4th Annual Report of the Deadly Force Review Panel

January 2024

Introduction

Pursuant to 5 MRS 200-K (7), the deadly force review panel submits its annual report to the Joint Standing Committee on the Judiciary. The report will offer general observations and a summary list of recommendations made to law enforcement agencies after the panel reviewed individual cases of the use of deadly force and a synopsis of cases reviewed during 2023. What has remained a constant theme over the years, as specially convened panels have examined instances of the use of deadly force by law enforcement officers in Maine, is the combination of mental health crises and firearms.[1] Sometimes, the mental health crisis arises spontaneously or is exacerbated by the use of alcohol and/or drugs, and sometimes it arises because of the use of alcohol and/or drugs.

A Brief History

In 2008, then Attorney General G. Steven Rowe convened an *ad hoc* task force to review law enforcement responses to situations involving individuals in a state of crisis due to serious mental illness, severe emotional distress, or suicidal ideation. The task force issued a report in December 2008, directing most of its observations and recommendations to what it called "antecedent conditions" related to mental health that could decrease the incidence of police interventions in highly dangerous situations. This involved recommended updates to statutes, outlining ways mental health professionals and law enforcement could collaborate to anticipate potentially volatile situations, and identifying the laws available to mental health professionals and law enforcement to respond to mental health crises.

In 2017, then Attorney General Janet T. Mills convened a task force "to conduct a broader analysis of police-involved deadly force incidents" to "form more accurate conclusions about why the incidents are occurring and whether we can prevent unnecessary deaths and injuries in the future." This task force met four times in 2018 and reviewed ten incidents that occurred during 2015 and 2016. The profile of the involved person was a male in possession of a deadly weapon, with a criminal history, who was suffering symptoms of depression, and most had alcohol or drugs in their system. Apart from recommendations related to police and dispatcher training as essential components of an effective response, the task force stated, "It is well known that access to mental health services, particularly the availability of forensic, crisis, and crisis stabilization beds in Maine, is a critical issue. All too often, persons exhibiting signs of a mental health crisis are in emergency rooms for extended periods due in large part to the lack of availability of inpatient mental health services. There needs to be efforts to expand access to crisis stabilization and inpatient mental health care, as well as intensive community supervision of individuals with mental illness who have been determined to pose a risk of serious harm to themselves or others." As a final note, the task force said, "…it is imperative that…persons affected by mental illness and substance abuse disorder or anyone in crisis have increasing access to inpatient treatment if

[1] Of the 29 cases reviewed by the Panel, weapons used by those confronting responding officers included five vehicles and three knives; the rest (21) involved firearms.

necessary, effective crisis response services, and that they are aware of the resources available to them….We hope these recommendations will inspire local and state resources and law enforcement agencies to work proactively and collaboratively to assist those in need to reduce the incidents in which both the public and law enforcement officers are in potentially deadly encounters."

The present Deadly Force Review Panel (the Panel) was created in 2019 by the 129th Legislature. Its charge is to examine deaths or serious injuries resulting from the use of deadly force by law enforcement officers and identify compliance with accepted and best practices, as well as to comment on whether practices or procedures require adjustment or improvement. In its first report in January 2021, the Panel noted, after reviewing its first three cases, that there was "…a lack of community-based behavioral/mental health services that, had they been available and utilized, may have mitigated the circumstances that culminated in the deadly force incidents." In its second annual report in January 2022, after having reviewed a total of 10 cases since its inception, the Panel said the following: "The Panel is hopeful that the Committee will seriously consider the recommendations in this annual report, particularly as they involve the critical need for additional resources for mental health services, especially in rural areas, to assist the community, law enforcement, and other first responders with the "typical individual" involved in an officer-involved shooting..." In its third annual report in January 2023, the Panel reiterated the call it made in its second annual report "for additional mental health services, especially in rural areas, to assist the community, law enforcement, and other first responders with the individuals most often involved in officer-involved shootings. This collaboration is essential to managing any continued threat that these individuals may pose to themselves, members of their households, law enforcement officers, and the community, especially when they have access to firearms." The report went on to say, "The Panel's observations of these incidents and characteristics of the individuals against whom deadly force was used are consistent. The individuals are … males who have mental health and/or substance use issues and have firearms or other weapons. They are known in their community to be troubled and often violent….Given this profile, it is not surprising that the primary focus of the Panel's recommendations is on training, support, and resources related to mental health services." That report alluded to the potential usefulness in some instances of the protective custody and so-called "blue paper" statutes (Title 34-B § 3862 and § 3863).

In 2023, the Panel received a list of incidents where Weapons Restriction Orders were obtained by law enforcement under the "Protection from Substantial Threats" statute (Title 34-B § 3862-A). According to that list, a total of 33 Weapons Restriction Orders were obtained by law enforcement since the statute's effective date on July 1, 2020. The Maine Chiefs of Police Association provided relevant training for law enforcement in April 2023. Following the Lewiston mass shooting in October 2023, considerable public attention was given to the infrequent use by law enforcement of the protective custody and "protection from substantial threats" statutes. In November 2023, the Department of Public Safety and Spurwink conducted training specific to Weapons Restriction Orders, and since then, Spurwink has done similar training for individual agencies. The most recent list of Weapons Restriction Orders contains an additional 145 entries for a current total of 179, a dramatic increase over just three months.

While the Panel makes recommendations in this 4th Annual Report regarding policy, training, and equipment for law enforcement, it urgently reiterates its call for resources for mental health services. The contributing causes leading individuals to armed confrontations with law enforcement remain the same; only the names change. Because of this, the Panel begins its recommendations with a section titled Recommendations to the Judiciary Committee regarding Behavioral Health System.

Recommendations to the Judiciary Committee regarding Behavioral Health System

The Panel recognizes the incredible work of the current Administration to rebuild Maine's behavioral health system. It has made historic and long-overdue investments. However, the Panel also observes that these investments have not yet appeared to impact deadly force incidents. It takes a long time to turn a ship. But as the 2023 reduction in overdose deaths shows, investment and persistence create progress.

In her State of the State address, Governor Mills called for:

Increased funding for Crisis Receiving Centers.

A process for law enforcement to obtain a warrant when law enforcement is unable to take a person into protective custody but has probable cause to believe that person is mentally ill, poses a likelihood of serious harm, and has access to firearms or other dangerous weapons.

More robust background check processes.

Strengthening of the straw purchases law proposed by this panel.

The Panel expresses full-throated support for the Governor's proposals. In addition, the Panel requests the Legislature and the Administration consider ways to:

Increase access to inpatient withdrawal management (detox).

Increase access to comprehensive co-occurring substance use disorder treatment.

Strengthen rates for outpatient psychiatry and therapy—vital programs for which the current rates, despite recent increases, do not cover the cost of delivering the service,

Increase capacity for short-term psychiatric hospitalization.

Increase funding for embedded behavioral health co-responders with law enforcement.

Strengthen the mobile crisis system.

Increase options for assisted outpatient commitment (progressive treatment program).

Improve the process for compelling assessments when an individual presents a likelihood of serious harm (blue paper).

Improve funding for law enforcement so they can hire and retain more qualified staff and provide more training time.

The panel recognizes some of these items are already in progress. The Office of Behavioral Health is actively working on a crisis system redesign. A new mobile crisis model and rate was just published and appears favorable. The Administration is actively working to increase the number of inpatient withdrawal management beds across the state—more are needed. Other services like outpatient therapy, outpatient med management, and embedded co-response could be partially addressed by MaineCare's Comprehensive Community Behavioral Health Clinics efforts. Still, sustainable rates are necessary for these services. All of these are problems that can be solved simply with increased funding.

Improving the involuntary assessment and hospitalization (Blue Paper), Progressive Treatment Program (Green Paper), and protection from substantial threats (Yellow Paper) processes are primarily legislative rather than financial fixes. The panel respectfully requests that the Judiciary Committee convene an Involuntary Assessment and Treatment Task Force to examine these three statutes, which aim to improve how we ethically compel mental health assessment and treatment for individuals the criminal justice system or state hospitals would otherwise serve.

Recommendations to Individual Police Agencies

All departments that participated in the use of deadly force should participate in the after-action internal review process.

The internal review process should try to determine the law enforcement officer's mindset and decision-making process during the use of force so that the Incident Review Team's report may better answer a) if changes are necessary to increase public and officer safety and b) whether training should be revised.

Internal Review Team (IRT) reports should specifically address policy, training, and equipment.

Protocols should be developed to ensure the transfer of information across department shifts.

Departments should consider using 34-B §§ 3862 and 3862-A (Protective Custody and Protection from Substantial Threats statutes) more frequently and as appropriate.

Departments should review and update vehicle pursuit policies regularly.

Failure of an officer's weapon and/or department ammunition should be investigated as a possible systemic issue.

Departments should investigate how a prohibited person acquired a firearm.

Recommendations to the Board of Trustees of the Maine Criminal Justice Academy

Enhance standards for the after-action internal review process.

Recommendations to Tactical and Negotiating Teams

Wait for additional officers before approaching a dangerous person.

Record communication and interventions with audio/video equipment.

An individual in crisis may respond better to questions than to commands or directives by law enforcement.

Emergency Medical Services (EMS) should be staged nearby in a safe location pending the conclusion of a potential use of deadly force situation.

EMS should examine the involved police officer(s) post-incident.

Recommendations Regarding Information/Communication

A protocol should be established for the public safety communications center to notify the appropriate Tactical Team commander when scene supervisors request it.

There should be an assessment of on-scene communication capabilities.

Recommendations for Mental Health Workers

Inquire about firearms.

Discharge planning for persons committed to state institutions should include documented inquiries into access by those persons to firearms and notification of the patient, family, and any caregivers of the prohibition against firearms.

Recommendations for Families and Friends of a Person in Crisis

Remove weapons and make them inaccessible.

Notify law enforcement when a friend or family member is deemed a danger to themselves or others.

Addendum A
Factual Summaries of Incidents Reviewed

Synopsis of case #21, fatal shooting of Gregory Lasselle.
During the afternoon of February 24, 2022, the parents of 27-year-old Gregory L. Lasselle went to the Pittsfield Police Department. They reported that Gregory had expressed suicidal ideations and threatened them with a tire iron and a large iron bar. They said they suspected that Gregory was having a mental breakdown or was under the influence of drugs. They said that there were multiple firearms in the house. Officers were unsuccessful in their attempts to contact Gregory via phone. They watched him at home through binoculars, and he appeared to be reading a book. The parents were uncomfortable returning to their residence and stayed in a motel for the night. The next morning, the parents returned to their residence, where Gregory threatened to kill them and the family dog with a rifle. Gregory's father wrestled the rifle from Gregory. The Lasselles fled their residence to the Pittsfield Police Department. After a 12-hour standoff, members of the State Police Tactical Team deployed a police dog to apprehend Gregory when he came outside the house, but Gregory dragged the dog across the icy ground to the entry of the residence, where he retrieved a rifle. When officers tried to wrestle the rifle from him, Gregory discharged it, nearly shooting an officer. Officers shot and killed Gregory. In the hours leading up to the shooting, officers tried repeatedly to persuade Gregory to come out of the house unarmed.

Synopsis of case #22, shooting and wounding of Kyle Edwards.
Around noon on Sunday, January 3, 2021, the owner of a stolen pickup truck saw a person, later identified as Kyle Edwards, driving the truck in Lewiston. The owner called the police and followed the truck until a police officer arrived. Mr. Edwards thereafter refused to stop, resulting in chases by Lewiston police officers. Sgt. David Levesque found the truck partially concealed behind a high snowbank behind a local church. Sgt. Levesque approached the parked vehicle on foot, commanding Mr. Edwards to show his hands. When Sgt. Levesque was 10-12 feet from the rear of the truck, Mr. Edwards quickly accelerated in reverse. Sgt. Levesque, fearful that Mr. Edwards would run over him, fired a single round at Mr. Edwards. The round struck Mr. Edwards in the head after penetrating the rear window and driver's headrest. Mr. Edwards survived the gunshot wound and later pled guilty to criminal charges.

Synopsis of case #23, fatal shooting of Kourtney Sherwood.
In the mid-afternoon of Monday, February 28, 2022, a 9-1-1 caller reported that Kourtney Sherwood was in a white GMC pickup in Topsham parked on the Brunswick-Topsham Bypass and that she was possibly armed with a gun and wanted to harm herself or others. Topsham police officers, Sagadahoc County Sheriff deputy sheriffs, and State Police troopers responded to the scene where they saw Ms. Sherwood in the driver's seat of the pickup truck parked in the breakdown lane in Topsham near the Brunswick town line. A deputy sheriff tried communicating with Ms. Sherwood using a public address system. However, Ms. Sherwood would not engage in communication or follow commands. The deputy sheriff told Ms. Sherwood they wanted to get help for her. He asked Ms. Sherwood to throw her gun out the window and to put her hands out the window. In response, Ms. Sherwood pointed a handgun out the window in the direction of the

deputy and Topsham police officers. Topsham Officer Mathew Bowers fired a single shot from a rifle, striking Ms. Sherwood in the head. Ms. Sherwood died the next day.

Synopsis of case # 24, shooting of Edward Hyman.
At 5:34 a.m. on October 9, 2021, as a result of a 9-1-1 call, Portland police officers, including Officer Nevin Rand, responded to the area of the Preble Street Resource Center on Oxford Street, where unhoused individuals were camped. The officers encountered a woman who said a man hiding under a blanket burglarized the Resource Center. Officer Rand and another officer found Edward Hyman under the blanket. Mr. Hyman stood and refused Officer Rand's commands to remove his hands from his coat pockets. Mr. Hyman began moving as if trying to retrieve a weapon inside his coat. Both officers drew their service weapons while repeatedly ordering Mr. Hyman to show his hands. Ignoring the commands, Mr. Hyman quickly approached the officers while bringing his hands together in an isosceles shooting stance. Officer Rand shot Mr. Hyman, who later affirmed that he feigned being armed and postured to shoot the officers so that the officers would shoot him.

Synopsis of case #25, fatal shooting of Jacob Poitraw.
On June 4, 2022, a motorist reported to the Presque Isle Police Department that Jacob Poitraw had brandished an AR-15-style rifle at him and his companion in an apparent road rage incident in Presque Isle. Sgt. Tyler Cote of the Presque Isle Police Department investigated the incident, and attempts were made to locate and arrest Mr. Poitraw. More than 24 hours later, Sgt. Cote spotted Mr. Poitraw driving a different vehicle, a pickup truck, in Presque Isle and attempted to stop the vehicle. However, Mr. Poitraw refused to stop, and a high-speed chase ensued, during which Mr. Poitraw deliberately backed his vehicle into Sgt. Cote's cruiser at a high rate of speed three separate times. When Mr. Poitraw backed into Sgt. Cote's police vehicle the third time and was pushing it backward, Sgt. Cote fired six rounds from his handgun through his cruiser's windshield. One round struck Mr. Poitraw. Mr. Poitraw died later that night at a local hospital. About three minutes elapsed from the initiation of the chase and the use of deadly force by Sgt. Cote.

Synopsis of case #26, fatal shooting of Peter Pfister.
In the early morning hours of Tuesday, June 21, 2022, law enforcement officers, including Detective Scott Duff and Corporal Caleb McGary of the State Police Tactical Team and Deputy Sheriff Dylan Hall of Hancock County, responded to a 911 report that Peter Pfister, 27, was holding his mother hostage at her residence in East Blue Hill and threatening to kill her. Shortly after their arrival, the officers encountered Mr. Pfister outside the residence. They shot him when he pulled a pistol from the small of his back and pointed it at Corporal McGary and Deputy Hall. Mr. Pfister died at the scene.

Synopsis of case #27, suicide of Kevin Harvey.
On August 5, 2019, at 11:42 a.m., Lewiston police officers, including Officer Jeffrey Burkhardt, responded to Robinson Gardens in Lewiston. A caller reported that her neighbor, Kevin Harvey, had a handgun and threatened to kill his girlfriend. The girlfriend fled her home at Robinson Gardens after Mr. Harvey threatened her with a gun. Mr. Harvey threatened murder/suicide. The girlfriend went to a neighbor's home. Mr. Harvey pursued her, entered the neighbor's residence,

and pointed the handgun at her. The neighbor managed to get Mr. Harvey out of the house. Lewiston police officers set up a perimeter. Officers did not know where Mr. Harvey was and believed that he may have barricaded himself in his home. As Officer Burkhardt and another officer made their way through the woods to take a perimeter position behind Mr. Harvey's home, they heard a gunshot in the woods just ahead of them. Officer Burkhardt saw a man (later identified as Kevin Harvey) prone on the ground. Both officers believed that Mr. Harvey was shooting at them. Officer Burkhardt fired one round. When officers approached Mr. Harvey, they found that Mr. Harvey was deceased from a self-inflicted gunshot wound to the head. It was later determined that the round fired by Officer Burkhardt did not strike Mr. Harvey.

The statute (Title 5, section 200-K) governing the Panel states that the Panel "shall examine deaths or serious injuries resulting from the use of deadly force by a law enforcement officer." [Emphasis added.] In this incident, although the law enforcement officer used deadly force, no death or serious injury resulted from his actions. Accordingly, the Panel declined to review this incident as it was not within its statutory authority to do so.

Synopsis of case #28, fatal shooting of Stephen Bossom.
On Friday, July 15, 2022, at approximately 4:00 p.m., a 9-1-1 caller reported a potential active shooter at the Sebasticook Lake Campground in Newport. Additional 9-1-1 callers said that a man, later identified as Stephen Bossom, an employee of the campground, was at the campground with a handgun, behaving erratically and yelling that there was an active shooter in the campground. Callers reported that Mr. Bossom's arm was bleeding and that he refused to relinquish the gun. Officers from the Newport Police Department, Penobscot County Sheriff's Office, State Police, and Dexter Police Department responded to the campground. Deputy Kenneth York and another deputy sheriff encountered Mr. Bossom, who was armed with a handgun. The deputies commanded Mr. Bossom to drop the gun, but Mr. Bossom refused. When Mr. Bossom pointed the weapon at Deputy York, Deputy York shot Mr. Bossom, who died at the scene.

Synopsis of case # 29, fatal shooting of Christopher Camacho.
On December 27, 2019, shortly after 7 p.m., 911 callers reported a robbery in progress at the Dollar General in Limerick. The callers said that the suspect, who was later identified as Christopher Camacho, age 16, had a handgun and a knife and was holding an employee at gunpoint and making the employee tape up his own arms. York County Deputy Sheriff Robert Carr, who was told that Mr. Camacho had a knife at an employee's throat, was dispatched. A customer leaving the store told the deputy that Mr. Camacho had a gun and a knife and that he and an employee were behind the front counter. Deputy Carr entered the store, where he saw Mr. Camacho holding a black handgun. An employee was standing back to and near Mr. Camacho. Ignoring commands to drop the gun, Mr. Camacho pointed it at Deputy Carr. When Mr. Camacho again pointed the gun at him, Deputy Carr fired two rounds at Mr. Camacho. One round struck Mr. Camacho, who died at the scene.

Addendum B:
Panel Membership

Michael Alpert, President, Greater Bangor Area Branch NAACP
Stephen Burlock, Esq., Assistant District Attorney (Retired), Vice Chair/Secretary
John Chapman, Esq.
Jack Clements, Chief of Police, Saco
Fernand LaRochelle, Chair
Anna Love, Chief, Attorney General Investigations
Joel Merry, Sheriff, Sagadahoc County
Jack Peck, Director, Maine Criminal Justice Academy
Michael Sauschuck, Commissioner, Department of Public Safety
Sandra Slemmer, designee of Mark Flomenbaum, M.D., Ph.D., Chief Medical Examiner
Benjamin Strick, Director of Adult Behavioral Health, Spurwink
Dan Tourtelotte, Maine State Law Enforcement Association
Vendean Vafiades, Esq.

The individuals serving on the Panel are appointed to bring their professional expertise to discuss these complex cases. Thus, members of the Panel may know or have had contact with individuals involved in the case under review. In such situations, members report such affiliations to the Panel, and that information is recorded in the meeting minutes. If Panel members determine that they have a conflict of interest, they are recused from voting on the Panel's observations and recommendations regarding that case.