesired outcome by causing further distress to an individual already in a psychotic mental state and/or impeding the ability of officers to recognize that the decedents had become

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<sup>27</sup> TPD General Order 2041, Levels of Resistance defines passive resistance as “Physical non-compliance that does not actively prevent the officer’s attempt at control.”

non-responsive.

### *A Note on Excited Delirium*

In Mr. Alvarado's death, the medical examiner found that the death was caused by "sudden cardiac arrest in the setting of acute methamphetamine intoxication and restraint with dilated cardiomyopathy as a significant contributing condition." For Mr. Ingram-Lopez, the death was caused by "sudden cardiac arrest in the setting of acute cocaine intoxication and physical restraint with cardiac left ventricular hypertrophy as a significant contributing condition." In both cases, then, medical examiners found that Mr. Alvarado and Mr. Ingram-Lopez's deaths were caused by a combination of drug use, physical restraint, and heart complications. These risk factors are commonly seen in a syndrome described as "excited delirium." As one of the SERB members, Dr. Andrew Tang, Trauma Medical Director at Banner University Medical Center, explains:

Excited delirium (ED) is a rare, but fatal entity that requires a high index of suspicion to diagnose and skillful officer-directed intervention tactics to decrease the risk of death. It is acknowledged by the medical community that the pathophysiology and exact mechanism of death in ED cases is still a poorly understood disease process.<sup>28, 29, 30</sup> However, certain predisposing factors and patterns of signs and symptoms have been identified that aid in diagnosis. The medical literature reveals that more than 95% of published fatal cases are male with a mean age of 36. The majority of cases involve stimulant abuse, most commonly cocaine and methamphetamine, although other drugs have been implicated. Of note, the blood levels of such drugs are often similar to those found in recreational drug users and less than those noted in acute overdose deaths. Persons with psychiatric illnesses comprise the second largest group of ED cases and deaths.<sup>31</sup> Acute psychiatric outbreaks such as mania or psychosis, or the abrupt cessation of psychotherapeutic medications can precipitate ED.<sup>32</sup>

Features leading to ED include: increased pain tolerance, fast respirations (tachypnea), sweating, agitation, fever (tactile hyperthermia), police noncompliance, lack of tiring, unusual strength, inappropriately clothed, and less commonly mirror/glass attraction.<sup>18-20</sup> Unfortunately, it takes a

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<sup>28</sup> Excited Delirium Syndrome (ExDS): defining based on a review of the literature. Vilke GM, DeBard ML, Chan TC, Ho JD, Dawes DM, Hall C, Curtis MD, Costello MW, Mash DC, Coffman SR, McMullen MJ, Metzger JC, Roberts JR, Sztajnkrcer MD, Henderson SO, Adler J, Czarnecki F, Heck J, Bozeman WP. *J Emerg Med.* 2012 Nov;43(5):897-905. doi: 10.1016/j.jemermed.2011.02.017. Epub 2011 Mar 25.

<sup>29</sup> The syndrome of excited delirium. Gill JR. *Forensic Sci Med Pathol.* 2014 Jun;10(2):223-8. doi: 10.1007/s12024-014-9530-2. Epub 2014 Feb 14.

<sup>30</sup> Excited delirium syndrome (ExDS): redefining an old diagnosis. Vilke GM, Payne-James J, Karch SB. *J Forensic Leg Med.* 2012 Jan;19(1):7-11. doi: 10.1016/j.jflm.2011.10.006. Epub 2011 Nov 2. PMID: 22152441

<sup>31</sup> *Id.*

<sup>32</sup> Morrison A, Sadler D. Death of a psychiatric patient during physical restraint. *Med Sci Law* 2001 Jan;41(1):46e50

high index of suspicion and astute consideration to tease these features apart from the exhibitions of drug intoxication and/or psychiatric outbreaks that often coexist. Individuals affected by ED often exhibit aggressive and bizarre behaviors that can lead to noncompliance with police demands. Struggle with law enforcement may ensue that involves physical, noxious chemical, or electronic control devices which can further exacerbate the underlying delirious state and altered physiology, leading to sudden death.<sup>18-20, 33</sup>

Officers in each case, including at least one officer in each case who was a trained and certified EMT, had received training on the risks of excited delirium, and were aware of the risk factors and appropriate responses to the treatment of an individual in restraints, including the need to move the individual into a “recovery position,” and ideally to have the individual sitting up or standing up, to reduce the likelihood of cardiac arrest or other critical care event. As seen in these two incidents, individuals experiencing excited delirium can deteriorate medically quite rapidly. As a result, it is important for officers to bring medics on the scene at the earliest safe opportunity, and for the officers and/or medics to continually reassess the restrained individual. Minutes count in ensuring restrained individuals don’t go into cardiac arrest or asphyxia.

Officers in the Alvarado case followed their training on these topics, engaging the decedent in verbal conversation, moving him into a less dangerous position, adjusting his restraints to ensure they were properly administered, and reassessing his situation regularly. The SERB, did however, express concern that there was a noticeable gap in communication of roughly five minutes between the last communication that was made with Mr. Alvarado, and when the attending officer realized that he was unresponsive. This was not the case for Mr. Ingram-Lopez, as the officers did not move him into a recovery position, did not engage him in conversation, and by covering him in blankets reduced their ability to monitor his health and responsiveness.

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<sup>33</sup> Excited delirium was mentioned as a concern by one of the passively observing police officers in the death of George Floyd, who used it to suggest to his colleagues that Mr. Floyd should be moved into a safer position that would reduce the risk of a heart attack or other health risk. Many feel that excited delirium is a post-hoc diagnosis used to justify inappropriate police behavior (See, e.g., O’Hare, M., Budhu, J. & Saadi, A., “Phony, racist ‘excited delirium’ used to justify police brutality,” *The Day*, July 26, 2020, accessed at [28](https://www.theday.com/article/20200726/OP03/200729631#:~:text=Across%20the%20United%20States%2C%20police%20officers%20are%20routinely,aggression%20and%20distress%2C%20typically%20accompanying%20drug%20abuse%20), the existence of excited delirium is supported in the medical literature and the medical professionals participating in the SERB were unanimous in their belief that the risk factors indicating a higher risk of death are accurate and real.</a></p></div><div data-bbox=)

## Section B: Contributing Factors and Recommendations

- B - 1** **CONTRIBUTING FACTOR:** Officer mindset focused on apprehension of suspect rather than de-escalation of situation and protection of all participants.

Particularly in the Ingram-Lopez case, it was apparent from the post-interviews conducted with the officers that they viewed their role as apprehenders of an individual who had an outstanding warrant for his arrest on domestic violence charges. If the officers had viewed their primary purpose as one of calming an inflamed situation in which an individual exhibiting mental or behavioral health symptoms was acting unpredictably, they might have approached the situation differently, taking more time to assess the situation and establish a mode of engagement that would have lessened the risk not only to the suspect, but to the officers themselves.

**RECOMMENDATION:** Review basic, post-basic, field, and in-service training programs to ensure they adequately develop skills in recognizing risk factors for excited delirium and responding to it as more of a medical/psychiatric emergency than a crime emergency.

*Implementation: TPD*

**RECOMMENDATION:** Create a Chief's Award for officers that effectively de-escalate situations and other incentives for officers to de-escalate rather than simply assert custodial control over events.

*Implementation: TPD*

**RECOMMENDATION:** Use the mandatory random audits of patrol BWC footage per agency policy to identify opportunities for improved de-escalation related performance on calls that don't end with an undesired outcome.

*Implementation: TPD*

- B - 2** **CONTRIBUTING FACTOR:** Drug use and intoxicated state of decedent.

The medical examiner's report makes clear that methamphetamine and cocaine use in these cases were contributors to each man's death. It is a sad reality that the use of drugs permeates our society and is often a contributing factor in behavior that leads to community calls to 911. This is a factor that is outside of the control of TPD or TFD, but awareness of it can assist the TPD and TFD in modifying their approach to such situations in an effort to optimize outcomes and prevent deaths when individuals are in restraints.

In the Alvarado case, the suspect's methamphetamine use was unknown to the officers responding to the scene, but it was a likely contributor both to the suspect's willingness to fight the officers and his "superhuman" strength that allowed him to resist three large officers for five full minutes.

In the Ingram-Lopez case, the suspect's cocaine use should have been made known to the officers (though his behavior, coupled with his nakedness, should by itself have created a high degree of suspicion of drug use in the minds of the officers) and might have suggested a high potential for the risk factors associated with excited delirium and a

need for emergency medical care.

In both cases, the use of stimulants was a risk factor increasing the likelihood of cardiac arrest or other fatal outcomes from excited delirium; TPD officers are aware of these risk factors and others (e.g., tactile fever/hyperthermia) and must act accordingly once individuals with known or suspected drug use are safely restrained to minimize the risk of death in such situations.

**RECOMMENDATION:** Add steps to TPD and TFD protocols to improve the evaluation of individuals exhibiting risk factors for excited delirium, including taking the temperature of individuals exhibiting these behaviors.

*Implementation: TPD/TFD*

**RECOMMENDATION:** Ensure that officers are aware of the role that drug use plays in 911 calls, in officer approaches when they arrive at scenes, in restraining individuals who are not of sound mind in the moment, and in the treatment of such individuals after restraints have been administered so that the negative health aspects of drug use are minimized throughout the interaction.

*Implementation: TPD*

**RECOMMENDATION:** The City of Tucson and County of Pima governments should work to expand drug treatment—particularly for harmful drugs such as cocaine and methamphetamine—and ensure that such treatment is readily available for all who need it, including the availability of a qualified detoxification facility like the Crisis Response Center, which currently assists TPD in responding to cases of drug use by community members whose behavior is deemed threatening to others.<sup>34</sup>

*Implementation: Tucson & Pima County Government Officials*

**B - 3 CONTRIBUTING FACTOR:** Community member witnesses were present on the scene and engaged with one suspect, impacting TPD officers' actions in the Alvarado case.

The presence of the father and son with Mr. Alvarado was out of TPD's control. Still, it is a contributing factor in Mr. Alvarado's case because it impacted the responding officer's decision making. The first responding officer did not know whether the suspect was armed, but reasonably believed that was a possibility given the possible connection to a recent shooting, and therefore decided to engage without backup to provide immediate protection for the community members.

**RECOMMENDATION:** None. The SERB did not feel qualified to second-guess the officer's decision in this instance. The officer made a good-faith decision to engage with a

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<sup>34</sup> The Pima County Crisis Response Center at the University of Arizona Medical Center South Campus in Tucson, and the Community Bridge Access Point (which takes less acute/violent individuals) are examples of this. They are heavily used by police (the CRC reports roughly 500 drop-offs of individuals each month by TPD, and a policy of never turning a TPD officer away). They accept cases with clinical profiles similar to those of Mr. Alvarado and Mr. Ingram-Lopez on a daily basis.



potentially armed suspect as quickly as possible to minimize the risk that the suspect might act to harm a community member and put himself in the path of danger as a result. While it is possible that a slower approach to the suspect might have permitted other de-escalation scenarios to unfold, it is equally possible that if the officer had reacted more slowly the suspect could have harmed the witness or himself. As a result, we note this contributing factor but without a recommendation for change in this instance.

**B - 4    CONTRIBUTING FACTOR:** Behavior of officers approaching the respective scenes.

As described above, the first officer to the scene in the Alvarado case entered the alley rapidly, and upon the decedent's attempt to escape, he exited the car, shouting at the decedent, and initiated physical contact.

In the Ingram-Lopez case, the officers ran past the individual who reported the call and immediately engaged with the decedent in aggressive fashion.

**RECOMMENDATION:** In situations where an officer knows the suspect is cornered and the officer has backup, deploy personnel in ways designed to minimize flight options, approach suspect slowly and calmly from a distance, with appropriate measures to protect the officer.

*Implementation: TPD*

**RECOMMENDATION:** Consistent with TPD General Order 2421, upon arrival at a 911 call scene, responding officers should attempt to speak to the individual who placed the call for assistance to ensure an understanding of the scene, and repeat the informational questions that PSCD should also have asked. This provides an additional layer of safety and communication for officers and community members alike and provides an opportunity to slow operational momentum.

*Implementation: TPD*

**B - 5    CONTRIBUTING FACTOR :** Officer decisions to go "hands on" rather than use de-escalation technique in the Ingram-Lopez case.

**RECOMMENDATION:** Where possible, de-escalate confrontations with suspects who may be using drugs by approaching them from a reasonable distance and building rapport and/or summon a trained drug detoxification or medical professional to assist if the situation cannot be de-escalated.

*Implementation: TPD*

**RECOMMENDATION:** Immediately upon the resolution of a "hands on" engagement, separate the officer(s) involved in altercations from the suspect, and insert officer(s) who were not involved in the altercation to manage the individual in custody. This mitigates the effects that stress and adrenaline have on decision-making and introduces a fresh perspective to the situation that can focus on careful monitoring of the person in custody, including health factors. Officers are replaced in order to calm emotions and

further de-escalate the situation.<sup>35</sup> *Implementation: TPD*

**B - 6**    **CONTRIBUTING FACTOR:** Officers' use of profanity.

TPD officers used profanity in each incident while engaging with members of the community. Officer use of profanity is contrary to TPD policies. It compromises community respect for and trust in the police and indicates a loss of self-control by officers. Further, officers' use of profanity escalates the tension of an interaction and potentially encourages individuals to disrespect the officers in return. It may also interfere with a person's ability to understand what the officer is asking or ordering them to do.<sup>36</sup> It is important that officers understand that profanity is not only unprofessional, but also usually ineffective in achieving its intended result. TPD has appropriately prohibited discourteous and abusive language toward the public in its General Order 1330.8 and has enforced that in the context of these two incidents.

**RECOMMENDATION:** TPD should provide additional education to its officers on the negative impacts of profanity on encounters with members of the public in terms of public perception, suspect compliance, and officer safety, and continue to impose appropriate discipline for the violation of profanity-related police directives.

*Implementation: TPD*

**B - 7**    **CONTRIBUTING FACTOR:** Failure to fully appreciate the rapid onset of cardiac arrest or asphyxia in restrained individuals who have taken stimulants. As seen in these two incidents, individuals experiencing excited delirium can deteriorate medically quite rapidly and unexpectedly. Ensuring constant attentiveness to individuals in custody may save valuable minutes in responding to subjects who go into cardiac arrest or asphyxia.

**RECOMMENDATION:** In cases where drug use is a contributing factor to the 911 call, ensure that TFD EMS is dispatched at the same time as TPD officers, so that medical care can be administered at the earliest possible opportunity while ensuring the safety of all

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<sup>35</sup> This replacement of "fresh" officers actually did occur in the Alvarado case. As in that case, the switch to a "second team" does not guarantee a better outcome. In the Ingram-Lopez case, however, such a switch would at a minimum have forced the responding officers to reposition themselves (and likely the decedent) at an earlier point in time, which might have prevented the unwanted outcome.

<sup>36</sup> Patton, C. L., Asken, M., Fremouw, W. J., & Bemis, R. (2017). The influence of police profanity on public perception of excessive force. *J. Police Crim Psych.* <https://doi.org/10.1007/s11896-017-9226-0>; Sharps, M.J., Torkelson, J.F., Hulett, D.L. et al. Police Profanity and Public Judgments of Guilt and Effectiveness in Officer-Involved Shootings. *J Police Crim Psych* 34, 87–90 (2019) <https://doi.org/10.1007/s11896-018-9268-y>; Clair White, David Weisburd, A Co-Responder Model for Policing Mental Health Problems at Crime Hot Spots: Findings from a Pilot Project, *Policing: A Journal of Policy and Practice*, Volume 12, Issue 2, June 2018, Pages 194–209, <https://doi.org/10.1093/police/pax010>; Trentham Furness, Tessa Maguire, Steve Brown, Brian McKenna, Perceptions of Procedural Justice and Coercion during Community-Based Mental Health Crisis: A Comparison Study among Stand-Alone Police Response and Co-Responding Police and Mental Health Clinician Response, *Policing: A Journal of Policy and Practice*, Volume 11, Issue 4, December 2017, Pages 400–409, <https://doi.org/10.1093/police/paw047>; Baseheart, J.R., Cox, T.C. Effects of police use of profanity on a receiver's perceptions of credibility. *JPCP* 9, 9–19 (1993). <https://doi.org/10.1007/BF02806658>

responding personnel. EMS can stand off at a safe distance, then move in to provide medical assessment when it is safe for them to do so.

*Implementation: TPD / TFD*

## Section C: Handling a Suspect in Restraints

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Restraint tactics and equipment were paramount issues of concern for the SERB and present in both cases. In the Alvarado case, officers employed several methods of restraint. First, officers attempted to use handcuffs. As the struggle intensified, officers made the determination that more restraints were required, and applied a Total Appendage Restraint Procedure (“TARP”). Due to the physical struggle, the first TARP was applied somewhat haphazardly, and officers decided to apply a second TARP. The mechanics of this restraint device made it possible for officers to put the decedent into the recovery position but did not allow them to sit the decedent upright. Beyond these tools, officers and paramedics also applied multiple spit socks. While officers did call for EMS shortly after engaging with the decedent, TFD personnel were instructed by TPD to check on the witnesses' wellbeing before evaluating the decedent. Once TFD did evaluate the decedent, however, they relied on a combination of decedent's vital signs (which were collected in a less than the optimal manner due to the decedent's struggling) and the intoxicated decedent's self-assessment that he was not injured. Additionally, it appears that the decedent's body temperature was not collected, an important vital sign for the evaluation of the potential for excited delirium.

In the Ingram-Lopez case, officers used two sets of handcuffs to restrain the decedent, primarily due to his large size. Because the decedent was naked at the time, officers, after successfully restraining the decedent, covered him nearly completely in an emergency blanket. After hearing the decedent make spitting and throat-clearing noises, the officers then lifted the blanket and applied a spit sock. The decedent was in this position for the majority of his interaction with officers. During this time, officers made no attempts to move him into the recovery position and ignored his continued requests for water. One officer reported later that he had no recollection of the decedent asking for water, notwithstanding the fact that he can be heard asking for it no fewer than 21 times. This further argues for specifically assigning an officer not involved in a physical struggle the responsibility of monitoring the health and welfare of a restrained person in a state of excited delirium. Officers also failed to call for EMS with any immediacy, only doing so until after they had discovered that the decedent had lost consciousness. From the time officers first noticed the decedent had become unresponsive to the time chest compressions were initiated was about 3 minutes. From the time that EMS was first summoned to their arrival at the decedent's side, over 7 minutes had lapsed. These are relatively long time periods in the context of cardiac arrest.

It's clear that in both situations, regardless of whether officers used the recovery position, the use of restraints that hide the face and/or cover the restrained individual worsened the officers' ability to perceive changes in the vital signs of the decedents, such as existence or ease of respiration, body movement, skin temperature, skin coloration, and pupil dilation or eyes rolling back. In both cases, officers were not instantly aware when the decedent in question had become unresponsive, and in the Ingram-Lopez case they had even incorrectly associated unconsciousness with the decedent becoming more cooperative.

## Section C: Contributing Factors and Recommendations

### C - 1 **CONTRIBUTING FACTOR:** Use of TARP on Mr. Alvarado.

It is important for TPD officers to have the ability to safely restrain individuals seeking to flee from or resist appropriate exercises of police custody. TARP is a well-known and long-used restraint system. At the same time, it requires officers to be in close physical proximity to a suspect who is resisting, creating risks for the officers and the suspect. It also can be administered in a “reverse” position, as it was in the Alvarado case, which may increase strain upon the restrained individual’s ability to breathe and which approximates a “hog-tying” position that has been banned in other departments across the country.

One interesting possibility for TPD and TFD responders confronting individuals who are exhibiting drug-related or behavioral health-related symptoms is to consider how to restrain a person safely without the use of weapons, as is practiced by Connections Health Solutions at the Crisis Response Center (CRC) in Tucson, a location where many individuals suffering from mental or behavioral health challenges are brought by TPD and TFD personnel for appropriate and focused care. An example of such training is attached as Appendix D.

Effective August 31, 2020, TPD has changed its policies to define any application of TARP or spit sock as a Type II Use of Force. TPD members must notify supervisors if any of these tools are utilized. TPD members may not utilize the TARP in a manner where the TARP is wrapped up and around the handcuffs and back to the feet. This is sometimes colloquially referred to as “hog-tying” or “suitcasing” and shall not be used moving forward. All other TPD trained TARP applications remain in effect. The updated policies are set forth as Appendix E.

**RECOMMENDATION:** Investigate equipment used by other departments and determine if better technology exists to replace TARP.

*Implementation: TPD<sup>37</sup>*

**RECOMMENDATION:** Train TPD officers in restraint techniques for individuals suffering from mental health or drug-induced problems that do not rely on weapons or undue uses of force (e.g., the “Seclusion/Restraint” and “Safe Clinch” training used at Connections Health Solutions, which prioritizes verbal de-escalation followed by non-weapon restraints leading to physical restraints in a “SAFE”, “Seatbelt” or “Over/Under” hold and an immediate restoration of assistance and rapport to the affected individual).

*Implementation: TPD*

**RECOMMENDATION:** Develop a quality improvement process around the tracking of non-

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<sup>37</sup> Here, and in other instances in our review, the implementing agency or department noted that solutions to the contributing factor in question might require additional funding to be able to be implemented. We offer no opinion on whether such funding is necessary, available or desirable in light of other civic priorities. Our review is limited to identifying modifications to the system that, if implemented, would have prevented these two in-custody deaths.

handcuff methods of restraint (e.g., TARP) use. Constantly reassess its efficacy.

*Implementation: TPD*

- C - 2 **CONTRIBUTING FACTOR:** Medical impact of physical restraint on medically compromised persons.

**RECOMMENDATION:** Review restraint tactics and implement alternative restraint strategies for persons experiencing manic states. Additionally, TFD should conduct an independent review of patients in restraints procedures to reduce likelihood of cardiac issues.<sup>38</sup>

*Implementation: TPD/TFD*

- C - 3 **CONTRIBUTING FACTOR :** Keeping Mr. Ingram-Lopez restrained in reverse position on his stomach and failing to place decedent in a recovery position.

**RECOMMENDATION:** TPD officers should constantly reevaluate the level of restraint necessary once restraints have been placed on a suspect. This is particularly true when a suspect is restrained in reverse position on stomach and failing to place decedent in a recovery position. Once an officer reasonably deems that the situation has become calm enough to make progress towards removing a backwards restraint or other steps to reduce the physical impact of restraint, those steps should be communicated to the suspect and performed where possible.

*Implementation: TPD*

- C - 4 **CONTRIBUTING FACTOR:** Failure to provide decedent water upon request in the Ingram-Lopez case.

Mr. Ingram-Lopez asked for water at least 21 times while he was being restrained. Officers ignored these requests, at one point receiving a bottle of water that was provided by his grandmother only to place it off to one side rather than administering it. The act of giving Mr. Ingram-Lopez water would have forced the officers to leave their positions on top of Mr. Ingram-Lopez and would have changed Mr. Ingram-Lopez' prone position to a safer upright or seated position, reducing the likelihood of further medical dangers. It would also likely have calmed the situation from an emotional perspective, changing the dynamic from "arrest" to "care."

**RECOMMENDATION:** Once an individual is restrained and safety is restored, restore rapport and communication with the restrained individual and satisfy requests such as this whenever possible. In training, emphasize that officers are interacting with human beings and responding to reasonable requests, such as providing water, can help prevent undesirable outcomes.

*Implementation: TPD*

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<sup>38</sup> Additional recommendation that is dependent upon clinical feedback from Andrew Tang MD/FACS, and Margie Balfour MD, PhD.

**C - 5 CONTRIBUTING FACTOR:** Use of spit sock.

The SERB does not know with certainty whether the spit sock contributed to or exacerbated any medical issues in either of these cases.<sup>39</sup> Members of the SERB were concerned, however, about the dehumanizing appearance of placing a hood on an individual and also concerned that not enough is known about the potential clinical impact of individuals in restraints having to breathe through the spit sock. Although the devices are designed to allow for a free airflow through the material, the negative effect might be psychological rather than physical, contributing to a person's sense of suffocation or exacerbating any claustrophobic feelings, and raising blood pressure and anxiety.

**RECOMMENDATION:** Given the unfavorable appearance and unclear efficacy of spit socks, research the efficacy and mental health effects of spit sock use and develop more robust, detailed protocols around their use.

*Implementation: TPD/TFD*

**C - 6 CONTRIBUTING FACTOR:** Inappropriate use of blankets in the Ingram-Lopez case.

The officers' use of emergency blankets to cover Mr. Ingram-Lopez seemed to originate with a desire to ensure that his naked body was not displayed publicly when the garage door was opened to the street. While this is reasonable, Mr. Ingram-Lopez was experiencing hyperthermia (feverish), and covering him with a blanket may have contributed to his increased body temperature.

More troubling, the officers made the choice to use a second blanket to cover the subject's head. This eliminated the ability of officers to monitor the suspect's condition closely and delayed their awareness of his consciousness.

**RECOMMENDATION:** Do not cover a restrained person's head with a blanket or other opaque or breath-reducing cover.

*Implementation: TPD*

**C - 7 CONTRIBUTING FACTOR:** Lack of clarity on primacy of TFD vs. TPD for individuals who are in police custody but have elevated risk factors for negative health outcomes.

It is standard practice for TFD medical responders to stand back at a safe distance until being invited to an incident scene by TPD, and we support this practice. In the Alvarado case in particular, SERB members noticed that TPD preferences seemed to dictate TFD actions. First, TPD officers on the scene directed TFD personnel to attend to a community member who was exhibiting distress before turning to the decedent, who was continuing to yell and resist his restraints. Second, TFD paramedics consulted with TPD on whether the decedent should go to a medical facility or to jail prior to completing

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<sup>39</sup> Additional research is needed to understand this topic. See, e.g., Lutz, M., Sloane, C. M., Castillo, E. M., Brennen, J. J., Coyne, C. J., Swift, S. L., & Vilke, G. M. (2019). Physiological effects of a spit sock. *The American journal of emergency medicine*, 37(2), 291-293.

the medical examination of the decedent. Some members of the SERB were concerned that this reflected a prioritization of the white community member over the Latino decedent, and a deference of TFD to TPD's custodial wishes.

**RECOMMENDATION:** Both TFD and TPD protocols should be clearly written to indicate that from the moment TFD personnel begin attending to an individual, that individual is in TFD custody and TFD's decisions about the individual's immediate health needs have priority over any criminal justice matters. This assessment should be made independent of any intentions of taking the suspect to jail, and TPD officers should be expressly prohibited from exerting any pressure – explicit or implicit – on other first responders to clear a suspect for being transported to jail. Only when TFD has expressly returned custody of the individual to TPD does TPD resume control of decisions regarding the individual's retention in custody.

*Implementation: TPD / TFD*

**RECOMMENDATION:** Upon TFD arrival, the TPD officer having incident command of the use of force event should brief medics on the incident and the state of those involved. If the incident commander is otherwise engaged, the incident commander should appoint another officer to brief TFD.

*Implementation: TPD / TFD*

- C - 8** **CONTRIBUTING FACTOR:** In each of the cases there was a break of 60-90 seconds in CPR chest compressions while restraints were removed from individuals and the individuals were transitioned to TFD emergency medical care.

**RECOMMENDATION:** Evaluate protocols that will allow for chest compressions to continue for restrained individuals who have lost consciousness while restraints are being removed and individuals are being transitioned to emergency medical care.

*Implementation: TPD/TFD*



## Section D: Post-Incident Managerial and Investigatory Practices

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This section addresses the contributing factors that combined to cause the TPD Office of Professional Standards and Executive Leadership Team to mishandle the viewing and publication of information about the in-custody death of Mr. Carlos Ingram-Lopez. Many of these recommendations have been independently implemented by TPD as of the time of this writing.

### Section D: Contributing Factors and Recommendations

**D - 1**    **CONTRIBUTING FACTOR:** Lack of structured training for TPD OPS investigative practices.

**RECOMMENDATION:** Investigate restraint and control deaths in the same manner as officer-involved shootings. TPD has expressed its intention to revise its officer-involved shooting procedure to reflect a similar process for any critical incidents – with some differences based on the incident. Notably, TPD is in the process of updating its procedures to reflect recent policy change to include the additional notification to the Independent Police Auditor.

*Implementation: TPD*

**RECOMMENDATION:** The Independent Police Auditor (“IPA”) should be given access to all officer involved shooting and in-custody death incidents. The IPA should act as an ombudsman to the department and report to the Chief of Police any concerns about how any event is being handled or reported.<sup>40</sup>

*Implementation: TPD*

**D - 2**    **CONTRIBUTING FACTOR:** OPS was led by a relatively new lieutenant (~1 year) reporting directly to an assistant chief, who did not emphasize standardized training on specific techniques useful in the OPS context, especially for officers whose prior roles at TPD were not investigative roles.

**RECOMMENDATION:** Ensure that supervisors and leadership within OPS provides individually-designed training to new OPS personnel that ensures they are trained on specific techniques for investigating cases in which officers may have deviated from protocol, and that investigators within OPS have senior-level agreement on strategies for individual interviews prior to conducting them in OPS investigations.

*Implementation: TPD*

**D - 3**    **CONTRIBUTING FACTOR:** The COVID-19 pandemic complicated normal operating

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<sup>40</sup> The office of Independent Police Auditor is responsible for a range of duties from evaluating OPS investigations to training new police recruits on civilian review. Currently, the IPA has a staff of one person. With public demands for civilian review and the amount of data to evaluate (particularly BWC video), we recommend that Mayor and Council fund additional staff for the office.

procedures in ways that reduced the efficient communication of OPS personnel with each other and with the TPD ELT including, but not limited to:

- Technological adaption problems.
- Breakdown in typical communication methods due to officers working remotely.

**RECOMMENDATION:** Ensure appropriate tools and training (e.g., MS Teams) to allow for replication of in-person environments during periods of remote or virtual working. Ensure that meetings leverage these technologies to allow for the same presentations that would have occurred in-person.

*Implementation: TPD*

**RECOMMENDATION:** Modify schedules as necessary to ensure that the assistant chief in charge of the OPS attends all regular staff meetings.

*Implementation: TPD*

D - 4 **CONTRIBUTING FACTOR:** Failure to show video to superior officers at the April ELT meeting. Officer concern over public backlash should have indicated the severity of the incident and merited showing the video to superior officers.

D - 5 **CONTRIBUTING FACTOR:** Failure of ELT to proactively insist upon viewing the BWC in cases of in-custody death, regardless of whether it was offered to them.

**RECOMMENDATION:** Create default rule that when an in-custody death occurs, at least two individuals on the ELT must watch the video. While TPD is moving in this direction, the SERB has included this as a formal recommendation to underscore its importance.

*Implementation: TPD*

D - 6 **CONTRIBUTING FACTOR:** OPS lieutenant permitted officers involved in Ingram-Lopez case to return to duty three days after the incident without a need for additional training, reinforcing to the ELT the lieutenant's view that the incident was not extraordinary and that the decision not to show the video to ELT was appropriate.

**RECOMMENDATION:** Engage impacted division commander(s) in review of the video after an OPS investigation, explaining the observations and conclusions of the investigation, and offering division commander(s) the opportunity to request additional training or other potential remedial activity for officers prior to returning them to full active duty.

*Implementation: TPD*

D - 7 **CONTRIBUTING FACTOR:** Failure to invite sergeant assigned to investigation to the April ELT meeting.

**RECOMMENDATION:** Include primary investigator(s) in all briefings of an in-custody death to any member of the ELT.

*Implementation: TPD*

- D - 8 **CONTRIBUTING FACTOR:** Failure of sergeant to explicitly question lieutenant's handling of the video and investigation.

As with many systems that have historically relied upon hierarchical decision-making, such as aviation (pilot) and healthcare (surgeon or chief physician), policing relies upon a hierarchical decision-making structure that emphasizes the chain of command and is intolerant of subordinates questioning the decision-making of superiors. This can lead to situations where subordinates who have accurately identified risks may refrain from clearly identifying them to superiors in a timely fashion, as occurred here. It is important that supervisors create a system in which subordinates feel comfortable pointing out the risks of decisions to their supervisors in appropriate and respectful ways without subverting the chain of command.

In this instance, while both OPS investigating sergeants felt that their lieutenant needed to show the video to the TPD ELT, neither expressly counseled her on this point or found a way to express their concerns. The prevailing attitude from multiple sergeants was "It's the lieutenant's call," even though they disagreed with the conclusion. (One of the sergeants later acknowledged that he would have acted differently if he had the choice before him again.) While ultimately the supervising officer does have the responsibility for the decision, encouraging feedback and respectful questioning of decisions, with rationales, both reduces risk and develops judgment in subordinate officers over time.

**RECOMMENDATION:** Cultivate a culture of "upward confirmation" where supervising officers actively solicit the agreement of lead OPS investigators in assessments and recommendations of disclosure and discipline, and ensure opportunities exist for disagreements to be thoroughly discussed and resolved.

*Implementation: TPD*

- D - 9 **CONTRIBUTING FACTOR:** Multiple management points within OPS were staffed by relative newcomers to the internal affairs functions.

**RECOMMENDATION:** Ensure there is adequate collective OPS experience to accurately assess the public significance of the incident in question among the office's leadership (sergeants, lieutenant, captain, assistant chief).

*Implementation: TPD*

- D - 10 **CONTRIBUTING FACTOR:** Pause in completion of administrative investigation while awaiting resolution of criminal investigation.

**RECOMMENDATION:** Complete administrative investigations expeditiously irrespective of criminal investigation.

*Implementation: TPD*

- D - 11 **CONTRIBUTING FACTOR:** Press releases biased in favor of defending police actions.

**RECOMMENDATION:** Accelerate public disclosure about incidents under investigation by the OPS, ensuring that CPARB and other useful recipients are aware of events that might impact public perceptions of TPD Limit disclosures as necessary while an investigation into the case is pending and allow for CPARB and the IPA to review the investigative records upon its conclusion to assure the public that the investigation was thorough and unbiased.

*Implementation: TPD*

## Section E: Overarching Structural Issues & Additional Group Recommendations

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Structural and systemic racism have long permeated, and continue to permeate, our society, and awareness of this has never been higher in the wake of the killing of George Floyd. While the SERB concluded that the TPD, PSCD and TFD personnel who were part of the cases under review did nothing that was explicitly racist, the SERB believed strongly that understanding how racism permeates social, economic, and political institutions is important background knowledge for these sentinel event reviews. As one member of the Board put it: "Whether we can point to some specific evidence or not, it's an issue that is essential to the community and it is out there."

Ultimately, the Tucson Police Department's legitimacy comes from the community, which gives the TPD its authority to investigate criminal activity and encroach to some degree on our freedom. Understanding the community's perceptions of racial justice will be necessary for the TPD to conduct its work in concert with community expectations.

Members of the SERB also felt that TPD, PSCD, and TFD should ensure that their employees are properly trained on how to handle such topics as:

- Responding to and triaging calls that have both mental/behavioral health and law enforcement aspects;
- De-escalation;
- Officer and medic responses to individuals experiencing respiratory distress;
- Safe and appropriate methods of restraint;
- Evaluating the medical condition of an individual in restraints; and
- Excited delirium.

In each of the cases the SERB reviewed, TPD officers had completed basic mental health first aid training. In the Ingram-Lopez case, the officers had not received CIT training. Furthermore, in the Alvarado case the TPD officers acted, in all material aspects, in accordance with the training, while in the Ingram-Lopez case they did not, demonstrating that training is not always an effective solution to error.

Under the circumstances, the SERB questioned whether the training provided on these topics was (a) adequate and (b) effective. Additional evaluations of training in these important areas will be important to improve all aspects of the Tucson criminal justice and emergency medical response systems.

The following recommendations, then, would be made by members of the SERB even if these tragedies had not occurred – they apply to all interactions between TPD and TFD personnel and the communities they serve.

## Section E: Overarching Contributing Factors and Recommendations

**E - 1 CONTRIBUTING FACTOR:** Indicators of systemic racism, cultural disregard or ignorance and an indifference to Latino life were perceived by at least some members of the SERB.<sup>41</sup> These indicators included:

- In the Alvarado case, asking EMS responders to treat the community members involved in the altercation, who were white, before treating the restrained individual, who was Latino.
- In the Alvarado case, officers gathered around the suspect after he was restrained acted unconcerned with the individual's welfare; one officer made demeaning comments about the individual. While these comments were not racial in nature, the overall display was one of indifference to the sanctity of this Latino's life.
- In the Ingram-Lopez case, neither the PSCD call-taker nor the officers involved spoke Spanish, or identified a Spanish-speaker who could assist.
- In the Ingram-Lopez case, the officers consistently disregarded the grandmother who placed the initial 911 call and who came out of the house to greet them, showing indifference to her ability to assist in resolving the conflict.

While certainly other factors also contributed to the tragic outcomes in these cases, the SERB is concerned that underlying cultural and racial biases also contributed in a myriad of seen and unseen ways. They should not be understated simply because they remain invisible. More time is needed to determine the role that systemic racism and bias may have played in these cases. This is an opportunity to develop a process for dissecting the culture of TPD, TFD, PSCD, and indeed that of the wider community from which these agencies derive their moral authority. Systemic biases in public-safety services emerge from systemic biases in the broader society.

**RECOMMENDATION:** PSCD, TPD, and TFD should collect, analyze, and publish data regarding (among other things) response times, nature of call, medical, drug, or mental health issues involved, type of force used, domestic violence or other, and outcomes across racial and gender lines to identify areas of disparate responses or disparate impacts on members of different groups. This will be an ongoing process and TPD and TFD should establish a multi-cultural stakeholder group to advise and work with the department.

*Implementation: TPD / TFD<sup>42</sup>*

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<sup>41</sup> As with many parts of our society, the SERB wrestled with how best to identify, understand, and address concerns that the very structure of policing has roots in racist ideologies that are generations old. While the SERB did not identify any explicitly racist behaviors, several moments were identified that conveyed a carelessness and callousness towards Latino members of the community that affect perceptions of the TPD and TFD and that impact how community members respond to TPD and TFD authority. There was consensus agreement among the SERB that all factors and recommendations contained in this report are deserving of serious consideration.

<sup>42</sup> TPD has created a dashboard that went live on September 11, 2020 and is available at <https://policeanalysis.tucsonaz.gov/>.

**RECOMMENDATION:** Establish either a standing committee or board that will work closely with TPD to explain and address issues of systemic racism and cultural bias within the organization.

*Implementation: TPD/TFD/PSCD*

- E - 2** **CONTRIBUTING FACTOR:** Dehumanization of suspects and perceived indifference of officers.

**RECOMMENDATION:** Re-emphasize the expectation of professionalism and implement consequences for violations. Use the BWC as an instructional tool to show how officer conduct can appear to be dehumanizing and therefore undermine public trust in and respect for the police.

*Implementation: TPD*

**RECOMMENDATION:** Engage the CPARB to lead a task force that will report back to TPD executive leadership on community views of the relationship between TPD and the people of Tucson, and how that can be improved.

*Implementation: TPD/CPARB*

- E - 3** **CONTRIBUTING FACTOR:** Potentially insufficient and/or ineffective education and training for officers in key areas, including:

- Triage of emergency calls to medical/behavioral health experts;
- De-escalation;
- Respiratory distress;
- Restraint; and
- excited delirium.

The officers responding in these cases had taken appropriate training classes in many of the areas described above. Often, however, these classes are limited in scope and timing, and in the heat of a confrontation, asking officers to remember the finer points of their training from years before may be a difficult task.<sup>43</sup>

**RECOMMENDATION:** Revisit the manner and method in which officers are trained, including training of supervisors on regular and consistent reinforcement of training in topics including:

- Reconfigure training to prioritize slowing down operational momentum officers experience in the field.
- Train more officers in crisis intervention, mindful of the concern that forcing officers into this type of training detracts from the efficacy of the training for not only the officer in question, but all involved.
- Develop a training program for officers on respiratory distress and new response

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<sup>43</sup> The Board recognizes the possibility that other TPD officers who received the same training might have handled these two incidents differently than the officers in these cases.

protocol for situations in which a suspect is restrained with arms behind their back or claims they cannot breathe.

- Conduct an external review of excited delirium training and procedures, informed by critical care professionals, to ensure TPD is following best practices for law enforcement response.
- Promote mindset of “care for all community members” over “take into custody” among the officers.

*Implementation: TPD*

**RECOMMENDATION:** With permission from the Ingram-Lopez family, use the in-custody death of Mr. Ingram-Lopez as a training tool for police and EMS. This incident demonstrates how failing to follow basic protocols can result in a tragic outcome.

*Implementation: TPD/TFD*

**RECOMMENDATION:** Explore ways to increase the deployment of alternative responses to behavioral health calls received by EMS, such as sending mental/behavioral health experts as primary responders with and/or instead of police officers. Appropriately trained professionals must be available 24/7, respond quickly and be able to provide direct treatment and/or directions based on their clinical training.<sup>44</sup>

*Implementation: Tucson & Pima County Government Officials*

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<sup>44</sup> The Regional Behavioral Health Authority currently funds and oversees 16 crisis mobile teams (CMTs) that respond to behavioral health calls across Pima County. These teams are composed of behavioral health clinicians, available 24/7, and dispatched by the Crisis Line. The “Sub-Zero” program which co-locates crisis call center staff with 911 call-takers is intended to increase the number of 911 calls diverted to a CMT response. Additional programs that would be responsive to this recommendation are currently under review by the Tucson Mayor and Council as a part of the Community Safety Pilot Program.



## Appendices

### Appendix A. Table of Contributing Factors and Recommendations

Contributing Factors to the In-Custody Deaths of Mr. Alvarado and Mr. Ingram-Lopez and Notification Issues from OPS			
Contributing Factors	Relevant Party	Recommendations	Implementation
Section A: Approaching the Scene			
A - 1 <b>CONTRIBUTING FACTOR:</b> Inability of 911 operator to effectively communicate with civilian due to language barrier.	PSCD	A - 1 <b>RECOMMENDATION:</b> Ensure all 911 operators speak conversational Spanish, or at least have Spanish interpretation instantly available in Comms. Additionally, establish an advanced language line to serve the large populations of foreign-language speakers in Tucson. <b>RECOMMENDATION:</b> In the event that the call-taker and the caller have a language barrier, provide multiple language translation cards to assist the dispatcher in asking yes/no questions to gather additional useful information.	PSCD  PSCD
A - 2 <b>CONTRIBUTING FACTOR:</b> Lack of gathering information from caller during 911 call and lack of transmitting information to responding officers.	PSCD	A - 2 <b>RECOMMENDATION:</b> Review communication procedures and develop more a robust list of questions for dispatch to ask callers.	PSCD, TPD, TFD, others
A - 3 <b>CONTRIBUTING FACTOR:</b> Failure of call-taker to identify Ingram-Lopez as a behavioral health crisis rather than a law enforcement emergency.	PSCD	A - 3 <b>RECOMMENDATION:</b> Encourage and publicize the use of 520-622-6000, a crisis line for the community to use to request for immediate non-law enforcement government service, including non-violent mental health or drug-induced interactions. <b>RECOMMENDATION:</b> When possible given COVID-19, return to the practice of having crisis center call staff, including individuals with mental and behavioral health training, be co-located in the same physical space, to enable real-time	Tucson & Pima County Government Officials  PSCD

<p><b>A - 4</b> <u><b>CONTRIBUTING FACTOR:</b></u> Dispatch's framing of call, including information given to responding officers and communication of outstanding DV arrest warrant.</p>	PSCD	<p><b>A - 4</b> <u><b>RECOMMENDATION:</b></u> Increase live supervision in PSCD over call-takers.  <u><b>RECOMMENDATION:</b></u> Ensure that all call-takers are trained in an interdisciplinary fashion, to include the law enforcement training that TPD call-takers previously received as well as the "medical" or other additional training that TFD call-takers previously received.  <u><b>RECOMMENDATION:</b></u> If there is an open line, remind TPD officers that they can ask the dispatcher to gather additional information from the caller.</p>	<p>PSCD</p> <p>PSCD</p> <p>PSCD/TPD</p>
<p><b>A - 5</b> <u><b>CONTRIBUTING FACTOR:</b></u> Failure of responding officers to pre-plan response to incident and establish clear incident command responsibilities.</p>	TPD	<p><b>A - 5</b> <u><b>RECOMMENDATION:</b></u> Ensure that primary officer establishes control and implements plan of engagement on each response to a civilian request for help.  <u><b>RECOMMENDATION:</b></u> Focus Incident Control plans on defusing immediate situation and restoring calm so that reasoned decisions can be made without further need for custodial control.</p>	<p>TPD</p> <p>TPD</p>
<p><b>Section B: Engagement and Placement of Restraints</b></p>			
<p><b>B - 1</b> <u><b>CONTRIBUTING FACTOR:</b></u> Officer mindset focused on apprehension of suspect rather than de-escalation of situation and protection of all participants.</p>	TPD	<p><b>B - 1</b> <u><b>RECOMMENDATION:</b></u> Review pre-service, field, and in-service training programs to ensure that they adequately develop skills in recognizing risk factors for Excited Delirium and responding to it as more of a medical/psychiatric emergency than a crime emergency.  <u><b>RECOMMENDATION:</b></u> Create a Chief's Award for Officers that effectively de-escalate situations and other incentives for Officers to de-escalate rather than simply assert custodial control over events.  <u><b>RECOMMENDATION:</b></u> Use</p>	<p>TPD</p> <p>TPD</p> <p>TPD</p>

<p><b>B - 2</b>    <u><b>CONTRIBUTING FACTOR:</b></u> Drug use and intoxicated state of decedent.</p>	<p>Decedent</p>	<p>mandatory random audits of patrol BWC footage per agency police to identify opportunities for improved de-escalation related performance on calls that don't end with an undesired outcome.</p> <p><b>B - 2</b>    <u><b>RECOMMENDATION:</b></u> Add steps to TPD and TFD protocol to improve the evaluation of individuals exhibiting risk factors for excited delirium, including taking the temperature of individuals exhibiting these behaviors.</p> <p><u><b>RECOMMENDATION:</b></u> Ensure that officers are aware of the role that drug use plays in 911 calls, in officer approaches to restraining individuals who are not of sound mind in the moment, and to the treatment of such individuals after restraints have been administered so that the negative health aspects of drug use are minimized throughout the interaction.</p> <p><u><b>RECOMMENDATION:</b></u> The City of Tucson and County of Pima governments should work to expand drug treatment—particularly for harmful drugs such as cocaine and methamphetamine—and ensure that it is readily available for all who need it, including the availability of a qualified detoxification facility like the Crisis Response Center, which currently assists TPD in responding to cases of drug use by community members whose behavior is deemed threatening to others.</p>	<p>TPD/TFD</p> <p>TPD</p> <p>Tucson &amp; Pima County Government Officials</p>
<p><b>B - 3</b>    <u><b>CONTRIBUTING FACTOR (Alvarado):</b></u> Civilian witnesses' engagement with suspect.</p>	<p>N/A</p>	<p><b>B - 3</b>    <u><b>RECOMMENDATION:</b></u> None. The SERB did not feel qualified to second-guess the officer's decision in this instance.</p>	<p>N/A</p>
<p><b>B - 4</b>    <u><b>CONTRIBUTING FACTOR:</b></u> Behavior of officers approaching the respective scenes.</p>	<p>TPD</p>	<p><b>B - 4</b>    <u><b>RECOMMENDATION:</b></u> In situations where an officer knows the suspect is cornered and officer has backup, deploy personnel in ways designed to minimize flight options, approach suspect slowly and calmly from a</p>	<p>TPD</p>

		distance with appropriate measures to protect the officer. <b><u>RECOMMENDATION:</u></b> Consistent with TPD General Order 2421, upon arrival at a 911 call scene, responding officers should attempt to speak to the individual who placed the call for assistance to ensure understanding of the scene, and repeat the informational questions that dispatch should also have asked.	TPD			
B - 5	<b><u>CONTRIBUTING FACTOR:</u></b> Officer decision to go “hands on” rather than use de-escalation techniques.	TPD	B - 5	<b><u>RECOMMENDATION:</u></b> Where possible, de-escalate situation by approaching drugged suspect from a distance and building rapport and/or summon a trained drug detoxification or medical professional to assist. <b><u>RECOMMENDATION:</u></b> Immediately upon the resolution of a “hands on” engagement, separate the officer(s) involved in altercations from the suspect, and insert officer(s) who were not involved in the altercation to manage the individual in custody.	TPD	TPD
B - 6	<b><u>CONTRIBUTING FACTOR:</u></b> Officers’ use of profanity.	TPD	B - 6	<b><u>RECOMMENDATION:</u></b> TPD should provide additional education to its officers on the negative impacts of profanity on encounters with members of the public in terms of public perception, suspect compliance, and officer safety, and continue to impose appropriate discipline for the violation of profanity-related police directives.	TPD	TPD
B - 7	<b><u>CONTRIBUTING FACTOR:</u></b> Failure to fully appreciate the lethal risks of the drug-induced state of decedents (and possible Excited Delirium) and summon medical assistance in a timely fashion.	TPD	B - 7	<b><u>RECOMMENDATION:</u></b> In cases where drug use is a contributing factor to the 911 call, ensure that TFD EMS is dispatched at the same time as TPD officers, so that medical care can be administered at the earliest possible opportunity while ensuring the safety of all responding personnel.	TPD/TFD	TPD/TFD

### Section C: Handling a Suspect in Restraints

<p><b>C - 1</b> <u><b>CONTRIBUTING FACTOR:</b></u> Use of Total Appendage Restraint Procedure (TARP) on Mr. Alvarado.</p>	<p>TPD</p>	<p><b>C - 1</b> <u><b>RECOMMENDATION:</b></u> Investigate equipment used by other departments and determine if better technology exists to replace TARP. <u><b>RECOMMENDATION:</b></u> Train TPD Officers in restraint techniques for individuals suffering from mental health or drug-induced problems that do not rely on weapons or undue uses of force. <u><b>RECOMMENDATION:</b></u> Develop a quality improvement process around the tracking of non-handcuff methods of restraint (e.g., TARP) use. Constantly reassess its efficacy.</p>	<p>TPD  TPD  TPD</p>
<p><b>C - 2</b> <u><b>CONTRIBUTING FACTOR:</b></u> Medical impact of physical restraint on medically compromised persons.</p>	<p>TPD</p>	<p><b>C - 2</b> <u><b>RECOMMENDATION:</b></u> Review restraint tactics and implement alternative restraint strategies for persons experiencing manic states.</p>	<p>TPD</p>
<p><b>C - 3</b> <u><b>CONTRIBUTING FACTOR:</b></u> Keeping Mr. Ingram-Lopez restrained in reverse position on stomach and failing to place decedent in recovery position.</p>	<p>TPD</p>	<p><b>C - 3</b> <u><b>RECOMMENDATION:</b></u> TPD officers should constantly reevaluate the level of restraint necessary once restraints have been placed on a suspect.</p>	<p>TPD</p>
<p><b>C - 4</b> <u><b>CONTRIBUTING FACTOR (Ingram-Lopez):</b></u> Failure to provide decedent water upon request in the Ingram-Lopez case.</p>	<p>TPD</p>	<p><b>C - 4</b> <u><b>RECOMMENDATION:</b></u> Once an individual is restrained and safety is restored, restore rapport and communication with the restrained individual and satisfy requests such as this whenever possible.</p>	<p>TPD</p>
<p><b>C - 5</b> <u><b>CONTRIBUTING FACTOR:</b></u> Use of spit sock.</p>	<p>TPD</p>	<p><b>C - 5</b> <u><b>RECOMMENDATION:</b></u> Research efficacy of spit sock use and develop more robust, detailed protocols around their use, if warranted.</p>	<p>TPD</p>
<p><b>C - 6</b> <u><b>CONTRIBUTING FACTOR:</b></u> Inappropriate use of blankets in the Ingram-Lopez case.</p>	<p>TPD</p>	<p><b>C - 6</b> <u><b>RECOMMENDATION:</b></u> Do not cover a restrained person's head with a blanket or other opaque or breath-reducing cover.</p>	<p>TPD</p>

<p><b>C - 7</b> <u><b>CONTRIBUTING FACTOR:</b></u> Lack of clarity on primacy of TFD vs. TPD for individuals who are in police custody but have elevated risk factors for negative health outcomes.</p>	<p>TPD/TFD</p>	<p><b>C - 7</b> <u><b>RECOMMENDATION:</b></u> Both TFD and TPD protocols should be clearly written to indicate that from the moment TFD personnel begin attending to an individual, that individual is in TFD custody and TFD's decisions about the individual's immediate health needs have priority over any criminal justice matters. <u><b>RECOMMENDATION:</b></u> Upon TFD arrival, the TPD officer having incident command of the use of force event should brief medics on the incident and the state of those involved. If the incident commander is otherwise engaged, the incident commander should appoint another officer to brief TFD.</p>	<p>TPD/TFD</p> <p>TPD/TFD</p>
<p><b>C - 8</b> <u><b>CONTRIBUTING FACTOR:</b></u> In each of the cases there was a break of 60-90 seconds in CPR chest compressions while restraints were removed from individuals and the individuals were transitioned to TFD emergency medical care.</p>	<p>TPD/TFD</p>	<p><b>C - 8</b> <u><b>RECOMMENDATION:</b></u> Evaluate protocols that will allow for chest compressions to continue for restrained individuals who have lost consciousness while restraints are being removed and individuals are being transitioned to emergency medical care.</p>	<p>TPD</p>
<p><b>Section D: Post-Incident Managerial and Investigatory Practices</b></p>			
<p><b>D - 1</b> <u><b>CONTRIBUTING FACTOR:</b></u> Lack of structured training for TPD OPS investigative practices.</p>	<p>TPD</p>	<p><b>D - 1</b> <u><b>RECOMMENDATION:</b></u> Investigate restraint and control deaths in the same manner as officer-involved shootings. <u><b>RECOMMENDATION:</b></u> Independent Police Auditor should be given access to all OIS and DIC incidents.</p>	<p>TPD</p> <p>TPD</p>
<p><b>D - 2</b> <u><b>CONTRIBUTING FACTOR:</b></u> OPS was led by a relatively new Lieutenant reporting directly to an Assistant Chief, who did not emphasize standardized training on specific techniques useful in the OPS context.</p>	<p>TPD</p>	<p><b>D - 2</b> <u><b>RECOMMENDATION:</b></u> Ensure that supervisors and leadership within OPS provides individually-designed training to new OPS personnel that ensures they are trained on specific techniques for investigating cases in which officers may have deviated from protocol, and that investigators within OPS have senior-level agreement on strategies for individual</p>	<p>TPD</p> <p>TPD</p>

<p>D - 3 <b><u>CONTRIBUTING FACTOR:</u></b> The COVID-19 pandemic complicated normal operating procedures in ways that reduced the efficient communication of OPS personnel with each other and with the TPD Executive Leadership Team (ELT).</p>	<p>TPD</p>	<p>interviews prior to conducting them in OPS investigations.</p>	
<p>D - 4 <b><u>CONTRIBUTING FACTOR:</u></b> Failure to show video to superior officers at the April ELT meeting.</p>	<p>Lt. / TPD</p>	<p>D - 3 <b><u>RECOMMENDATION:</u></b> Ensure appropriate tools and training (e.g., MS Teams) to allow for replication of in-person environments during periods of remote or virtual working.</p>	<p>TPD</p>
<p>D - 5 <b><u>CONTRIBUTING FACTOR:</u></b> Failure of ELT to proactively insist upon viewing the BWC in cases of in-custody death, regardless of whether it was offered to them.</p>	<p>ELT/TPD</p>	<p><b><u>RECOMMENDATION:</u></b> Modify schedules as necessary to ensure that the Assistant Chief in charge of the OPS attends all regular staff meetings.</p>	<p>TPD</p>
<p>D - 6 <b><u>CONTRIBUTING FACTOR:</u></b> OPS lieutenant permitted officers involved in Ingram-Lopez case to return to duty three days after the incident without a need for additional training, reinforcing to the ELT the lieutenant's view that the incident was not extraordinary and that the decision not to show the video to ELT was appropriate.</p>	<p>TPD</p>	<p>D - 5 <b><u>RECOMMENDATION:</u></b> Create default rule that when an in-custody death occurs, all senior leadership, to include the PIO, need to watch the video.</p>	<p>TPD</p>
<p>D - 7 <b><u>CONTRIBUTING FACTOR:</u></b> Failure to invite sergeant assigned to investigation to the April ELT meeting.</p>	<p>TPD</p>	<p>D - 6 <b><u>RECOMMENDATION:</u></b> Engage squad commander(s) in review of the video after an OPS investigation, explaining the observations and conclusions of the investigation and offering squad commander(s) the opportunity to request additional training or other potential remedial activity for officers prior to returning them to full active duty.</p>	<p>TPD</p>
<p>D - 8 <b><u>CONTRIBUTING FACTOR:</u></b> Failure of sergeant to explicitly question lieutenant's handling of the video and investigation.</p>	<p>TPD</p>	<p>D - 7 <b><u>RECOMMENDATION:</u></b> Include primary investigator in all briefings of a DIC to any member of the ELT.</p>	<p>TPD</p>
		<p>D - 8 <b><u>RECOMMENDATION:</u></b> Cultivate a culture of "upward confirmation" where supervising officers actively solicit the agreement of lead OPS investigators in assessments and recommendations of disclosure and discipline, and ensure opportunities exist for disagreements to be thoroughly discussed and resolved.</p>	<p>TPD</p>





<p><b>E - 2</b>    <u><b>CONTRIBUTING FACTOR:</b></u> Dehumanization of suspects and perceived indifference of officers.</p>	<p>TPD</p>	<p><b>E - 2</b>    <u><b>RECOMMENDATION:</b></u> Re-emphasize the expectation of professionalism and implement consequences for violations. Use the BWC as an instructional tool.</p>	<p>TPD</p>
<p><b>E - 3</b>    <u><b>CONTRIBUTING FACTOR:</b></u> Potentially insufficient and/or ineffective education and training for officers in key areas.</p>	<p>TPD</p>	<p><b>E - 3</b>    <u><b>RECOMMENDATION:</b></u> Engage the CPARB to lead a task force that will report to TPD executive leadership on community views of relationship between TPD and the citizens of Tucson, and how it can be improved.</p> <p><b>E - 3</b>    <u><b>RECOMMENDATION:</b></u> Revisit the manner and method in which officers are trained.</p> <p><u><b>RECOMMENDATION:</b></u> With permission from the Ingram-Lopez family, use the in-custody death of Mr. Ingram-Lopez as a training tool for police and EMS.</p> <p><u><b>RECOMMENDATION:</b></u> Explore a way to ensure that mental/behavioral health experts are available to respond with and/or instead of police officers</p>	<p>TPD</p> <p>TPD</p> <p>TPD/EMS</p> <p>Tucson &amp; Pima County Government Officials</p>

## Appendix B. Participants in the Sentinel Event Review Board (SERB)

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Margie Balfour, MD, PhD – Chief of Quality & Clinical Innovation, Connections Health Solutions  
Steve Erdman – Grievance Chair, Sergeant, Tucson Police Officers Association (TPOA)  
Julianne Hughes – Principal Assistant City Attorney  
Claudia Jasso – Chief Development Officer, Amistades, Inc  
Mitchell Kagen – Independent Police Auditor  
Sharon McDonough – Deputy Chief, Emergency Medical Services, Tucson Fire Department  
Annabelle Nunez – Board Chair, Community Police Advisory Review Board (CPARB)  
Jamie O’Leary – Director, City of Tucson Public Safety Communications Department  
Ernesto Portillo – Council Aide, City of Tucson Ward 3  
Ted Prezelski – Management Assistant, City of Tucson Ward 2  
Joe Puglia – Captain, Training Division, Tucson Police Department  
Nathaniel Sigal – Senior Policy Advisor, Mayor Regina Romero  
John Strader – Captain, Operations Division South, Tucson Police Department  
Tonya Strozier – Principal, Holladay Fine Arts Magnet Elementary School  
Andrew Tang, MD, FACS – Trauma Medical Director, Banner University Medical Center

### **Technical Participants**

Chad Kasmar - Deputy Chief, Tucson Police Department  
Eric Kazmierczak – Assistant Chief, Administrative Services Bureau, Tucson Police Department  
Lisa Markkula – Strategic Communications Administrator, Tucson Police Department  
Kristi Ringler – Management Assistant, Office of the Chief of Police, Tucson Police Department

### **Sentinel Event Review Experts**

John Hollway, Esq. – Executive Director, Quattrone Center for the Fair Administration of Justice,  
University of Pennsylvania Law School  
Michael Scott, J.D. – Clinical Professor, School of Criminology & Criminal Justice, Arizona State  
University

### **Facilitators**

Jose A. Vazquez, Esq. – Facilitator – Immigration Attorney, Law Offices of Wolf Sultan Vazquez,  
P.C.  
Monica Prieto – Lieutenant, Violent Crimes Section, Tucson Police Department

## Appendix C. Principles of “Just Culture” Event Reviews

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When Sentinel Events like the three reviewed by the SERB occur, important concepts of procedural justice govern both the decision about whether to discipline the police officers or other responders who participated in the events and how those decisions are communicated both within and outside TPD, TFD, and PCSD. It is essential both for the community and for participants in the events from TPD, TFD, PCSD, etc. and their peers to understand the principles that guide management decisions on whether an individual participant receives discipline. It is also important to acknowledge that the police officers and medics that participated in and were present for these tragedies have participated in a traumatic event for all involved, and the community must include them in its duty of care.

A “just culture” mindset can provide such guidance. Just culture approaches the aftermath of a sentinel event by asking who was hurt, what the needs of those people are, and how those needs can be met.<sup>45</sup> The needs may require discipline, but they may also require additional training, consolation, and other support. “A just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control . . . [and that] many errors represent predictable interactions between human operators and the systems in which they work. [It] recognizes that competent professionals make mistakes, [and] acknowledges that even competent professionals will develop unhealthy norms (shortcuts, “routine rule violations”). A just culture has zero tolerance for reckless behavior.”<sup>46</sup>

A decision grid like the one below can assist TPD management, the IPA and civilian oversight groups like the Tucson CPARB in a case-specific inquiry to determine whether officers involved in such instances should be disciplined or should receive other support when they are involved in sentinel events like the three reviewed by the SERB. In situations where the participant followed protocols or established “best practices,” reactions other than discipline are warranted. In situations where the participant deviated from protocol, an evaluation of the individual’s actions and motivations that combines an “intentionality test” with a “reasonableness” test can lead to more objective and more productive responses that may include, but not be limited to disciplinary action. An example is set forth below in Figure 1.

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<sup>45</sup> Dekker, S. (2012). *Just culture: Balancing safety and accountability*. Ashgate Publishing, Ltd.

<sup>46</sup> See, e.g., [www.psnet.ahrq.gov](http://www.psnet.ahrq.gov).

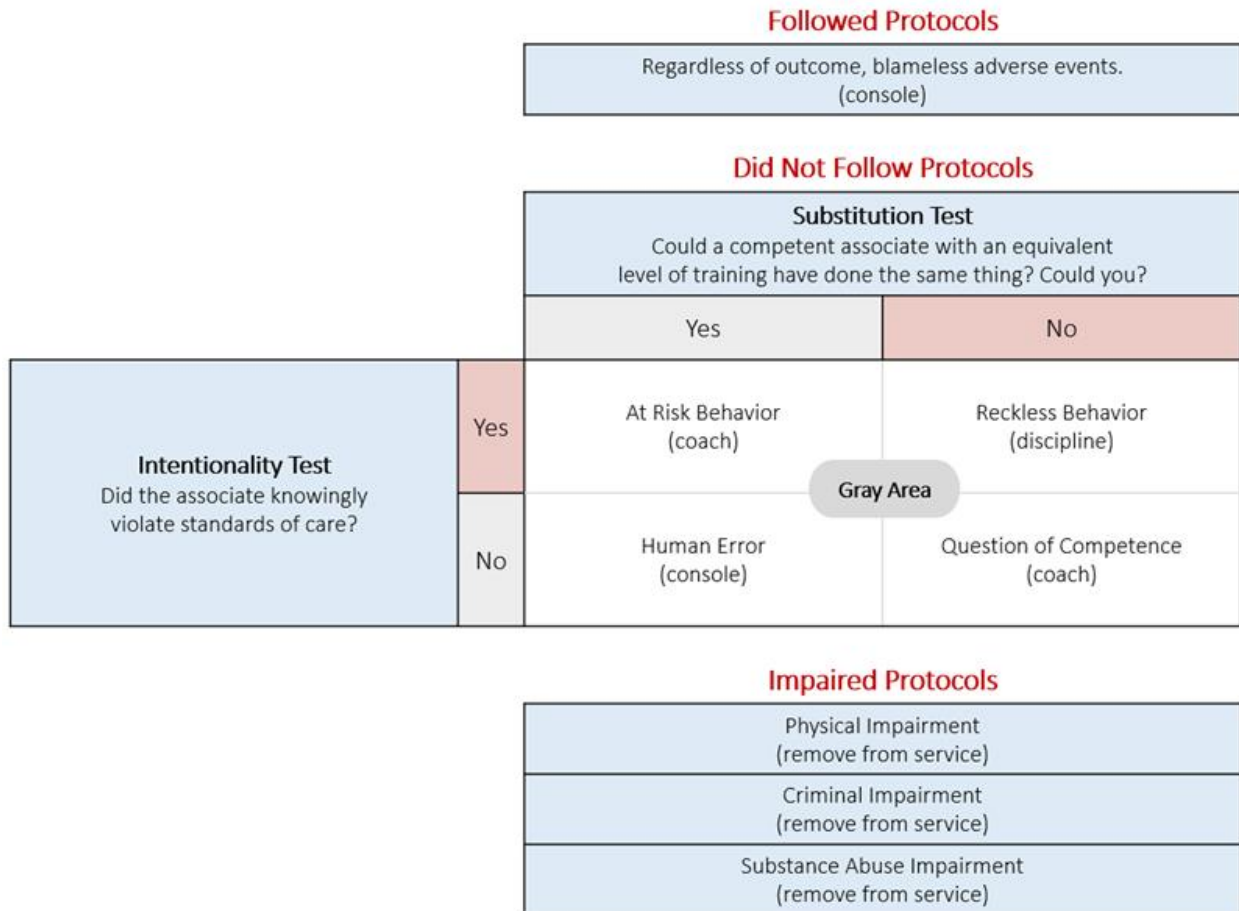
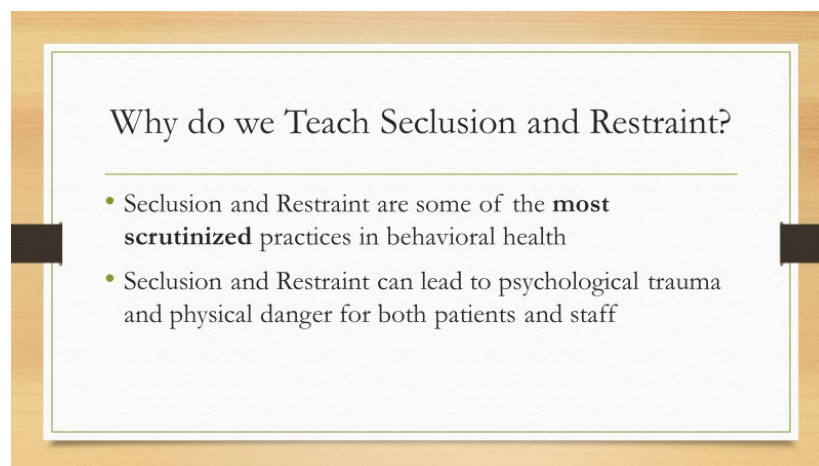
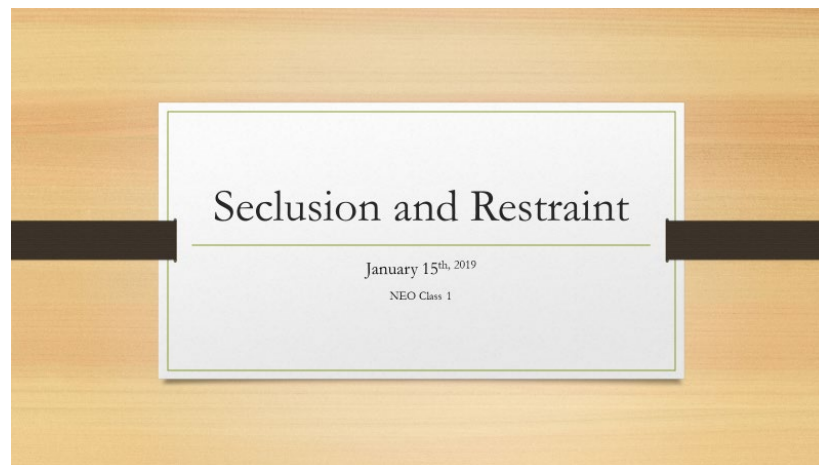


Figure 4. Just Culture Decision Chart.

## Appendix D. Connections Health Solutions Behavioral Health Training Information

Note: These slides are taken from a training session conducted by Connections Health Solutions, a behavioral health center that must sometimes address agitated individuals and calm them without the use of weapons. They are presented here as an example of methods of restraint and de-escalation used by health care professionals who cannot turn to weapons of any sort in these situations. Their precise application in law enforcement scenarios is unknown, and the SERB does not present them as recommendations for TPD to use without modification or customization for actual law enforcement scenarios – but the potential for their use to help TPD or TFD approach scenarios with individuals exhibiting mental health, behavioral health, and/or drug-induced states of agitation should be evaluated. Note: The slides reference statutory requirements for certain activities to be performed every few hours; in practice, the duration of these restraints is on the order of minutes not hours. It should also be noted that these slides are part of a more comprehensive training program that involves in-person training with role playing and physical demonstrations, refresher trainings, and review of data trends and video footage.



## Definitions

- **Restraint:** Limiting or restricting a person's movement
- This includes:
  - Physical holds
  - Carries
  - Mechanical Restraints
- Helping someone who is falling or having difficulty walking is not considered a restraint

## Definitions

- **Seclusion:** The involuntary confinement of a person in a room or area from which the person cannot leave or the person believes he or she is confined by staff direction. The door is closed in a seclusion.

## Definitions

- **Side Room:** A voluntary tool offered to a patient in a designated area. The area must be:
  - Lit
  - Unlocked
  - Unoccupied

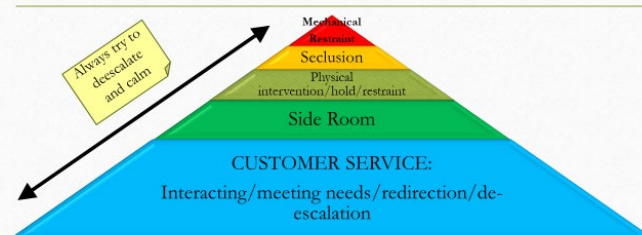
## When do we use seclusion/restraint?

- We **seclude** patients only when there is an immediate danger to others
- We **restrain** patients only when they are an immediate danger to themselves
- We must exhaust all other options before resorting to seclusion/restraint and not intervene with these methods prematurely

## What would you do in each scenario and why?

- Bill is pacing the unit and begins cursing to himself in a raised voice.
- Bill has started repeatedly banging his flat palm on the glass in the bubble.
- Bill now purposely spilled his water on the floor.
- Bill just started screaming at another patient and getting in the patient's face.
- Bill is on the floor and banging his head against the floor with great force.
- Bill just lunged at your coworker and started hitting him in the head.

## Intervention Pyramid



## Human Rights

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- Seclusion and Restraint **must never** be used to:
  - Make an example of a patient
  - Frighten, demean, or humiliate patients
  - Retaliate against a patient
  - Discipline a patient

## What is my role? The team approach

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- All of us work together as a team to prevent incidents from happening by:
  - Providing excellent customer service
  - meeting patients needs
  - interacting with patients
  - being alert to changes in patient behavior

## Your Role during an Patient Escalation

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We all help by:

- Being alert and vigilant as to what is happening on the unit
- Not leaving units unattended during codes
- Covering the floor while BHS staff are intervening
- Helping to deescalate other patients who may be upset by the incident
- Helping our fellow staff to **tap out** when they are tired or upset



### Criteria for Seclusion/Restraint:

- Ordered only by the licensed prescriber on duty
- After all other least restrictive methods to manage behavior have been exhausted
- Must be renewed by provider every three hours
- Continued only until the crisis situation is over
- Only in a designated area for seclusion and restraint
- In a manner that maximizes the person's physical and emotional well being

### Requirements for Seclusion/Restraint:

- The person in seclusion or restraint must be placed on a **1 to 1 status** for the duration of Seclusion or Restraint
- An RN initiates documenting the person's behavior, physical status, and all other categories on the flow sheet in 15 minute increments every 5 minutes for patients with identified medical issues. The RN must initiate the flow sheet, and is also responsible for the last set of recorded vitals during a seclusion restraint.
- For mechanical restraints:
  - Pulse, respiration, and circulation must be checked every 15 minutes.
  - A full set of vitals is completed every 30 minutes and when the patient is released from mechanical restraints.
  - **PATIENT MUST BE FACE-UP**
  - Door must remain open

### Requirements for Seclusion/Restraint

- The nurse completes a face-to-face assessment every hour and the end of S/R
- A full set of vital signs must be taken at the end of Seclusion
- The patient must be offered fluids and toilet visit a minimum of every two hours
- The patient must be offered meals at all regular meal times

## Restraint technique

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- Do not place pressure on joints
- No more than 2 staff actually place mechanical restraints on the patient
- We use four-point restraints
- When releasing mechanical restraints, ALL restraints need to be removed at once.

## Reporting Requirements

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- A seclusion and restraint packet must be completed in real-time, on the shift that it occurred on.
- A RHBA incident report must be completed if a patient dies or is injured during a physical restraint, mechanical restraint, or a seclusion
- An employee injury report must be filled out if a staff member is injured during a physical intervention (form located on the team site)
- An incident reported must be completed if the patient sustained any injuries during the Seclusion/Restrain
- Any damage to the facility must also be noted in the Environmental Event Report (form located on team site). An email may be sent to Trent Barber or William Urbina with Facilities

## Debriefing of the Patient

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- A face-to-face debriefing must occur as soon as possible after the incident
- The patient may decline to participate in the debriefing
- The debriefing form must be filled out and include the circumstances that resulted in the seclusion or restraint
- Support should be given to other patients who may have witnessed the incident. All staff can assist in calming other patients.

## Debriefing of the Staff

- All staff involved in the S/R must receive a debriefing as soon as possible
- If any injuries occurred they must be documented in the incident report and the debriefing form including:
  - Circumstances that caused the injuries
  - Preventative plan for the future

## Appendix E. Revised Tucson Police Department Policies Regarding TARP and Spit Socks

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### **Effective Immediately / August 31st, 2020:**

Members **SHALL NOT** utilize the TARP in a manner where the TARP is wrapped up and around the handcuffs and back to the feet. This is sometimes colloquially referred to as "hog-tying" or "suitcasing" and shall not be used moving forward. All other trained TARP applications remain in effect.

### **In-Person Training:**

Starting today, Defensive Tactics (DT) Instructors will be going throughout Patrol Services Bureau (PSB) briefings to demonstrate approved TARP restraint techniques and answer any related questions. Our goal is to have all PSB training completed by early next week but if for some reason you miss the in-person training, advise your supervisor immediately so your training can be completed.

### **Mandatory Reporting when Using a TARP or Spit Sock:**

Any application of the TARP or spit sock is now a TYPE II Use of Force. A supervisor shall be notified if any of these tools are utilized and it shall be documented in Blue Team as a Type II Use of Force.

If there are any questions regarding the utilization of the TARP, contact Officer Justin Kneup or Officer Abel Urzua at the training academy for details.

## Appendix F. Nextdoor: Reducing Implicit Bias Through Clarifying Questions

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An everyday example of using specific questions to reduce implicit bias can be seen in the popular community app Nextdoor.<sup>47</sup> Nextdoor was receiving “suspicious activity” postings from its user base that raised concerns about implicit bias from the individuals reporting the activity. They sought to defuse concerns that the app would induce fear in the community about innocuous activity being conducted by others. To address this, they added a step in the “suspicious activity” posting that encourages people to do the following:

- Focus on behavior. What was the person doing that concerned you, and how does it relate to a possible crime?
- Give a full description, including clothing, to distinguish between similar people. Consider unintended consequences if the description is so vague that an innocent person could be targeted.
- Don't assume criminality based on someone's race or ethnicity. Racial profiling is expressly prohibited.

### CASE STUDY: NEXTDOOR APP

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**COFOUNDER WANTED TO CURB IMPLICIT BIAS. THEY CREATED A CHECKLIST AND CUT RACIAL PROFILING BY 75%.**

Users must work through the checklist before they can send a “suspicious behavior” alert to their neighbors.



- 1 WHAT IS IT ABOUT THIS PERSON'S BEHAVIOR THAT MAKES THEM SUSPICIOUS?**  
This redirects users to identify the behavior, not the race, as suspicious.
- 2 DESCRIBE THE PERSON.**  
The answer cannot be a description that's purely based on social category. Additional information, such as hair, clothing, and shoes, is required.
- 3 HAVE YOU HEARD OF RACIAL PROFILING?**  
Users are told the definition of racial profiling and that it is prohibited on the site.

[\\*https://behavioralscientist.org/the-bias-inside-a-conversation-with-psychologist-jennifer-eberhardt/](https://behavioralscientist.org/the-bias-inside-a-conversation-with-psychologist-jennifer-eberhardt/)

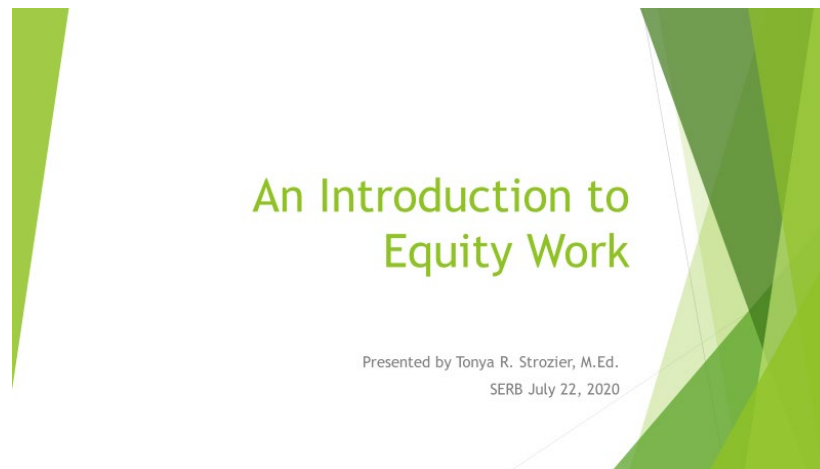


As a result of these simple changes – essentially transforming “see something, say something” into “see something suspicious, say something specific,”<sup>48</sup> Nextdoor estimated a 75% reduction in implicit bias in its crime and safety postings. We believe a similar approach could greatly enhance officer and community safety and reduce community concerns about implicit bias in the everyday work of first responders in Tucson.

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<sup>47</sup> [www.nextdoor.com](http://www.nextdoor.com).

<sup>48</sup> Quote from Stanford psychologist Jennifer Eberhardt, found at <https://behavioralscientist.org/the-bias-inside-a-conversation-with-psychologist-jennifer-eberhardt/>, August 8, 2020.



Turn and Talk:

If you committed a crime today, would you want to be African American, Latinx, Asian, or Indigenous in America?

Why or why not?

The previous groups experience racial injustice to some degree in the following areas:

- ▶ Law enforcement
- ▶ Criminal justice system
- ▶ Education
- ▶ Employment/Professional standards
- ▶ Healthcare
- ▶ Science
- ▶ Wealth/Financial Planning
- ▶ Housing
- ▶ Politics
- ▶ Language
- ▶ Beauty industry
- ▶ Arts and Entertainment
- ▶ Places of worship (segregated hour)

Systemic Racism

Vocabulary

- ▶ Marginalized
- ▶ Race - Social construct
- ▶ Racist - shows or feels discrimination or prejudice against people of other races, or who believes that a particular race is superior to another.
- ▶ Racism - Always has to do with power
- ▶ Dominant culture - A dominant culture is one whose values, language, and ways of behaving are imposed on a "subordinate" culture or cultures through economic or political power.
  - ▶ US systems designed for white, male, English-speaking, middle class+, Christian, neurotypical, able-bodied, heterosexual, cis-gender, etc.





## The call to Defund the Police...why?

- Based on history of mistrust and treatment of communities of color; inequity
- Address structural barriers created by racism, classism along with the policies, practices, and cultural patterns that reinforce marginalization
- A belief that law enforcement can't be changed from the inside out.
- Reallocate resources to more social services
- Redirect services i.e. homeless, mental health

### Turn and Talk

How can equity be achieved in your policing or your field of work?





- ▶ **Ideological (cultural; structural).** Invisible and informs who we are. The intentional ideological development of racism and oppression (in the water we drink). i.e. tells us who is dangerous and who is not
- ▶ **Institutional.** The ideology because a policy or practice. Demonstrated by how institutions and systems reinforce and manifest ideology (make us keep drinking the water). i.e. Who is being arrested?
- ▶ **Internalized.** How we internalize the ideological ideas of oppression (the water we drink) and start to believe them. i.e. Black women are aggressive message; internalized narrative of enslavement
- ▶ **Interpersonal.** The way we play oppression out on each other (the water we spit up on each other).

## 4 I's as key to systemically dismantling racism

- overlap
- interdependent
- influence each other

## Turn and Talk

How do the four I's play out in your personal relationships or profession?

## Game: What comes to mind...

- ▶ A person in prison
- ▶ A convicted felon
- ▶ Politician
- ▶ CEO



EVERYONE has biases (for or against)



We are responsible for knowing them and measuring the potential impact on others (not about intent)

We have an opportunity to grow

We have an opportunity to lead change



### SERB Ethos (spirit of a culture manifested in guiding beliefs and ideas)

- ▶ Extend care (I noticed...I wonder)
- ▶ Willingness to have our beliefs and ideas challenged by others
- ▶ Shared commitment to dismantling racism and oppression in policing
  - ▶ Understand the role that institutional racism and other forms of oppression play in our society and have the skills, vision, and **courage** to dismantle them.
- ▶ An **intentional** inspection of seminal cases that seeks out and responds to potential biases in policies, procedures, and practices in order to prevent future harm
- ▶ Engage in humble inquiry
- ▶ Lean into discomfort

SERB has an opportunity to make recommendations to TPD that will begin the shift to equity

- Develop a vision for equity
- Regularly examine data through an equity lens



## Example...

Community Foundation for Southern Arizona  
Diversity Statement

We believe that diversity, equity, and inclusion is central to our purpose, is a fundamental tenant of our work, and is critical to improving the lives of future generations in Southern Arizona. We seek to challenge and change the practices, norms, and structures that create or perpetuate past, present, and future inequities.

We believe that philanthropy is a vehicle to create equity. Our interactions with all individuals and communities are characterized by humility, respect, and transparency. We know that communities are experts regarding their own needs and solutions, and that it is our role to be an active listener. We invest in developing leadership capacity within all of Southern Arizona's diverse communities, and we trust that those communities are capable of creating systemic change.

We believe that diversity and inclusion drive innovation. We courageously confront racism and discrimination, and establish practices that embed our values at the core of who we are. We actively recruit the participation and inclusion of Southern Arizona's diverse cultural and social groups in all of our activities, at all levels of policy development, and throughout all decision-making processes.

We believe in doing better. We engage in continuous and intentional self-evaluation throughout all levels of the organization, and we openly solicit feedback from Southern Arizona's diverse populace. We acknowledge that growth requires change, and we are committed to transformation.

## Sources

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- Re-center Race & Equity in Education. 5 Shifts to Cocreate Equity
- Reynolds, J. and Kendi, I. (2020). *Stamped: Racism, Antiracism and You*



Phone (520) 603-7074  
Fax (520) 577-6699  
bestrada@dakotacom.net  
5632 N Cherokee Ridge Rd.  
Tucson, AZ 85750

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*Providing technical services to the health and social services field*

# Results from the Cultural Proficiency Continuum Self-Assessment

*Report written for:*  
*Claudia Jasso*  
*Chief Development Officer*  
*Amistades, Inc.*

*Report written by:*  
*Antonio L. Estrada,*  
*Barbara D. Estrada*  
*Impact Consultants, Inc.*

*August 10, 2020*

## Introduction

In response to the recent sentinel events in which Tucson Police Department (TPD) officers were involved, a Sentinel Event Review Board (SERB) was formed to examine the contributing factors for each event. The SERB is comprised of individuals that represent law enforcement as well as other sectors of the community.

## Methods

The Cultural Proficiency Continuum Self-Assessment (CPCSA) was developed by Amistades, Inc. in order to assess the SERB's self-reported knowledge about the six domains along a cultural proficiency continuum. The domains describe aspects of cultural competence, in order of least to most culturally proficient and include, Cultural Destructiveness, Cultural Incapacity, Cultural Blindness, Cultural Pre-Competence, Cultural Competence, and Cultural Proficiency. Respondents are asked to respond "yes," "no," or "unsure" as to how well they can describe four aspects of each domain. Respondents could also write in comments about each domain. The CPCSA was provided to all 21 members of the SERB and each person completed the form individually. Sixteen (16) individuals completed the CPCSA, and all were used in this analysis.

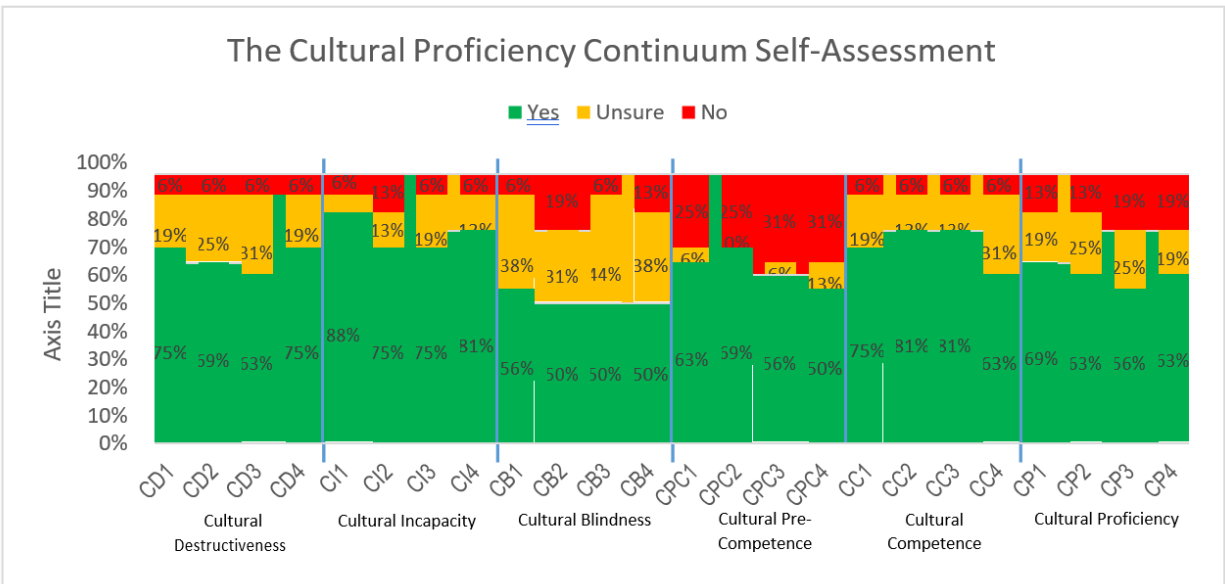
## Analysis

It was not clear from the construction of the CPCSA how many responses were required in each domain. The CPCSA is included at the end of this report for reference. Some respondents placed one check mark in one of the columns for a total of one response per domain, whereas other respondents placed a check mark next to each of the bullets, for a total of four responses per domain. In order to have comparable data across all respondents, for the respondents where one check mark was present we assumed the same answer for all 4 bullets. A frequency distribution of each of the resulting 24 items (6 domains with 4 items each) was completed and the results presented in the graph below.

## Results

In the graph below, each of the bars represent one of the items from the CPCSA and they are listed from left to right in the order they appear in the CPCSA. Vertical lines separate each of the 6 domains. Each bar is divided into three segments representing the percentage of the 16 respondents who answered "yes," (in green), "unsure," (in orange), and "no" (in red) for each question.

Most respondents are able to describe the domain of Cultural Destructiveness (63%-75%), Cultural Incapacity (75%-88%), Cultural Competence (63%-81%), and Cultural Proficiency (56%-69%), two domains stood out as perhaps needing more attention. The respondents were most "unsure" about how to describe the Cultural Blindness items (31%-44%), and at least a quarter were "unable" to describe Cultural Pre-Competency items (25%-31%).



## Conclusions

As revealed in the analysis, the majority of respondents to the Amistades CPCSA report relatively high levels of knowledge regarding the overall domain of cultural competency. More importantly, they can distinguish between the domains of Cultural Destructiveness at the negative end of the continuum and Cultural Proficiency at the positive end of the continuum. The domain in most need of additional attention is the Cultural Blindness domain, which is a very important finding. With only half of respondent being able to describe the domain, a significant proportion are “unsure.” Clearly, more training in the area of Cultural Blindness. Cultural Blindness leads everyone to be treated the same without the recognition of cultural influences on behavior.

## THE CULTURAL PROFICIENCY CONTINUUM SELF ASSESSMENT

Read each of the points on the continuum presented in *italics*, and the indicators that follow. Marking *Yes* indicates that you can provide most of the requested descriptions. Marking *No* indicates that you do not have sufficient knowledge to make any of the descriptions. Marking *Not Sure* indicates that you may be struggling with the description of that point on the continuum and are not certain of your own base of knowledge.

<b><i>The Continuum and Indicators</i></b>	Yes	No	Not Sure	Comments On This
<b>Cultural Destructiveness</b> – <i>I can describe how cultures that are different from mine are negated, disparaged, or purged by:</i> <ul style="list-style-type: none"> <li>• Describing how systems of oppression (i.e., racism, sexism, homophobia) are represented in the history of our country</li> <li>• Describing how historical oppression is usually invisible in our history and literature texts.</li> <li>• Describing how the invisibility of culture in schools leads to non-dominant groups not being viewed as legitimate.</li> <li>• Describing one specific example of cultural destructiveness in our school.</li> </ul>				
<b>Cultural Incapacity</b> – <i>I can describe how my cultural values and beliefs can be elevated and how cultures that are different from mine can be suppressed by:</i> <ul style="list-style-type: none"> <li>• Describing how superiority and inferiority are represented in the history of our country (e.g., Jim Crow laws and the need for civil rights acts, school desegregation).</li> <li>• Describing discriminatory practices present in some educational settings.</li> <li>• Describing instances of low expectations held by educators.</li> <li>• Describing examples of subtle messages to people that they are not valued.</li> </ul>				
<b>Cultural Blindness</b> – <i>I can describe how I can act to not see or differences among cultures and to not recognize differences by:</i> <ul style="list-style-type: none"> <li>• Describing how the messages that people intend to send are often not what is heard by others.</li> <li>• Describing the value placed in this country on pretending not to see difference.</li> <li>• Describe how textbooks do not include the meaningful representations of non-dominant groups.</li> <li>• Describing how we use expressions such as <i>you need to work a little harder</i> and <i>don't be so sensitive</i> to dismiss people's struggles.</li> </ul>				

<b><i>The Continuum and Indicators</i></b>	Yes	No	Not Sure	Comments On This
<b>Cultural Pre-Competence</b> – <i>I can describe how my lack of knowledge, experience, and understanding of other cultures limits my ability to interact with people whose cultures are different from mine by:</i> <ul style="list-style-type: none"> <li>• Giving examples of the frustration of knowing that current practices are not effective and not knowing what to do.</li> <li>• Describing instance of jumping to easy solutions that have no sustaining effect.</li> <li>• Describing the paradigmatic shift that occurs when moving from talking about <i>others</i> as being the problem to discussing how one changes their <i>practices</i> to meet the needs of people from other cultural groups.</li> <li>• Describing the movement at this point in the continuum as representing a <i>tipping point</i>.</li> </ul>				
<b>Cultural Competence</b> – <i>I can describe my use of the essential elements as standards for adapting my behavior by:</i> <ul style="list-style-type: none"> <li>• Describing how I am aware of the impact my culture has on others.</li> <li>• Describing how valuing diversity is different from tolerance.</li> <li>• Describing how one adapts to diversity in order to be effective.</li> <li>• Describing how one uses the essential elements to leverage change, personally and organizationally.</li> </ul>				
<b>Cultural Proficiency</b> – <i>I can describe my constructive experiences in a variety of cultural settings by:</i> <ul style="list-style-type: none"> <li>• Describing how learning about cultures is a life-long process.</li> <li>• Describing examples of advocacy as a moral construct.</li> <li>• Describing examples of esteeming the cultures of others.</li> <li>• Describing how one learns about the cultures of others, including organizational cultures.</li> </ul>				