

# The Garfield Street Officer-Involved Shootings of Alfonso Limon, Jr., Jose Zepeda, and Justin Villa:

Independent Audit of the  
Oxnard Police Department's Investigation and Review

February 2017



323-821-0586

[www.oirgroup.com](http://www.oirgroup.com)

7142 Trask Avenue | Playa del Rey, CA  
90293

*Prepared by:*  
Michael Gennaco  
Principal, OIR Group  
[michael.gennaco@oirgroup.com](mailto:michael.gennaco@oirgroup.com)

# Introduction

In October of 2012, an attempted traffic stop led to a vehicle pursuit and, ultimately, a multiple officer-involved shooting by the Oxnard Police Department (“OPD”). One suspect, Jose Zepeda was killed, and a second, Justin Villa was wounded before being taken into custody. A third man, Alfonso Limon, completely uninvolved in the earlier activity, was also fatally shot by OPD officers.

This report – by the Los Angeles-based police practices firm OIR Group – is the product of a unique and independent assessment of that critical incident. It was commissioned by the City shortly after the incident at the request of the then-Chief of Police, and intended as a supplement to the formal criminal and administrative investigations that were already occurring, and which are discussed in more detail below.<sup>1</sup> OIR Group’s role was not to duplicate the other processes and their results. Instead, our assignment was to provide a rigorous outside evaluation of OPD’s investigative and administrative responses, as reflected in this tragic case and its aftermath.

This report assesses the thoroughness of OPD’s investigation and the rigor of its systemic internal review process. It is intended to be a vehicle for moving the Department forward, and to that end, we offer recommendations for improvement in these areas. The report also suggests ways that OPD could provide further guidance to its officers and better prepare them to respond to future similar events.

It is important to recognize, however, that – in addition to requesting this evaluation and as we note repeatedly below – OPD conducted its own review of both the criminal and administrative investigations into this critical incident and developed a robust action plan. We found these efforts to be impressive in both scope and productivity, in that OPD self-identified numerous issues on its own regarding officer performance and the effectiveness of its internal review protocols. As further detailed below, OPD developed

---

<sup>1</sup> At the time of this request, the Chief also requested us to review an in-custody death that occurred relatively close in time to this officer-involved shooting. Our review of that incident was publicly released in February 2016.

a comprehensive after-action plan designed to systemically address each need it had identified.

Speaking from the experience of having worked with numerous agencies on similar events, we found much to admire in OPD's internal responses. The Department developed several relevant training bulletins to provide feedback to its officers. It also documented the informal remediation and briefings that it provided to involved personnel as its critique of the incident evolved. Most importantly, the Department improved its policies to provide additional guidance and performance expectations for its officers on a going forward basis.

The most important thing a police agency can do in response to a tragic outcome is to learn from it – to perform an exacting investigation and review so that the organization and its officers can be better trained and equipped to deal with tomorrow's field challenges. In our view, the depth and thoughtfulness of OPD's process could well serve as a paradigm for other law enforcement agencies.

The interest that the Chief and City officials had in seeking an additional, independent evaluation is further testament to their commitment to glean as much constructive information as possible from what occurred. Our report, as detailed below, evaluates the specific elements of the OPD findings and remedial actions. We find much to affirm regarding the former, and much to praise regarding the latter. At the same time, we have identified additional issues and recommendations for further reflection and potential additional corrective action.

We could not have completed this review without the full cooperation of the OPD. During our visits to Oxnard and throughout the review period, we received unfettered access to documents and decision makers, and each police official with whom we visited spoke with candor about the incident.

Consistent with that perspective, we expect that the Department will thoughtfully consider the additional recommendations we offer here, and are hopeful that our review will provide another opportunity for positive and useful introspection.

## Factual Overview:

On October 13, 2012, at approximately 10:08 p.m., two officers from the Oxnard Police Department (OPD) attempted to pull over a car for failing to stop at a stop sign. The car's driver was an individual later identified as Rafael Hernandez. There were also two passengers: one in the front seat later identified as Justin Villa, and one in the back later identified as Jose Zepeda. Their car seemed to yield, but then drove away as the two officers got out of their patrol car. This prompted the officers to get back in their car in order to follow; after a brief time, the vehicle driven by Mr. Hernandez again stopped.

The two officers again exited their car, and an eleven minute standoff ensued as the three men largely ignored commands from the officers to place their hands up and get out of the suspect vehicle. At one point, Zepeda was observed to "flip off" the officers and positioned his hand in the shape of a gun and simulated a shooting motion at the officers. Later in the sequence, both Zepeda and Hernandez smoked cigarettes with what was seen by the officers as exaggerated casualness. Expedited back up was requested over the radio, and additional OPD officers and two sergeants responded to the location.

Shortly before the car stop, OPD officers were informed via radio that nearby a citizen had reported to police that a man in a gray sweatshirt had been observed brandishing a gun and police officers were dispatched to that location. One of those officers ended up responding to and being involved in the officer-involved shooting.

Eventually, Mr. Hernandez started his car and sped away, followed by numerous OPD officers in multiple patrol vehicles. Mr. Hernandez then abruptly stopped the car on Garfield Street, at which point passengers Villa and Zepeda both got out and began to run. As Mr. Zepeda ran away, he fired one round at pursuing OPD officers. OPD officers returned fire, striking Mr. Villa and possibly striking Mr. Zepeda.

As additional OPD officers arrived on scene, Mr. Zepeda continued to engage with officers by firing three more rounds. Nine OPD officers responded to the location and used deadly force. This resulted in the death of Mr. Zepeda, as well as that of another man named Alfonso Limon who was mistakenly identified by officers as one of the suspects. Mr. Limon had simply been walking on Garfield Street with his brother when Zepeda ran by him and police officers advanced, with some of them eventually training and firing their weapons at him. Mr. Villa was later discovered in a nearby shed and a law enforcement K-9 was used to take him into custody. Mr. Villa's injuries included a gunshot wound to the knee as well as K-9 bites, and he was transported to the hospital.

The driver, Mr. Hernandez, had remained in the suspect car and was taken into custody without further incident.

The autopsies found that Mr. Limon suffered 22 gunshot wounds from 15-21 gunshots, while Mr. Zepeda suffered seven wounds from 5-6 gunshots.<sup>2</sup> The investigation found that a total of nine OPD officers had collectively fired between 69-70 rounds,<sup>3</sup> with some officers firing pistols, others rifles, one a shotgun, and one firing both a rifle and a pistol. The breakdown for rounds fired by officer is as follows:

- Officer 1: 19 rounds
- Officer 2: 18 rounds
- Officer 3: 11 rounds (two pistol, nine rifle)
- Officer 4: 6-7 rounds (rifle)
- Officer 5: 6 rounds
- Officer 6: 4 rounds
- Officer 7: 2 rounds
- Officer 8: 2 rounds (shotgun)
- Officer 9: 1 round

OPD asked the Ventura County Sheriff's Office to lead the formal criminal investigation into the incident, while agreeing to provide investigative support. Upon the conclusion of the investigation, the Ventura County's Office of the District Attorney declined to file charges against the involved officers, based on its finding that the OPD officers' use of deadly force complied with the Penal Code. On the Department's initiative, the matter was also presented to the Federal Bureau of Investigation for review. The FBI determined that a federal civil rights investigation into the matter was not warranted. The Office of the United States Attorney further confirmed that the United States Department of Justice intended to take no action with regard to the Garfield officer-involved shooting.

Additionally, OPD conducted an administrative investigation into the performance of its officers. Mr. Limon's family members brought a civil rights action in federal court which resulted in a multi-million dollar settlement, a memorial plaque noting the tragic death of Alfonso Limon, and a commitment by the City to annually recognize his death.

---

<sup>2</sup> The uncertainty about the exact number of shots leading to injuries is not unusual; often one gunshot can be responsible for multiple wounds because of how the bullet travels through the body.

<sup>3</sup> As detailed below, the uncertainty about whether 69 or 70 total rounds were fired by officers stemmed from an inability to ascertain the precise number of rifle rounds fired by one officer. Accordingly, as discussed in further detail below, OPD developed a uniform rifle load requirement to address this issue on a going-forward basis.

# Investigative Issues

## **A. The Assignment of the Initial Investigation to the Ventura County Sheriff's Office**

As noted above, the initial investigation into this matter was conducted by the Ventura County Sheriff's Office ("VCSO"). Requesting an outside agency to conduct the investigation eliminates the dynamic of having officer conduct being investigated by colleagues, and we have no disagreement with OPD's decision to take that step in this case.

There are, however, drawbacks to this approach. Some maintain that the mere assignment of the investigation to another law enforcement agency does little to address the perception of bias when an officer is involved. And the choice to defer to another agency also means surrendering control and decisions about the thoroughness, manner, and pace of the ensuing investigation. This can complicate matters over which the first agency still has responsibility, such as assignment of the involved officers during the pendency of outside reviews.

In this case, one particular issue that became problematic was the uncertainty about "sharing" investigative material between the investigative agencies. When the involved officers were interviewed by VCSO shortly after the incident, OPD's administrative team was able to listen in on the interviews. At that time, it was also OPD's expectation that the VCSO tape recordings of the interviews would also soon be shared so that it could use the evidence for administrative purposes. As it happened, it was only significantly later that OPD was able to obtain that information, and it came from the attorneys who had represented the officers in their interviews.

For these reasons, it is important for law enforcement agencies to establish written protocols for evidence development and sharing that will reduce potential misunderstandings and inefficiencies in the officer-involved shooting context in the event that a request for outside investigative assistance is made. To its credit, through its Law Enforcement Coordinating Committee, operational and procedural guidelines regarding officer-involved shootings have been developed and implemented in Ventura County. The written protocols provide law enforcement in the County a clearer understanding of each entity's role in the investigation and review of officer-involved shootings. While providing helpful guidance on a multitude of issues surrounding such investigations, the current guidelines do not specifically address the specific issue of information "sharing"

during the pendency of an investigation conducted by an outside agency. To provide additional clarity regarding expectations, Oxnard should raise this issue with its law enforcement partners so that this matter might be expressly addressed in the County guidelines.

***Recommendation 1: OPD should initiate a dialogue with the Ventura County Law Enforcement Coordinating Committee to address the question of information sharing when a request is made for outside investigative assistance.***

### **OPD's Limited Set of Administrative Interviews**

To their credit, the involved officers were interviewed within hours of the incident and provided voluntary statements to VCSO detectives. However, only two of the involved officers were then subject to an administrative interview by OPD. As a result, OPD's administrative review of the matter was almost entirely dependent on the interviews conducted by VCSO to evaluate officer performance and related issues.

There may be some occasions in which a thorough detective interview is also sufficient for administrative matters, particularly when the administrative investigators have an opportunity to listen in on those interviews and to provide their own additional questions before the conclusion. This, in our view, was not one of them. In an officer-involved shooting of this magnitude, with its consequences and level of complexity, thorough administrative interviews of every shooter officer should have been conducted.

Such interviews in this case could have more thoroughly covered the kind of tactical decision-making that is generally not a focus of the initial questioning but was significant in this incident. Administrative interviews also could have followed up on additional information collected and analyzed by investigators, such as the autopsy result, bullet trajectories, casings analysis, and review of any video and audio evidence. In fact, as detailed below, the tactical review eventually conducted by OPD was limited by the insufficient factual record developed about involved officer tactical decision-making as a result of the decision not to conduct an administrative interview of all involved officers.

OPD's decision not to re-interview officers involved in the shooting also significantly undercut fact collection from critical on-scene OPD personnel. Instead of interviewing the on-scene sergeants and witness officers who did not use deadly force, VCSO decided to rely exclusively on their written police report accounts. The wisdom of that decision aside, OPD necessarily should have interviewed these parties during its administrative review so that the decision-making of supervisors and officers could have been more fully explored and more insight could have been obtained. A police report – in which the

officer determines what is important to write – can never substitute as a fact-gathering tool for a thorough interview where the interviewer determines the scope and breadth of the inquiry.

***Recommendation 2: OPD should more fully recognize the importance of administrative interviews and conduct them for any involved officer and any witness officer or on-scene supervisor who is not interviewed during the initial investigation.***

## **B. Investigative Issues Identified by OPD**

As noted above, OPD was not the lead investigative agency but did provide investigative support to VCSO. As part of its review process into the incident, OPD identified performance issues involving its personnel relative to the investigative process.

### *Insufficient Supervision of Involved Officers at the Scene*

Immediately after the shooting, one field sergeant managed the crime scene and the apprehension of Mr. Villa and the other dealt with the officers involved in the shooting. OPD noted that as the sergeant was gathering information from each of the officers, he also had to deal with crowd control issues and was unable to directly oversee the involved officers. OPD found that as a result, while he was questioning individual officers, the remaining officers discussed the incident among themselves. At one point, the sergeant instructed officers not to discuss the incident, but the officers nonetheless continued talking.

After a shooting involving multiple officers, it is important for supervisors not only to collect preliminary information from them but also to ensure that they do not discuss the incident among themselves – an inclination that is understandable but that creates witness contamination issues. OPD recognized this principle and as a remedial action recommended that all sworn personnel be provided training reminding them to refrain from discussions with other involved officers in the aftermath of a critical incident. OPD indicated that this remedial action could be accomplished during briefing trainings and unit meetings.

While OPD should be commended for identifying and devising remediation for this issue, the Department could have and should have done more to address the supervision dynamics at the scene. For example, during its after-action review OPD should have given more consideration to how the field sergeant might best have responded to the challenge of competing priorities – such as by requesting additional resources or delegating a non-involved senior officer or detective as de facto “acting sergeant” to

assist with either crowd control or chaperoning the involved officers. The devising of effective remedial measures and related training would have also have been a valid and constructive response.<sup>4</sup>

***Recommendation 3: OPD should brief its field supervisors regarding the need to continually assess resources at a scene and request additional supervisory experience to respond or, if exigency arises, delegate an experienced patrol officer as an interim supervisor when necessary.***

#### *Delayed Clean Up and Restoration of Crime Scene*

Per practice, a crime scene was established soon after the shooting and was maintained until VCSO detectives processed and collected all evidence. The next day, at approximately 5:00 pm, the perimeter was broken down, and the public was allowed back into the area. However, still at the scene was discarded crime scene tape, blood stains, medical waste, and other debris.

In addition to providing a potential health and safety hazard by leaving medical waste behind and not cleaning the blood stains, breaking down the perimeter of the crime scene without timely restoring it as much as possible to its original condition could be interpreted as an indication of disrespect and disdain for the neighborhood. The trauma that the shooting already clearly had on the residents of the Colonia neighborhood was only exacerbated by OPD's neglect to ensure that a thorough cleanup of the crime scene was conducted. While there was no evidence that this shortcoming was intentional, the inattention to this important detail was not helpful in moving community-police relationships forward.

To its credit, OPD recognized during the after action review that a relevant company should have removed all debris and biohazardous material prior to restoring public access into the area.<sup>5</sup> As a remedial measure, OPD recommended that all investigative personnel be provided training reminding them of the need to properly clean up a crime scene while it is still secured. OPD determined to accomplish this training during unit meetings.

---

<sup>4</sup> The limited number of field sergeants immediately available to assist in this type of incident presents a real challenge for Oxnard and other similarly-sized police departments which only emphasizes the importance of considering creative arrangements to temporarily increase field supervision until additional supervision can be identified and deployed.

<sup>5</sup> Apparently a "clean up" company was called to the location but its response to the Garfield location was delayed.

While the additional training will prove beneficial and may lessen the likelihood of this reoccurrence, it might also be helpful for OPD to develop a crime scene checklist for handling supervisors. Included in this list of responsibilities would be to ensure that necessary tasks are accomplished and checked off by the supervisor. In addition to providing an abbreviated reminder to crime scene supervisors of their responsibilities and Departmental expectations, a “signoff” requirement increases the likelihood that all appropriate tasks are done.

***Recommendation 4: OPD should consider developing a crime scene checklist to ensure that expected tasks are accomplished and to enhance the Department’s ability to hold supervisors accountable when they are not.***

*Improper Questioning Outside of Miranda*

As noted above, Mr. Villa was transported to the hospital after his arrest to be treated for the gunshot wound to the leg and the K-9 bites. According to the reports, an OPD officer was dispatched to provide security several days after the incident. The OPD officer reported that he struck up a conversation with Villa and asked him if he knew why he was in the hospital. He said Villa provided information regarding his involvement in the officer-involved shooting. The OPD officer continued the conversation and asked Villa specific questions about the incident and his narcotic use.

OPD noted that Villa had been interviewed the day before by VCSO detectives. Initially, Villa had waived his Miranda rights, but he ultimately refused to answer questions about the incident and requested to speak to an attorney. Accordingly, and as OPD later recognized, the OPD officer should not have questioned Villa regarding the incident.

As a remedial measure, OPD had their Major Crimes detective supervisor counsel the officer on the limits to custodial interrogations. While OPD should be commended for identifying this issue and addressing it, the transgression was a significant one, and potentially prejudicial to the ongoing investigation being conducted by the Sheriff’s Department. Under the circumstances, a more stern and formal response may have been warranted.

*Use of Witnesses/Juveniles to Serve as Translators*

In assisting VCSO’s scene investigation, OPD officers were asked two days after the incident to assist with a neighborhood canvass to identify additional potential witnesses to the incident. These officers were challenged with language barriers in accomplishing this important task. In at least two instances, officers used the young children of the

potential adult witnesses' to serve as translators. In at least two other instances, officers asked spouses to translate for them.

During its administrative review and to its credit, OPD recognized the inefficiencies and quality issues related to this improvised approach; it therefore authored a training bulletin regarding canvass interviews. The training bulletin included instruction on how to obtain witness statements when there is a significant language barrier. The bulletin instructed officers to obtain the assistance of an uninvolved bilingual officer or using the language line interpreter service instead of the disfavored techniques identified in this incident. The bulletin was also discussed at patrol briefings to further instill these principles.

### *Improving Photographic Techniques*

After the incident, an OPD detective responded to the hospital to photograph Mr. Villa's injuries. The detective used a pen as a scale to reference the size of the wound. During its review, OPD determined that the detective should have used a Department photo evidence card which has a scale for exactly such a purpose.

As part of its systemic remediation effort, OPD provided department-wide training regarding the proper method to photograph evidence and injuries. The training included instruction on the use of a photo evidence card to accurately document the size of a wound or other evidence.

### *Forensic Evidence Not Timely Collected*

Shortly after the incident, an OPD detective responded to the booking facility to obtain a urine sample, swab for gunshot residue, and collect all clothing from Mr. Hernandez. Once the detective arrived at the jail, he noticed that Hernandez' hands had not been bagged. Standard police procedure in shooting incidents is to secure with plastic bags any individuals who may have used firearms until a gunshot residue examination is performed. OPD officers who were with Hernandez informed the detective that they had not been instructed to secure Mr. Hernandez' hands. The officers also told the detective that Hernandez had been allowed to urinate unsupervised in a cell and that they had heard Mr. Hernandez wash his hands.

During its administrative review, OPD recognized that clear instruction should have been given to the officers regarding obtaining a urine sample and preservation of potential gunshot residue. OPD recommended that all sworn personnel be provided training

reminding them that all suspects from a shooting scene have their hands bagged and constantly monitored until a gunshot residue test has been performed. OPD committed to provide this training during briefings and unit meetings.

#### *OPD Engaged in Further Analysis Regarding the Shooting of Mr. Limon*

After the VCSO investigation was completed and analyzed, OPD had internal questions about the District Attorney's determination that one of the initial rounds fired by a responding officer struck and disabled Mr. Limon, causing him to fall to the ground. As a result, OPD investigators reviewed the autopsy information regarding the wound tracks and the evidence collected with regard to bullet trajectory. They also consulted with the pathologist who performed the autopsy. OPD concluded that while it was plausible that the District Attorney's version of the incident may have been correct, it was also plausible from the evidence that Limon sustained all of the gunshot wounds while lying on the ground. OPD is to be commended for the additional analysis undertaken on this issue, even though that analysis proved not determinative.

#### **C. Investigative Issues Not Identified by OPD but Warranting Attention**

##### *Involved Officers' Use of "Furtive Movements" to Describe Observations of Suspects*

The term "furtive movements" has traditionally been used in law enforcement parlance as a catch all phrase to describe any actions by suspects that suggest they are secreting or producing a weapon or other contraband. However, progressive police agencies are training officers to avoid the use of the term because it does not describe actual movements with particularity, and can seem a blanket or convenient justification for the police response. Officers are now guided to report the actual movements observed.

During their interviews to VCSO detectives, several of the involved officers described observing the suspects make "furtive movements" during the encounter. Because there was generally no follow up by detectives asking the officers to describe the movements with more particularity, the interviews at times lacked specific accounts from the officers of what they observed the suspects actually do that raised the threat level.

***Recommendation 5: OPD should consider issuing a training bulletin reminding officers of the need to be precise in reporting observed physical movements of individuals comprising a threat and to avoid reliance on the term "furtive movements".***

### Medical Examiner Response Time

In this case, both Mr. Limon and Mr. Zepeda were pronounced deceased by paramedics and, as a result, left at the scene. In such cases, protocols require the medical examiner to be called and eventually a representative from that office picks up the decedents and transports them away from the scene. In this case, it was at least nine hours after the shooting incident before the medical examiner responded to the location to pick up the bodies. Unfortunately, this delay is not unusual in officer-involved shooting scenarios. While some have defended the protocol as driven by a need for criminologists to methodically take photographs of the decedents and otherwise process the crime scene, it seems to give inadequate weight to the sensitivities and community perceptions involved in the treatment of people killed by the police. Certainly, a nine-hour delay between the incident and the removal of the decedents seems problematically long.

***Recommendation 6: OPD should work with the County's Office of the Medical Examiner and Coroner to develop crime scene protocols in officer-involved shootings so that individuals pronounced at the scene are examined and taken away as expeditiously as possible.***

### Evidence Issues with Individuals Pronounced at Scene

The investigative reports indicate that an OPD officer asked emergency medical personnel for a sheet that he then placed over Mr. Limon's body until medical examiner's personnel arrived several hours later. While the intent was apparently to shield the body from the purview of neighborhood residents out of respect for the family, placement of a sheet over the body could potentially compromise the subsequent forensic examination. For that reason, police agencies are increasingly using body screens to keep the decedent from public purview without contaminating the body.

Since this incident and to its credit, in 2014, OPD recognized the need to a more professional method of protecting crime scenes and specifically bodies that may be lying on the ground in public view. As a result, in 2015, crime scene barriers were purchased by the Department to protect the dignity and integrity of sensitive crime scenes.

#### **D. Performance Issues Identified by OPD's Administrative Review**

Following its administrative review of the incident, OPD determined that the use of deadly force deployed by the nine officers involved in the shooting was consistent with the Department's use of force policy. As detailed further below, OPD determined that

one of the officers involved in the shooting violated the Department's policy on the safe handling of firearms and OPD's Safety Standards.

To its credit, OPD also identified the following performance issues during its administrative review:

*Inappropriate Comments at Inception of Traffic Stop*

During the administrative investigation, OPD reviewed the audio recorder of one of the initial officers. The recorder captured comments made by the officer's partner to the occupants of the car that were inappropriate, unprofessional, and potentially catastrophic. In an attempt to gain compliance with his instructions, the officer repeatedly used profanity and referred to the occupants as "stupid." While the officer told the occupants at one point to put their hands up, he instructed his partner to shoot one of the occupants in the back of the head if his hands came up. At another point, the officer audibly told another responding officer that he was about to shoot one of the occupants.

Officers sometimes argue that profanity is a tactical choice that helps demonstrate the seriousness of their instructions and promotes compliance. This assertion, debatable at best, is completely inapplicable to the litany of profanity and insults hurled by the officer on this occasion – which seemed just as likely to provoke aggression as cooperation. Even more concerning was the officer's instruction to his partner to use deadly force if one of the occupants' hands came up, particularly when he was instructing the occupants to raise their hands. These conflicting directions could have led to an inappropriate use of deadly force.

To the Department's credit, it identified these inappropriate comments during the internal review and was sufficiently concerned that it audited over one hundred other audio conversations of citizen contacts initiated by the officer. The audit located one other situation in which a similar use of profanity occurred. Based on those two incidents, OPD determined that the officer's use of threatening and foul language violated Departmental policy, and remedial action was taken.<sup>6</sup>

In addition, OPD also disseminated a training bulletin regarding use of inappropriate language. The training bulletin was intended to remind Department employees that the use of inappropriate language, including profanity, to "relate" to subjects, control, or otherwise gain compliance was not condoned.

---

<sup>6</sup> Considering the extent and nature of the comments captured on tape, more serious remediation than was actually interposed might have been the better course of action.

During the time frame of the Garfield shooting incident and review, OPD was examining the performance of its field training officers to determine whether appropriate instruction, guidance, and modeling was being given to trainees regarding how to talk to citizens. A significant audit was conducted in which hundreds of audio recordings of police-citizen encounters were reviewed. In the few instances in which field training officers were found to be performing below Department expectations, appropriate remedial action was taken. OPD's is to be commended for its devotion of significant resources to examine the issue and correct any direction inconsistent with the philosophy and expectations of the Department.

#### *Safety Tactics Not Followed by Officer*

OPD also found that during the standoff traffic stop, the same officer did not follow appropriate officer safety tactics. As the officer gave instructions to the occupants, he stood in the roadway in between his unit and the vehicle. It was only after other officers responded that they were able to physically pull him back to a position of cover.

Officers are taught to protect themselves by moving to a position of cover if individuals are non-compliant and presenting a potential threat. However, this officer chose instead to stand his ground in the street. This placed him in potential peril and increased the likelihood that he would need to use deadly force.

To its credit, OPD recognized that this officer had violated Department safety standards with this decision. As part of the remedial action, the officer attended a four-hour training session including range and tactical decision-making under stress. The tactical training consisted of traffic stop scenarios in which threat recognition and situational awareness were evaluated. The officer successfully completed the training that was specifically designed for him.

#### *OPD Units Did Not Follow Emergency Driving Policies*

OPD noted that at the initiation of the incident, after the suspect vehicle failed to yield, one of the initial officers provided their location and requested expedited backup over the radio. In response, eight units carrying a total of eleven officers responded Code 3 (with lights and sirens on an emergency basis). Of the eight units, only four advised dispatch that they were responding Code 3.

OPD determined that based on the limited information initially broadcast its policy only authorized two units to respond Code 3. It further found that responding officers should

not have authorized their own Code 3 response and that they should have notified dispatch of their response.

OPD further noted that while recent driver training provided by the Department had covered laws and policy regarding pursuits and Code 3 driving, the curriculum had not included training on authorized Code 3 response to a request for backup. OPD recommended that on a going forward basis, Department driver instructors and the curricula include instruction on initiating Code 3 response, how to request assistance, and the total number of units authorized to respond Code 3 to a request for backup.

OIR Group reviewed a training PowerPoint presentation devised to address these issues. The training included discussion of the pursuit policy, the need to broadcast when officers decided to respond with emergency lights and siren, and the policy's limitation on the number of cars involved in a pursuit.

While OPD should be commended for identifying this issue and developing a remedial plan designed to address the wide-ranging performance deficiency, the Department did not identify or address the role of field supervisors and dispatch regarding this issue. As noted above, when four units radioed that they were responding Code 3 to the location, dispatch and the field supervisors should have recognized that this already constituted twice as many units than there should have been per policy, and taken instant remedial action.<sup>7</sup> Because OPD did not fully recognize the significance of this inaction by supervisors and dispatch, it did not address the role of supervisors and dispatch in its remedial plan.<sup>8</sup>

In addition, the remedial plan did not include any proactive auditing to ensure that OPD officers had incorporated training and policy into their field performance. Because of the high percentage of violations in this case, and the significance of this issue for public safety, such an audit would likely have been resources well spent. Instead of waiting for the next critical incident to uncover significant non-compliance, an audit program would ensure that field performance is consistent with training and policy, and proactively identify any officers who may need additional intervention.

---

<sup>7</sup> Of course, the supervisors could not have been responsible for knowing that four other units were also responding Code since the officers did not radio this information to Dispatch. But supervisor instruction to authorize only two units to the location might ostensibly have caused the other four units to also shut down their unauthorized Code 3 response.

<sup>8</sup> As a result of discussions with OPD about this issue, the Department has agreed to include supervisors' responsibility during Code 3 driving into its driver training curriculum and program.

***Recommendation 7: OPD should revisit its driver training curricula to ensure that supervisors are acutely aware of their responsibilities of ensuring that Code 3 responses are within Departmental policy, and to hold them accountable when they do not appropriately intercede.***

***Recommendation 8: OPD should consider proactively auditing Code 3 responses to ensure that officers are following training and policy.***

*Potential Jeopardy of Ride-Along*

One of the responding OPD officers drove to the location of the shooting and left his ride-along unsupervised in his patrol car as he responded to assist officers involved in the shooting. As a result, the ride-along witnessed portions of the shooting and remained in the patrol car for several hours after the officer-involved shooting. The car was positioned a little over one hundred feet from Mr. Zepeda's position.

While OPD recognized the officer's interest in assisting fellow officers, it concluded that he should have considered the safety of his ride-along and should have dropped her off at a safe location prior to responding to the officer-involved shooting. OPD concluded that the officer placed the ride-along in a potentially dangerous situation.

OPD recommended that the ride-along form/application be amended to include Department policy language which addresses the safety of ride-alongs and officers' responsibility. It was further recommended that the form include an area for the officer's signature and that a training bulletin be drafted and circulated to all sworn personnel. Consistent with the recommendation, the revised form had an area for the officer's signature. A training bulletin was also drafted and circulated to OPD officers setting out important considerations for field response and activity when a ride-along is present.

*Inappropriate Comment Made to Emergency Medical Personnel*

VCSO investigators interviewed an EMS paramedic who responded to the scene. The paramedic told investigators that he parked the ambulance and as he was gathering his medical equipment, an unknown officer told him that he would not need his equipment and then escorted him into the scene in order to assess Mr. Zepeda.

OPD determined that the officer should not have implied that Zepeda was deceased by telling the paramedic that he did not need his medical equipment. OPD's attempt to identify the officer was unsuccessful, but OPD averred that if the identity had been

determined, the officer would have received remediation regarding the inappropriateness of the statement.<sup>9</sup>

### **E. Tactical Issues**

To its credit, a tactical review was performed of the incident by a member of OPD's command staff. The tactical review identified the following issues, and here we address both the strengths and perceived deficiencies of that process:

#### *Backdrop Issues Identified (Although Not Fully Developed)*

Police officers are trained to consider their "backdrop" in determining whether to use deadly force. Backdrop in the police context is defined as the objects that exist in the vicinity of or downrange from the target. The concept and concern recognizes that even the most accurate shooters may miss their target, particularly in dynamic and stressful situations, and bullets that are even slightly off target may end up striking unintended persons, causing potentially catastrophic consequences.

In OPD's tactical review, the concern about backdrop focused on two OPD officers' initial volley of shots fired at Zepeda which may have resulted in Mr. Limon being inadvertently struck by gunfire. During the detective interview, one of the officers described the surrounding area and conditions including parked vehicles, nearby residences, and the rear parking lot. The second officer was not questioned and did not provide information regarding backdrop during the VCSO interview.<sup>10</sup>

The tactical review noted that the two officers did not observe any bystanders in the area or identify any other conditions which caused them concern about firing their weapons at Zepeda. The review concluded that although an innocent bystander, Limon, may have been inadvertently struck by police gunfire, it would not be reasonable under the circumstances to expect that the officers should have known that there was a bystander a significant distance down range.

---

<sup>9</sup> The difficulty OPD had in identifying the officer may have been compounded by the fact that the paramedic was not interviewed until approximately three months after the incident.

<sup>10</sup> As detailed above, this issue and other tactical aspects of the incident were not fully explored during the initial VCSO detective interviews of the involved officers. OPD's decision not to re-interview the officers limited the facts available during the Department's tactical review and prevented further insights about this critical aspect of the incident from being developed. This limitation showcases the importance of adequate questioning about the involved officers' decision-making, either during the initial interview or a subsequent administrative interview.

The tactical review concluded that although OPD determined that officers reacted reasonably and appropriately to the deadly actions posed by Zepeda, it recognized that officers could always benefit from training where the backdrop is a concern. OPD's tactical review recommended that range and scenario training incorporate situations where the officer must consider the backdrop. Pursuant to the recommendations, OPD developed a descriptive curriculum considering these issues entitled "Backdrop Assessment Range".

While OPD should be credited for considering and addressing this issue, it limited its inquiry into the backdrop presented to the initial two officers when they fired at Zepeda. A thorough inquiry would have also considered the backdrop of officers when Mr. Villa was inadvertently shot and the backdrop of all other involved officers when they fired, particularly since the shooting occurred in a neighborhood with residences and vehicles close by.<sup>11</sup>

***Recommendation 9: When OPD conducts a tactical review of an officer-involved shooting it should consider and analyze the backdrop of every shooter officer.***

*Clearing of Vehicles and Cover: Insufficient Examination of Optional Tactical Approaches*

The OPD tactical review noted that after the initial exchange of gunfire, the lead officer ran past the suspect vehicle having knowledge that the vehicle was possibly occupied by an armed suspect. The review noted that after this officer pursued Zepeda, the next officer elected to leave a position of cover and took a position behind the suspect vehicle in order to confront Hernandez, who remained seated in the vehicle.

The OPD review opined that, ideally, officers should not run past a vehicle that has not been cleared. However, the OPD review concluded that the officers' acts were reasonable, given the threat posed by Zepeda and the presence of the second officer to handle the suspect vehicle. OPD's conclusions notwithstanding, the tactical review recommended that the use of cover and clearing vehicles before running past them should be reinforced during scenario-based training.

While OPD should be credited for identifying the vehicle-clearing and cover issues, more could and should have been explored regarding the involved officers' actions after arriving on Garfield. A significant percentage of the involved officers reported that they

---

<sup>11</sup> In fact, several parked vehicles were struck by stray gunfire from officers' guns and bullet strikes upwards of twenty feet high were found on a nearby commercial building.

either left positions of cover to advance on the perceived suspects or never sought cover during the episode.<sup>12</sup> However, the OPD review did not conduct administrative interviews to more fully explore these tactical decisions, nor did they critique these decisions. Officers are trained that when engaged with an armed suspect, they should seek cover in order to reduce the threat presented to them by the gunman and to approach cautiously. However, in this instance, the involved officers largely abandoned those principles of officer safety and aggressively pursued the suspects, increasing their vulnerability to return fire. Moreover, their positions of vulnerability may have contributed to their inaccurate perception of a non-involved individual as a threat, resulting in deadly force mistakenly being deployed on him.

The tactical review should also have considered alternative approaches to the situation that evolved on Garfield Street. When the traffic stop was first made, field sergeants instructed the officers that they were not to pursue any of the suspects that ran from the car. However, because administrative interviews of the involved officers were largely not conducted, it is unclear how changing circumstances militated in favor of an all-out foot pursuit of a suspect that was now shooting at them, with another suspect out of the car and a third remaining behind the wheel.<sup>13</sup> If anything, the fact that one of the suspects was now shooting at the officers suggested that any adjustments to the tactical plan should be in the direction of less risk, not more.

An alternative approach that was not discussed in OPD's tactical review would have been for the officers to proceed more cautiously and devise a plan that used the advantages of cover, communications, and resources to more safely take the suspects in custody. Such a plan could well have averted the mistaken engagement with Mr. Limon. OPD may have determined in the end that the dangers presented by Mr. Zepeda firing upon officers

---

<sup>12</sup> For example, one involved officer told investigators that he “fanned out into the street” as he neared the location of the suspects on Garfield. As OPD recognized with its officers’ positioning at the initial traffic stop, such tactical positioning away from cover places the officer in a position of vulnerability, increases the threat level of the officer, and is inconsistent with principles of officer safety.

<sup>13</sup> To its credit, while not in specific response to this incident, OPD adopted in 2014 a thoughtful foot pursuit policy that provides guidance to its officers on how to conduct a foot pursuit, one of the most potentially dangerous activities in which officers engage. The policy is a model which similarly situated police agencies should consider adopting.

called for immediate action, but the administrative interview and tactical review processes work best when the analysis of alternatives is thoughtful and thorough.<sup>14</sup>

***Recommendation 10: In conducting tactical reviews, OPD should consider all of the tactical decision-making of its involved officers, including:***

***(a) Any decision not to seek or to leave cover by any officer***

***(b) Whether a safer approach to apprehension more consistent with principles of officer safety would have been preferable.***

### *Use of Color Codes*

During the exchange of gunfire, one of the involved officers experienced a malfunction with his rifle. As a result, the officer yelled out the color code “Red” which signifies to officers that he is out of ammunition or his weapon has malfunctioned. The officer then transitioned to his pistol but, inconsistent with the color code doctrine, did not indicate his changed status by yelling out the color code “Green” to indicate that the officer has reloaded or now has an operational weapon. Officers who fired at Mr. Limon mentioned that they heard the officer yell out the color code “Red” and believed that he was in a vulnerable position and unable to respond to a deadly threat due to his status. The officers indicated that the officer’s use of the color code “Red” was one of several reasons causing them to fire at Limon.

Another officer used color codes twice during the exchange of gunfire. The first occurred after the officer’s first volley of shots when he fired all the rounds in his pistol and yelled out “Red” to advise other officers of his status as he reloaded his pistol. OPD’s tactical review opined that this was an appropriate use of the color codes. The second situation occurred after the last exchange of gunfire. At that time, the officer took cover behind another officer and yelled out “Red” as he conducted a tactical reload.<sup>15</sup> OPD opined that this situation would not have warranted the use of the color code.

To its credit, the OPD tactical review identified and critiqued this issue and recommended that the Special Enforcement Unit develop specific language concerning

---

<sup>14</sup> The Garfield scenario does not equate with “active shooter” scenarios when officers come onto a scene in which a gunman is already shooting at civilians; here Zepeda was firing at officers as a result of being pursued by them.

<sup>15</sup> A tactical reload is a procedure by which police officers change out their ammunition clip when they are in a position of relative safety so that they have a full clip of ammunition should the further need to engage arrive.

when to use a certain code as described above and train consistently using these codes. The review further recommended that the Firearms Training Unit review what is being taught to officers to ensure that the training was consistent with the doctrine. The review recommended that a training bulletin be drafted by the Special Operations Commander and circulated to all sworn personnel.

A training bulletin was subsequently produced pursuant to the recommendation.<sup>16</sup>

### Shooting Stance

OPD's tactical review determined that one of the involved officers deviated from what the Department's Firearms Training Unit trains on shooting stances. According to the review, OPD teaches a "Modified Weaver" shooting stance, which consists of a two-handed handgun grip. The review noted, however, that this officer used a single-handed shooting platform as he fired his weapon at Zepeda. OPD concluded that given the proximity of Mr. Limon to Mr. Zepeda, the officer should have used the most accurate and stable shooting stance possible, such as the Modified Weaver shooting stance. The review noted that a single-handed stance is less accurate than a two-handed stance, because there is no second hand available to stabilize the shooting.

OPD's review noted that the officer was no longer employed by the Department prior to the completion of the investigation, but that if he had still been employed it would have been recommended that he receive additional training regarding appropriate shooting stances, particularly under stressful conditions.

OPD is to be commended for identifying this issue during its tactical review. However, there is no evidence that OPD examined the shooting stances of the other eight involved officers during its tactical review to determine whether they comported with Departmental training. Comprehensive administrative interviews would have captured this information and a full review would have examined the shooting techniques of each of the involved officers.

***Recommendation 11: OPD's tactical review should review the shooting stance of all officers involved in a deadly force incident to determine whether the deadly force deployment complied with firearms training.***

---

<sup>16</sup> In addition, OPD developed a shotgun and rifle combat course designed to increase officer proficiency while combat shooting on the move and in pairs.

## Fire Discipline

OPD's tactical review noted that officers are trained to address a deadly threat using controlled fire. With regard to one involved officer, the review noted that there was a significant difference between the actual number of rounds fired by the officer and his own belief about that number. Moreover, the tactical review noted that there was a significant difference between this officer's total rounds and those fired by officers who were positioned close to him: eighteen rounds versus a range of two to seven. OPD's tactical review opined that this officer may have been indiscriminately firing his weapon.

The OPD review recommended that fire discipline should become a point of emphasis in the Firearms Training Unit's range fundamentals. It recommended that fire discipline should be discussed at every session and stressed during range discipline. In addition, OPD developed tactical training devoted to backdrop assessment, reinforcing to officers the need to be aware of the target and what lay beyond it. The OPD review noted that if the involved officer had still been employed, it would have recommended that he receive additional range training regarding fire discipline.

OPD is to be commended for identifying the issue with this particular officer and addressing the issue systemically. However, it is unclear why the Department's tactical review solely focused on fire discipline for this officer. As noted above, one of the involved officers shot 19 rounds (emptying his ammunition clip) and another 11 rounds, yet there is no analysis of whether either officer may have also been indiscriminately firing his weapon.<sup>17</sup> It was incumbent upon the tactical review to have considered the fire discipline of every officer who discharged a significantly higher number of rounds.

The review could also have used the forensic evidence available to further consider this issue. For example, the crime scene photographs showed multiple bullet strikes – twenty feet high above street level – to the building behind where Mr. Zepeda was standing. Similarly, photographs showed other stray rounds striking uninvolved vehicles, raising questions about the intended target and why the rounds were so far off their mark.

***Recommendation 12: OPD's tactical review should consider and analyze fire discipline issues for every officer who fires an inordinate number of rounds.***

***Recommendation 13: When evaluating controlled fire and backdrop issues, OPD should consider and analyze the crime scene photographs and forensic evidence.***

---

<sup>17</sup> One distinction between these two officers may have been that their firing involved different volleys. However, this distinction should have been set out in the Department's tactical analysis.

### Lack of Effective Radio Communication

OPD's tactical review noted that information and descriptions of the occupants during the high-risk traffic stop was not broadcasted. The review opined that as a result, officers responding to the termination point of the pursuit did not know the number of outstanding subjects or any pertinent suspect descriptions. The review further noted that there was a lack and delay of information broadcasted after the initial exchange of gunfire. Officers responded to the scene with limited information regarding the location of the suspects. The Department's review found this understandable: given the rapidly evolving series of events, it would have been difficult for officer to broadcast the location of the incident and exact location of any suspects. The review also opined, however, that if Zepeda's specific location had been broadcasted to other officers, it may have prevented those officers from entering the scene without cover.

OPD's tactical review recommended that the Department continue placing strong emphasis on radio communications during training scenarios, including Tactical Decision Making Under Stress.

OPD's identification of this tactical issue is commendable but additional potential tactical shortcomings during this incident were worthy of additional discussion. The lengthy initial encounter during the traffic stop afforded responding officers ample time (eleven minutes) to broadcast a description of each of the three suspects, yet no description was put out, even though two sergeants were on scene and the potential for further conflict had been established. While the Garfield events were much more compressed in time, there were numerous officers on scene. It is noteworthy that none of them chose to provide location information about Zepeda once he started firing at officers.

The lack of radio communication among officers may have had real consequences in this incident. As the OPD review articulated, officers responding to the scene had no information as to the whereabouts of the active shooter, causing some of them to enter Garfield Street from a dangerous direction and end up in a position of peril as they entered the location. It is critical that OPD, consistent with its tactical review, reinforce to officers and supervisors alike of the vital need to communicate during tactical operations.

### Situational Awareness

OPD's tactical review noted that numerous officers responded to the scene in order to assist the initial responding officers engaged with Zepeda. The review observed that

some officers approached southbound on Garfield without having knowledge of Zepeda's location. These officers continued southbound on Garfield without cover. Zepeda responded by raising his arms in a shooting stance toward one of those officers. In response, that officer and others fired at Zepeda.

The tactical review noted that officers not having knowledge of where the threat is located should enter a similar scene with caution, use cover, and coordinate their approach with officers already on scene. For those officers who responded southbound on Garfield, they followed none of these tactically essential principles and performed in a manner inconsistent with training.

OPD's tactical review recommended that the Department develop critical incident scenarios involving separate groups of officers that rely on radio communications.

In response to this recommendation, a memorandum was drafted noting that radio communications would be emphasized during future scenario-based training. With particular regard to the Garfield shooting incident, the memorandum noted that the Tactical Decision Making Under Stress (TDMUS) scenarios developed for the involved officers, personnel were required to communicate with their partners during two officer scenarios, as well as with dispatch. The memorandum indicated that in order to ensure that officers receive continued emphasis regarding these recommendations through scenario based training, the concepts had been written into a lesson plan for future TDMUS scenarios. The memorandum further noted that during recent active shooter training scenarios, groups of officers were required to communicate with other groups as they moved to address threats.

#### Rifle Magazine Loads

OPD's tactical review noted that two officers used their rifles during the incident but were unable to recall the total number of rounds they loaded into their rifle magazines and the exact number of rounds they fired. While several spent rifle cases were located at the scene, forensic investigators were unable to identify with certainty the rifle from which they were expended. As a result, the investigation was unable to determine precisely how many rounds each officer fired.

A solution to this issue on a forward going basis is to promulgate a Department standard magazine load for rifles. The OPD tactical review identified this solution and recommended the adoption of a Department standard. It recommended that the Firearms

Training Unit determine the appropriate number of rounds that should be loaded into rifle magazines based on capacity and that a policy revision order and training bulletin so instruct officers.

Consistent with this recommendation, OPD promulgated an Operational Revision Order. The Order defined new procedures for the loading of rifle magazines, including a uniform standard of loading the ammunition which was set at load capacity minus two rounds. The Order also set out other requirements for maintaining the rifles.

## **F. Performance Issues Not Identified by OPD**

### *No Analysis of Field Supervisor Performance at the Initial Traffic Stop*

As detailed above, OPD identified and addressed important performance issues by one of the initial responding officers during the traffic stop, including the use of inappropriate language and the choice not to seek cover. Moreover, as detailed above, OPD identified issues after the shooting where the field supervisor's competing responsibilities prevented him from properly ensuring that the involved officers did not discuss the incident among themselves. However, OPD did not sufficiently assess the performance of the field supervisors at the initial traffic stop.

Because the traffic stop ended up resulting in an eleven minute standoff, two field supervisors were able to respond to the scene. Upon arrival, those supervisors were able to deploy officer personnel and made some effective and advisable decisions such as the order to retrieve OPD's armored vehicle, overseeing the deployment of spike strips<sup>18</sup>, and ensuring that less lethal munitions were available on scene. Most importantly, as detailed above, one of the field supervisors instructed the officers that if any of the vehicle occupants ran from the car, the plan would be for the officers to stay with the vehicle.

However, as OPD acknowledged and as explained above, during that eleven minute interval, potentially important communications did not occur, to the detriment of subsequent performance in the incident. Most importantly, no communications were made about the clothing being worn and further descriptions of the vehicle occupants. This left officers who were not at the initial scene but responded to the Garfield Street

---

<sup>18</sup> Spike strips are devices which officers can deploy on the road that will cause the suspect vehicle's tires to deflate, rendering the vehicle immobile.

location with little descriptive information about them, and may have contributed to their inability to recognize Mr. Limon as an uninvolved person.<sup>19</sup>

It is unclear whether the field supervisors formulated or communicated a plan to on-scene officers about how to respond should the vehicle occupants attempt to leave in their car.<sup>20</sup> Specific officers were not designated to follow the vehicle and the sergeants did not set out their role if that eventuality occurred. As a result, when the vehicle was restarted and moved forward, the on-scene officers scrambled into the nearest radio car and all went into pursuit, leaving the two sergeants behind with the last remaining radio car. As a result, the field sergeants were the last to arrive at the Garfield location, and were not available to effectively supervise or coordinate the initial response by the lead officers.

Additional tactical options that were available at the initial scene were also insufficiently considered and assessed by OPD's tactical review. For example, there was no apparent assessment of the spike strip deployment and whether another deployment option could have been more effective. Likewise, there was no consideration of whether the less lethal options could have been deployed on scene more effectively to prevent the vehicle from driving away. Finally, there was no apparent assessment of why OPD's armored vehicle was not available at the initial location to assist in the apprehension of the suspects and when it would have arrived.<sup>21</sup>

Even if OPD's tactical review had determined to more thoroughly assess the performance and decision-making of the on-scene supervisors, it would have been disadvantaged by the paucity of related information collected during the investigation. As noted above, the sergeants were not interviewed by VCSO or OPD about their actions and decisions.

---

<sup>19</sup> On the night of the incident, Mr. Limon was wearing a gray sweatshirt and sweatpants returning from playing basketball. Zepeda, Hernandez, and Villa were dressed differently. The three men also were of different body types than Limon.

<sup>20</sup> A contemporaneous audio recording from one of the field sergeants includes him apparently indicating that not all of the officers should follow the vehicle although it is unclear from the recording when and to whom in the sequence of events this statement was made. Because the sergeant was not interviewed about the incident, no further information exists about the circumstances surrounding this statement.

<sup>21</sup> Curiously, the officer who was reportedly instructed to retrieve the OPD armored vehicle omitted from her written report any mention of her efforts to do so.

***Recommendation 14: OPD’s tactical review should include a detailed assessment of field supervisors’ performance and supervisorial decision-making.***

*The Consequence of Zepeda Being Separated from His Gun at Time of Final Volley Not Articulated in Tactical Analysis*

A commercial surveillance video of the incident captured the final actions of Mr. Zepeda. Towards the end of the scenario, it is evident from the video that Mr. Zepeda was separated from the handgun he had been using to fire upon the officers and no longer armed. That being so, the video shows Mr. Zepeda motioning with his hands as if he is still carrying a weapon which apparently caused the final volley by OPD officers resulting in him going down for a final time. The “shooting motion” that he made toward officers could have been perceived by them that he was still armed and an actual threat. In evaluating the reasonableness of officers’ use of deadly force, it is their perception that must be considered.

For that reason, we do not disagree with OPD’s conclusion that even though Mr. Zepeda was unarmed at the time the final volley was discharged by officers, they could have reasonably perceived him to continue to be a threat to them or their colleagues. What would have been helpful, however, is for involved officers to be questioned about this perception in an administrative interview and for this fact to be explicitly recognized and analyzed during OPD’s tactical review.

*Driving with Rifles Out of Rack*

At least one of the involved officers indicated driving to the Garfield Street location with his rifle out of its rack and slung over his shoulder. The officer described this technique as “tricky”. Some agencies have determined that emergency driving with a rifle deployed out of its rack is a dangerous maneuver that officers are accordingly trained to avoid. Because this issue was not identified by OPD, similar analysis was not undertaken.

***Recommendation 15: OPD should consider whether its officers should be trained not to deploy rifles out of their rack when performing emergency driving.***

*First Aid to Wounded Suspect Not Immediately Rendered*

A commercial surveillance video of the incident depicts Mr. Zepeda going down a final time as a result of a burst of gunfire. Eventually, an OPD officer approached him and shined a flashlight on him, the gun nearby, the wall, and other objects. However, the officer did not approach the body to check for vitals nor make any attempt to render aid.

Police agencies are increasingly recognizing the need to train officers on transitioning from “apprehension mode” to “rescue mode” after shots are fired. In the Garfield Street shooting incident, while there were immediate efforts to render aid to Mr. Limon, especially after officers began to recognize he had no connection to the suspects, those same efforts were not undertaken with regard to Mr. Zepeda.

As noted above, OPD expressed its concern about the comment made by one of its officers to paramedics about there being no need to tend to Mr. Zepeda. However, OPD did not attempt to identify the first officer to approach Zepeda and determine whether his actions were consistent with Departmental expectations about rendering aid.

***Recommendation 16: OPD should train its officers on the need to transition from apprehension mode to rescue mode and then remediate those personnel who do not successfully make this transition.***

## **G. Post-Incident Issues: Strengths and Potential Improvements**

### *OPD Outreach*

Because of OPD’s unfortunate fatal shooting of Mr. Limon, an uninvolved citizen, there was an understandable reaction by friends, family, and community within minutes of learning of his death. To OPD’s credit, its command staff promptly reached out to the Limon family, organized meetings with community members and worked to regain their trust through continued dialogue. OPD also enlisted the support of the United States Department of Justice Community Relations Service, experts in facilitating dialogue between affected communities and police departments. Also, within weeks of the incident, the City announced that it would retain OIR Group to conduct an independent review of the Garfield shooting. The displays of community outreach, while, as detailed below, did not dispel all of the family and community’s concerns, were admirable gestures by the Chief and her command staff. That outreach continues to this day; the newly installed Chief recently met with family members of Mr. Limon.

### *The Aftermath of the Officer-Involved Shooting: Issues Involving the Limon Family*

As noted above, immediately after the shooting incident concluded, emotions ran understandably high on all sides as it was soon learned that an uninvolved person had been shot and killed by police. Mr. Limon’s brother was an eyewitness to the shooting and, according to his account to VCSO detectives, after he saw his brother being shot, screamed at OPD officers that his brother was not involved and not armed. The brother

also related that he was told by OPD officers to leave the scene but when he tried to follow their instructions, he was briefly detained by another set of officers. At the time the brother was interviewed, he was “caught” within the crime scene which had been locked down and thus was unable to get to his mother to provide consolation and support to her.<sup>22</sup>

The Limon family lived very close to where the shooting occurred and other family members expressed frustration at their inability to tend to Mr. Limon as he lay in the street. According to one family member, one on-scene OPD officer withdrew his firearm and threatened to use deadly force if the family member tried to get to Mr. Limon but another officer interceded and instructed the officer to put his weapon away. Some of the crowd displayed hostility at responding OPD officers as they attempted to manage the scene and one officer reported being spat upon while on scene.<sup>23</sup>

While, as noted and discussed above, OPD recognized during its review that one sergeant on scene was left with the untenable responsibility of both dealing with the crowd and trying to keep involved officers from discussing the incident among themselves, the Department could have engaged in additional investigation and analysis into this aspect of its response. After VCSO completed its investigation and the civil proceedings were concluded,<sup>24</sup> OPD could have inquired in more depth from the Limon family regarding how the Department’s on-scene handling of the event impacted them and engaged in more fact collecting from its members with regard to issues raised by the family. At the conclusion of OPD’s review of these actions, it could have reported back to the Limon family and provided additional explanation regarding the officers’ post-shooting actions.

---

<sup>22</sup> The interviewing VCSO detectives indicated that they would try to find a way to escort the brother out of the crime scene so that he could see his mother, but it is unclear from the investigative report whether such was effectively done. To their credit, at the end of the interview the VCSO detectives told the brother that they were sorry for his loss.

<sup>23</sup> This officer showed remarkable restraint in response to this action.

<sup>24</sup> OPD was challenged with regard to the timing of any such assessment by the fact that the investigation was almost immediately handed over to VCSO and the fact that for a number of months the family members were involved in ongoing litigation against the City and represented by attorneys.

### Post-Litigation Remedial Action

As part of the settlement agreement to the civil litigation, the City agreed to a number of remedial actions. One condition was that for at least five years, the City agreed to annually commemorate the day of the Garfield shooting to be “Community Safety and Anti-Violence Day” and include in the City Proclamation that it is made in honor of the tragic death of Alfonso Limon, Jr. In 2014, the City timely honored this commitment. However, in 2015, through unintentional oversight, the City failed to place the proclamation on the City Council agenda. The City rectified the situation by commemorating the event at a subsequent Council meeting. According to the City, as a result of improved internal controls instituted after the 2015 lapse, the 2016 commemoration was timely honored.

Per the settlement agreement, the City further agreed to make a request to the VCSO that the Limon family be given access to and be allowed to inspect the surveillance video of the incident. While OPD has provided the Limon family copies of this video, it has yet to make a formal request of VCSO to allow the Limon family access to inspect the original surveillance video which remains in Sheriff’s custody.<sup>25</sup>

***Recommendation 17: Pursuant to the settlement agreement, OPD should make a request of VCSO to allow the Limon family to be given access and allowed to inspect the original surveillance video.***

### Collateral Property Damage

The investigative report notes damage to at least two uninvolved vehicles parked on Garfield Street as an apparent result of the gunfire by OPD officers. In addition, scene photographs depict commercial properties with numerous bullet strikes as a result of the officers’ gunfire. There is no documentation in the file however, regarding whether the City eventually reimbursed the owners of the property and vehicles for the resulting damage.

Increasingly, cities and police departments have recognized the real financial and potential emotional loss suffered by uninvolved residents when stray bullets end up damaging their property. As a result, some law enforcement agencies assign personnel to

---

<sup>25</sup> Because VCSO is not a party to the settlement agreement, it has discretion whether or not to honor Oxnard’s request once made.

proactively identify any damage caused as a result of police activity and work with the property owners to make them financially whole as soon as possible. This proactive orientation can advance the healing of the community and promote greater trust between residents, the police department and the City. OPD and the City could benefit from devising a similar program when the use of deadly force results in property damage to uninvolved community residents.<sup>26</sup>

***Recommendation 18: OPD should work with the City to devise protocols designed to proactively address property damage to uninvolved residents as a result of police activity and ensure that the issue of any property damage is analyzed as part of its critical incident review.***

#### *Body Cameras/Use of Audio/Video Recorders*

Following the Garfield shooting, and consistent with a growing trend in American policing, discussions increased about the desirability of equipping OPD officers with body-worn cameras. In the settlement eventually reached between the Limon family and the City of Oxnard, the City agreed to review and consider equipping officers with video recording devices and acknowledge that audio recording is already mandated by policy.

In August 2014, OPD promulgated an Operational Revision Order relating to video recording devices which was modified again in 2016. We have reviewed the current policy and while aspects of the policy are consistent with best investigative and evidence collection practices, as detailed below, the policy should be improved in several significant respects.

First, we note that the policy provides the following important guidance regarding Departmental expectations:

- Recognition that at no time is an employee expected to jeopardize his/her safety in order to activate a recorder.
- Instruction to officers that the use of recorders does not reduce the requirement to provide thorough written documentation of the incident.

---

<sup>26</sup> In this case, the two vehicle owners did file claims to recover the loss they suffered as a result of damage to their car by stray bullets. Almost a year later, after filing such claims and providing estimates of damage, the property owners still had not been compensated by the City for their loss. Our experience with other jurisdictions has educated us that reimbursing uninvolved property owners for their loss can be accomplished without any admission of responsibility or liability.

- Reiteration that all recordings made by personnel acting in their official capacity shall be deemed as property of the Department.
- Placing the responsibility on the employee for making sure that audio/video equipment is in good working order and a notification requirement to supervisors if equipment not properly functioning.
- With regard to video cameras, instructing supervisors to delegate the recording function to another officer or employee so that supervisors can facilitate scene supervision.

However, the following aspects of the Department's current recording policy are problematic and worthy of further examination.

***OPD should return to the activation requirement for body-worn cameras when initiating Code 3 driving operations and when transporting arrestees.***

OPD's 2013 policy regarding audio recordings contained a requirement that tape recorders were to be activated when initiating Code 3 driving operations.<sup>27</sup> In 2016, when promulgating its body-worn camera policy, the Department inadvertently did not include the requirement that officers activate their body cameras when initiating a Code 3 response.

Similarly, in its 2013 version of the audio recording policy, OPD recognized that the transport of arrestees was important to capture with its audio recorders. However, when OPD revised the audio policy to include body worn cameras, it inadvertently removed the activation requirement for prisoner transport. The requirement to activate the body camera during prisoner transport should be reinserted into the policy.<sup>28</sup>

***OPD's requirement that it need seek permission from the involved officers to use body camera recordings for training purposes should be eliminated.***

Body camera recordings provide tremendous potential for training to its officers. Field performance can be effectively critiqued and "lessons learned" can be effectively imported to the whole Department. For example, if body cameras had been deployed at the time of the Garfield incident, the footage captured would have provided excellent teaching tools for OPD to export to its officers.

---

<sup>27</sup> OPD should be credited for being at the advent of this progressive mandatory activation requirement before even acquiring body worn cameras.

<sup>28</sup> When OIR Group brought to OPD's attention these inadvertent changes in the body worn camera policy, OPD agreed to reinsert these requirements in its policy.

However, current policy would have required OPD to obtain permission from each of its involved officers before being able to use the recordings for training purposes. This is so, despite the recognition in the policy that body worn camera recordings are the property of the Department. The policy should not allow officers the ability to veto use of the recordings for training purposes and the policy should be amended accordingly.

***The policy should explicitly require that body camera recordings relating to a use of force and citizen complaint be retained indefinitely.*** The current body worn camera policy requires that all recordings should be retained for at least 2 ½ years with any recording associated with a case being kept for the life cycle of a case. Body camera footage associated with an officer use of force and/or complaint should be retained indefinitely and the body worn camera policy should be amended accordingly.

***When an officer uses force or is the subject of a complaint, the officer should provide an account of the incident prior to reviewing the body camera footage.*** The revised policy instructs officers to review any recordings as a resource when preparing written reports documenting the incident. While we agree that officers should review recordings when preparing incident reports supporting arrests or other documentable situations, there should be exceptions when the officer's conduct is the focus of review such as a citizen complaint or use of force. In those situations, the policy should require that the officer provide a "pure statement" of the incident through interview or police report and then afford the officer the opportunity to review the recording to learn whether the recording refreshes the officer's recollection. If so, the officer should then be afforded the opportunity to articulate any supplemental recollection as a result of reviewing the recording.

***Release of Recordings.*** The policy should set out more specific guidelines regarding release of recordings, particularly in the use of force context. For example, some Departments have created policy whereby body worn camera recordings of deadly force events are released after a set period of time or after the District Attorney has completed the review of the matter. However, rather than a case by case determination, a specific release policy should be promulgated so that the public has a clear understanding of whether and when such recordings are to be made available.

***Recommendation 19: OPD should revise its policy for body worn cameras and other recording devices as follows:***

- a. Revert back to the 2013 policy language requiring officers to activate body cameras when initiating a Code 3 response and when transporting arrestees;***

- b. Eliminate the policy language requirement that OPD must seek permission from the involved officer before using body camera footage for training purposes;*
- c. Provide express direction and guidance regarding how to capture recorded evidence of uses of force and incidents resulting in a citizen complaint;*
- d. Include a permanent retention requirement for body camera recordings related to a use of force and citizen complaint;*
- e. Require involved officers to provide a “pure statement” of recollection in use of force, citizen complaint situations, or any other circumstances when the officer’s conduct is being reviewed before affording the officer to review any recordings of the incident;*
- f. Set out clear release criteria for recorded material, particularly events relating to use of force.*