

The Minkler Incident

Findings

and

Recommendations

Dedication



Joel Wahlenmaier

Fresno County Deputy Sheriff

Killed in the Line of Duty



Javier Bejar

Reedley Police Officer

Killed in the Line of Duty

February 25, 2010

Sheriff's Message

Detective Joel Wahlenmaier and Officer Javier Bejar left their homes and loved ones on February 25, 2010, to do their duty and did not return. We will never forget Joel and Javier's valor and their families' sacrifices. Joel and Javier died in defense of the innocent and in service to the public by upholding their oaths to keep the peace with honor and bravery. These peace officers will forever be remembered as human beings, not as statistics.

There are two families and two law enforcement agencies that have endured the terrible trauma of suddenly being left without a father, a husband, a friend and a brother officer. Abraham Lincoln once said to a grieving mother who lost sons to war, "I pray that our heavenly Father may assuage the anguish of your bereavement, and leave you only the cherished memory of the loved and lost, and the solemn pride that must be yours to have paid so costly a sacrifice upon the altar of freedom."

Today, the men and women of law enforcement continue to serve the public by placing themselves at the helm of danger. This report is an independent assessment and unflinching analysis of how such an incident occurred, and what can be done to prevent future occurrences.

Sheriff Margaret Mims, Fresno County Sheriff's Office

Acknowledgement

In the highest traditions of law enforcement's rich history, the policing actions demonstrated by the peace officers involved were admirable and courageous. The Minkler Incident subjected the officers to significant rounds of gunfire, presenting a highly dangerous and violent situation.

Law enforcement personnel from the following local, state and federal policing agencies are recognized for placing themselves in harm's way and for their efforts in addressing and investigating the incident's aftermath.

California Department of Forestry and Fire Protection

California Department of Justice

California Highway Patrol

Clovis Police Department

Fresno County Sheriff's Office

Fresno Police Department

Hanford Police Department

Orange Cove Police Department

Parlier Police Department

Reedley Police Department

Sanger Fire Department

Sanger Police Department

Selma Police Department

U.S. Bureau of Alcohol, Tobacco, Firearms & Explosives

U.S. Federal Bureau of Investigation

U.S. Marshal's Service

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Critical Incident Report

On Thursday, February 25, 2010, a search warrant was served by peace officers in Minkler, California. Rick Liles, a security officer who was not working due to an injury, responded with gunfire. Liles' violent behavior exposed numerous community members and peace officers to serious bodily injury and death. When the incident ended, two peace officers were killed and another was wounded.

Fresno County Sheriff Margaret Mims directed an independent review to identify the challenges faced, the decisions made, the strategies utilized and the lessons learned. This included law enforcement activities before, during and after the incident.

This report is solely based on the documents reviewed and the interviews conducted by the authors. As a result, the authors do not, and cannot comment or base any conclusions on any person's account with whom they did not speak or any documents which were not reviewed.

The Report's Purpose

- Assess Policing Actions – Policy, Tactics and Training
- Review Force Used
- Develop Findings
- Identify Law Enforcement's Best Practices
- Provide Advisory Recommendations
- Enhance Policing Knowledge
- Improve Peace Officer Safety, Skills and Awareness

Fresno County

Fresno County is located in California's Central San Joaquin Valley. Over 930,000 people live and work within 6,017 square miles. Agriculture is the primary industry and the county is considered the United States' most agriculturally rich area.

Town of Minkler

Minkler is a small community of 5.9 square miles in eastern Fresno County. The town has a population of 30 with one small business called the "Minkler Cash Store."

Fresno County Sheriff's Office

The Fresno County Sheriff's Office (FCSO) is a full-service law enforcement agency. When the incident occurred, the workforce consisted of over 1,100 employees assigned to civilian, correctional and sworn positions. Patrol and investigative services are provided to a geographically diverse county with mountainous terrain, a heavily populated central area and vast agricultural lands.

Fallen Deputy Heroes

In the service of Fresno County, 12 FCSO peace officers have been killed in the line of duty. The first death occurred on March 13, 1907, when FCSO Deputy Joe D. Price was transporting an arrested criminal. Since then, 11 additional deputies, including Joel Wahlenmaier, have made law enforcement's ultimate sacrifice. These deputies are honored on the Fresno County Peace Officer's Memorial.

Reedley Police Department

The Reedley Police Department is a full-service law enforcement agency with over 40 civilian and sworn employees. The police department provides service to over 24,000 people within 5.1 square miles.

Fallen Officer Hero

Police Officer Javier Bejar was the first Reedley police officer to die in the line of duty. A memorial garden was dedicated in his honor at the Reedley Police facility and his name was added to the Fresno County Peace Officer's Memorial.

Before The Incident

Prior to the critical incident, the following California Department of Forestry Fire and Protection (CAL FIRE) and FCSO policing activities occurred:

- FCSO's Response to Crimes in Minkler by Patrol Deputies
- CAL FIRE's Response to Arson Crimes in Minkler
- CAL FIRE's Preliminary & Follow-up Investigations
- FCSO's Preliminary Investigations by Patrol Deputies
- FCSO's Follow-up Investigations by Detectives
- CAL FIRE's Search Warrant Preparation
- CAL FIRE'S Search Warrant Operational Plan

Arson and Shooting Crimes

Between August of 2009 and Tuesday, January 19, 2010, a series of fires occurred in Minkler near Kings Canyon Road. California Department of Forestry and Fire Protection (CAL FIRE), Fire Prevention Specialists investigated 17 fires. Eleven of the seventeen fires, or 65%, were determined to be arson caused. The remaining six fires, or 35%, were classified "undetermined, but suspicious in nature." Since the majority of the fires originated at night, the CAL FIRE investigator concluded that the arsonist was using the hours of darkness to remain undetected.

Starting in May of 2009 through Monday, February 22, 2010, the FCSO received 14 service requests. Minkler homeowners reported hearing gunshots and discovering bullet holes in commercial and residential properties. On five separate occasions, Minkler Cash Store employees found holes in the building. They believed that the damage was caused by gunshots that occurred at night when the store was closed.

A Victim is Shot

On Monday, February 22, 2010, at 2205 hours, five bullets were fired into a Minkler home. A 69 year old female resident suffered a minor gunshot injury. At the scene, medical personnel treated her bruised hip. This was the first crime in which a person was injured.

FCSO Preliminary Patrol Investigation

During the preliminary patrol investigation, the following occurred:

- The bullets fired into the shooting victim's home likely originated from the area near the Minkler Store.
- It was recognized that Rick Liles and the shooting victim's homes are across the street from the Minkler Store. However, the deputies found no physical evidence near the Minkler Store or Liles' residence.
- When the deputies knocked on Liles' front door, he did not answer.
- A patrol deputy was aware from reading the "Beat Forum," a FCSO crime information resource, that a surveillance camera had been installed by CAL FIRE at a neighbor's home to capture activity at the Liles' residence.

The FCSO patrol deputies and field sergeant felt that Rick Liles was responsible. Their conclusions were based on previous responses and preliminary investigations to other Minkler crimes and service calls.

Investigating Detective Notified

One of the responding patrol deputies who were at the shooting victim's house telephoned Detective Wahlenmaier at his home. During their telephone conversation, the following happened:

- The patrol deputy asked if the camera footage would link this firearm assault to Rick Liles. Wahlenmaier said the camera did not have "night vision" and he would check with CAL FIRE to see if video evidence existed.
- Wahlenmaier related that a search warrant with CAL FIRE was being prepared and he would participate in the service. Wahlenmaier was going to search for ammunition and firearms that may be linked to the Minkler shooting crimes.
- The patrol deputy said there had been previous shooting incidents resulting in damage to the Minkler Store and a nearby power transformer and that Rick Liles was believed to be responsible. Wahlenmaier acknowledged that he was aware of the previous crimes.
- This patrol deputy, who had prior FCSO detective experience, told Wahlenmaier to use a *Risk Assessment Matrix*. Wahlenmaier responded that it was not their (FCSO) warrant and no *Risk Assessment Matrix* would be completed.

- Due to the gunfire at multiple Minkler incidents, the deputy suggested that Special Weapons and Tactics (SWAT) personnel may be necessary to serve the warrant. Wahlenmaier responded that it was a CAL FIRE search warrant and FCSO was going to “piggy back off their warrant,” hoping to find physical evidence related to the shooting.

A Supervisor’s Concern

The next day, Tuesday, February 23, 2010, the field sergeant who supervised the investigation where the woman was shot, telephoned Wahlenmaier. The sergeant related concerns that “Liles was going to hurt someone badly.” Wahlenmaier agreed and said the case was a priority.

Search Warrant Preparation

Prior to the shooting victim incident on February 22, CAL FIRE had requested FCSO assistance with warrant preparation and service. Wahlenmaier was assigned this responsibility. However, his independent efforts were without the traditional support from another FCSO detective.

Detective Wahlenmaier, his immediate supervisor (detective sergeant) and the CAL FIRE Specialist all agreed that the search warrant justification was legal but “weak” in substance. Collectively, they speculated that the judge might not approve the warrant.

During warrant service preparation, Wahlenmaier did not complete a FCSO *Risk Assessment Matrix*. When asked about the *Risk Assessment Matrix*, the following occurred:

- Wahlenmaier told a fellow detective, “It was a seven and we are going to serve it.”
- Wahlenmaier informed the detective sergeant, “Yes, we will handle this” when asked if he completed the matrix.

Detective Wahlenmaier and his sergeant concluded that Wahlenmaier’s analysis did not find sufficient reasons (points) to justify the completion of a *Risk Assessment Matrix*.

Speculation

Approximately one year earlier, a detective remembered that Wahlenmaier had used FCSO SWAT personnel for a warrant service. Since that operation experienced no resistance, discovered no firearms and found only a small amount of marijuana, Wahlenmaier was “teased” by fellow detectives. This detective speculated that the intended humorous behavior may have improperly influenced Wahlenmaier to not involve SWAT.

FCSO Requires an Operational Plan

On June 21, 2007, FCSO issued Department Order 1279, “Planned Tactical Operations” This order is a planning and execution guide for tactical operations, such as arrest/search warrants. The order requires compliance with the following:

- Case Preparation – The Planning Initiates (*Risk Assessment Matrix*)
- Scouting and Intelligence Gathering
- The Operational Plan
- Contingency Planning – Plan for the Worst Case Scenario
- Briefing
- Caravanning to the Location/Terrain
- Deployment
- Door Breaching
- After Action Debriefing

This order states on page two, “The *Risk Assessment Matrix* shall be used during the planning stages of any search warrant or arrest warrant to determine the relative threat level of the operation(s) and whether additional assets (e.g. the use of SWAT) should be consulted or required. The intent of the *Risk Assessment Matrix* is to ensure appropriate units/personnel are performing planned operations based on training and skill level.”

The Operation Plan for the Search Warrant

The CAL FIRE Specialist, the search warrant affiant, completed the following Incident Command System (ICS) forms on Wednesday, February 24, 2010. It was noted that these forms had a completion date of Thursday, February 25, 2010.

- ICS 202 – Incident Objectives
- ICS 203 – Organization Assignment List
- ICS 204 – Division Assignment List
- ICS 205 – Incident Radio Communications Plan

- ICS 206 – Medical Plan

Following the ICS 206 Form were two pages. The first page was titled “Synopsis.” The Synopsis Section, a brief paragraph, documented that Rick Liles was involved in the following crimes:

- Causing Arson Fires – 11 Occurrences
- Shooting at the Minkler Cash Store - Five Occurrences
- Shooting at a Neighbor’s Residence – Two Occurrences
- Wounding a Neighbor with a Bullet

The following information was also noted in the Synopsis Section:

- Rick Liles lived with his spouse, Dianne Liles.
- Rick Liles was believed to have shot his neighbor due to an “on-going dispute.”

Tactical Operations – Review & Approval

The ICS forms constituted the Operational Plan for search warrant service at Rick Liles’ residence. According to the detective sergeant, the detective lieutenant or the patrol lieutenant watch commander, the following occurred:

- Wahlenmaier presented the CAL FIRE Operational Plan to the Detective Sergeant without a *Risk Assessment Matrix*. When asked why there was no matrix, Wahlenmaier explained that it was unnecessary.
- The Detective Sergeant notified his lieutenant that FCSO detective personnel were going to serve a search warrant with CAL FIRE personnel the next day, February 25, 2010.
- When the Detective Lieutenant asked if FCSO SWAT was going to serve the warrant, the sergeant responded “no.”
- The detective lieutenant did not receive a copy of the CAL FIRE Operational Plan. Instead, the detective lieutenant was verbally briefed by the sergeant.
- Either the Detective Sergeant or Wahlenmaier provided the Patrol Lieutenant Watch Commander a copy of the CAL FIRE Operational Plan.

- The Patrol Watch Commander felt that the sergeant gave him the plan, stating “Detectives were going out on a warrant to collect some evidence, and they did not expect the guy to be there.”
- The Lieutenant Watch Commander accepted and reviewed the CAL FIRE Operational Plan. He concluded there were no firearms and noted there was no attached FCSO *Risk Assessment Matrix*.
- Based on the Detective Sergeant’s comments, the Lieutenant Watch Commander concluded that the warrant involved an empty house, where detectives would “Grab some evidence and leave.”
- The three FCSO supervisors confirmed that they did not request a separate FCSO Operational Plan with a *Risk Assessment Matrix*.
- At no time did the reviewing FCSO supervisors see a *Risk Assessment Matrix*.

Pre-Incident Indicators

Before the search warrant service involving Rick Liles and his residence, the following information was either available to, known by or shared with Detective Wahlenmaier. Furthermore, these facts were known by various FCSO personnel.

- Over a two year period, the resident injured by gunfire on February 22, 2010, had verbal confrontations with Rick Liles. Liles’ animosity stemmed from being moved from a double-wide mobile home to a single-wide mobile home owned by this resident.
- Seventeen arson fires occurred in the town of Minkler starting in August, 2009.
- The majority of the fires originated at night so the perpetrator would be undetected.
- The fourteen FCSO service calls in Minkler involved “Shots being fired.”
- In 2009, between May 22 and December 31, there were six “Shots being fired” service calls.
- In 2010, between January 1 and February 22, there were eight “Shots being fired” service calls.
- Four of the fourteen “Shots being fired” service calls, or 28.5%, occurred in February of 2010. In fact, three of the four “Shots being fired” service calls occurred nine days before planned warrant service.

- Bullet holes were discovered in various Minkler commercial and residential properties.
- The Minkler Store owner concluded from the angle of a bullet hole, that this was caused by a gunshot that originated from Rick Liles' mobile home.
- The following four FCSO crime reports were completed and related to Rick Liles' possible criminal activities:
 - February 22, 2010 - Assault with A Deadly Weapon
 - January 18, 2010 - Shooting into an Inhabited Dwelling
 - January 12, 2010 - Vandalism
 - October 5, 2009 – Vandalism
- On Monday, February 22, 2010, three days prior to the warrant service, Liles was believed to have shot at his neighbor's home with a rifle, causing minor injury to the resident's hip.
- There was recent evidence that Liles possessed firearms, including a rifle.

The Operational Plan Briefing

On Thursday, February 25, 2010 at 0900 hours, CAL FIRE and FCSO law enforcement personnel met at the CAL FIRE building located just outside the City of Sanger. A CAL FIRE Specialist, who was the search warrant affiant, and Detective Wahlenmaier, who was FCSO's lead investigator, conducted a 15 to 30 minute briefing. The CAL FIRE Search Warrant Operational Plan was used to brief the Operations Team. Other facts and the following information were shared:

- Rick Liles was strongly believed to be responsible for the arson fires.
- Three days before, Rick Liles was suspected of shooting at an inhabited dwelling where a woman was wounded.

Following this briefing, 13 search warrant team members went to the CAL FIRE parking lot to stage, acquire equipment, dress and caravan to the search warrant site. The involved personnel are documented on an ICS 203 Form, titled "Organization Assignment List."

The Critical Incident

Search Warrant Service

The Search Warrant Team approached the mobile home, providing repeated “Knock and Notice” announcements. When there was no acknowledgement, a loud speaker was utilized by a uniformed patrol deputy. Again, no response was received. A telephone call was initiated, receiving an answering machine’s recorded message.

Due to no answers, Detective Wahlenmaier followed the plan to force entry by breaching the locked door. Initially, Wahlenmaier kicked the door several times and then forced entry with a tool. The outer door opened to an enclosed area that was attached to the mobile home. This small room was cluttered with a washer, dryer and other items. Due to the clutter and limited space, only three team members could enter.

Within this small space, the team encountered another locked door. “Knock and Notice” announcements were repeated and shortly thereafter, a male adult voice calmly inquired who they were seeking. This person then said that they had the wrong house and the person they wanted was next door. One of the team members then demanded that the door be opened in compliance with the search warrant.

“Shots Fired, Deputy Down”

Detective Wahlenmaier set the “Hallagan” entry tool in the door frame. As the entry tool was struck with a “Ram,” outbound gunfire erupted from inside. Wahlenmaier was struck above his body armor, falling to the ground where a team member intentionally laid on top of him and covered the closed doorway with his firearm. The other team member exited the enclosed porch to a predetermined “rally” position as he expected the other two detectives to follow.

After Wahlenmaier was wounded, the team member who remained inside the porch with Wahlenmaier speculated that the armed suspect did not know where he and Wahlenmaier were. He decided to remain quiet and prepare for the door to open. Thus, he placed his foot on the door to receive a warning and slow the door’s opening.

Another detective who was not inside of the enclosed porch chose not to redeploy to the “rally” point, returning gunfire and moving to an alternate position. The detective, who had earlier exited the enclosed porch, assembled a rescue team as he believed two deputies were down from gunfire.

The remainder of the “stacked” entry team, who could not enter the enclosed small area, remained in position or moved to nearby parked vehicles to acquire superior firearms and more

ammunition. Once rearmed, they joined other team members and prepared for an entry to rescue the deputies.

The detective, who was a member of the initial porch entry team, developed a rescue plan with specific assignments and appropriate weaponry. This included three deputies to extract and carry the wounded detectives from the porch. If necessary, other rescue team members would provide cover fire.

The rescue team was met by concentrated, focused and immediate gunfire. As the gunfight continued, the rescue team entered the enclosed area to extract the wounded detectives. The entry team discovered that the detective inside with Wahlenmaier was not wounded. This detective then returned cover fire to further protect rescue efforts.

The third member of the rescuing team, a uniformed deputy, could not enter due to limited space. This team member assumed a cover fire position, protecting the rescuers and Wahlenmaier with suppressive gunfire. While the rescue was underway, this deputy was struck in the face and front upper torso. Although his face was wounded with debris or bullet fragments, his torso was uninjured due to his body armor.

Initially, the rescue team was not successful in extracting Wahlenmaier. Despite exhaustion, team members eventually determined that Detective Wahlenmaier's equipment belt was caught on a broken piece of door frame that was lying on the ground underneath Wahlenmaier. A detective re-entered the porch area and freed Wahlenmaier's equipment belt, allowing Wahlenmaier to be successfully evacuated to an ambulance. Detective Wahlenmaier was transported to County Regional Medical Center (CRMC) in Fresno. Unfortunately, Detective Wahlenmaier was pronounced dead at the hospital.

Law Enforcement Response

During the hours that followed the shooting of the two FCSO deputies and a Reedley Police Officer, hundreds of peace officers at various ranks and from local, state and federal law enforcement agencies responded.

Armed and Barricaded Suspect

This incident started at approximately 0950 hours when Rick Liles refused law enforcement entry in compliance to a legal search warrant. At 0953 hours, SWAT was requested. For the next hour and ten minutes, Rick Liles engaged various peace officers with gunfire.

During this armed and barricaded incident, Liles concealed himself inside his mobile home, shooting at peace officers and refusing to surrender. The law enforcement victims of Liles'

firearm attacks were in uniform and recognizable as peace officers. Liles was armed with multiple handguns and rifles, possessed significant ammunition and had a police radio scanner.

Possible Female Hostage

When the first SWAT Team Leader arrived, this FCSO sergeant moved to a position of advantage behind a large metal storage container. This was approximately 40 feet from the mobile home where the two deputies were wounded.

Due to a detective's radio transmissions, the SWAT sergeant concluded that this detective was "running the call." This detective provided the following information:

- All injured law enforcement personnel had been evacuated for medical treatment.
- A perimeter was established around the trailer.
- The suspect was identified as Rick Liles and there was a physical description.
- Liles was believed to be firing a rifle.
- A brief synopsis of deployed law enforcement personnel, the gun battle and the suspect was provided.
- It was believed that Liles' wife, Dianne Liles, was inside the mobile home and that she was not wanted for criminal charges.

Based on the aforementioned information and the SWAT Team Leader's observations, he directed that no additional law enforcement personnel be sent forward. Although it was unknown if Dianne Liles was involved in the gun battle, it was recognized that she was possibly being held against her will. This potential hostage situation dictated specific tactical objectives and narrowed tactical options.

"Shots Fired, Officer Down"

As the first hour passed, Rick Liles continued to fire numerous rounds from different handguns and rifles at peace officers. Various officers were "pinned down" in unsafe positions. Due to the significant amount of gunfire coming from Liles' trailer, the officers were unable to safely redeploy. As Liles continued to shoot at various officers, SWAT leaders were staffing an armored vehicle with SWAT personnel to rescue these officers.

As Liles continued heavy and sporadic gunfire, Reedley Police Department (RPD) Officer Javier Bejar deployed 244 feet south of Liles' residence. While Bejar was behind a marked police

vehicle's front passenger door he exchanged gunfire with Liles. At 1053 hours, Officer Bejar was shot in the head.

Bejar was immediately rescued by a team of officers from the California Highway Patrol, FCSO and RPD. Despite Liles' heavy gunfire, Bejar was safely moved to an unmarked police truck and transported to a waiting paramedic unit. Medical personnel provided treatment and transported Bejar to CRMC.

On Monday, March 1, 2010, Officer Bejar was removed from life-support and his organs were donated. One of the recipients was a California peace officer.

Special Weapons Team Enters

Liles continued to direct excessive and sporadic gunfire at different officers. This gunfire created an immediate danger to the lives of community members and the trapped peace officers. It was obvious that Liles was heavily armed, barricaded, and refusing to surrender.

Special Weapons and Tactics teams from the following law enforcement agencies responded:

- FCSO
- Fresno Police Department (FPD)
- Clovis Police Department (CPD)

While the aforementioned SWAT teams were deployed in Minkler, the Tulare SWAT team agreed to be available for emergency response to their policing jurisdictions.

During the next seven hours, the FCSO, FPD and CPD SWAT teams successfully accomplished the following:

- Established a Tactical Operation Center (TOC).
- Established inner perimeter containment of Liles' mobile home.
- Evacuated community members and peace officers using armored vehicles.
- Recognized that Liles' wife was inside the mobile home.
- Staffed an "Arrest/React Team."
- Directed peace officers at outer perimeter positions to assume "low cover" positions, ensuring that their firearms were not pointed at inner perimeter personnel.
- Identified an adjacent mobile home as a "cover/containment" position for SWAT personnel. This was not immediately staffed due to the proximity to Liles' position.

- Deployed SWAT snipers.
- Deployed Crisis Negotiation Teams with FCSO personnel as the primary team and CPD in a support role to speak with anyone inside Liles' residence.
- Developed tactical options if Liles' wife was used as a hostage or "shield."
- Conducted aerial reconnaissance using the FCSO Air Unit with all three SWAT Team Commanders (FCSO, FPD, and CPD) aboard the same flight.
- Gathered information from the peace officers who were extracted via the
- Multi-Jurisdictional armored vehicle.
- When Officer Bejar was shot, a SWAT team member effectively provided cover fire during his rescue.
- Deployed Tactical Emergency Medical Services (TEMS) personnel.
- Provided slow and timed cover fire at selected times into the upper eaves of Liles' residence to protect fellow officers.
- Used the armored vehicle as a platform to provide cover fire.
- Recognized the need for an additional armored vehicle.
- Used the armored vehicle to "run over a fence" to create an unobstructed breach point path for a potential emergency entry.
- At 1146 hours, directed all SWAT personnel to switch to a common radio frequency.
- Conducted a site orientation with the armored vehicle for the CPD and FPD SWAT Team Leaders.
- Provided the SWAT Reaction Team with diversionary devices.
- Used the armored vehicle's public address system to provide verbal commands to anyone inside the mobile home to exit.
- Used the armored vehicle to safely detain Dianne Liles when she exited the mobile home in compliance with verbal commands.
- Interviewed Dianne Liles after she left the residence, developing a "diagramed layout"
- Developed a Chemical Agent Introduction Plan.

- Recognized that Dianne Liles' statement could be a diversion to lure additional peace officers inside the mobile home.
- Notified SWAT personnel that chemical agents would be deployed into Liles' residence.
- Used the armored vehicle as a platform to insert micro particle CS (non-burning) into the mobile home, monitoring that these rounds were not exiting on the opposite side of the structure.
- Utilized the armored vehicle to deploy a pole camera and a Recon Scout remote-controlled "Throwbot" to conduct an interior visible search.
- Used a Sting-Ball, less lethal force option, to determine the downed suspect's reaction to the entry team.
- Recognized that the "Three Side" of Liles' residence was flooded with water near a dangling electrical outlet. Consequently, power to the mobile home was shut off.
- Completed outbuilding structure searches.
- Ensured that SWAT personnel who used deadly force were available to the investigators.

The Person Responsible

During the arrest warrant service and throughout the time that followed, Rick Liles' reactions to law enforcement presence created a dangerous and difficult situation that demanded immediate tactical and use of force policing actions. After a prolonged gun battle with numerous gunshots that exposed community members and peace officers to deadly dangers, the incident finally ended after Liles committed suicide by a self-inflicted gunshot to the head.

Rick Liles was 51 years of age, previously divorced and currently married to Dianne Liles for three years. He worked as a security officer for the past ten years and was not working due to an injury. A family member provided the following account of Rick Liles' activities and behavior:

- Firearms – Always armed with a weapon while inside and outside of his home.
- Concealed Weapons – In public, concealed his firearm from view.
- "A Loner" – Depressed, quiet and kept to himself.
- Drugs - Taking multiple prescriptions.
- Ammunition, Magazines & Firearms – Maintained significant amounts of loaded magazines and firearms throughout the mobile home.

- Discharged Firearms - Routinely went outside at night and fired weapons at property. Occasionally, he would illegally discharge a firearm from his bedroom window.
- “Suicide by Cop” – Frequently stated that he would “Take some cops out, and then kill himself.”
- Monitoring – A few days before the warrant service, he “kept looking out the window.”
- Alcohol & Illegal Drugs – Only used prescription medications.
- Hallucinations - Worried about “spiders on the walls and monkeys in the house.”
- Barricaded - Kept his residence’s front door secured with wood planks and a padlock. As to the rear door, there were no steps and it was secured with nails.
- Police Scanner – Maintained and monitored a police scanner.
- Consistently Mentioned – He would “take out the people who had wronged him and people who had done him dirty.”
- Workplace Violence – Expressed anger and hate towards people and “Wanted to hurt people from previous jobs and relationships who had done him wrong.”

Just prior to killing himself, Rick Liles went to the rear bedroom door where Dianne, his spouse, was lying on the floor and requested a kiss. When Diane kissed him, Rick Liles told her that he loved her and “Everything would be over soon.” She noticed that her husband was wearing his wedding ring that he had not been recently wearing.

Rick Liles’ toxicology report revealed the following medications:

- Fluoxetine (Prozac)
 - Therapeutic level, usually prescribed for depression.
- Diazepam (Valium)
 - Low level, usually prescribed for anxiety.
- Temazepam
 - Low level, usually prescribed for insomnia.
- Hydrocodone (Vicadin)
 - Therapeutic level, usually prescribed for pain.
- Blood samples were negative for the following:
 - Alcohol
 - Amphetamines
 - Barbiturates

- Cannabinoids
- Cocaine
- Metabolite
- Opiates
- Phencyclidine

Rick Liles' Property

During Liles' firefight, the following items were available to assist and support his lethal firearm attacks on community members and peace officers:

- Radio Scanner – Police Frequencies
- Gun Safe
- Ammunition – Hundreds of Rounds
- Pistols – Six Semi-Automatic
 - Browning, .22 Caliber
 - Colt, .38 Caliber
 - Heckler & Koch, .45 Caliber
 - High Standard, .22 Caliber
 - Llama, .45 Caliber
 - Ruger, .22 Caliber
- Revolvers – Two
 - Colt, .38 Caliber
 - Colt, .357 Caliber
- Rifles – Five
 - Colt AR-15, .223 Caliber (Scope Attached)
 - Remington, .243 Caliber (Scope Attached)
 - Remington, .22 Caliber
 - Ruger, .22 Caliber, Two Rifles

The Funerals

Separate viewing, funeral and burial services were conducted for Deputy Sheriff Joel Wahlenmaier and Police Officer Javier Bejar. Thousands of family members, friends, loved ones, community members and peace officers paid respect and gratitude to these brave peace officers for their ultimate sacrifice.

Detective Joel Wahlenmaier

Joel was a husband and father of two children. He joined the Fresno County Sheriff's Office on June 15, 1998. His twelve years of law enforcement service resulted in acknowledgements and recognition for his professionalism and bravery. He was described as "an all-around good man who would hunt elk in Montana, swipe your fries at lunch and carry your little girl back up the snowy hill when she was sledding."

Officer Javier Bejar

A former combat veteran of the United States Marines Corp, Javier was a married man who joined the Reedley Police Department in September of 2005. His five years of law enforcement service likewise resulted in acknowledgement and recognition for his professionalism and bravery. He was described as a leader who consistently motivated others at the Reedley Police Department, and the one who was always upbeat, with a unique sense of humor.

Findings and Recommendations

These findings and recommendations are offered for review. This information is based on contemporary law enforcement policies, procedures and practices. Best policing practices were determined using ethical, legal, proper and safe professional standards that enable us to protect and serve in the highest tradition of law enforcement.

The findings and recommendations are grouped into the following three sections:

- **Before the Incident**
- **During the Incident**
- **After the Incident**

Note: A list of the findings with page numbers can be found starting on page 77.

The following words of caution are offered. Whenever the reader reviews a finding and associated recommendation, they are reminded that the policing actions taken were either appropriate, subject to improvement or inappropriate. At first glance and without considering the aforementioned range of conclusions, the reader may conclude that all recommendations and findings indicate improper law enforcement actions. This is not correct, as a number of the decisions were consistent with modern day police practices. However, this does not discount that lessons were indeed learned.

This sentiment is likewise reflected in a supervisor's comment "experience is a cruel teacher." Such acknowledgement is a major step in paving the way towards improving the future performance of Fresno County's law enforcement leaders. This report will provide police leaders the opportunity to use firsthand knowledge to improve the effectiveness and safety of peace officers in Fresno County, and throughout our great nation.

Before The Incident

Finding No. 1 - Complacency

After the 69 year old Minkler resident was shot, separate telephone calls were personally made to Detective Wahlenmaier by the FCSO patrol deputy and the sergeant who responded. They expressed concerns regarding the existing threats posed by Rick Liles. During one of the conversations with Wahlenmaier, the patrol deputy urged the following:

- To Complete a *Risk Assessment Matrix*
- To Consider using FCSO SWAT for the Warrant Service

Recommendation:

Although we will never know or fully understand why Detective Wahlenmaier did not use these suggestions or recognize other pre-incident indicators, it is logically inferred that these actions reflect complacency. It is imperative that all members of any policing agency maintain and practice officer safety by continually checking and counter-checking each other's actions. This ensures that common and repetitive police behavior does not create complacency.

Finding No. 2 - Centralizing Information

During the investigation of Rick Liles' criminal acts and prior to the development of the search warrant operation plan, it was found that FCSO personnel did not use available information.

Recommendation:

The FCSO should make a critical assessment of whether current information and records systems support operational patrol and investigative responsibilities. This includes a review of current crime analysis, crime mapping, information/intelligence availability and records management practices.

It is recommended that FCSO consider centralizing these functions into one division. These responsibilities should be supervised by a FCSO civilian or sworn supervisor with a rank equivalent to a lieutenant or higher.

Finding No. 3 - Recognizing Crime Trends

The Operational Plan synopsis identifies Rick Liles as being responsible for eight separate shooting incidences and eleven arson fires in the area of his residence. The shooting crimes were the following:

- Minkler Cash Store – Five Occasions
- Minkler Residence – Two Occasions
- PG&E Transformer

Only some of these incidences were formally documented. Therefore, many of these crimes did not receive additional directed patrol, follow-up, supervisory or enforcement activities. It was determined that further policing actions may have identified Rick Liles as being the primary suspect.

Recommendation:

Due to the number of shooting and arson crimes in Minkler prior to the incident, it is recommended that current practices be examined to determine if crime trends are being recognized and appropriate actions taken by patrol, detective and supervisory personnel. Furthermore, the commanding officers of the patrol and detective divisions need to determine if these incidences constitute crime reports.

Finding No. 4 - No Check for Firearms

It was determined that a pre-warrant check for firearms registered to Rick Liles was not conducted or directed by the involved FCSO and CAL FIRE investigators and supervisors. A follow-up investigation found the following 11 handguns registered to Rick Liles:

- Colt, Semi-Automatic Pistol, .357 Caliber
- Colt, Semi-Automatic Pistol, .45 Caliber
- Heckler & Koch, Semi-Automatic Pistol, .45 Caliber
- Raven, Semi-Automatic Pistol, .25 Caliber
- Ruger, Semi-Automatic Pistol, .22 Caliber
- Ruger, Semi-Automatic Pistol, .22 Caliber
- Sig Sauer, Semi-Automatic Pistol, .9mm Caliber

- Smith & Wesson, Semi-Automatic Pistol, .357 Caliber
- Smith & Wesson, Semi-Automatic Pistol, .357 Caliber
- Wesson, Semi-Automatic Pistol, .357 Caliber
- Wesson, Revolver, .44 Caliber

During the firearm inquiry, it was noted that Rick Liles possibly possessed additional registered firearms. To clarify this, correspondence is necessary from a law enforcement agency.

Recommendation:

After reviewing FCSO's procedures, it was noted that the *Risk Assessment Matrix* and the *Operational Outline* require firearm/weapon information. There is a clear responsibility to determine if the warrant subject has access to or is carrying firearms. To further enhance public and officer safety, it is recommended that additional information be added to the aforementioned forms requiring a firearm registration check with the *California Law Enforcement Telecommunications System (CLETS)*.

Finding No. 5 - Supervisor Responsibilities

It was determined that the following actions did not comply with FCSO *operational plan* policies:

- The Detective Sergeant accepted an outside agency's Operational Plan that did not include a FCSO Risk Assessment Matrix.
- The Detective Lieutenant did not receive, request or review a copy of the Operational Plan with a Risk Assessment Matrix.
- The Lieutenant Watch Commander recalled nothing on the Operational Plan that mentioned a firearm. However, the Operational Plan stated "Recover Items Consistent with Arson and PC 246, Shooting into an Inhabited Building."
- The Lieutenant Watch Commander noticed but did not question the Detective Sergeant about the absence of a *Risk Assessment Matrix*.

This policy was not followed by Detective Wahlenmaier and the detective sergeant. A *Risk Assessment Matrix* should have been completed and presented to reviewing supervisors. Furthermore, the reviewing detective sergeant and lieutenant, and patrol lieutenant watch commander should have initiated corrective action.

Recommendation:

Fresno County Sheriff personnel should receive annual and documented training regarding planned tactical operations, risk assessment and plan approval at the ranks of sergeant and lieutenant.

Finding No. 6 - Operational Plan Review

The CAL FIRE plan does not fully address the necessary operational and safety requirements found in FCSO forms, orders and policy. It was a mistake for Detective Wahlenmaier and the detective sergeant to substitute this plan in place of the more thorough FCSO requirements. Furthermore, this should have been recognized by the detective lieutenant and the patrol lieutenant watch commander.

Recommendation:

In this incident, detective and supervisor review should have recognized the inherent dangers presented by Rick Liles and followed FCSO protocol. It is imperative that these actions be further reviewed and that steps are taken to prevent a reoccurrence.

Finding No. 7 - Recognizing a Red Flag

During the warrant service *operational plan* review process, it was clear that the two agencies, CAL FIRE (specialized peace officers) and FCSO (patrol and detective peace officers) were combining investigative and tactical responsibilities. However, the following “Red Flags” were present:

- *Operational Plan* – Administrative Responsibilities Combined
- *Operational Plan* – Not Consistent with FCSO Policy
- Specialized Personnel – Proficiency Level of Tactical Knowledge & Skills
- Containment – Mixture of CAL FIRE & FCSO Personnel
 - 1 & 2 Corner – CAL FIRE & FCSO Peace Officer
 - 2 & 3 Corner – CAL FIRE & FCSO Peace Officer
 - 3 & 4 Corner – CAL FIRE & FCSO Peace Officer

Note: Law enforcement technology identifies the main entrance to a structure as Side One. The remaining structure sides are numbered in a clockwise direction as

Sides Two, Three and Four. The structure's corners are identified as the 1 & 2 Corner, the 2 & 3 Corner, the 3 & 4 Corner and the 4 & 1 Corner.

Recommendation:

Before an *operational plan* is approved for two different policing agencies in a combined tactical operation, reviewers must resolve the following:

- **Proficiency** – Are the involved personnel tactically efficient?
- **Training** – Have they trained together?
- **Use of Force Policy** – Are they different?
- **Use of Force Options** – Available options approved by both agencies?
- **Communications** – Are radio communications compatible?
- **Leadership** – Who is the Officer-in-Charge?

When these issues cannot be resolved to the reviewer's satisfaction, the agencies must decide who will handle the operational phase. Once that decision is reached, the uninvolved agency must stage at a location that will not place them in proximity to the operation and the rapidly changing conditions that can occur.

This is a best practice. However, when agencies combine for various policing activities, they can certainly complete operational assignments together as long as they have trained together and have mutually acceptable rules of engagement.

Finding No. 8 - Leadership/Supervisory Actions

It was found that three supervisors, a detective sergeant, a detective lieutenant and a watch commander lieutenant, should have been more diligent in reviewing and commenting upon the proposed *operational plan's* policing actions.

Recommendation:

The supervisors' *operational plan* review required attention to detail and an understanding of safe policing practices. Regardless of whether past incidents, current practices or established cultural attitudes adversely impacted their actions, none of these are acceptable reasons. Their performance duties require training and command evaluation.

Finding No. 9 - Questioning the Briefing Information

Based on comments from the Search Warrant Service Team members who attended the briefing, it was determined that appropriate discussion of the crimes involved and the potential for violence did not occur. It was felt that too much reliance was given to the information provided by the briefers, Detective Wahlenmaier and the CAL FIRE Specialist.

After the incident, various team members expressed opinions that more questions should have been asked. Specifically, this involved recognition of firearms being involved in past and recent crimes and that the suspect's behavior had escalated into more frequent and violent crimes.

Unfortunately, the briefers' conclusions and theories that Liles was not armed and that he only discharged firearms due to a rooted desire to vandalize rather than injure were erroneous. With the luxury of hindsight, greater attention should have been given to the shooting of Liles' neighbor with a rifle three days prior.

Recommendation:

Personnel involved in similar operational briefings need to carefully evaluate the information presented, concentrating on the suspect(s) potential for violence and the possibility of firearms. There should never be hesitation in recognizing that suggested operations may be unsafe and that proper policing resources are not present.

Furthermore, briefing leaders must ensure interactive participation. A best practice is the use of a PowerPoint presentation with visually rich media content to facilitate awareness, discussion and understanding.

Finding No. 10 - The Warning Signs

The Search Warrant Team members recalled various personal reactions to the briefing information. The following are some of their comments:

- Conclusion – “Simple Warrant, Go to Blossom Café for Brunch”
- Cooperation – “Liles had Refused to Open the Door Earlier”
- Dispute – “On-going with Neighbor”
- Firearms – “Did Not Have any Guns”
- Firearms – “Limited Information”
- Firearms – “Liles Possibly had a Rifle”

- Focus – “On Incendiary Materials”
- Guard Experience – “Worked as a Security Guard”
- Gunshot Wound – “A Woman was Shot”
- Psychological Issues – “Liles had Them”
- Reaction To - “Right from the Get-Go I Did Not Like It”
- Wanted To – “Did Not Have the Courage to Speak Up”
- Wanted To – “Looking Back, I Kick Myself for Not Stopping It”

Recommendation:

Peace officers require frequent supervision and training reminders to not ignore policing instincts that warn of danger. Furthermore, policing professionals must never lack the courage to speak their mind when their law enforcement knowledge indicates something is wrong.

Finding No. 11 - No Equipment Inspection

The search warrant team concluded the *Operational Plan Briefing*, equipped themselves, changed clothes at their vehicles and then proceeded to the warrant location without an equipment inspection. Some team members were not carrying their primary handgun. This FCSO policy violation was recognized by the detective sergeant supervisor. However, this oversight was not corrected by the sergeant supervisor and operators.

Recommendation:

Regardless of assignment, all FCSO team leaders and unit commanders, especially at the sergeant and lieutenant ranks, should annually attend supervisory decision-making training. This in-house ethical and tactical training should emphasize the challenges encountered, supervisory strategies utilized and the lessons learned from this and other incidents. The following are some of the organizational problems that are addressed with enhanced supervisory knowledge and skills:

- **Cultural Attitudes** – Experience and frequency breed complacency.
- **Why Things Go Wrong in Police Work** – Strength is demonstrated when all supervisors consistently require policy compliance.

- **“It’s Not My Job”/“No One Told Me”** – Documented and interactive training is necessary to defeat these time-honored excuses.
- **Tactical Deficiencies** – More supervisors become confident and proficient with tactical decisions and responsibilities.
- **Unsafe Supervisors** – The key to making others more efficient is to not just talk about a known supervisor’s deficiencies, but instead to ensure that this individual becomes competent to do the right thing. Sometimes, the right thing is unpopular with subordinates.

During The Incident

Finding No. 12 - “Surround and Call-Out”

When Rick Liles refused to open his mobile home’s door, the team members, especially the team leader, should have immediately assessed the consequences of a forced entry. Absent of an immediate defense of life situation, the “Surround and Call-Out” option was the safer policing action.

Recommendation:

In today’s world of increasing violence against peace officers, a suspect with firearms refusing to surrender from a structure, demands that involved personnel are able to demonstrate the knowledge, skills and strength to safely re-deploy to positions of advantage. It is recommended that FCSO SWAT personnel provide training to patrol, detective and specialized unit supervisory personnel to ensure that there is no reluctance to utilize this option and that there is no hesitation to seek an opinion or request a response from FCSO SWAT.

Finding No. 13 - Rescuing Officer(s) Down

Detective Wahlenmaier’s rescue by warrant team members was heroic and valorous. Selected team members were directed to holster their firearms, run toward outbound gunfire to grab and carry wounded deputies, and to provide cover fire despite limited ammunition. Their efforts were successful.

Recommendation:

Ensure that annual “officer down” training continues at all ranks. Improved skills and enhanced knowledge are the result of realistic scenario training with Simmunition firearms and ammunition.

This can be implemented into a multi-year training plan that includes “Low Frequency, High Impact Events” such as pursuit driving, emergency vehicle operations, pursuit intervention techniques, and crisis decision-making. This training will reduce liability, address complacency and improve morale and readiness.

Finding No. 14 - Who Goes to the Hospital?

The FCSO Sheriff was faced with deciding whether to respond to the hospital or the in-progress incident. The Sheriff decided to immediately respond to the hospital while the Undersheriff was directed to the Minkler incident.

Recommendation:

This is another situation in which there are both pros and cons. However, it is recommended that a chief, director or sheriff's presence at the hospital is extremely important for employee welfare and interactions with the officer(s) family and friends, media and community/political leaders. The operational incident can be effectively managed by a designated command/staff officer.

Finding No. 15 - Driver and Scribe for Staff Personnel

This incident resulted in the immediate response of the FCSO Sheriff, Undersheriff, and Captains. These leaders were constantly communicating, making decisions and responding to different locations, e.g., the incident, the hospital, the victim peace officer's home, etc. While traveling, the FCSO Undersheriff acknowledged the benefits of having a FCSO deputy to drive with and strategize.

Recommendation:

As critical incidents develop, circumstances and consequences tend to expand rather than contract. If personnel are available, it is recommended that a driver and a scribe be present as valuable assets. This practice is a small investment that pays significant dividends when remembering decisions made and documenting after-action information.

Finding No. 16 - Radio Broadcasts/Transmissions

It was determined that radio transmissions from responding personnel created congested radio traffic. Despite these challenges, FCSO Communications personnel received various compliments from fellow civilian and sworn employees for their communication skills during crisis.

Recommendation:

Personnel should receive periodic briefing reminders concerning radio discipline. Also, communications personnel should provide updated broadcasts that enable responders to have information, including the incident's location, the identification of high-risk areas, gunfire, etc.

Communications personnel should receive periodic and realistic scenario training for emergency service calls and radio broadcasts related to critical incidents.

Finding No. 17 - Sensitive Radio Broadcasts

During the incident, the medical condition of Detective Wahlenmaier was accidentally mentioned over a FCSO radio frequency. Immediately, the FCSO SWAT Commander advised personnel to desist from similar radio broadcasts.

Recommendation:

During radio transmissions, it is a best practice to never mention an injured or deceased peace officer's name. This prevents the following:

- Premature awareness by the victim's family.
- Improper notification by a law enforcement officer to the victim's loved ones.
- Untimely information release to media.

Finding No. 18 - Display of Incorrect Incident Address

Some FCSO personnel responding to the "Shots Fired, Deputy Needs Help" request were unsure of the correct address. During a critical time period, this resulted in additional radio communications. The following contributed to the confusion:

- When the Operational Team conducted their pre-search warrant briefing at the CAL FIRE facility in Sanger, this address was individually entered into the FCSO Computer Assisted Dispatch (CAD) System for each deputy.
- Shortly thereafter, the Search Warrant Service Team moved from the briefing location to a different address in Minkler.
- The CAD System required the dispatcher to individually relocate each FCSO deputy to the Minkler location.
- When the assistance request was made, the dispatcher had not finished relocating all FCSO personnel.

Recommendation:

Improve the FCSO CAD system to allow a dispatcher to quickly move multiple units with minimal computer functions.

Finding No. 19 - Abandoning Police Vehicles

Since the ingress and egress of police personnel was not supervised, operational effectiveness was adversely impacted by the police vehicles left abandoned in the middle of Highway 180. Abandoning marked and unmarked police vehicles completely blocked travel on the highway, and prevented the armored vehicle and other emergency rescue vehicles from arriving to a staging location.

Recommendation:

It is recommended that the agencies involved in this incident provide training that reinforces the need to “Read the Scene,” and that addresses how to tactically park police vehicles when arriving at critical incidents.

The following additional strategies are offered:

- Identify a staging area for personnel and police vehicles.
- Assign an officer and eventually a supervisor to manage police personnel ingress and egress.
- Identify response routes to the critical incident and determine if different ingress/egress will require multiple postings.
- Use an available department or ICS form to properly document the following information:
 - Agency
 - Name – First & Last
 - Rank
 - Serial Number
 - Mobile Phone Number
 - Specialized - Equipment/Skills
- Determine if responding personnel are wearing readily identifiable police uniforms and have appropriate safety equipment.
- Advise personnel of the radio frequency being utilized.
- Direct responding personnel where to properly position their vehicles.

- Compose squads/teams with a supervisor to receive missions.
- If staffing permits, create squads that are composed of peace officers from the same policing agency.
- Assign a supervisor or senior officer to supervise each squad.
- Determine an assistant squad leader for each squad.

Finding No. 20 - Vehicle Radio Volume

Many of the police units that were initially parked near the incident were left with their doors and windows open, and the radio volume too loud. This allowed radio broadcasts to be heard within the inner perimeter.

Recommendation:

Recurrent roll call training should address police vehicle movement and positioning in response to violent crimes in progress where gunfire is occurring. Officers should be reminded that the volume of their police radio may provide tactical information to the suspect(s) involved.

Finding No. 21 - Communication Compatibility

Fresno County Sheriff and surrounding law enforcement personnel experienced communication problems. Primarily, some county law enforcement agencies could not communicate via a mutual radio frequency. As a result, timely communications were adversely impacted.

Recommendation:

Acquiring mutual radio frequencies similar to those in Orange County, California, would resolve the problems experienced and thus enhance public safety.

Finding No. 22 - Reading the Scene

Although noble in their efforts, far too many peace officers arrived and unsafely entered the inner perimeter without a mission. This created tactical issues of where to put them and how to move them when SWAT supervisors arrived.

Recommendation:

Peace officers need constant reminders regarding “reading the scene” and applying self discipline to self-initiated activities at critical incidents. Also, supervisors arriving at a critical incident need to establish the following:

- **Routes with Travel Directions** – Ingress/Egress
- **Perimeters** – Inner/Outer
- **Recognition** – Active Shooter, Barricaded Suspect, Hostage(s)
- **Teams** – Reaction, Arrest, Rifle, Entry/Search
- **Resources** – Request Specialized Units
- **Staging Area** – Fire Department, Paramedics
- **Command Post & Tactical Operations Center (TOC)**

Finding No. 23 - Establishing Tactical Priorities

The first FCSO SWAT supervisor immediately recognized that multiple officers were unsafely positioned behind a storage container within the inner perimeter. This supervisor safely and wisely relocated these officers to a position of advantage. Simultaneously, the supervisor established the following priorities:

- **Reaction Team** – Assign & Position
- **Snipers** – Direct to Positions
- **Containment** – Establish Inner SWAT Perimeter
- **Rescues** – Remove Community Members/Police in Hot Zone
- **TOC** – Determine a Strategic Location

Recommendation:

A review from a police dash camera video disclosed that numerous officers excessively positioned themselves behind the storage container within the danger zone. All police personnel must better understand how to safely respond and deploy to an in-progress and violent incident where shots are being fired.

Finding No. 24 - Selecting a Command Post Site

In this incident, the CP and the Tactical Operation Center (TOC)'s locations were relocated from their original position. This relocation was properly done based on the rapidly changing complexities.

Recommendation:

Unfortunately, and unlike the Minkler Incident, far too many police deployments have resulted in ineffective or unsafe CP or TOC site establishments. It is imperative that supervisors be trained to select functional and safe locations. Before an incident escalates and makes relocation necessary, an experienced decision maker should have alternative locations pre-identified.

Finding No. 25 - Who should be Incident Commander?

Although various senior command and staff officers were present, the Incident Commander position was staffed with a lieutenant. This person served as the Patrol Area Commander which includes the Minkler Area.

Recommendation:

It is recognized that opinions and practices differ regarding the incident commander's rank. Nonetheless, it is recommended that a critical incident of this nature be managed by a command/staff officer. Generally, law enforcement command/staff officers start at the rank of captain.

Before staffing any ICS position, an individual's law enforcement experience, knowledge and skills must be taken into consideration. When a command/staff officer feels that their management of this incident can be strengthened, they should select a qualified individual to serve as the Assistant Incident Commander or the Operations Officer.

Finding No. 26 - Watch Commander Involvement

During the incident, the on-duty Patrol Watch Commander, a lieutenant, moved to his personal office which was down the hall from the Watch Commander's Office. This relocation was not a best practice. Consequently, operational effectiveness was impacted when other FCSO personnel reported to the Watch Commander's Office. This absence of leadership resulted in expressed animosity from peers and created time delays in utilizing the knowledge and skills sets of others.

Recommendation:

At a time of crisis, the facility Watch Commander is an essential leadership and management position. The Watch Commander must remain available and visible to agency personnel as this office becomes a hub of activity and decision making.

Finding No. 27 - Controlling the Response

Initially, all FCSO on-duty personnel were allowed to respond to the Minkler incident. This created a void in available units for other County emergencies and service calls. Fortunately, this was recognized and necessary adjustments occurred.

Recommendation:

The Patrol Watch Commander and the Communication Supervisor need to immediately recognize potential staffing shortages. Communication between these two supervisors is critical.

Finding No. 28 - Deploying the SWAT Teams

It was found that the FCSO, FPD and CPD SWAT Team Commanders were skilled leaders. Their actions reflected a commitment to public and peace officer safety, and knowledge of contemporary SWAT strategies. However, their personal insights corroborated the need for further discussions amongst themselves regarding future incidents that require more than one SWAT team.

Recommendation:

It is recommended that all SWAT Team Commanders within Fresno County policing jurisdictions meet to discuss the following issues:

- **How to Use the Teams** – The FCSO SWAT Team Commander acknowledged that one of the teams he deployed should have been placed on “Stand-by” for emergency or mission specific needs. Unless each team requires an immediate mission, the decision to place a team on “Stand-by” is a best practice.
- **Training Exercises** – Future exercises should duplicate the arrival of multiple SWAT Team Commanders at a single incident.
- **Liles’ Criminal Actions** – The involved SWAT Commanders should further review the dynamics caused by Rick Liles and assess if there were opportunities to deploy additional offensive and defensive strategies.

Finding No. 29 - FCSO SWAT Team Staffing

The SWAT demands of this incident required the FCSO SWAT Commander to deploy non-SWAT personnel for selected missions. It was also learned that previous SWAT policing incidents in Fresno County frequently occurred in open and rural areas. These previous missions have clearly demonstrated the need for additional FCSO SWAT personnel.

Recommendation:

A staffing review of the FCSO SWAT Team should be conducted to determine if additional SWAT personnel are needed.

Finding No. 30 - Armored Vehicle Availability

It was found that Fresno County has one armored police vehicle that is shared between three SWAT teams, CPD, FCSO and FPD. The Incident Commander (IC) received multiple requests for an armored vehicle. The first armored vehicle arrived at 1042 hours followed by a second armored vehicle from Hanford Police Department at 1220 hours. Throughout the incident, these two armored vehicles were effectively used to support the following missions:

- **Ballistic Protection** – Community Members/Peace Officers
- **Blocking Barrier** – Between Suspect and Victims
- **Chemical Agents** – Deployment
- **Platform** – Cover Fire
- **Reconnaissance** – Intelligence Gathering/Site Orientation
- **Rescues** – Community Members/Peace Officers
- **Surveillance Devices** – Deployment
- **Transportation** – Community Members/Peace Officers
- **Verbal Communications** – Suspect(s) Surrender

It was determined that Fresno County needs an additional armored vehicle to safely police similar incidents.

Recommendation:

It is recommended that FCSO acquire a separate armored vehicle. Due to the county's size and the potential for similar incidents, a SWAT response could require the immediate necessity for multiple armored vehicles. A second armored vehicle would address the following:

- Enhance Public/Peace Officer Safety during Critical Incidents
- Provide More Options to the SWAT Commander
- Improve Availability for Simultaneous Critical Incidents
- Allow Multiple Armored Vehicle Deployment
- Provide a Vehicle for SWAT Training Exercises

Finding No. 31 - Communicating During a Gun Battle

Some of the involved personnel who discharged their firearms felt that communications could have been enhanced. Specifically, radio broadcasts or verbal words should have provided additional tactical and use of force information.

Recommendation:

The involved agencies should reassess whether classroom, range and scenario training includes communication between deployed and responding personnel. This should include the following:

- **Suspect(s) Information**
 - Threat Zone - Area Controlled by Suspect's Gunfire
 - Building Involved – Sides 1, 2, 3 or 4
 - Cover versus Concealment
 - Description – Clothing/Physical
 - Direction of Gunfire
 - Movement
 - Position

- Weaponry
- **Peace Officer Information**
 - Communications – Non Verbal, Radio & Verbal
 - Direction of Gunfire – Crossfire Avoidance
 - Perimeters – Inner/Outer
 - Response Route – “Friendly Fire”/”Blue on Blue”
 - Resources – Backup, Supervisor, Air, SWAT, etc.

Training should include uniformed non verbal hand signals that are complimented by a handout that specifically identifies the gestures with easily understood tactical terminology.

Finding No. 32 - Rescuing another Officer Down

Officer Bejar was critically shot in the head during an exchange of gunfire with Liles at 1053 hours. Officers from RPD, CHP and FCSO heroically rescued Officer Bejar while other peace officers provided necessary cover fire. Despite Liles’ heavy gunfire, Bejar was safely moved to an unmarked police truck and transported to a waiting paramedic unit. Medical personnel provided treatment and transported Bejar to CRMC.

Recommendation:

It is recommended that involved agencies annually create realistic officer down training scenarios similar to the challenges faced in this incident. These scenarios will improve skills and enhance officer safety knowledge.

Finding No. 33 - Using Incident Command System

The comments of FCSO personnel clearly indicated that best Incident Command System (ICS) practices were not followed. Consequently, operational effectiveness could have been improved.

Recommendation:

It is recommended that FCSO determine if there were people or systematic problems that adversely impacted performance. This review should provide equipment, personnel and training recommendations. Furthermore, the FCSO ICS Cadre should be evaluated to determine if there are proficient and trained personnel to adequately staff required ICS positions.

Finding No. 34 - Wearing ICS Vests

As the incident progressed and local, state and federal peace officers continued to arrive, it was noticed by various peace officers that FCSO Incident Command personnel were not wearing Incident Command System (ICS) vests. During critical time periods, this created unnecessary confusion and impacted operational effectiveness.

After the incident, it was found that no one within the FCSO chain of command or accompanying law enforcement leaders recognized this problem. Direction should have immediately been given to utilize ICS vests for identification of specific responsibilities.

Recommendation:

In regards to whether FCSO personnel wear ICS vests at incidents, a review should occur. This assessment must determine if a preconceived notion exists that ICS vests are unnecessary or if supervisors are failing to do the right thing with their incident management responsibilities.

The following practices are recommended:

- Availability – Are the vests easily accessible?
- ICS Guidelines – Is the guideline in each vest’s pocket?
- Recognition – Does the vest identify the position staffed?
- Reference Guidelines – Are they utilized for optimal performance?
- Supervision – Are personnel being directed to wear vests?
- Training – Are the vests worn during training exercises?

Finding No. 35 - Information Documentation

It was acknowledged by several FCSO command, staff and supervisory personnel that they did not personally take notes or use a scribe to immediately document specific times when challenges were faced and actions taken. A specific example of not immediately documenting command post operations was found in a two-page document titled “Incident Commander Log.” This log details that a FCSO deputy was assigned scribe responsibilities at 1:40 p.m. This documentation started nearly three hours after the Incident Commander, a FCSO lieutenant, assumed command.

Furthermore, it was found that FCSO's "G-Drive," located within the computer database, contained incident management forms. These forms were not used.

Recommendation:

Current FCSO personnel practices and systems related to documenting and tracking policing actions at similar critical incidents require assessment. All supervisory and command personnel should be versed in and required to follow documenting procedures as outlined in the Standardized Emergency Management System (SEMS), the National Incident Management System (NIMS) and the Incident Command System (ICS). Training must include practices in which a report officer's documentation is recognized for some of the following reasons:

- Incident Management
- Tactical Debriefing
- Litigation Defense
- Financial Accountability/Reimbursement
- Recognition of Community, Police and Support Personnel

Finding No. 36 - Information Systems Specialists

An assisting agency arrived at the CP with an Information Systems (IS) Specialist. This Specialist proved to be a valuable asset.

Recommendation:

When managing critical incidents, it is beneficial to have command post, dispatch and IS personnel on scene. These people should likewise be included in ongoing ICS training scenarios.

Finding No. 37 - Press Information Officer Needed

The FCSO Press Information Officer (PIO) position is staffed with a sworn deputy. When this deputy nobly responded to the "11-99, Shots Fired" call, the facility watch commander said that chaos developed due to significant media inquiries.

Recommendation:

At any time, a FCSO supervisor may need to staff a PIO position. It is recommended that FCSO train other personnel to handle PIO responsibilities. Furthermore, whenever FCSO personnel with specialized knowledge and skills, i.e., the PIO, respond to an emergency, this person should return as soon as possible to their assignment.

Finding No. 38 - Mobile Phones not Standardized

During the early stages, the Command Post received Rick Liles' picture on a cellular telephone. This image was important tactical information.

It was found that Fresno County Sheriff supervisors' mobile telephones are not standardized. Some cellular phones are able to send and receive visually-rich media content, pictures and video, while others lack this and other functions.

Recommendation:

All FCSO supervisors should be issued standardized cellular telephones. This enables a seamless exchange and sharing of contemporary media files and information.

Likewise, these mobile devices should be distributed with a current and installed department directory. This installed directory should be frequently maintained as new assignments, hires and promotions take place.

Finding No. 39 - Video Links

Due to the rural area, the FCSO IC did not have a clear understanding of the following:

- Gunfire – Areas Controlled by the Suspect(s) (Danger, Hot or Threat Zone)
- Perimeters – Inner and Outer
- Positions/Movements – Peace Officers and Police Vehicles
- Routes – Escape and Police Ingress/Egress
- Suspect(s) – Location

Recommendation:

Policing agencies should ensure that effective video links exist between air and ground personnel. Additionally, the following strategies are offered:

- Periodic Testing – Operational Effectiveness
- Identification - “Dead Spots”
- Television(s) - Monitor Media Broadcast(s)

Finding No. 40 - Additional Ammunition in Magazines

FCSO policy allows personnel to carry two ammunition magazines for semi-automatic pistols, and two ammunition magazines with a 20-round capacity for AR-15 rifles. The personnel involved in the initial exchange of gunfire quickly expended their ammunition.

Recommendation:

Agency policy should be modified to allow personnel to carry additional ammunition in approved handgun and rifle magazines. AR-15 magazines are available in 30-round capacity and would enhance sustained use of force capabilities.

Finding No. 41 - Air Support was not Available

When the incident started, all Fresno County law enforcement aircraft were unavailable due to maintenance. This included primary and backup aircraft from the California Highway Patrol, FCSO and FPD.

It is worthy to also mention that the FCSO helicopter mechanic was able to reassemble Eagle One, generally a four hour task, in 45 minutes with help from FPD helicopter mechanics. When Eagle One arrived it proved to be an asset.

Recommendation:

Supervisors from all three County law enforcement agencies with aircraft should meet and discuss the challenge to ensure that one Fresno County law enforcement aircraft is always available.

Finding No. 42 - Surveillance Equipment

Fresno County Sheriff’s Office SWAT personnel deployed FPD’s “Recon Scout Throwbot” reconnaissance robot to explore the hostile and dangerous environment in Liles’ home. This machine provided real-time, mission-critical reconnaissance to enhance public and officer safety.

Recommendation:

The FCSO should purchase a reconnaissance robot.

Finding No. 43 - Bomb Squad Response

The Clovis Police Department (CPD) SWAT Commander acknowledged that his recent attendance at the *U.S. Department of Justice Hazardous Devices School* was a causal factor in his decision to employ their department's explosive technician.

Recommendation:

The FCSO should assess if SWAT personnel would benefit from attending the *U.S. Department of Justice, Hazardous Devices School* in Alabama (256) 313-8800 and on-line at www.fbi.gov/about-us/cirg/hazardous-devices.

Finding No. 44 - First Aid Kits

First aid kits were not available to some personnel.

Recommendation:

All policing agencies should ensure that personnel have available emergency medical supplies. It is recommended that all field and tactical personnel have access to emergency medical supplies to treat gunshot wounds. Ideally, a department mandate would identify specific equipment and direct where to carry these items.

Today, a number of peace officers are attaching these basic and potentially life-saving supplies to their body armor or a pouch on their equipment belt. During an annual inspection, a medical equipment checklist should be used.

After the Incident

Finding No. 45 - Rounds Fired

A search of Liles' residence after the incident revealed that 86 expended cartridge casings were fired. Liles' gunfire resulted in the killing of two peace officers, the wounding of another officer and the attempted murders of community members and peace officers who were in his line of fire. It is truly a miracle that more people were not wounded and killed. The following cartridges were recovered:

- .22 Caliber – 3 Casings
- .38 Caliber – 2 Casings
- .38 Super Caliber – 2 Casings
- .45 Caliber – 18 Casings
- .223 Caliber – 56 Casings
- .243 Caliber – 5 Casings

In response to Liles' deadly gunfire, it was determined that 607 law enforcement rounds were fired by 25 peace officers from six different agencies. The FPD investigation provided the following information:

- Peace Officer Gunfire Came from Two Areas
 - Near the Front Door to Liles' Mobile Home
 - Eighty Yards East of Liles' Mobile Home on Highway 180

The front door to Liles' mobile home was where FCSO Detective Walhenmaier and Deputy Harris were shot. Highway 180 is where RPD Officer Bejar was shot.

- Peace Officer Gunfire Occurred After/During the Following:
 - After Detective Wahlenmaier was Critically Wounded
 - In Response to Liles' Gunfire
 - After another FCSO deputy was Wounded
 - In Response to Liles' Gunfire

- After Officer Bejar was Critically Wounded
- In Response to Liles' Gunfire
- Into the Eaves to Stop Liles' Shooting
- Into the Eaves to Ensure No Innocent Party was Injured
- Into the Eaves to Enable Armored Vehicle Rescues

A review of the FPD investigation found that the peace officers who discharged their firearms, fired in the immediate defense of life. Their gunfire was specifically directed at Rick Liles or at the eaves of Liles' home. These actions were taken to prevent and stop Liles from wounding and killing others. The peace officers' gunfire complied with acceptable law enforcement ethical, legal and use of force standards.

Although six hundred rounds might be considered excessive by some, the readers are reminded of the following:

- **Independent Assessment** – Each peace officer who fired a weapon did so in compliance with an independent assessment of the need to immediately protect life from serious bodily injury or death.
- **Public Safety** – No innocent party was injured from law enforcement gunfire.
- **Liles' Continuous and Excessive Gunfire** – Directly endangered community members and peace officers to serious bodily injury and death.
- **Dianne Liles** – Dianne Liles was safely extracted from the residence by FCSO SWAT personnel without gunshot injury.
- **Peace Officer Gunfire Control** – Stopped at approximately 11:03 a.m.
- **“Friendly Fire” or “Blue on Blue”** – No peace officers were struck by another officer's gunfire.

The aforementioned findings clearly indicate that the officers' return gunfire was neither indiscriminate nor undisciplined. Throughout this extended time period of 75 minutes, there was a justifiable need for the involved law enforcement officers to discharge their firearms. Their gunfire was directed at Liles, intending to prevent him from murdering people and peace officers.

Recommendation:

Regarding the peace officers who discharged their firearms, it is recommended that their respective agencies evaluate their individual actions. As to the following tactical and use of force considerations, there should be a finding for each involved peace officer:

- **Tactics** – Safe/Unsafe
- **Drawing/Exhibiting a Firearm** – In/Out of Policy
- **Use of Force** – In/Out of Policy

Once this review is completed, recognition, training or discipline should occur.

Finding No. 46 - Who Should Handle the Investigation?

For multiple reasons, the FCSO Undersheriff decided to accept FPD's offer to conduct the criminal and officer-involved shooting (OIS) investigations. In accepting this offer, the following reasons were cited:

- A non-involved policing agency would ensure the investigation's integrity.
- The emotional impacts suffered by FCSO and RPD personnel were significant.
- The FCSO detective personnel who would traditionally handle this investigation were involved in the use of deadly force and worked with Detective Wahlenmaier.

Based on the comments of FCSO and FPD personnel at various positions and ranks, their collective view was that this investigation would have best served the communities and agencies involved by remaining with FCSO. It is important to remember that these conclusions were reached with the benefit of hindsight and a period of post recognition about the consequences and impact on the involved policing agencies.

Recommendation:

Such investigative decisions are debatable, as both pros and cons point to relinquishment and retention. Generally, it is recommended that similar investigations be conducted by the involved agency that has jurisdiction.

Before this decision is made, the following factors should be considered:

- Budget Impact

- Credibility
- Criminal Scientific Investigation Capabilities
- Investigative Knowledge and Skills
- Personnel Staffing Adjustments/Impact
- Timely Information for Community & Media Transparency
- Timely Information for Department Personnel

Finding No. 47 - Investigative Steps Taken

Unknown to the FCSO Undersheriff, a FCSO supervisor had contacted non-involved FCSO detective personnel with homicide and officer-involved shooting investigative experience. Had these efforts been communicated to the Undersheriff, the investigation would have remained with FCSO.

Recommendation:

Prior to accepting an investigative offer from an outside law enforcement agency, command and staff officers should assess their agency's capabilities. Furthermore, this decision must be approved by the agency's chief, director or sheriff.

Finding No. 48 - Effective Strategies Utilized

The FPD employed two sergeants and ten detectives to conduct the criminal and OIS investigations.

Recommendation:

When conducting an OIS investigation involving multiple peace officers from different agencies, the following strategies initiated by FPD are worthy of consideration:

- Establishing a liaison officer to the six agencies that had peace officers using deadly force.
- Using California Highway Patrol (CHP) to obtain aerial photographs.
- Utilizing the California Department of Justice (DOJ) to collect evidence within the mobile home while FPD detectives collected exterior evidence.

- Establishing a crime scene perimeter for three consecutive days, closing Highway 180.
- Maintaining an effective crime scene perimeter during intermittent rain.
- Conducting over 90 interviews.
- Interviewing 25 peace officers from six different agencies who used force.
- Capturing photographs of grease boards to preserve documented actions.
- Using CHP Multidisciplinary Accident Investigation Team (MAIT) to create diagrams and obtain Global Positional Satellite (GPS) technology to mark outside casing locations.
- Creating the following diagrams:
 - Buildings & Vehicles
 - Casings
 - Evidence – Specific Items
 - Scene - Overall

Finding No. 49 - What was happening with FPD?

On the first Monday following the incident, FCSO executives met. There was a perception by some command/staff officers that there was a lack of understanding of the FPD investigation. It was found that FCSO personnel assigned to “shadow” the FPD investigation only did so for one duty shift. Therefore, contemporary information was not available and the mission to work with FPD was not occurring.

Recommendation:

If approved by the investigating agency (FPD), one or more FCSO detectives should have been constantly interacting with FPD personnel. These personnel should have knowledge of FCSO policy, investigative skills and not have been involved in the incident.

Finding No. 50 - Communication Breakdown

Media inquiries were constant, demanding and intense. Numerous media members wanted insights from the FCSO Sheriff and the FPD and RPD Police Chiefs. This was coupled with a never-ending list of issues that required their immediate attention. Furthermore, there were significant emotional burdens and tensions amongst agency personnel.

The day after the incident, the Sheriff and Chief of RPD received a last minute notice to attend a press conference hosted by the Fresno Police Chief. The lack of time to prepare for the press conference was not ideal, nor appreciated, by the Sheriff and Chief of RPD. This created tension and a perception of agencies acting independently of each other. While it could not be determined whether this was the result of the pressing need for media transparency or simply a courtesy oversight, the following concerns were also cited from various law enforcement personnel at different ranks within the FCSO and RPD:

- Information Sharing between Agencies – Timely & Thorough
- Press Conference – Agency Specific versus Joint Conference
- Topics – Who should present/comment on these?
- Spokesperson – Who should be the spokesperson?
- Press Release – Agency Specific versus Joint Release
- PIO Liaison – Between the FCSO, FPD & RPD

Recommendation:

It is recommended that Fresno County law enforcement chiefs, directors and the sheriff convene. During this discussion, media protocols for future incidents involving multiple policing agencies should be considered. Also, it would be beneficial for the leaders of the FCSO, FPD and RPD law enforcement agencies to meet individually to share personal and agency reactions to the media actions taken.

Finding No. 51 - Hospital Decisions

The Community Regional Medical Center's (CRMC) Security Director commended various FCSO command and supervisory personnel for their leadership efforts. This individual felt that a supervisor's presence at the trauma door entrance was essential in effectively directing people, minimizing congestion and solving problems.

Fresno County Sheriff's Office supervisors, involving the ranks of sergeant, lieutenant, captain and sheriff, are commended for the following:

- Ensuring that immediate emergency medical care was available for the wounded peace officers.
- Protecting evidence for the administrative and criminal investigations.
- Initiating support for the victim peace officers' family members and loved ones.

- Establishing liaison with the hospital's administrative staff and security personnel.
- Alerting the hospital's emergency room staff regarding Officer Bejar's injury and estimated arrival time.
- Arranging for Detective Wahlenmaier's family to enter the hospital through a selected entrance to avoid public contact.
- Coordinating security efforts with the Department of Corrections personnel who were guarding an inmate in the Intensive Care Unit where Officer Bejar was taken.
- Recognizing the personal trauma that was affecting a hospital employee who was married to a FCSO Deputy.
- Assigning a "Companion Officer" to both victim peace officer families.
- Assigning a FCSO detective to identify the involvement of arriving law enforcement officers.
- Establishing an appropriate location for a law enforcement command post within the hospital.
- Coordinating with hospital personnel three "Down Rooms" for employees, family members, friends and loved ones.
- Recognizing the emotional grief and suffering of the aforementioned groups of people and escorting these individuals to the "Down Rooms."
- Arranging for food to be brought to the hospital.
- Ensuring that the FCSO Sheriff and other law enforcement command and staff officers were briefed before escort to various locations.
- Arranging for a Catholic priest to administer "Last Rights" to Detective Wahlenmaier.
- Posting uniformed personnel "24/7" for Officer Bejar's safety.
- Arranging for marked FCSO police vehicles to escort Detective Wahlenmaier to the morgue.

Recommendation:

It is recommended that the aforementioned best practices be documented and available to all FCSO personnel.

Finding No. 52 - Police Vehicle Parking/Security

It is also recognized that vandalism could occur at the hospital and may be directed at recognizable police vehicles. Motivating factors for this criminal behavior may be attributed to an individual(s) previous experiences with law enforcement, their personal reactions to the incident or their relationship with the suspected offender(s).

Recommendation:

The following are recommended strategies:

- A uniformed peace officer(s) should be assigned to manage police vehicles' parking, positioning and security.
- If staffing permits, a supervisor should initially be given this responsibility.
- If parking space is limited and master keys are not available for police vehicles, keys should be left with an officer who is managing the parking and providing police equipment security.
- The aforementioned activities shall always be coordinated with hospital security.

Finding No. 53 - Hospital Guidelines

Although there were numerous beneficial and proactive actions taken at the hospital by involved agencies, it was determined that additional hospital guidelines were not available to address the myriad of issues that occurred.

Recommendation:

Whenever a peace officer(s) is hospitalized from a line-of-duty incident, there should be digital or written guidelines available. The following best practices should be included:

- Department personnel shall be posted throughout the officer(s) hospitalization.
- Posted peace officer(s) shall take positions outside of the wounded officer's room to enable private moments and to demonstrate a visible police presence.
- If hospital security personnel use portable radios, a hospital radio should be provided to the police security detail.
- Officers' last names shall not be available to the hospital's telephone operator(s).

- Protection detail personnel shall determine if patients on the officer's floor or within the hospital create a security concern. At first glance this may sound unusual, yet on more than one occasion; a recovering officer was located on the same floor as injured criminals, gang members, parolees-at-large and wanted people.
- It may be necessary to refer telephone calls for injured officer(s) to a nurse's station for the review of the involved policing agency's security team.
- Record checks of hospital patients and staff should be conducted within legal and policy guidelines.
- When staffing is adversely impacted by the hospital police detail, consider strategically parking a marked police unit(s) without an officer for a visible presence. However, there should always be one officer assigned outside the recovering officer's room.
- Consult with the employee association's President or Directors for food, lodging and transportation support.
- Arrange for designated parking spaces.
- Coordinate with the spouse or most significant family member to determine who should be present during medical briefings.
- Determine if the media may have access to the family.
- Consider that medical activities in the emergency, operating and recovery rooms may require evidence recovery with a documented chain of continuity.
- If the officer is deceased and will be moved from a secured area, the movement route should be scouted.
- Prior to the officer's movement, the detective supervisor shall be consulted to determine that evidence recovery and photographs have been completed.
- Due to mobile phone technology with built-in cameras and the ability to capture video, the officer(s) face should be covered to avoid potentially harmful media coverage.
- The sheet covering the body should be absent of blood so that a potential media print photograph does not create another horrific moment for loved ones and friends.

Finding No. 54 - Anticipating Responses

After Detective Wahlenmaier and Officer Bejar were transported to the emergency room, two Fresno County Supervisors arrived at the hospital. The supervisors wanted to meet with the families, FCSO and RPD personnel.

Recommendation:

When a peace officer is seriously injured and transported to a hospital, it is reasonable to likewise expect the arrival of community, political and religious leaders. Anticipating the needs of community members prior to their arrival will help streamline accommodations, expectations and law enforcement capabilities. The following should be considered:

- Their arrival and response is appropriate.
- Immediate notification of their arrival should be provided to the hospital incident commander.
- A pre-designated room for leaders to gather.
- A determination of what their intentions and expectations are.
- A plan to assist the leaders' objectives.
- Generally, leaders wish to meet with the spouse. If this cannot be accommodated, consider having another family member receive their support.
- Verify that there is no animosity toward the official.
- Determine if the leader should be brought to where the family is or whether the family should be brought to the leader.
- Officials should not be present where the officer is receiving emergency medical treatment.
- Emergency medical treatment may also occur in a hospital room during early recovery stages.
- If the officer's condition permits, determine whether it is appropriate for this meeting to occur.

- Generally, these meetings involve local, state or federal elected government officials.
- During the initial stages of an officer's hospitalization, it is strongly recommended that neither media presence, nor photography be permitted. Depending on the department and officer(s) consent, this may be appropriate at a later time.

Finding No. 55 - The Notification

The FCSO Sheriff had previously considered her responsibility in the event she had to deliver a death notification to an employee's family, friends or loved ones. After delivering this sad news and experiencing her personal pain and trauma, she reflected on how such a delicately sensitive message should be best-handled in the future.

To determine this, the Sheriff met with other peace officer spouses who had lost loved ones. During these meetings, she inquired as to how family notifications are best communicated. After receiving valuable insights, she decided that this information would be shared with the next sheriff.

Recommendation:

It is offered that other chiefs, directors and sheriffs consider meeting with spouses of previously injured or killed peace officers for their suggestions.

Finding No. 56 - Vehicle Availability

The FCSO Sheriff and the Patrol Captain rode to the hospital together. Although this provided a unique opportunity to strategize, both leaders acknowledged that the events that followed required their personal department vehicles.

Recommendation:

Due to multiple command/staff responsibilities at similar incidents, the availability of an individual vehicle for each command/staff officer is important.

Finding No. 57 - The Impact on Police Services

The tragic murders paralyzed individuals and created staffing concerns at the involved agencies. An example of the aforementioned occurred at the RPD, where peace officers from other agencies staffed RPD's policing responsibilities for three consecutive days.

Recommendation:

Before a similar incident occurs, law enforcement chiefs, directors and sheriffs should discuss potential staffing needs for their and neighboring law enforcement agencies.

Generally, personnel needs are greater for smaller police agencies.

Finding No. 58 - Tactical Debriefing Delayed

The tactical debriefing for the FCSO Search Warrant Service Team and other involved personnel was delayed for over a year. The following factors contributed to the delay:

- A command/staff misperception that the psychological debriefings had previously addressed tactical concerns.
- Within different units, a previously time-honored practice of returning to work and not discussing the tactical operation's actions and consequences occurred.

It was noted that FCSO Department Order 1279, "Planning and Execution of Tactical Operations" requires incident analysis and evaluation for both individual and team assessment. The order's purpose is to identify training needs and to reinforce sound risk management practices.

Recommendation:

It is recommended that current FCSO written policy be followed when a critical incident occurs. Furthermore, operations should be immediately debriefed by involved personnel. This responsibility should be placed at a minimum of a lieutenant's rank or a FCSO Unit Commander's position for patrol, detective and specialized units.

Although the aforementioned is an ideal standard, it must be recognized that an incident of this magnitude may result in a debriefing delay. A general and reasonable standard to complete the tactical debrief is within a two-week period.

Finding No. 59 - Preventing Further Trauma

In relation to the Minkler Incident, the FCSO Undersheriff personally ensured that all public correspondence was reviewed prior to being distributed/shown to family members. This was

invaluable as some of the received correspondence was inappropriate or pertaining to improper language.

It was recognized that the Undersheriff acknowledged the possibility that someone may pretend to be the spouse of a peace officer killed in the line of duty. If someone offered to talk to the fallen peace officer's spouse, it was imperative that legitimacy be established. This was found to be a proactive recognition in avoiding a potential problem.

Recommendation:

If an agency decides to create a keepsake for the fallen officer's family, it is essential that all documents be reviewed. Furthermore, if anyone wishes to contact the family, their intentions must be credible and welcomed.

Finding No. 60 - Reactions to a Peace Officer's Death

When the Undersheriff asked a deputy if there was anything that the Undersheriff could personally do for the deputy, the deputy replied: "Bring back Joel."

Recommendation:

This response reminds us that the psychological, personal trauma, and emotional nightmares experienced from a peace officer's death can be extremely complex. These reactions have tremendous personal impacts, varying from employee to employee. It is recommended that accredited police psychologists be immediately available for employees as resources, confidants and outside support.

Finding No. 61 - Responsibility for the Officers' Deaths

Immediately after the incident, various FCSO and RPD peace officers expressed feelings of "responsibility and guilt" for Joel Wahlenmaier and Javier Bejar's deaths. The involved agencies did an admirable service in providing professional psychological support.

Recommendation:

Although these feelings naturally occur and usually subside with time, it is imperative that civilian and sworn law enforcement personnel receive immediate and on-going psychological support services. Furthermore, readers are reminded that Rick Liles is directly responsible for murdering Deputy Wahlenmaier and Officer Bejar.

Finding No. 62 - Trauma Support

The traumatic events associated with this critical incident precipitated feelings of anger, disillusionment and guilt. These feelings are natural and can be expected as part of the physiological and psychological trauma.

Recommendation:

Although the FCSO has an employee program, “Companion Officer,” both FCSO and RPD do not have a “Trauma Response Team.” It is recommended that all policing agencies have a program staffed by agency personnel and a police psychologist.

Without properly trained and available trauma response personnel, the natural reactions to a critical incident are seldom acknowledged and understood. If not immediately addressed, these reactions can lead to self-destructive behavior, poor work performance, termination and suicide.

To minimize these effects, a “Trauma Response Team,” comprised of selected personnel trained by the agency’s police psychologist, is imperative. A Trauma Response Team can immediately play a part in the recovery process. This team protects employees from emotional and psychological injuries by helping them “make sense” of the incident and provides opportunities to ask questions, vent and share concerns. After a critical incident, the Trauma Response Team can be a bridge to connect with a Psychologist sooner than later.

The reality of police work dictates that personnel resources must be available to handle service calls and specialized operations. Before personnel are made available for their next duty tour, police supervisors and managers must quickly determine when lessons learned need to be discussed. The time period between critical incidents is impossible to predict. Consequently, police leaders must either “stand down” personnel or arrange for an outside agency to respond to directed, initiated or requested police activities.

Finding No. 63 - Helping Support Personnel

Although FCSO’s Companion Officer Team members were providing admirable support at the hospital, it was recognized that some team members were also experiencing emotional distress. Consequently, outstanding assistance and support was provided by the Fresno Police Department’s Companion Officer Team members.

Recommendation:

It is recommended that these personnel be acknowledged.

Finding No. 64 - Deviating

Three days after the incident, some FCSO personnel (of various supervisory ranks) expressed concern about a comment made by the Sheriff. The Sheriff said that members of the Search Warrant Service Team would not be disciplined.

Recommendation:

Clearly, a policing agency leader has the authority to make this statement. However, any leader's statement is subject to interpretation and comparison to past practices. There are times in which employees will not understand why this exemption from discipline did not happen for them and it is difficult for them to recognize why these specific actions were exempted or mitigated.

It is refreshing when a leader is told by others that there is a belief that policy standards are not being equally applied. Notwithstanding this occurring, the sheriff needs to evaluate this statement and consider if this requires further leadership attention.

Finding No. 65 - Honor Guard(s) at the Morgue

When an honor guard was requested at the Morgue, supervisory differences of opinion developed. The supervisors could not reach consensus. Initially, no uniformed personnel were deployed. At a later time, an Honor Guard was posted at the morgue.

Recommendation:

Frequently, decision makers look for a written policy that authorizes when to honor the fallen. This is another example in which a law enforcement agency should create protocols to manage unusual but predictable situations involving peace officer death. This documentation will establish best practices to assist those decision makers and reduce adverse impacts on employee welfare.

It is recommended that uniformed personnel always be posted when injured law enforcement personnel are hospitalized at a medical facility. However, the decision to post police personnel at the morgue should be evaluated and referenced to include a combination of criminal investigation, employee welfare, service responsibilities, and site security. Such decisions are unique to each incident.

Finding No. 66 - Honor Guard

The FCSO Honor Guard's exemplary appearance and outstanding duty performance at both funerals, the California Peace Officer Memorial Ceremony and the National Law Enforcement

Officer's Memorial Ceremony, was acknowledged and commended by community members and law enforcement personnel.

Recommendation:

The continued efforts and time devoted to the FCSO Honor Guard is worthwhile. The benefits are numerous, ranging from community, law enforcement, political and professional appreciation.

Finding No. 67 - Planning a Peace Officer's Funeral

At separate services for Deputy Wahlenmaier and Officer Bejar, thousands of people paid their respects. Personnel at various ranks, including the FCSO Sheriff and the RPD Chief of Police, made significant individual and team contributions in preparation for the well-planned services.

Recommendation:

It is wise to contact agencies that have previously dealt with funeral services for peace officers. Furthermore, some law enforcement agencies and the Concerns for Police Survivors (COPS) organization have developed written guidelines.

Finding No. 68 - "Walking Around"

The FCSO Sheriff immediately recognized that her presence was needed throughout the organization. Although time consuming, her personal contacts with FCSO civilian and sworn personnel were extremely important for the healing process.

Recommendation:

The "Management by Walking Around" theory is a sound practice. When dealing with an incident of this magnitude, it is recommended that the chief, director or sheriff carve time from demanding schedules to determine the pulse of their organization.

Finding No. 69 - Community E-mails and Cards

The Sheriff's Office immediately received consolation e-mails and cards from around the world. Recognizing the importance of FCSO civilian and sworn personnel seeing these supportive notes, the Sheriff wisely organized this correspondence into books for viewing.

These books were first given to the Detective Team where Joel Walhenmaier worked and then placed outside of the Sheriff's Office for everyone to view. At a later point, copies of the books were given to Joel's parents and spouse.

Recommendation:

This leadership action was extremely effective and should be considered by other law enforcement leaders.

Finding No. 70 - Donations

Hundreds of community members coupled with law enforcement officers across the nation sent donations to FCSO and RPD. The FCSO and RPD employee associations opened bank accounts for the slain peace officers. These funds were subsequently distributed to the wives of Detective Wahlenmaier and Officer Bejar.

Recommendation:

Law enforcement agencies in conjunction with their employee associations should establish best practices that outline the creation of an account(s) for officers killed in the line of duty. Establishing an account with a reputable financial institution or a law enforcement credit union should take place before an incident occurs. These steps will ensure that the information required is already in place and available for media access. Such access allows for clear and immediate identification through approved donation processes.

Finding No. 71 - Creating a Non-Profit Account

It was determined that the FCSO will need to purchase police equipment to enhance public and officer safety.

Recommendation:

It is recommended that the FCSO consider establishing a non-profit account to accept donations. During challenging economic times, additional funds may be necessary to acquire the identified police equipment.

Finding No. 72 - Community Correspondence

In a letter dated March 22, 2010, Minkler community members expressed their deepest sympathy to the Fresno County Sheriff's Office, the Clovis, Fresno and Reedley Police Departments and the Fresno County Board of Supervisors. In the same letter, Minkler "community, neighbors and citizens" documented their frustrations, citing inaction from law enforcement and CAL FIRE after numerous reports of arson and gunfire incidents over the course of several months. Furthermore, they expressed interest in looking forward to an "outside investigation." The following nine questions were specifically documented in the letter:

- “Why would you send your men into a ticking-time bomb situation hoping everything would be text book for you?”
- “Why wasn’t Mr. Liles taken for questioning beforehand?”
- “Why did it take so long to investigate him shooting the (Minkler) store?”
- “Why did it take two days to investigate (the shooting victim’s) gunshot wound?”
- “Why did the community have to live in an unsafe environment for so long?”
- “Why wasn’t the SWAT team brought in earlier?”
- “Why did Mr. Liles and (two) officers lose their lives?”
- “Weren’t the events that led up to this shoot-out a typical cry for help from this man?”
- “Why were so many shots fired by peace officers involved in this incident?”

Recommendation:

This letter is a harsh reminder that policing action and inaction, whether service or tactical responses, will always be subject to examination and public scrutiny. Transparency and timely responses to public concerns are key cornerstones for modern day community policing and partnerships.

Finding No. 73 - FCSO Training

Based on actions taken by various FCSO personnel, training needs were identified in this report.

Recommendation:

The FCSO has a significant number of knowledgeable and talented people. However, and frequently throughout the law enforcement field, the pace of police services results in employees and supervisors failing to follow policies and taking shortcuts. When this occurs, potentially devastating problems can develop.

It is recommended that the training calendars for the FCSO units with lessons learned be examined, ensuring that necessary topics to prevent reoccurrence are incorporated into upcoming training activities. Consideration should be given to various training issues, including the following:

- **Frequency** – Topics Requiring “On-Going” Training

- **Leadership** – Following Policy
- **Recognition** – Why Things Go Wrong in Police Work
- **Trainers** – Contemporary and Qualified
- **Supervisory** – Why Things Go Right in Police Work

Finding No. 74 - Introducing Startle and Surprise

This incident involved rapidly changing conditions coupled by extreme stress that required immediate decision making and lethal action.

Recommendation:

The involved law enforcement agencies' trainers should ensure that students are exposed to firearm and scenario training that presents changing behaviors under stressful conditions. An emphasis must be placed on realistic training that involves immediate tactical decision-making with ethical, legal and proper use of force considerations. This includes training exercises that address when to shoot and when not to shoot, and the pros and cons of physical/verbal tactical options.

Finding No. 75 - Firearms Training at Distance

During the incident, peace officers exchanged gunfire with Liles at various distances. The distances between Liles and the involved peace officers ranged from close proximity to approximately 80 yards.

Recommendation:

It is recommended that firearm training activities be compared to the distances experienced. An assessment is needed to determine if current firearms qualification and training requirements provide the knowledge and skills to be proficient and safe at extended distances.

Finding No. 76 - Gunfire to Support Policing Actions

The involved law enforcement personnel expressed divergent opinions and understanding regarding the following tactical and use of force terms:

- Cover Fire
- Directed Fire

- Distraction Fire
- Suppressive Fire

Recommendation:

It is recommended that a department's use of force policy should properly and thoroughly address the ethical and legal complications surrounding lethal force. It is recommended that this include definitions, tactical and use of force considerations, and general guidelines. If approved, this concept should be included in periodic use of force training.

Finding No. 77 - Rifle Qualification at Distances

According to some FCSO personnel, current firearm qualification activities with a rifle only occur at 25 yards.

Recommendation:

An examination of rifle qualification distances should be evaluated. If the range supports rifle qualification at both the 25 and 50 yard range, this incident supports using both distances to enhance proficiency and skills.

Finding No. 78 - Rifle Optics

The FCSO is commended for supplying personnel with a combination of firearms. This includes a primary and a secondary semi-automatic pistol, a shotgun and a rifle.

Recommendation:

Fresno County Sheriff's Office should direct their firearms training staff to assess whether current rifle sights support accuracy and distance challenges. Department or individual purchase of approved equipment should be considered.

Finding No. 79 - Ballistic Helmets

Ballistic helmets are not issued to FCSO and RPD field personnel. If ballistic helmets were purchased, FCSO would face a traditional reluctance to not wear this safety equipment. This conclusion is supported by a current practice in which some FCSO field and supervisory personnel choose not to wear their "riot" helmet.

Recommendation:

It is recommended that FCSO replace current helmets with a minimum Three-A Level ballistic helmet equipped with a “riot” shield. This helmet would facilitate gunfire protection and personal protection during civil disorder. Furthermore, policy should clearly state when wearing the ballistic helmet is mandatory versus optional.

Finding No. 80 - Patrol Cars are not Keyed Alike

During the incident, major traffic congestion occurred when vehicles from multiple law enforcement agencies were left in the street. These cars hampered the movement of armored and other emergency vehicles from traveling on Highway 180.

Recommendation:

It is recommended that FCSO consider standardizing patrol vehicles’ ignition keys or creating a master system key ignition that allows authorized personnel, or all officers involved, to move a patrol car at any time.

Finding No. 81 - Emergency Response Capabilities

Due to the absence of emergency vehicle equipment (lights/siren) or a take-home police vehicle, a Chief of Police and several FCSO SWAT personnel experienced response delays. This adversely impacted the SWAT Team’s readiness to accept missions and deploy.

Recommendation:

It is recommended that all FCSO SWAT personnel be provided with take-home vehicles equipped with emergency lights and siren. Special Weapons and Tactics personnel working undercover assignments should also have vehicles equipped with emergency lights and sirens that do not compromise their undercover peace officer identity. Consideration should also be given to a portable emergency light system and a secreted siren.

An audit should determine if additional FCSO law enforcement vehicles need emergency lights and sirens to enhance response capabilities.

Finding No. 82 - FCSO SWAT Rifles

The FCSO SWAT team arrived at this incident without five SWAT rifles. These rifles were unavailable due to the testing process related to a previous officer-involved shooting incident.

In this Minkler incident, two additional SWAT rifles were discharged and taken for testing. The absence of seven SWAT firearms created a rifle shortage.

Recommendation:

A review of the firearm testing process for officer-involved shooting incidents should be conducted to determine if tested weapons are being returned in a timely manner to meet operational needs. If this process does not support timely weapon return, additional rifles that are properly equipped should be added to FCSO’s SWAT Team’s rifle inventory.

Finding No. 83 - Code Three Authorization

During the review, some FCSO personnel expressed policy misunderstandings regarding the initiation of emergency driving with lights and siren without a supervisor’s permission. It was found that policy permits personnel to initiate this action. This *Code Three Policy* is located in the FCSO Pursuit Policy.

Recommendation:

In reference to the perceptions found to be incorrect, training needs to be provided to FCSO personnel. It is recommended that a separate FCSO administrative/operational order be developed. This directive should specifically address the circumstances in which an employee can self-initiate emergency vehicle operations with lights and siren. This procedure should also remain in the FCSO Pursuit Policy.

Finding No. 84 - SWAT Resources

The three involved SWAT teams did not have a shared list of specialized equipment.

Recommendation:

A list that identifies personnel resources and specialized equipment should be created and shared with each Fresno County SWAT team.

Finding No. 85 - Specialized Warrant Team

Various FCSO personnel requested that a specialized warrant service team be developed to serve warrants.

Recommendation:

It is recommended that FCSO determine if a specialized unit should be established for warrant service.

Finding No. 86 - Commanding Incidents in the Field

Similar to other law enforcement agencies, FCSO has developed a practice where the watch commander coordinates events from their office. Usually a sergeant will then respond to the field incident. If the event meets FCSO's threshold of significance, the watch commander who is generally a lieutenant, will direct another lieutenant to assume incident command.

Recommendation:

When a critical event requires experienced leadership and a timely arrival, it is recommended that the Patrol Watch Commander immediately respond. If this recommendation is approved, protocols should be established as to what rank can temporarily assume facility management.

Finding No. 87 - Completing the Report

This incident attracted nationwide attention and involved multiple local, state and federal policing agencies. Hundreds of peace officers were involved and their agencies' review and reports required extensive staffing. The following are some of the reasons that contributed to the delay in this report's completion:

- County government review and approval procedures to initiate this report resulted in a significant delay.
- Related law enforcement reports from different policing agencies required significant investigation time.
- The criminal and use of force investigation reports were provided via media storage that required significant time to convert the data into working documents.
- Due to various concerns from involved employees, employee associations, legal advisors and policing agencies, there were delays before employees were able to participate.

Recommendation:

It is recommended that the involved government and policing agencies streamline their outside contract review and approval procedures. As to the other contributing reasons, discussions at command and staff levels should occur.

The Awards

On Monday, June 6, 2011, Sheriff Margaret Mims awarded the following honors for bravery and courage in the highest traditions of law enforcement. This recognition occurred at a public ceremony in Fresno, California in the presence of Deputy Wahlenmaier and Officer Bejar's spouses and loved ones. Hundreds of other community members also attended, as well as the media.

Medal of Honor

Detective Mark Chapman, *Fresno County Sheriff's Office*

Detective Mark Eaton, *Fresno County Sheriff's Office*

Deputy Mark Harris, *Fresno County Sheriff's Office*

Sergeant Leo Lopez, *Fresno County Sheriff's Office*

Detective Robert McEwen, *Fresno County Sheriff's Office*

Detective Sergio Tescano, *Fresno County Sheriff's Office*

Medal of Valor

Detective Ken Brookman, *Fresno County Sheriff's Office*

Purple Heart

Officer Javier Bejar, *Reedley Police Department*

Deputy Mark Harris, *Fresno County Sheriff's Office*

Detective Joel Wahlenmaier, *Fresno County Sheriff's Office*

Medal of Merit under Valor

Officer Javier Bejar, *Reedley Police Department*

Sergeant Michael Chapman, *Fresno County Sheriff's Office*

Detective David Cunha, *Fresno County Sheriff's Office*

Deputy Tom Grilione, *Fresno County Sheriff's Office*

Deputy Jeff Simpson, *Fresno County Sheriff's Office*

Deputy James White, *Fresno County Sheriff's Office*

Official Commendation under Valor

Corporal Jason Boust, *Sanger Police Department*

Officer Jon Cardinale, *Reedley Police Department*

Officer Ryan Deuel, *Reedley Police Department*

Lieutenant Marc Ediger, *Reedley Police Department*

Captain Ron Eldridge, *California Department, Forestry & Fire Protection*

Officer Guillermo Garza, *Orange Cove Police Department*

Lieutenant Joe Garza, *Reedley Police Department*

Officer Eric Grijalva, *Sanger Police Department*

Officer Sean Haller, *California Highway Patrol*

Officer Zack Hild, *Reedley Police Department*

Officer Clinton Horne, *Reedley Police Department*

Sergeant Todd Lowery, *Reedley Police Department*

Officer Robert Pulkownik, *Sanger Police Department*

Officer Rafael Rivera, *California Highway Patrol*

Sergeant Terry Schneider, *Reedley Police Department*

Corporal Robert Theile, *Sanger Police Department*

Official Commendation under Achievement

Aviation Mechanic Chad Kuenzinger, *Fresno County Sheriff's Office*

Community Reaction to the Awards

Sheriff Mims eloquently described each honoree's individual actions, in light of their award. Her unique ability to find the right words at yet another difficult "moment in time" were well received and appreciated. Those in attendance were extremely complimentary of Sheriff Mims' actions, and of the men and women of the Fresno County Sheriff's Office and their brothers and sisters in law enforcement.

Throughout the crowd, many recognized this as a profound tribute to the fallen officers. A significant number of individuals shared that this award ceremony would further help their healing process, bring more closure to their pain and nightmares, and also enable them to move forward with their personal lives.

The Sheriff's Decision

Sheriff Margaret Mims requested a review by outside law enforcement consultants. Her goals were to: assess FCSO performance during this critical incident, identify lessons learned, acknowledge what went right, determine what went wrong, and to ensure that best policing practices were utilized. Her willingness to initiate a review with outside constructive criticism is rare in law enforcement circles. This is a true effort to establish transparency and is indicative of a law enforcement agency that is striving to improve its service and public safety readiness.

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The Future

Today, law enforcement personnel continue to encounter complex and dangerous incidents that present serious threats to community members. Clearly, it is difficult to predict when the people of California will experience the next critical incident in which lives are endangered.

Unfortunately, there is no question that something will occur that will require the immediate and safe response of California Peace Officers.

Authors

This report was prepared by retired Los Angeles Police Captain Rich Wemmer and retired Huntington Beach Police Lieutenant Ed Deuel. Rich and Ed are active members of the California Commission on Peace Officer Standards and Training (POST) Law Enforcement Officers Killed & Assaulted (LEOKA) Advisory Council. Both are recognized for their contributions to peace officer safety and training, and have been involved in numerous publications of critical incident reviews and POST Reports. They have served as commentators, panel members and subject matter experts for POST Telecourses. Collectively, they have 68 years of experience training local, state and federal peace officers throughout the United States. Their efforts have been widely acknowledged for making peace officers more efficient and safer.

Rich is the recent recipient of the *Lifetime Achievement Award for Excellence in Training* by the California Commission on Peace Officer Standards and Training in Sacramento, California. Ed's most recent accolade includes the prestigious *Golden Badge Award* for his training contributions in Orange County, California.

Addendum

The Warrant

The Operational Plan

Department Order 1279

The *Risk Assessment Matrix*

The Timeline