



Iowa FACE report: **Law enforcement officer killed in line of duty**

Case Number: **2011 IA 013**

Date: **20 February 2013**

Summary

A 39-year-old Sheriff's Deputy was fatally shot by a county resident with history of mental illness during a 45-minute shootout at a rural property. The Deputy Sergeant (victim), Sheriff, and a Chief Deputy travelled to a rural property to conduct a welfare check on the resident who had exhibited signs of mental instability in the days prior to the shooting. The rural resident, who was known to local officers and grew up in the community, had a history of bipolar disorder. Five weeks prior to the shooting, the resident's family members initiated involuntary commitment proceedings but the petition was denied. The resident was discharged from the hospital days later. No family members or local health care providers were apprised of the individual's diagnosis or of any prescribed medications following his evaluation.

On the morning of the incident, law enforcement agents spoke with the rural resident by telephone to let him know they were planning to stop at his home to check on his welfare. The three officers arrived at the farm and went to the porch to announce their arrival, but the resident did not respond. Not knowing the resident's location, the officers used a public address system to announce their arrival and then saw the resident through the window, holding a gun. Officers took cover in their vehicles and the resident opened fire from inside the house, disabling both vehicles driven to the site. Officers then took cover behind one of their vehicles, radioed for help, and returned fire. In the course of the ensuing gunfire, the resident came out of his house, firing a shotgun at the officers who had taken cover behind a vehicle. One of the shots passed through a deputy's vehicle and struck the deputy in the head, killing him instantly.

When the resident turned toward the house, the two remaining law enforcement agents at the scene made a decision to retreat down the 0.2-mile lane while under fire. During the time that had passed, law enforcement personnel from multiple agencies in the surrounding area were arriving at the roadway. Over the three-hour period that followed, tactical police and a family member attempted to negotiate by phone with the resident who refused to cooperate. Tactical teams deployed to the farmstead shot and killed the resident when he exited his house armed and preparing to fire.

The following recommendations are made to prevent similar scenarios in the future:

- 1. Provide law enforcement with training on dealing with mentally ill persons. Training should cover topics such as recognizing signs of a citizen with mental illness, effective methods to communicate/interact with those who have mental illness, and information regarding potential support resources in the community.*
- 2. Develop a system that provides quick access to law enforcement agencies regarding the most recent status and potential conditions of citizens with serious mental illness, so law enforcement personnel have concise clear information about behaviors that may be encountered when responding to a situation involving a mentally ill citizen.*
- 3. Mental health care providers and caregivers should carefully assess the home environment of patients, especially with respect to weapons accessibility, or other means by which mentally ill patients may harm themselves or others. In some cases, efforts should be made to communicate with community stakeholders, such as local mental health providers and law enforcement regarding potential hazards present in a home environment.*

Introduction

A county law enforcement agent was fatally shot by a rural resident with a history of mental illness, when the law enforcement agent and two fellow officers arrived at a farmstead to conduct a welfare check. Iowa FACE learned of this fatality on the day of the event, through news media sources. Iowa FACE conducted interviews with Iowa Department of Criminal Investigation (DCI) agents who investigated this incident, and with the county Sheriff who was present at the scene. Information from the state news media, and the Iowa Office of the State Medical Examiner's preliminary report and final autopsy were also used to develop this case study.

Investigation

The incident occurred in a rural Iowa county with population 10,511 and 4,571 households (2010 US Census).

The county Sheriff's Department employed seven law enforcement agents, including the victim. The 39-year old victim graduated from the Iowa Law Enforcement Academy and was employed as a Deputy in the Sheriff's Department for 11 years. He was promoted to rank of Sergeant in 2006. His past experience and achievements included clandestine laboratory officer, crucial response team, emergency medical technician, and volunteer fire fighter.

Background

The rural resident involved in this case was a long-time area resident with prior convictions involving alcohol abuse, disorderly conduct, and carrying weapons. A family member noted that he struggled with mental health problems for three decades and had been diagnosed with bipolar disorder. In 1996, he was found not guilty by reason of insanity of crimes including carrying weapons and stalking, and was released to his parents' care following a psychiatric evaluation. For the next 15 years, the resident lived with his elderly parents who agreed to be responsible for his care. Two years prior to the fatality, the resident was hospitalized following a psychotic episode, around the same time that one parent began to experience declining health.

Five weeks prior to the fatality, the Sheriff's Department assisted the rural resident's family to commit him to a psychiatric hospital. The resident was evaluated at the hospital, and according to information the family provided the DCI, was released three days later, after a judge ruled against his committal. Upon release, the resident's family members (including the primary caregiver) made inquiries regarding the patient's diagnoses, prognosis, and prescribed medications, but were denied access to this information due to federal medical privacy laws. The resident's parents moved to a nursing home shortly after the family attempted to have him involuntarily committed to a mental hospital. Upon returning to his home, the mentally ill resident no longer had supervision or assistance with respect to his prescribed care. Following the Sergeant Deputy's fatality, the resident's family was told the resident likely suffered from psychoses.

Days prior to fatality

Over a three-day weekend period preceding the fatality, three events occurred suggesting the resident was unstable. A fourth event was later confirmed to be associated with the resident.

- The Sheriff's office was notified that the rural resident phoned a local hospital, asked for an employee who was not present, and made threatening statements.
- In the early morning hours 1 ½ days later, (i.e., the day preceding the fatality), the resident (who had never been married) called the Sheriff's office while driving around in his vehicle, and reported his wife had been kidnapped and taken to Texas. While on the phone, the resident became increasingly agitated and incoherent.
- Early the same morning and an hour after the resident called the Sheriff's office, a man reported to the Sheriff's office that the rural resident had come into his home looking for the rural resident's wife (the same person the resident reported as having been kidnapped). The resident searched for the imaginary wife, and then left. A Sheriff's Deputy on staff responded and investigated.
- The same evening, a different man - who lived less than two miles from the rural resident - reported that while his family was away, someone came to their farm, shot at the buildings, tore up the yard, and struck the garage with a vehicle. A Sheriff's Deputy investigated and found shell casings, paint transfer from a vehicle on the garage, and other debris in the yard.

The following morning was the beginning of the work week, and the Sheriff's Department employees on duty met to discuss the incidents described above. They contacted the county attorney for advice and decided to make a welfare check on the resident, who was identified in the first three incidents above.

Day of incident

After reviewing reported events involving the rural resident, the Sheriff, Deputy Sergeant (victim), and Chief Deputy decided to go to the resident's home to check on the resident's mental status and look for evidence that may tie him to the shooting event described above. The officers spoke to the resident by telephone at

1035 to notify him they wanted to stop at his home; the resident was willing to meet with the officers, but then made incoherent statements at the end of the call. The officers drove two departmental unmarked vehicles – a white pickup and a dark colored sport utility vehicle (SUV) - to the farmstead and made several attempts en route to contact the resident, who did not answer. They arrived at the farmstead at 1132 and traveled up a lane nearly a quarter-mile long to the farmstead (Exhibit 1). Upon arrival, they noticed a vehicle with paint the same color as the paint transfer left on the vandalized garage where a deputy had conducted an investigation the evening before.

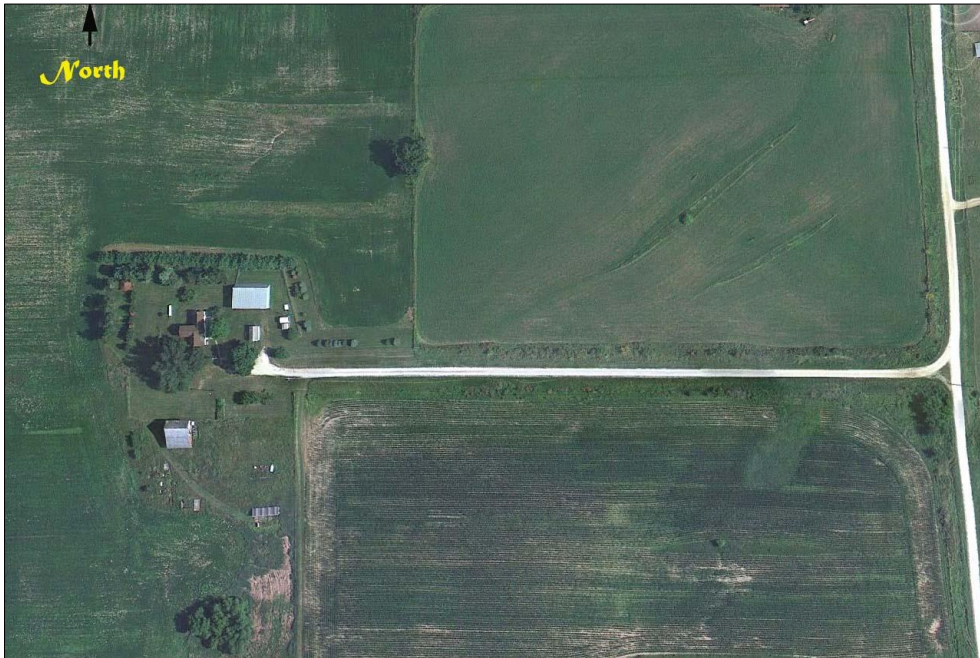


Exhibit 1: Fatality occurred at farmstead located at end of a 1040-foot lane

At the residence, the Sheriff knocked on the door, announced his presence, and asked if the resident was OK. There was no response, and the Sheriff went back to his deputies at the vehicles to discuss what to do next. Not knowing the location of the resident, the officers used a public address system to announce their presence and ask for the resident. At that point, the Deputy Sergeant saw the resident in the house with a long gun. The officers took cover in their vehicles, and the resident immediately opened fire

from inside the residence (shooting through the window), disabling both vehicles. The officers then got out of their vehicles and moved to cover behind the SUV and returned fire, but they could not see the resident's precise location. (A depiction of the residential site, including locations of the officer's vehicles, is shown in Exhibit 2.)

The Deputy Sergeant radioed for help at 1142, and local law enforcement agents from surrounding agencies began to travel to the scene. At 1219, the Deputy Sergeant warned responding officers not to come up the lane because they could easily be seen and shot. He also advised responding officers to turn off their sirens and not approach the house. Shortly after this communication, the resident exited the house and approached the officer's vehicles, and another exchange of gunfire ensued. One of the resident's shots, fired from near the front of the Sheriff's white pickup, travelled through the windows of the Deputy Sergeant's SUV and struck the Deputy Sergeant in the head, killing him instantly. The resident then departed the area of the officer's vehicles and turned toward the house. The Sheriff and Chief Deputy determined to retreat to the safety of responding officers, and ran back to the road through the ditch adjacent to the lane. The resident continued to fire at them, taunting them to 'come back.'

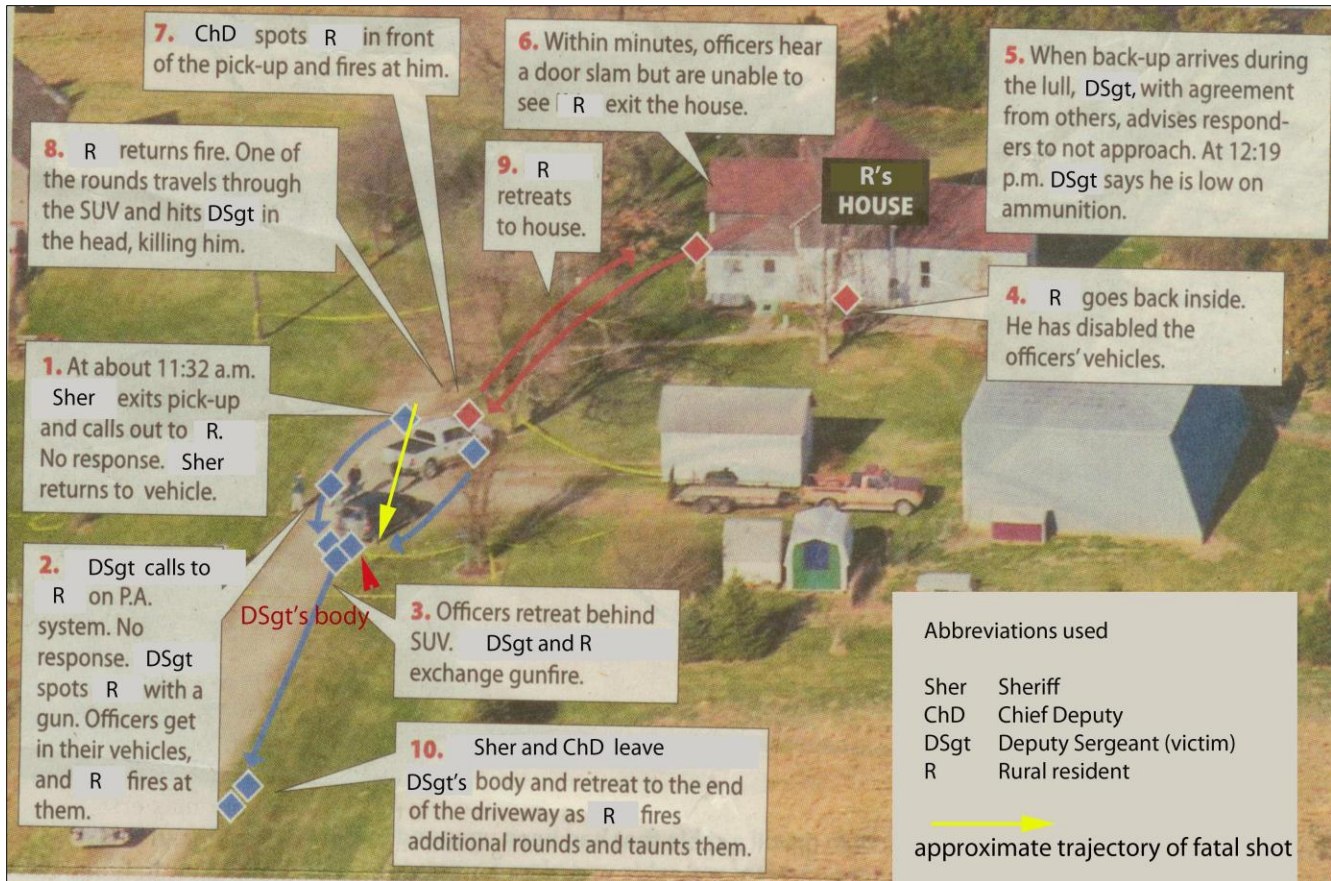


Exhibit 2. Depiction of shootout scene, including placement of vehicles driven by Sheriff (white pickup) and Deputy Sergeant (dark SUV). Placement of individuals is approximate.

Adapted from a figure published in *The Des Moines Register*.

Source: Iowa Department of Public Safety

The Sheriff and Chief Deputy reached the end of the lane where multiple agencies had gathered, and informed officers of the situation at the residence. State police tactical teams were deployed to the house around 1310. Tactical teams, working with the resident's family member, unsuccessfully attempted to negotiate with the resident, who refused to come out of the home. At 1530, state police tactical teams deployed to the house shot and killed the resident when they observed him outdoors, loading a rifle and preparing to fire.

Follow up investigation showed the Sheriff's pickup truck was shot seven times, and the Deputy Sergeant's SUV was shot 23 times. The rural resident fired 49 rounds: 14 rounds were fired from a 12-gauge shotgun from outside the residence; of these, nine 12-gauge shotgun shell casings were found beside the driver's side door of the Sheriff's pickup, remnants of shots fired by the resident at the officers from approximately 15 yards away, including the shot that killed the Deputy Sergeant. An additional 35 rounds were fired from various caliber long guns from inside the residence. A large knife, a hatchet, six rifles, and a shotgun were

found inside the home,¹ and a handgun, rifle, and shotgun were carried by the resident at the time of his death.² DCI personnel reported the resident “had the ammunition to sustain a firefight.”

Cause of death

The Office of the State Medical Examiner final autopsy reported the cause of death as a single (12-gauge) shotgun wound (slug) of the head. The local Medical Examiner noted the hostile environment and “unstable mental shooter” as contributing factors.

Recommendations and discussion

- 1. Provide law enforcement with training on dealing with mentally ill persons. Training should cover topics such as recognizing signs of a citizen with mental illness, effective methods to communicate/interact with those who have mental illness, and information regarding potential support resources in the community.**

Compared with other occupational groups outside the mental health field, law enforcement professionals interact most frequently with individuals with mental health disorders (Borum, 1998). The Criminal Justice/ Mental Health Consensus Project indicates that about seven percent of police contacts in large metropolitan cities involve a person with mental illness. A significant proportion of contacts involve either transportation of mentally ill persons to psychiatric care or responding to an individual in crisis. Unfortunately, field officers have very limited training in mental illness. In one California study, it was reported that only about half of all law enforcement agencies provide mental health training after the academy (Husted, 1995). In a national study of police departments, only three percent of sworn officers have received special mental health training. Another thirty percent rely on “mobile crisis teams” to provide the support. Fortunately, police officers feel that the topic of mental illness is important, in particular regarding issues related to the dangers that may be encountered when interacting with those with mental illness; the ability to recognize mental illness; and management of problem behaviors (Vermette, 2005). These are issues relevant to this case. The National Alliance on Mental Illness (NAMI) has helped train police officers in some of Iowa’s most urban counties, but the Sheriff’s Department in this small rural county was not aware of the availability of this training.

There is limited publically-available information on the variety of encounters that rural law enforcement personnel experience with persons having mental illness. Because rural communities have a reduced amount of mental health resources, law enforcement may not have an effective support system to aid in responding to those with mental illness. For example, neither mobile crisis teams nor specialized treatment centers are readily available in rural communities. It is therefore critical that steps be taken proactively to train law enforcement, particularly in rural communities, on recognizing and responding to citizens with mental health disorders. Local policies and guidelines should be developed and incorporated into training, to educate law enforcement agents who encounter persons with mental illness. In 2007, the Georgia Association of Chiefs of Police created a Mental Health Ad Hoc Committee, which recently recommended that “all officers understand signs of mental illness, how to proceed with an encounter, and be familiar with available state and local resources.”

¹ Three .22-250 rifles, three .45-70 rifles, and one 12-gauge shotgun

² One 9mm pistol, one 30-06 rifle, and one 12-gauge shotgun

2. Develop a system that provides quick access to law enforcement agencies regarding the most recent status and potential conditions of citizens with serious mental illness, so law enforcement personnel have concise clear information about behaviors that may be encountered when responding to a situation involving a mentally ill citizen.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule regulation protects the privacy of individual health information. Under HIPAA, however, covered entities (e.g., hospitals, social workers, psychiatrists) may disclose personal health information, *“including psychotherapy notes, when the covered entity has a good faith belief that the disclosure: (1) is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others and (2) is to a person(s) reasonably able to prevent or lessen the threat. This may include, depending on the circumstances, disclosure to law enforcement, family members, the target of the threat, or others who the covered entity has a good faith belief can mitigate the threat. The disclosure also must be consistent with applicable law and standards of ethical conduct.”* ([http://www.hhs.gov/ocr/privacy/hipaa/faq/ferpa and hipaa/520.html](http://www.hhs.gov/ocr/privacy/hipaa/faq/ferpa%20and%20hipaa/520.html))

A significant challenge is access, however. Prior to responding to a call, law enforcement has no easy way to access medical records, as no electronic database system is currently in place to facilitate that access. There have been some recommendations put forth by the Council of State Governments Justice Center from the US Department of Justice to develop memorandums of understanding (MOUs) with mental healthcare providers and also to “explore the possibility of linking information systems to share certain information either on an ongoing or a one-time basis.” It is further recommended that communications exchange be provided on an as-needed basis to “inform appropriate incident response or disposition.” An effective system that conveyed to law enforcement personnel the status of the rural resident’s recent diagnosis, prognosis, or compliance with follow-up care (following evaluation at the time of attempted committal), combined with response education and training (Recommendation 1), could have prevented this occupational fatality.

Law enforcement agencies, themselves, including the local department involved in this case, strongly support this recommendation. The 2007 Mental Health Ad Hoc Committee formed by the Georgia Association of Chiefs of Police recently recommended that legislation be put forward that would allow law enforcement to obtain mental health records for review, as part of a criminal history background check.

3. Mental health care providers and caregivers should carefully assess the home environment of patients, especially with respect to weapons accessibility, or other means by which mentally ill patients may harm themselves or others. In some cases, efforts should be made to communicate with community stakeholders, such as local mental health providers and law enforcement regarding potential hazards present in a home environment.

It is critical that the providers and caretakers engage in careful planning for the release of a person with mental illness into the community. In this case, the rural resident’s recent evaluation (available to family members after the shooting) referenced “likely psychoses” in addition to bipolar disorder. The rural resident also had a criminal history background, and because of this, coordination and open dialogue should have been conducted between the providers, caretakers and local law enforcement. This type of collaborative and multidisciplinary planning can lead to careful and thoughtful placement of the mentally ill person.

Two specific conditions can be attributed to the fatal shooting of this county law officer. First, the rural resident’s primary caretaker was not apprised of his diagnosis or medication orders at the time of his recent discharge following the attempted committal five weeks prior to the shooting. The primary

caregiver had no opportunity to assure or assist the rural resident with taking prescribed psychiatric medications. When not adherent to medications, persons with psychoses are occasionally driven by their delusions or hallucinations to harm themselves or others. Second, he was released to a home which was known by his primary caregiver and by local law enforcement to have firearms (typical of rural households, and also based on his prior charges of carrying weapons), a fact presumably *not* known by the health care providers who evaluated him or the judge who ruled on the committal petition.

Because those with certain mental illnesses are at risk of violent behaviors, and access to weapons can greatly increase risk of suicide and homicide, Sherman et al. recommend that weapons risk management programs be implemented with mental health cases like this rural resident's. Such programs – which involve multidisciplinary assessment of patients' risk of harming themselves or others, assessment of access to weapons, treatment, and discharge planning with caregivers – are effective in reducing the risk for harmful actions among these patients (Sherman, 2001).

EVENT TIMELINE

Prior to day of incident

- 5 weeks *Committal order sought for rural resident based on mental health problems, resident released days later*
- 3 days *(Friday evening)*
Resident phoned hospital, requested to speak to employee, became upset; SD notified*
- 1 day *(early Sunday morning)*
Resident called SD reporting "wife" had been kidnapped, was agitated and incoherent
Report to SD of resident entering a rural home, looking for his "wife"
(Sunday evening)
Report to SD that a different rural home had been vandalized (evidence later linked to the resident)

Day of incident (Monday)

- 1035 *Sheriff, Chief Deputy, & Deputy Sergeant reviewed Sunday events & decided to contact resident over concerns regarding mental health issues*
SD called resident who agreed to meet with officers; Sheriff and Chief Deputy travelled an unmarked pickup; Deputy Sergeant followed in an unmarked SUV
- 1132 *Officers arrived at resident's farmstead; attempts to contact resident en-route and at the farmstead were unsuccessful*
Deputy Sergeant saw resident with gun, inside the house; officers took cover in their vehicles; resident opened fire on vehicles; officers moved to cover behind SUV
- 1142 *Deputy Sergeant radioed report of shots fired*
- 1219 *Deputy Sergeant warned responding agencies to turn off sirens and not approach; minutes later, resident came outside; gunfire exchanged. Deputy Sergeant was hit by shotgun slug travelling through SUV window. Resident returned to house, officers made way back to road*
- 1310 *State Patrol tactical teams deployed around home*
- 1530 *Resident spotted outside with firearms, shot and killed by tactical team*

**SD: Sheriff's Department*

Iowa FACE thanks the Iowa Department of Criminal Investigation and local county Sheriff's Department for their time and assistance in developing this case report.

Keywords: deputy, law enforcement, shooting, intentional injury

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This investigation was conducted by Stephanie Leonard. The report was authored by Stephanie Leonard and Marizen Ramirez, and reviewed by Renee Anthony and John Lundell.

Fatality Assessment and Control Evaluation (FACE) Program

The National Institute for Occupational Safety and Health (NIOSH), an institute within the Centers for Disease Control and Prevention (CDC), is the federal agency responsible for conducting research and making recommendations for the prevention of work-related injury and illness. In 1982, NIOSH initiated the Fatality Assessment and Control Evaluation (FACE) Program. FACE examines the circumstances of targeted causes of traumatic occupational fatalities so that safety professionals, researchers, employers, trainers, and workers can learn from these incidents. The primary goal of these investigations is to make recommendations to prevent similar occurrences.

The Iowa FACE Program is one of nine state-based programs funded by NIOSH that conducts surveillance of occupational fatalities and conducts in-depth investigations of targeted Iowa cases. FACE investigations are intended to reduce or prevent occupational deaths and are completely separate from the rulemaking, enforcement and inspection activities of any other federal or state agency. Under the FACE program, investigators interview persons with knowledge of the incident and review available records to develop a description of the conditions and circumstances leading to the deaths in order to provide a context for the FACE Program's recommendations. The FACE summary of these conditions and circumstances in its reports is not intended as a legal statement of facts. This summary, as well as the conclusions and recommendations made by Iowa FACE, should not be used for the purpose of litigation or the adjudication of any claim. For further information, visit the Iowa FACE Program website at <http://www.public-health.uiowa.edu/face/> (or toll-free at 1-800-513-0998), and the NIOSH FACE Program website at www.cdc.gov/niosh/face/ (or toll free at 1-800-CDC-INFO (1-800-232-4643)).

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