

Independent Review of the Police Response to the Homicide of David Josiah Lawson



February 2020

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National Police Foundation Assessment Team

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The National Police Foundation (NPF), based in the Washington, DC area is the oldest nationally known, independent, non-profit, non-partisan, and non-membership driven organization, dedicated to advancing policing through innovation and science. One of the ways to accomplish this goal is by examining sentinel events around the country. The goal of this analysis is to examine this incident and offer recommendations for improved protocols, and the identification of new tactics and ideas which can help prepare law enforcement in their efforts to provide the most professional service possible for our communities.

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Acknowledgements

The National Police Foundation (NPF) assessment team acknowledges the leadership of the City of Arcata and the Arcata Police Department (APD) for requesting, and engaging in, this analysis in an effort to identify opportunities to improve the APD's capacity to serve their community, and in the process, to provide clarity—based on research—on the response to this incident.

We also appreciate the assistance of first responders from the APD, Arcata Fire District, Humboldt State University Police Department, and dispatchers from the APD, California Highway Patrol, and Arcata Fire District for their professionalism and commitment to continual improvement of the public safety profession.

Finally, the NPF acknowledges the impact that the homicide of Josiah Lawson has had on his family; friends; and, Humboldt State University students, faculty, and staff. We appreciate the support and access Josiah Lawson's family, the City of Arcata, and others provided to our team as we worked to review this case and develop recommendations for advancing the response and investigation of similar incidents in the future.

Executive Summary

Located on the California coast, about 300 miles from San Francisco or Sacramento, the City of Arcata is a rural community of approximately 18,000 residents and home to Humboldt State University (HSU). On April 15, 2017, in the early morning hours at an off-campus house party that had begun the night before, HSU student David “Josiah” Lawson was stabbed during a physical altercation. He was given first aid by friends and by first responders who began to arrive three minutes after the first 9-1-1 call was received. Josiah did not survive his extensive wounds and was later pronounced dead at Mad River Community Hospital. Arcata Police Department (APD) officers arrested a suspect at the scene and the Humboldt County District Attorney’s (HCDA) Office filed homicide charges against him within several days.

On May 5, 2017, at the conclusion of the preliminary hearing held on the charges, Judge Reinholtsen of the Superior Court of Humboldt County ruled there was insufficient evidence presented by the prosecution to support the homicide charges. The suspect was released from custody.¹

Following the preliminary hearing, the APD continued their investigation. Almost two years later, on February 28, 2019, a criminal grand jury was convened to hear evidence in the case. On March 13, 2019, the HCDA Office announced that after hearing the evidence, the grand jury declined to issue any indictments in the case. As it stands now, the case has been turned back over to APD for further investigation and current APD Chief Brian Ahearn has renewed investigative efforts.

In 2018, the City of Arcata retained the services of the National Police Foundation (NPF) to analyze the APD’s response to the incident and homicide of Josiah Lawson on April 15, 2017, and the subsequent investigation. The NPF assessment team began gathering and reviewing information beginning in July 2018. The purpose of this NPF after-action review is to critically, objectively, and thoroughly examine the response to, and initial investigation of, the homicide of Josiah Lawson. This review provides an overview of the incident response and subsequent investigation immediately following the incident, as well as lessons learned for improving future incident response and investigations.

During this review, the NPF assessment team found that APD officers responded quickly and professionally to a highly chaotic scene—an event that would have been challenging for any agency of any size and sophistication. APD first responders focused their attention on providing lifesaving measures at the highly-charged scene.

However, Arcata had not provided the appropriate level of organizational leadership, planning, and training to respond to, and investigate, this type of a complicated and chaotic homicide scene. Many of the basic tenets of crime scene security and management were not followed in this case. The nature of the incident and the limited APD resources available illustrated the need for a comprehensive, regional, multi-agency response protocol to be in place to ensure the tools and skills necessary to handle a major incident were available to responders. However, such a plan was not in place, leaving the department ill-equipped to handle the scene and investigation on its own.

¹ Superior Court of California County of Humboldt. Honorable Dale A. Reinholsten, Judge. Preliminary Hearing Transcript 4, 938.

The keys to success in response to this challenge lies in broad organizational leadership, planning, supervision, and training. Every community expects their police department to have a level of proficiency that provides for their safety through preparedness, training, and resource management. Enhanced planning for rarely occurring but significantly traumatic incidents involving multiple victims and witnesses has to be part of every department's operational plan, regardless of their size. A coordinated response coupled with a regionally coordinated chain of command would have greatly increased the probability of a more successful outcome of the investigation. The reasons for this, as explained in the report, began with issues that face many small law enforcement organizations across the nation, including lack of resources to fully staff and train a police force to effectively respond to and investigate major crimes.

Major themes of the report include:

- APD first responders to the homicide scene demonstrated professionalism in providing lifesaving efforts while attempting to de-escalate a challenging and chaotic situation.
- The APD's planning and preparation of supervisory and specialized personnel was insufficient to respond to, and investigate, an incident of this magnitude. Key APD personnel were not provided sufficient training and access to equipment to thoroughly and effectively manage the crime scene and investigation.
- Appropriate organizational leadership, and supervision and coordination between agencies—crucial for the efficient allocation of resources during investigations and to ensure thorough case management and quality assurance throughout the case review process—were not provided in this case.
- While the APD does focus resources on relationship-building with the community, more can be done. Relationship-building efforts and communication between the police and all segments of the community are the foundation of trust and valuable to counter misinformation and gather accurate information prior to and following a critical incident.

This analysis of the response and investigation around the April 15, 2017 homicide of Josiah Lawson is intended to provide objective feedback to the APD and the City of Arcata—not in judgement, but in careful study. The investigation of this complicated case is ongoing and has been over the last two years. This review, including the resulting report and lessons learned, is not intended to influence the outcome of any criminal or civil litigation, but to provide a learning opportunity for the APD and the City of Arcata.

Introduction and Background

This section provides an overview of the scope, goals, and methodology for this review. It also provides background information on the City of Arcata and the Arcata Police Department (APD) to set the context for the department's response to the April 15, 2017 homicide of Josiah Lawson and the findings and recommendations found in this report.

Scope and Goals of the Review

In 2018, the City of Arcata retained the services of the National Police Foundation (NPF) to analyze the APD response to the homicide of Josiah Lawson on April 15, 2017, and the subsequent investigation. The City of Arcata's administration believed an independent review of the circumstances surrounding the emergency response and the initial investigation of this event would provide lessons learned from the experience and necessary recommendations to improve the APD's future responses.

The goal of the NPF review was to examine the response to, and investigation of, the homicide of Josiah Lawson and to provide recommendations for improving future response to similar incidents involving multiple parties and multiple witnesses.

The scope of analysis includes a review of:

- The City of Arcata's initial response to the incident;
- The initial response from mutual aid / co-responding agencies;
- The regional coordinated efforts of mutual aid;
- Review and recommendations on improvement of scene and evidence security;
- Review of homicide investigation during the first 72 hours; and,
- Use of best practices and recommendations on improvement as necessary.

This report also includes lessons learned and recommendations for:

- Improving APD's response to, and investigation of, similar incidents in the future; and,
- Improving the response of the APD and coordination with area agencies that regularly respond through mutual aid or overlapping agency boundaries.

During this review, the NPF assessment team also noted circumstances, systems, and issues that are outside of the scope of the originally outlined work, but that provide important context for outcomes in this case as well as recommendations for moving forward. As such, the report also discusses the impact of decisions made by APD staff during the initial response on subsequent investigative efforts and case outcomes.

Methodology

To conduct this review, the NPF assembled a team of subject matter experts with extensive

experience in public safety incident response and investigations.² From August 2018 through August 2019, the NPF assessment team:

- conducted 24 in-depth in-person and phone interviews with non-involved parties who had knowledge of the case;
- reviewed materials including numerous incident reports, policies and procedures, and transcripts of related court proceedings;
- conducted comprehensive and extensive review of approximately 50 hours of recorded interviews of witnesses and other involved parties;
- examined open source media relating to the response to the incident and the investigation; and,
- researched national and international promising practices and resources.

The NPF assessment team also conducted in-depth review and analysis of six hours of APD dashboard camera (dash cam) video and audio recordings during preparation of this report. Each APD patrol vehicle was equipped with mobile camera systems that provided dashcam video (mobile auto video or MAV) and personal audio recordings (officer) from the time of the officers' initial arrival until when each individual officer cleared the call. Recognizing that the cul-de-sac around 1120 Spear Avenue—where the incident occurred—was narrow and unlighted, all three patrol vehicles were parked on the street just outside of the cul-de-sac. Parking there would minimize potential officer safety issues and avoid blocking the small driveway, which could prevent fire and ambulance vehicles from being able to reach the incident area. Consequently, no video is available of the activity in the driveway in front of 1120 Spear Avenue. However, each of the officers was equipped with audio transmitters that connected to the dashcams mounted in the patrol vehicles.

Based on the analysis of this body of information, the NPF assessment team developed the lessons learned and recommendations contained in this report. A full detailed methodology can be found in Appendix A.

Limitations of this Report

While the City of Arcata and APD provided substantial access to relevant case information, this study was limited, because the homicide of Josiah Lawson continues as an on-going, active investigation. As would be expected, the NPF could not interview potential witnesses or partygoers outside of the first responders who were on scene the morning of April 15, 2017. Additionally, Humboldt State University (HSU) administration and staff members declined to formally respond to requests for an interview, except for the HSU chief of police.

Arcata Background

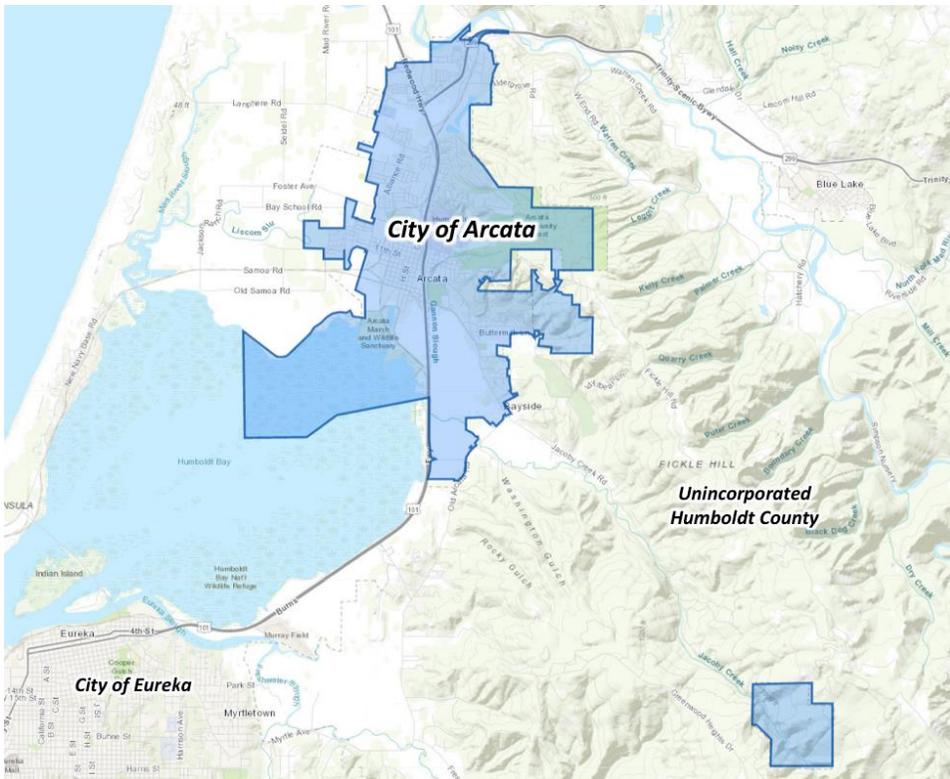
The City of Arcata and Humboldt State University

The City of Arcata is a rural community located in Humboldt County, on the California coastline,

² Full bios of assessment team members can be found in Appendix B: About the Assessment Team.

approximately 275 miles north of San Francisco. Humboldt County covers 3,568 square miles of coastline and forest land and has a population of 134,754.³ Within Humboldt County, Arcata encompasses 9.1 square miles, with a reported population of approximately 18,000 in 2017.⁴ Central to the City of Arcata is HSU, one of 23 campuses in the California State University system. With an enrollment of over 6,000 students, the student body represents a significant portion of the City of Arcata’s population.⁵

Figure 1: Map of the City of Arcata



Sources: Arcata City Limits downloaded from City of Arcata, <https://www.cityofarcata.org/322/MapsGIS>; map image developed by Bureau of Land Management, Esri, HERE, Garmin, USGS, NGA, EPA, USDA, NPS.

The Arcata Police Department

The APD serves the City of Arcata. During the 2016-2017 budget year, the department was authorized for 37.5 full-time equivalent staff members, including one chief of police, two lieutenants, five sergeants, eighteen police officers, and six dispatchers.⁶

³ United States Census Bureau. (2017). QuickFacts: Humboldt County, California; Arcata city, California. Retrieved from <https://www.census.gov/quickfacts/fact/table/humboldtcountycalifornia,arcatacitycalifornia/PST045217>

⁴ Ibid.

⁵ Humboldt State University. (n.d.). About Humboldt State University. Retrieved from <https://www.humboldt.edu/about>

⁶ NPF assessment team communication with Arcata Police Department. (2020, February 12). See also: City of Arcata. (2016). Public Safety Budget Overview. Retrieved from <https://www.cityofarcata.org/DocumentCenter/View/4792/21---Police-Services-PDF>

Department Organization

As of April 2017, the chief of police and a command staff of two lieutenants led the APD. The chief had been with the department since 1994 and was appointed chief in March 2010.⁷ Command responsibilities were split between two lieutenants. One lieutenant was assigned as the commander of the Operations Division with oversight of patrol functions. The lieutenant had more than seven years in grade. The second Special Services Division lieutenant was responsible for administrative functions and for the management of the Investigations Unit; at the time, this position was vacant with the lieutenant on extended leave pending retirement. Thus, the APD was functioning with one active command officer at the time of the April 15, 2017 incident.

Five sergeants served the department, four of whom were assigned to the patrol division. These four uniformed patrol supervisors were assigned to 12-hour shifts responsible for the oversight of officers responding to calls for service. The fifth sergeant—the Special Services Division sergeant—supervised investigations functions, including the Investigations Unit, and had seven years of supervisory and investigative experience. This sergeant had been serving as the investigations' supervisor for approximately five years.⁸ The APD's plan called for him to remain in that position while newer sergeants were gaining experience as patrol supervisors. The sergeant had been the lead detective sergeant on five homicides before April 2017.⁹

The sergeant had also completed the California Peace Officer Standards and Training (POST)-certified training in homicide investigations and other pertinent major crime investigation training (rape investigations, child abuse/sexual assault investigations, and interview and interrogation techniques). The only other detective with similar training, and assigned to conduct such investigations, was unavailable in April 2017, due to extended injury leave. Thus, all investigative and collateral assignments were the responsibility of the sole Investigations Unit sergeant, who would serve as a supervisor of the case, among other responsibilities.

APD patrol officers were assigned as acting patrol sergeants and in that role were also the watch commander (AWC) when sergeants were not on-duty. These were usually filled by senior officers. The acting sergeants (AWC) received no additional tactical or investigative supervisory training beyond that of a patrol training officer, other than for the completion of basic administrative tasks.

⁷ Chief Tom Chapman resigned from the APD in April 2018. Following his departure, Richard Ehle served as interim chief from June 2018 to November 2018, when the current chief, Brian Ahearn, was appointed. For more, see: <https://krcrtv.com/north-coast-news/eureka-local-news/arcata-police-dept-welcomes-new-police-chief-brian-ahearn>

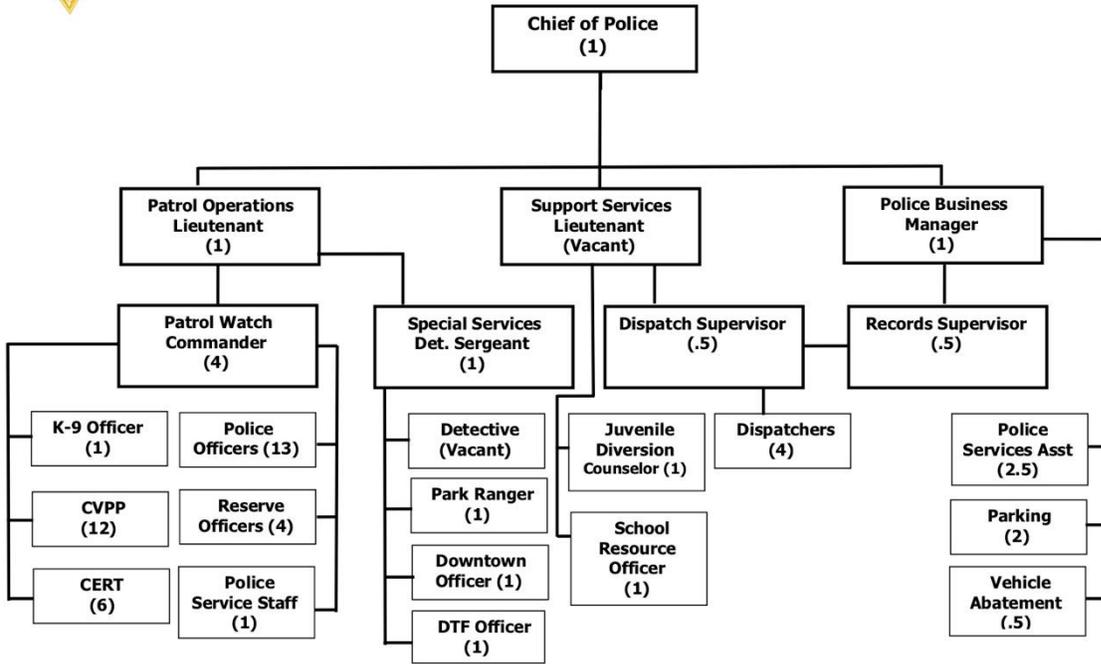
⁸ NPF assessment team interview with former chief, APD, August 15, 2018.

⁹ Arcata Police Department. Homicide and OIS Investigations. Provided to the NPF assessment team, December 9, 2019 and February 12, 2020.

Figure 2: APD Organizational Chart, 2017



ARCATA POLICE DEPARTMENT



ARCATA POLICE ORGANIZATIONAL CHART- April 2017

Fluctuations in staffing and vacancies due to injury leave and/or unfilled positions reduced total sworn staffing by 3-4 positions in 2017.

Source: Arcata Police Department. (2017). Provided to the NPF assessment team and reviewed February 2020.

Pre-Existing Regional and Organizational Relationships

Crime statistics provided by the APD from 2013 through 2017 indicate that the City reported few violent crimes: one homicide in 2017 (the homicide of Josiah Lawson), a vehicular manslaughter in 2016, and, two homicides in 2015.¹⁰ As a small department with relatively few violent crimes, the APD relies on—and is thus accustomed to collaborating with—partners from the HSU Police Department (HSUPD), California Highway Patrol (CHP), and Humboldt County Sheriff’s Department (HCSD) to support some responses.

Emergency Communications in Arcata

Humboldt County lacks a fully interoperable communication system. When a 9-1-1 call is made in Humboldt County, depending on the origin location of the call and whether a landline or cell phone is used, the call will be received by one of seven public safety answering points (PSAPs). Each of the emergency service agencies’ dispatch centers in the county has separate staffing, radio hardware,

¹⁰ APD crime statistics, 2013-2017, reviewed by the NPF assessment team, August 2018-May 2019.

and software.¹¹ The APD and HSUPD monitor each other's radio frequencies and have independent dispatch centers. Dispatchers from the different law enforcement, fire, and ambulance services rely on the use of the telephone to transfer calls to other agencies to coordinate and dispatch specific services or to provide event updates.

¹¹ Arcata-Mad River Ambulance, Inc., letter to Measure Z Committee, February 14, 2017, provided to the NPF assessment team, reviewed August 2018-July 2019.

Incident Description

In the early morning hours of April 15, 2017, the Arcata Police Department (APD) responded to a report of a fight at a late-night party in Arcata, California. The incident was determined to be a physical altercation that resulted in the stabbing of Humboldt State University (HSU) student David “Josiah” Lawson. Upon their arrival, APD officers located Josiah Lawson being given first aid by persons at the scene. Police officers and Arcata Fire Department (AFD) personnel provided emergency medical attention for Josiah Lawson until an ambulance arrived and transported him to Mad River Community Hospital where he was pronounced dead.¹² APD officers arrested an individual at the scene of the party after he was identified by witnesses as the assailant responsible for Josiah Lawson’s death.

The Humboldt County District Attorney's (HCDA) Office filed homicide charges against the arrested suspect within several days of the incident.¹³ On May 1, 2017, approximately two weeks after the incident, the suspect appeared before the Superior Court of Humboldt County for a preliminary hearing on the charges. After a five-day preliminary hearing concluding on May 5, the Court found there was insufficient evidence to support the charges to hold the suspect to answer for a Superior Court trial and dismissed the complaint.¹⁴

In his comments, the judge stated,

“...Under the evidence that’s presented 16 days after the incident and the test that the Court has to apply, that the evidence meets the requirement. Again, the requirement is that: Such a state of the evidence that would lead a person of ordinary caution or prudence to believe or conscientiously entertain a strong suspicion of the guilt of the accused. And at this point, I don’t find the evidence is sufficient to make that finding. That is not to say that evidence may be developed in the future that may very well suggest to the contrary or may very well identify someone else who may have done this. Because that’s the one thing we’re certain about. It happened. Mr. Lawson was stabbed to death at a party with lots and lots of people there. And none of those people seem to have seen it happen, which is somewhat difficult to believe.”¹⁵

On March 13, 2019, a grand jury decided not to indict the same suspect based on evidence gathered by the APD thus far, leading the HCDA Office to announce that it would not file charges in the case.¹⁶ The APD continues to investigate the case.¹⁷

¹² Mobile auto video (MAV) and personal audio recordings from acting watch commander (AWC), APD, April 15, 2017.

¹³ The suspect was charged with homicide under California law, with the specific degree to follow if held by the preliminary hearing.

¹⁴ Greenson, T. (2017, May 5). Judge Dismisses Murder Charge in Slaying of HSU Student. *North Coast Journal*. Retrieved from <https://www.northcoastjournal.com/NewsBlog/archives/2017/05/05/judge-dismisses-murder-charge-in-slaying-of-hsu-student>

¹⁵ Superior Court of California County of Humboldt. Honorable Dale A. Reinholsten, Judge. Preliminary Hearing Transcript 4, 938.

¹⁶ Papanek, M., D. Brown, and N. Javid. (2019, March 13). Breaking: DA on grand jury in Lawson case: ‘No charges will be filed’. *KRCR News*. Retrieved from <https://krcrtv.com/north-coast-news/eureka-local-news/breaking-da-decides-not-to-bring-charges-to-anyone-after-reviewing-lawson-case>

¹⁷ Mukherjee, S. (2019, March 22). ‘Justice for Josiah’ advocates call on Arcata to turn Lawson case over to state. *Times Standard*. Retrieved from <https://www.times-standard.com/2019/03/20/justice-for-josiah-advocates-call-on-arcata-to-turn-lawson-case-over-to-state/>

The following timeline and description of the events that occurred on April 15, 2017, is based on APD computer aided dispatch (CAD) data, incident reports, audio and video recordings from the incident, and logs and reports from other responding agencies.¹⁸ Since timestamps were derived and compared from various sources, times should be taken as an approximation. The timeline should serve as a reference tool for the reader to better understand the sequence of events.

Figure 3: Incident Timeline

April 15, 2017	
3:00:26 a.m. ¹⁹	The APD received the first 9-1-1 call related to the party, reporting that it appeared a fight was about to occur.
3:01:10 a.m. ²⁰	The CHP received a 9-1-1- call reporting that someone had just been stabbed. The call was transferred to the APD Communication Center for APD response.
3:01:52 a.m. ²¹	The CHP received a 9-1-1 call reporting that someone brought out a gun and a knife. The call was transferred to the APD Communication Center for APD response.
3:02:16 a.m. ²²	The APD initiated a call for service.
3:02:25 a.m. ²³	The APD received the transferred call from the CHP regarding the report that someone brought out a gun and a knife.
3:02:55 a.m. ²⁴	APD officers were dispatched to the Spear Avenue location.
3:03:03 a.m. ²⁵	The first APD officer indicated arriving on scene.
3:04:17 a.m. ²⁶	The second APD officer indicated arriving on scene. The dispatcher notes a report of approximately 100 people at the scene.
3:05:14 a.m. ²⁷	The third APD officer—the AWC—indicated arriving on scene.
3:05:39 a.m. ²⁸	The first APD officer was recorded exiting the driveway with a handcuffed suspect.
3:05:42 a.m. ²⁹	The APD AWC reached the victim, who was being rendered first aid by a friend. ³⁰ The AWC and second officer began attending to the victim. They began to assess the scene and tell witnesses to step back. The AWC tells some individuals at the scene who seek to help that they can help by directing the ambulance to the location when they arrive. ³¹
3:06:08 a.m. ³²	HSUPD officers were dispatched to the scene.

¹⁸ A more detailed list of materials examined for this review can be found in Appendix A: Methodology.

¹⁹ APD raw call data, April 15, 2017. Reviewed by NPF assessment team August 2018-August 2019.

²⁰ CHP incident detail report, 3:01:12 a.m., April 15, 2017. Reviewed by NPF assessment team August 2018-August 2019.

²¹ Ibid.

²² APD CAD incident report, April 15, 2017. Reviewed by NPF assessment team August 2018-August 2019.

²³ APD raw call data, April 15, 2017.

²⁴ APD CAD incident report, April 15, 2017. Reviewed by NPF assessment team August 2018-June 2019.

²⁵ Ibid.

²⁶ Ibid.

²⁷ Ibid.

²⁸ APD first arriving officer MAV recording, April 15, 2017. Reviewed by NPF assessment team August 2018-August 2019.

²⁹ APD AWC MAV recording, April 15, 2017. Reviewed by NPF assessment team August 2018-August 2019.

³⁰ Judge comments from preliminary hearing, May 5, 2017. Transcript reviewed by NPF assessment team August 2018-June 2019.

³¹ APD AWC and APD second arriving officer MAV recordings, April 15, 2017. Reviewed by NPF assessment team August 2018-August 2019.

³² APD CAD incident report, April 15, 2017.

3:06:26 a.m. ³³	HSUPD officers arrived to assist the APD.
3:09:16 a.m. ³⁴	The AWC requested additional units for crowd control. The HSUPD reported having no additional units available and the AWC requested dispatch to contact the HCSO or CHP to respond.
3:10:20 a.m. ³⁵	AFD firefighters/paramedics, including the AFD captain, arrived at the scene. They reached the victim after making their way through the crowd and began to attend to the victim.
3:12:50 a.m. ³⁶	The AFD members used an AED device on the victim.
3:14:25 a.m. ³⁷	The crowd yelled as firefighters moved the victim from out of the bushes. The AFD members attempted to move the victim into a more open area and continued to attend to the victim.
3:14:33 a.m. ³⁸	The AWC again requested additional units, broadcasting a Code 30 request for assistance for crowd control.
3:15:07 a.m. ³⁹	An ambulance from the Arcata-Mad River Ambulance, Inc. arrived at the scene.
3:19:22 a.m. ⁴⁰	The ambulance began to move out of the driveway with Josiah Lawson. Many partygoers left the scene, with some following the ambulance to the hospital.
3:20:24 a.m. ⁴¹	The AWC directed additional officers that arrived from the HCSO and CHP to respond to Mad River Community Hospital. Other officers remain to support crime scene management.
3:20:57 a.m. ⁴²	The APD CAD noted the ambulance was en route with a Code 3 (emergency response) to the Mad River Community Hospital, located approximately one mile from the scene. The ambulance arrived at the hospital shortly thereafter.
3:23:29 a.m. ⁴³	The first officer on scene, who arrested the suspect, interviewed the suspect in the back of the patrol vehicle at the Spear Avenue location. The first and second officers began informal interviews with individuals at the scene.
3:32:59 a.m. ⁴⁴	The AWC located a knife believed to be the weapon used in the assault.
3:46:05 a.m. ⁴⁵	The AWC notified the lieutenant and detective sergeant of the incident via cell phone.
4:07 a.m. ⁴⁶	Josiah Lawson was pronounced dead at Mad River Community Hospital.

The Incident

Early in the morning hours of April 15, 2017, in Arcata, California, approximately 100 young people,

³³ Ibid.

³⁴ Ibid.

³⁵ APD first arriving officer MAV recording, April 15, 2017.

³⁶ APD AWC MAV recording, April 15, 2017.

³⁷ Ibid.

³⁸ APD CAD incident report, April 15, 2017.

³⁹ APD AWC MAV recording, April 15, 2017.

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² APD CAD incident report, April 15, 2017.

⁴³ APD first arriving officer MAV recording, April 15, 2017.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Forensic Medical Group, Inc. (2017, April 19). Autopsy Findings. Reviewed by NPF assessment team August 2018-June 2019.

including college students attending HSU, the College of the Redwoods, and local residents, were having an off-campus party.⁴⁷ The party had begun Friday night, April 14, and carried over into the Saturday morning hours of April 15, at 1120 Spear Avenue—a house located in a cramped Arcata cul-de-sac.

Word of the party had spread via social media throughout the evening. Partygoers included members of an HSU club known as "Brothers United," a multicultural club of male HSU students concerned with advancing social justice issues, and its president, David "Josiah" Lawson.⁴⁸ Brothers United was described as a club that seeks to "assist and navigate towards graduation, maturity, and success through Brotherhood . . . through scholarship, philanthropy, fundraising, social events and to create a safe haven for all males in campus."⁴⁹ Josiah Lawson had come to HSU from the Southern California community of Moreno Valley in the fall of 2015 and joined Brothers United.⁵⁰ A 19-year-old sophomore, Josiah Lawson was a Criminal Justice major with the goal of becoming a lawyer.⁵¹

Figure 4: 1120 Spear Avenue, Arcata, California



Source: Google Maps.

Shortly before 3:00 a.m., an argument occurred between a group of uninvited local women who had heard of the party on a social media platform and invited guests. One of the local women was unable to locate her cell phone and made accusations that others at the party may have taken it.⁵² The

⁴⁷ APD CAD incident report, April 15, 2017.

⁴⁸ Burns, R. (2017, April 21). United by Tragedy, HSU Community Celebrates the Life and Mourns the Death of David Josiah Lawson. *Lost Coast Outpost*. Retrieved from <https://lostcoastoutpost.com/2017/apr/21/david-josiah-lawson/>

⁴⁹ Clubs & Activities. (n.d.). Humboldt State University. Retrieved from <https://clubs.humboldt.edu/categories/all-clubs>

⁵⁰ NPF assessment team interview with family member of victim, October 23, 2018.

⁵¹ Durham, J. (2018, September 21). Additional resources for Lawson case. *Mad River Union*. Retrieved from <https://madriverunion.com/additional-resources-for-lawson-case/>

⁵² Superior Court of California County of Humboldt. Honorable Dale A. Reinholsten, Judge. Preliminary Hearing Transcript 4, 938.

accounts of the party suggest a significant amount of alcohol consumption along with other intoxicants.⁵³

The scene became heated during a verbal exchange. The argument led to several physical altercations, involving both men and women, bringing others into the fray in support of their respective friends. One individual used pepper spray.⁵⁴ In the course of the melee, in the narrow driveway area in front of the residence, HSU student Josiah Lawson was stabbed multiple times.⁵⁵

The scene grew more chaotic after the assault. A female friend of the suspect was reportedly heard saying, “I hope that n****r dies” as Josiah Lawson lay on the ground bleeding.⁵⁶ These remarks, coupled with the allegations of theft and the reports of a young black man being stabbed by a white suspect, became the foundation for the allegations by the community that followed—particularly that this incident was racially motivated and that the law enforcement and EMS response was slowed because of racial bias.

The Initial Response

At 3:00:26 a.m., the APD Communications Division received the first 9-1-1 call related to the party, made by a male resident of one of the homes along the shared driveway with 1120 Spear Avenue.⁵⁷ The caller reported that it appeared a fight was about to occur at the Spear Avenue location and that there were “five or ten of them” screaming and getting ready to fight.⁵⁸

Less than a minute later, at 3:01:10 a.m., the CHP received a 9-1-1 call reporting that someone had been stabbed.⁵⁹ At 3:01:36 a.m., CHP transferred this call to the APD Communications Division to be able to dispatch APD officers to the scene.⁶⁰ The caller reported that a person had been stabbed twice—once in the chest and once under his ribs—and that the victim was bleeding and about to die. The APD initiated a call for service at 3:02:16 a.m.⁶¹ The CHP would alert the California Department of Forestry and Fire Protection (Cal Fire) for ambulance and fire/EMS services, and Cal Fire would call the AFD and Arcata-Mad River Ambulance, Inc. (AMRA) for local EMS response.

Seconds after transferring the call about the stabbing, the CHP received another 9-1-1 call that they would transfer to the APD reporting that someone had brought out a gun and a knife.⁶² The caller would later tell the APD dispatcher that she had not seen a gun, but said there were fights and to

⁵³ APD police reports, April 15, 2019, reviewed by NPF assessment team August 2018-June 2019. See also: Araujo, M. (2017, May 2). Girlfriend, friends detail fight at Arcata party. *Times Standard*. Retrieved from <https://www.times-standard.com/2017/05/02/girlfriend-friends-detail-fight-at-arcata-party/>

⁵⁴ Superior Court of California County of Humboldt. Honorable Dale A. Reinholsten, Judge. Preliminary Hearing Transcript 4, 938.

⁵⁵ Ibid. See also: Autopsy report, March 2, 2018, reviewed by NPF assessment team August 2018-June 2019.

⁵⁶ One HSU student testified at the preliminary hearing that he heard a female friend of the arrested suspect, make the statement then repeat it while the victim was laying on the ground. Another HSU student made similar allegations in news interview. For more, see: <https://madriverriverunion.com/eyewitness-alleges-police-emt-racism-2/>.

⁵⁷ APD raw call data, April 15, 2017. Reviewed by NPF assessment team August 2018-June 2019.

⁵⁸ APD communications log, reviewed by NPF assessment team, August 2018-March 2019.

⁵⁹ CHP incident detail report, 3:01:12 a.m., April 15, 2017. Reviewed by NPF assessment team August 2018-August 2019.

⁶⁰ APD raw call data, April 15, 2017.

⁶¹ APD CAD incident report, April 15, 2017.

⁶² CHP incident detail report, 3:01:54 a.m., April 15, 2017. Reviewed by NPF assessment team August 2018-June 2019.

“hurry, please hurry!”⁶³ Telephone calls continued to be made between CHP dispatchers, the lone APD dispatcher on duty, the AFD dispatcher, and AMRA dispatcher throughout the early morning as they tried to relay information to each other regarding the incident.

Responding Officers

During the April 15, 2017 incident, the APD night shift on-duty staff consisted of an acting sergeant/watch commander (AWC), three other patrol officers, and a lone dispatcher. Throughout the fast-moving, multifaceted incident, the lone dispatcher was pressed to answer phones, handle radio traffic, add data into the APD CAD system, and request mutual aid support. APD officers were dispatched to the Spear Avenue location at 3:02:55 a.m.⁶⁴ The first APD officer on scene indicated arrival seconds later, at 3:03:03 a.m.⁶⁵ Additional officers arrived over the next few minutes with the second officer arriving at 3:04:17 a.m. and the third officer—the acting watch commander (AWC)—arriving at 3:05:32 a.m.⁶⁶ Another patrol officer was assigned as an overlap from 5:00 p.m. to 3:00 a.m. The AWC advised the dispatcher to contact the officer and direct him to hold over and respond to the incident, however the officer did not respond.⁶⁷

The APD thus had four officers on duty during that twelve-hour night shift that began at 6:00 p.m. the evening before, with three of them responding to the scene. The shift had been uneventful with few calls for service. The first officer to arrive on the scene had been with the APD for 10 months and had an additional nine years of experience as a deputy with the Humboldt County Sheriff’s Office. The majority of the officer’s career had been as a patrol deputy. The second officer that arrived on the scene was a new APD officer with a total of seven months of law enforcement experience after graduating from the academy. The third officer to arrive on scene was an eight-year veteran officer who was assigned as the AWC for the evening. The first officer and the AWC had experience responding to large parties involving young adults.

The first APD patrol officer to arrive parked on Spear Avenue at the entrance to the driveway shortly after 3:03 a.m.⁶⁸ The dash cam video recorded numerous people walking and running away from the driveway as the officer exited and walked towards the house.⁶⁹ The second officer arrived at the incident approximately one minute later, at 3:04:17 a.m.⁷⁰ The third officer (the AWC) arrived on Spear Avenue less than a minute later, at 3:05:14 a.m.⁷¹ Moments later, at approximately 3:05:39 a.m., the first officer on scene is recorded exiting the driveway with a handcuffed suspect that appeared to be bleeding from injuries to his face.⁷² The handcuffed subject was placed into the officer’s patrol vehicle. According to the officer’s report, the subject detained had been identified

⁶³ Cellphone call made by arrested person’s associate.

⁶⁴ CHP incident detail report, 3:01:54 a.m., April 15, 2017. Reviewed by NPF assessment team August 2018-June 2019.

⁶⁵ APD CAD incident report, April 15, 2017.

⁶⁶ Ibid.

⁶⁷ NPF assessment team interviews, AWC and command staff, APD, August 13-16, 2018.

⁶⁸ APD CAD incident report, April 15, 2017.

⁶⁹ No audio from first officer’s transmitter was captured until he returned to his vehicle with the handcuffed prisoner.

⁷⁰ APD CAD incident report, April 15, 2017.

⁷¹ Ibid.

⁷² APD first arriving officer MAV recording, April 15, 2017.

by witnesses as the suspect in the stabbing.⁷³ Recognizing the tense crowd that was forming, and as guided by officers' training and standard protocol, the officer remained in the proximity of the patrol vehicle with the detained subject throughout the rest of the incident, to ensure the safety of the suspect.

The AWC was directed to the victim by some of the partygoers as she walked into the driveway area. At approximately 3:05:42 a.m.,⁷⁴ the AWC and the second officer reached the victim, who was being rendered first aid by a friend. The AWC and second officer began to assess the scene and tell witnesses to step back. The second officer began attending to the victim. Neither officer had been provided tactical medical equipment or specialized training, so they relied on their first aid training. "Here, put pressure," the AWC said to the second officer, who placed pressure on the victim's wounds to try to stop the bleeding.⁷⁵ The AWC directed individuals at the scene to go out to the street and direct the ambulance to their location. The AWC confirmed via radio with APD dispatch that an ambulance was en route to the scene Code 3 (emergency response). At approximately 3:09:16 a.m., the AWC requested additional units for crowd control.⁷⁶

Officers reported that the second officer on scene applied direct pressure to the victim's extensive stab wounds in an attempt to control the victim's bleeding, while the AWC was engaged in CPR chest compressions.⁷⁷ The mobile auto video (MAV) audio recording supports that the AWC and the second officer on scene engaged in both CPR and efforts to control the bleeding for approximately four to five minutes, until the firefighter paramedic team arrived and took over.⁷⁸ A friend of the victim later testified at the preliminary hearing that he observed the two police officers, "a lady cop and a male cop," attending to the victim. He said the "lady cop" was giving the victim CPR and the "male cop" was applying pressure.⁷⁹

The AWC's MAV audio recording captured what appeared to be a highly chaotic and emotionally charged scene. Yelling and screaming from partygoers can be heard in the background on the recording during the time the officers were attempting to assist the victim.

Despite the charged scene, based on the audio recordings, it appears that the two APD officers were continuously engaged in the life-saving efforts for the victim during this initial response. The recording indicated that the officers were on the ground with the victim continuously until the firefighters and paramedics arrived. The audio recordings indicated the officers were focused on the victim even while they were surrounded by numerous agitated and emotional partygoers.

⁷³ APD police report related to the homicide of Josiah Lawson, reviewed by NPF assessment team, August 2018-May 2019.

⁷⁴ APD AWC MAV recording, April 15, 2017.

⁷⁵ It was determined from the recording that the second officer on the scene was placing pressure on the victim's wounds per the AWC's direction. He can be heard confirming that he had both wounds covered at 5:50 on the MAV recording ("I've got them both") in response to a question by a friend of the victim.

⁷⁶ APD CAD incident report, April 15, 2017.

⁷⁷ NPF assessment team interview, personnel, APD, August 13-16, 2018.

⁷⁸ At 9:46 on the MAV recording the AWC stated, "When she tells you to move, move." In reference to clearing the way for the fire captain to have access to the victim.

⁷⁹ Superior Court of California County of Humboldt. Honorable Dale A. Reinholsten, Judge. Preliminary Hearing Transcript.

Mutual Aid Arrives

At least 21 first responders from multiple agencies were involved in the response.⁸⁰

Involved personnel consisted of officers, firefighters, ambulance personnel, and dispatchers from the following agencies:

- APD: three officers, one dispatcher.
- AFD: one battalion chief, one captain, three firefighters, and one dispatcher.
- AMRA: two crewmembers, one dispatcher.
- HSUPD: one sergeant, one officer, and one dispatcher.
- CHP: two officers, at least two separate dispatchers.
- HCSO: two deputies.

After being dispatched to the scene at 3:06:08 a.m., an HSUPD officer and HSUPD sergeant, responded to assist the APD officers.⁸¹ They arrived at approximately 3:06:26 a.m. in separate vehicles and entered the driveway area together.⁸²

Initial fire personnel reached Spear Avenue at approximately 3:10 a.m.⁸³ One of the male partygoers approached the fire vehicles to direct them to the victim. The firefighters ran behind the male subject across Spear Avenue and into the driveway area toward the victim.⁸⁴ Four AFD firefighters/paramedics would respond from the Mad River Station and the battalion chief responded from the McKinleyville Station. The firefighters donned their emergency personal protective equipment prior to leaving their stations. Personnel from the AMRA, located at their Arcata base station at the time of the incident, responded to Spear Avenue with the ambulance.

Fire and police personnel could see the victim's condition was grave. An AFD captain, an experienced firefighter/paramedic with 28 years on the job and five years of field supervisory experience, began attending to the victim. An AED unit was used but indicated "No shock advised."⁸⁵ The captain observed the victim laying in a cramped and grassy area that did not allow adequate space for her and her staff to make use of their equipment. They took immediate action to move the victim out into a more open area.

⁸⁰ The event dispatch was initiated at 3:02:16. The APD Computer Aided Dispatch (CAD) log indicated an update from the on-scene AWC that the victim was en route to Mad River County Hospital at 3:20:57.

⁸¹ APD CAD incident report, April 15, 2017.

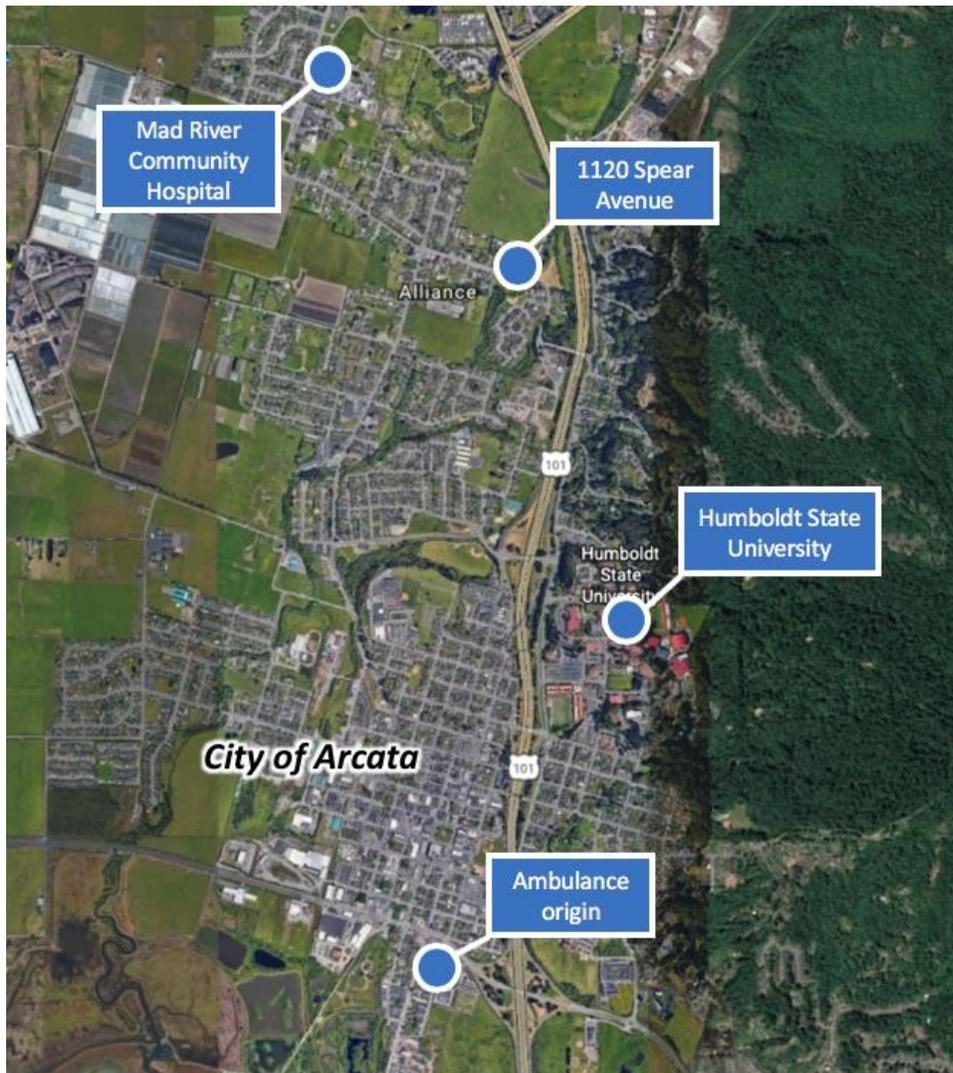
⁸² APD first arriving officer MAV recording, April 15, 2017.

⁸³ APD first arriving officer MAV recording, April 15, 2017.

⁸⁴ Firefighter arrival was recorded at approximately 7:46 on the first arriving officer's MAV.

⁸⁵ An AED is a medical device that can analyze an individual's heartbeat and deliver an electrical shock to help the heart re-establish an effective rhythm if necessary. The AED has an onboard analytic component to determine when shock should be applied. For more see Red Cross. (n.d.). What is AED? Retrieved from <https://www.redcross.org/take-a-class/aed/using-an-aed/what-is-aed>

Figure 5: Map of Relevant Locations



Source: Google Earth.

When fire personnel arrived to provide emergency medical services, the AWC was released from her lifesaving role and resumed supervisory duties, which included directing other law enforcement officers at the scene. The AWC was recorded on video as she checked on the status of the first officer on the scene who had the suspect detained in his car. However, within seconds, loud yelling and screams could be heard coming from the driveway area.

The firefighters reported that they were pushed and shoved by persons in the crowd as they tried to move the victim to a more advantageous place to continue their rescue and medical aid to the victim. An agitated man shouted to them, “you’re doing it wrong!”⁸⁶ His comments enlivened others who had crowded around the area. The AFD captain who was attending to the victim later reported that the anger and tension in the crowd made her feel threatened for herself and her crew.⁸⁷ The

⁸⁶ APD AWC MAV recording, April 15, 2017.

⁸⁷ One person “came at me like he was going to beat me up. It was scary. I felt vulnerable. I was the only female out there. I thought

AWC observed the crowd and immediately re-engaged in crowd control efforts as tempers flared with partygoers.

At 3:14:33 a.m., the AWC again requested additional units, broadcasting a "Code 30," for emergency response, indicating the urgent need for help in controlling the disorderly people as she ran back into the driveway area from Spear Avenue. The crowd remained highly agitated for approximately two minutes until the ambulance arrived and started to back into the driveway area.⁸⁸

The crowd became confrontational a second time when the victim was placed on a gurney and into the ambulance. A firefighter and an emergency medical technician were in the back of the ambulance with the victim. One of the victim's friends attempted to enter the ambulance to travel to the hospital with them. He was not allowed in the ambulance but held onto the door so it could not be closed. By the end of the encounter, which lasted approximately a minute, fire personnel pushed the subject away from the door allowing it to be closed and allowing the ambulance to depart.⁸⁹ The ambulance was en route to the Mad River Community Hospital with the victim approximately 17 minutes after the APD officers were dispatched to the call.⁹⁰

Many of the partygoers left the scene within several minutes after the victim was transported to Mad River Community Hospital, located approximately a mile away. A group of 10 to 12 of the partygoers followed the ambulance to Mad River Community Hospital and congregated in the parking lot and Emergency Room waiting room.

Four additional officers from the HCSO and CHP arrived at the crime scene in response to the Code 30 broadcast requesting emergency assistance from regional law enforcement agencies. At approximately 3:20 p.m., as the ambulance left the area, the AWC directed the deputies to respond to the Mad River Community Hospital to deal with the victim's friends, because she believed they were going to demand to see the victim and inadvertently interrupt lifesaving efforts at the hospital.

Josiah Lawson was pronounced dead at Mad River Community Hospital at 4:07 a.m.⁹¹

I was going to get the shit kicked out of me." NPF assessment team interview with captain, AFD, August 16, 2018.

⁸⁸ The intensity of the crowd was captured on the AWC and second arriving officer's MAV recordings from 11:40 to 12:30.

⁸⁹ APD AWC MAV recording, April 15, 2017; NPF assessment team interviews with AWC, APD, and captain, AFD, August 14-16, 2018.

⁹⁰ MAV recording indicated the ambulance left the scene at 17:25 minutes after officers had been dispatched to the incident.

⁹¹ Forensic Medical Group, Inc. (2017, April 19). Autopsy Findings. Reviewed by NPF assessment team August 2018-June 2019.

Incident and Preliminary Investigation Analysis

This section of the report provides an analysis of the Arcata Police Department (APD) response to, and investigation of, the homicide of Josiah Lawson. It also provides recommendations and lessons learned for APD as they move forward. Through this review, the National Police Foundation (NPF) assessment team found that, while responding officers did their best to save the life of the victim and manage the scene, the department lacked personnel with the appropriate experience and had inadequate supervision, command and control, and training to handle an event of the complexity and magnitude of the homicide of Josiah Lawson. Contingency plans necessary to mitigate absent staffing and ensure effective service delivery and performance had not been implemented. On the night of the incident, the APD lacked the skilled supervisory capacity required to provide proficient oversight and management of the scene and subsequent investigation. In addition, lack of coordination of resources and inadequate police-community relationships contributed to the chaos of the scene.

Arcata leaders interviewed by the NPF assessment team noted that financial challenges in the region over the last decade led to limited budgets for training and other APD resources.⁹² The ability to mitigate the risks and address those issues, however, requires strong leadership, prioritization of training, and accountability throughout the organization, along with collaboration with regional public safety resources to ensure coordination of effort in large scale incidents. Leadership and management decisions made by the APD and the City of Arcata had limited internal staffing and expertise prior to the April 15, 2017 incident, which thwarted the department's ability to successfully respond to, and investigate, the homicide. Reduced staffing, supervision, and command personnel—in addition to a scheduled vacation—also limited the capacity of APD management to respond to an emergency. Despite this recognition, there was no contingency plan put in place to ensure proper command and control should a major event occur. Those decisions resulted in a series of organizational failures, tactical missteps, and investigative and leadership errors, which have damaged the investigation and marred the department's reputation and credibility in many areas of the community.

This review revealed that the supervision, crime scene management and processing, reporting and follow-up investigations, and oversight were all severely lacking in the 2017 homicide investigation, even compared to a 2015 homicide investigation by APD that the NPF assessment team briefly reviewed.⁹³ According to police reports on the 2015 investigation, the APD sergeant who arrived on scene made assignments to control the crime scene, take preliminary photographs, and locate and interview witnesses. The sergeant also made the request for additional resources (police volunteer staff), which occurred within minutes of the initial response. The NPF assessment team's review of the 2015 homicide revealed that the circumstances of two events differed, but there should have been few differences after each of the incidents had been stabilized. The disparity of the manner in which these two homicides were managed and investigated appears to be due to the on-scene supervisory experience and command oversight. Experienced on-scene supervision, initial

⁹² NPF assessment team interviews, APD personnel, August 13-16, 2018.

⁹³ The NPF assessment team did not conduct a full and comprehensive review of the 2015 response and investigation, but it did review reports and documentation from this event as a way to determine historical patterns and trends of systems within the APD.

command engagement, and on-going command oversight did not occur in the 2017 homicide.

Preparation, Training, and Equipment

Organizations must ensure personnel are adequately trained and equipped and have the appropriate regional support necessary to respond to major incidents, regardless of the size of the organization. Proper response and investigation of critical incidents requires a well-coordinated and well-planned effort. During the April 15, 2017 incident, APD officers arrived on scene quickly and took immediate action focused on providing lifesaving measures for the victim. At the same time, the NPF assessment team found that inadequate training and preparation left personnel underprepared to thoroughly manage the initial response and investigation.

Training and Preparation for the Response and Investigation of Major Incidents

During their response to the incident, the men and women of the Arcata police and fire departments showed a primary focus on lifesaving measures for the victim, relying on the equipment they had immediately available to them and associated training. Arriving at the victim's side within minutes of the first 9-1-1 calls, the responding APD officers provided lifesaving efforts in the midst of an emotionally charged and chaotic situation until fire personnel and paramedics arrived on the scene. The APD acting watch commander (AWC), in particular, demonstrated strong leadership skills during the initial response, working to provide first aid⁹⁴ while de-escalating and managing a multi-faceted and challenging incident—although she did not later provide the same level of proficiency for crime scene management and evidence collection. Upon arrival, Arcata Fire Department (AFD) paramedics took over lifesaving efforts and similarly demonstrated a commitment to providing care to the victim.

The AWC was a field training officer and was compliant with all California Peace Officer Standards and Training (POST) officer requirements. She had completed a field evidence collection course put on by the Federal Bureau of Investigation (FBI) and was POST-certified in Interview and Interrogations and Field Training Officer courses. The officer had been serving as an AWC intermittently for as long as two months at a time. The department provided the officer training in the completion of routine administrative tasks.

However, officers acting in the AWC role had not received sufficient incident command training that would have been beneficial for the events the APD responded to on April 15, 2017. Limited training provided by the APD left some members underprepared to thoroughly manage such a major incident and conduct a comprehensive investigation on their own. APD personnel serving as acting supervisors had not been provided specialized supervisory training in the management of critical incidents, crime scene management of major crimes, or homicide investigation.⁹⁵

The National Incident Management System (NIMS) provides stakeholders—including those at all

⁹⁴ Officers relied on their first aid training, as they had not been provided tactical medical equipment and related specialized training.

⁹⁵ NPF assessment team interviews, APD personnel, August 13-16, 2018.

levels of government, nongovernmental organizations, and the private sector—with shared vocabulary, systems, and processes to manage incidents of any cause, size, location, or complexity.⁹⁶ NIMS includes Incident Command System (ICS) principles valuable in managing and coordinating any incident.⁹⁷ NIMS is part of California POST-mandated training, and APD personnel had completed some online training on NIMS. However, APD AWCs were undertrained in the concepts of NIMS or any incident command protocol necessary to be able to manage a large-scale incident. APD AWCs were also inadequately briefed on mutual aid protocols regarding the delegation of tasks at a major crime scene, including crime scene security. The APD AWC position was an assignment shared by numerous senior officers, but no specific qualifications were used for the selection, no specific supervisory training was provided, and no actual authority was afforded to the position.

Furthermore, limited tools, training, and experience among APD responding officers challenged the ability of APD members to properly process crime scene evidence in the initial stages of the investigation. After the victim was transported to the hospital, the AWC located a knife at the scene that the AWC decided should be collected and photographed. The AWC and the officers were audio recorded as they debated how they were going to photograph the knife, since they did not have "city issued phones."⁹⁸ The seven-month tenured officer used a department-issued point-and-shoot digital camera to photograph the scene. It was the first homicide crime scene he had worked on and he was dependent upon the evidence collection coursework he received during his basic police academy training. According to NPF assessment team interviews, the APD specialized evidence collection equipment, including high-quality cameras and measuring devices remained at the department or in an assigned vehicle since the department reorganization in 2016.⁹⁹ This specialized equipment was not maintained and, other than the previously assigned evidence technician, no other department members had been trained in use of the equipment.

During the initial investigation, the department's only detective—the investigations sergeant who would take over investigative and supervisory duties from the AWC—responded to the incident. The sergeant called two additional officers—who had been off-duty—to assist in the investigation. Neither of these responding officers was assigned to the investigation unit. According to interview statements, an APD officer who had tested for and been identified as the next in line to be moved to a detective position on April 25, 2017 (10 days after this incident), was notified of the investigation by the detective sergeant. The newly assigned detective had no formal homicide investigation training, but he was immediately assigned to assume the detective role and was directed to respond and to process the crime scene for evidence.¹⁰⁰

According to then-APD Chief Chapman, recruiting, retention, and budgetary issues contributed to the loss of experience and expertise. In 2015, the department internally reorganized and developed a training plan that Chief Chapman felt was sufficient to accommodate their attrition problem at the

⁹⁶ Federal Emergency Management Agency. (2017, October). *National Incident Management System: Third Edition*. Washington, DC: U.S. Department of Homeland Security. Retrieved from https://www.fema.gov/media-library-data/1508151197225-ced8c60378c3936adb92c1a3ee6f6564/FINAL_NIMS_2017.pdf

⁹⁷ Federal Emergency Management Agency. (2017, October). *National Incident Management System*.

⁹⁸ AWC's audio recording, reviewed by NPF assessment team, August 2018-May 2019.

⁹⁹ NPF assessment team interviews, APD personnel, August 13-16, 2018.

¹⁰⁰ NPF assessment team interviews with former chief and sergeant, APD, August 13-16, 2018.

time.¹⁰¹ As part of the plan, the lone full-time evidence technician position was eliminated, and that employee was promoted to a records and dispatch staff supervisor position. Crime scene processing and evidence collection responsibilities were spread throughout the agency without commensurate training, supervision, and management oversight. All sworn officers in the department completed internal evidence collection training that the chief reported focused on best practices for field evidence collection.

However, despite beliefs by department leadership that they were prepared and did not need additional investigative assistance from other agencies, the change diluted the availability of staff experienced in handling a homicide. These decisions influenced the management of the response to this incident and the outcome of this investigation.

Lessons Learned and Recommendations

Lesson Learned 1: The APD first responding officers to this incident were not sufficiently trained in National Incident Management System (NIMS) and Incident Command System (ICS) protocols and did not establish command and control at the scene. NIMS and ICS help incident managers across organizations establish a common approach to incident management and work together. Training in, and regular application of, NIMS and ICS protocols is critical to ensuring coordination and collaboration among all responding agencies and individuals. Furthermore, as the NIMS guidelines states, “Using ICS for every incident helps hone and maintain skills needed to coordinate efforts effectively.”¹⁰²

Recommendation 1.1: All personnel, particularly those engaged in supervisory duties, should be trained in NIMS and ICS principles with increasing levels of training based on their level of responsibility within the department. Much of NIMS training is available at no cost online.¹⁰³ Additionally, consistent training and implementation of command system principles, through regular application in response to day to day calls, would build confidence in the system and help department members better understand their roles and responsibilities during both more common events and critical incidents.¹⁰⁴

Recommendation 1.2: On-scene supervisory personnel should establish command and control at major incidents using NIMS and ICS principles. Command and control of major incidents is critical to ensuring effective and efficient deployment of resources and crime scene management. The application of protocols can be scaled to fit the needs of the agency so that even small agencies are able to apply them to appropriate critical incidents.

¹⁰¹ NPF assessment team interview with former chief, APD, August 15, 2018.

¹⁰² Federal Emergency Management Agency. (2017, October). *National Incident Management System*.

¹⁰³ Federal Emergency Management Agency Emergency Management Institute. (n.d.). National Incident Management System. Retrieved from <https://training.fema.gov/nims/>

¹⁰⁴ Straub, F., H. Aden, J. Brown, B. Gorban, R. Monroe, and J. Zeunik. (2017). *Maintaining First Amendment Rights and Public Safety in North Minneapolis: An After-Action Assessment of the Police Response to Protests, Demonstrations, and Occupation of the Minneapolis Police Department's Fourth Precinct*. Washington, DC: Office of Community Oriented Policing Services. Retrieved from <https://www.policefoundation.org/wp-content/uploads/2017/03/Maintaining-First-Amendment-Rights-and-Public-Safety-in-North-Minneapolis.pdf>

Lesson Learned 2: APD officers who responded to this incident did not have the requisite skills and supervisory training in tactical response. The APD had not provided tactical and supervisory training for their AWCs. The department relied on utilizing senior officers as supervisors (AWCs) on the night shift for an extended period of time. Although using senior officers in such a manner is not unique to the APD, the APD is responsible for providing these officers with the supervisory training needed to handle the role.

Recommendation 2.1: APD should provide supervisory and leadership training to officers commensurate with their roles and responsibilities. Many small agencies rely on more-tenured officers to assume supervisory roles on a temporary basis, particularly during vacancies, because it is not practical to ensure all positions throughout an agency are filled at all times. Vacancies will occur unexpectedly or through the need for planned time off. Particularly as vacancies occur, police management should anticipate vacancies and provide the appropriate level of supervisory training to officers who will be filling supervisory roles for the continuation of essential public safety services. The AWC had not been provided adequate field supervisory training to manage a large incident, including the initial oversight, coordination, and processing of the crime scene.

The APD should build upon formalized supervisory and leadership training to establish a structured in-service program to identify and develop the expertise of its members. Any member serving in a field supervisory position—whether on a temporary or permanent basis—should be trained in operational, investigative, and administrative duties commensurate with the position. Training should include managing basic responses to active crime scenes, including the coordination of tasks and security of the scene. The program should include structured feedback to those serving in such roles as part of a continuous quality assurance philosophy. Furthermore, establishing a structured in-service supervisory program for the department to include civilian supervisors will further advance the chief’s leadership commitment to providing highly professional police services to the community. Providing training helps upgrade the level of performance for all members of the department and provides the opportunity to advance succession planning efforts, while also serving as an incentive for staff retention.

Recommendation 2.2: APD should work with their California Peace Officer Standards and Training (POST) representative to conduct a training needs assessment and develop a comprehensive training plan. The vast majority of small police departments function under a generalist philosophy, in which patrol officers are required to fulfill collateral duties beyond that of agencies with more specialized internal resources. Agencies such as the APD need to conduct regular assessments of their service delivery capacity to identify strengths and gaps. The California POST can assist the APD with such an analysis and help develop a template for the agency.¹⁰⁵ The APD should work with the POST to identify formal supervisory, investigative, and leadership programs that are available for their personnel including dispatch staff. Such an effort can also provide an opportunity to coordinate leadership and

¹⁰⁵ California Commission on Peace Officer Standards and Training. (n.d.). Training Managers. Retrieved from <https://post.ca.gov/training-managers>

supervisory programs for neighboring agencies, that would advance the goal of coordinated regional response protocols in emergency situations. The College of the Redwoods and Humboldt State University may also offer resources and partnerships to assist in this effort to the mutual benefit of all.

Lesson Learned 3: The APD should ensure all staff leading and supporting investigations are provided the training, supervision, and resources to effectively manage these investigations. During the initial investigation of the homicide, the APD responding staff did not have the training and experience necessary to effectively manage the investigation and did not ask for additional investigative assistance from other agencies.

Recommendation 3.1: In addition to on-the-job training, the APD should explore the opportunity, when possible, to periodically provide comprehensive formal investigations training to prepare officers for their role.¹⁰⁶ Logistical obstacles may preclude the option of formalized training in advance of specialized assignments being filled. Maintaining a liaison with the regional POST representative and monitoring training opportunities from other sources can build upon the expertise of the entire organization. An illustration of specific training, such as through the National Forensic Academy's 10-week training program for law enforcement agencies, may help to improve understanding of evidence recovery and submission for those with evidence collection responsibilities when possible.¹⁰⁷

In-service training can also be beneficial to those members transitioning in assignment to an investigative function. The department's decision to immediately assign an officer who had been identified as next in line for a detective position to the case immediately was sound. Still, the newly identified detective and the department would have been better served if the detective had been paired with a veteran investigator. Given the shortage of APD staff, assigning an investigator from another agency would have been helpful given the circumstances of this case.

Recommendation 3.2: APD should establish a formal process to identify officers with the collateral skills and ability for roles and responsibilities in major investigations. The department should also assess whether trained personnel are available on a 24-hour basis. If internal resources are unavailable, provisions should be made in advance for on-call regional assistance if needed. For example, participation in a regional major crimes task force would provide expertise to the department and assist in preparation for promotion that would advance succession planning efforts. Police agencies should establish a formal process for selecting patrol officers to become detectives and selecting investigations supervisors.¹⁰⁸

¹⁰⁶ Police Executive Research Forum. (2018, October). *Promising Strategies for Strengthening Homicide Investigations: Findings and Recommendations from the Bureau of Justice Assistance's Homicide Investigations Enhancement Training and Technical Assistance Project*. Washington, DC: Bureau of Justice Assistance. Retrieved from <https://www.bja.gov/Publications/promising-strategies-for-strengthening-homicide-investigations.pdf>

¹⁰⁷ Law Enforcement Innovation Center. (n.d.). Forensic Training. Retrieved from <http://leic.tennessee.edu/home/training/forensic-training/>

¹⁰⁸ Police Executive Research Forum. (2018, October). *Promising Strategies for Strengthening Homicide Investigations: Findings and Recommendations from the Bureau of Justice Assistance's Homicide Investigations Enhancement Training and Technical Assistance Project*. Washington, DC: Bureau of Justice Assistance. Retrieved from <https://www.bja.gov/Publications/promising-strategies-for-strengthening-homicide-investigations.pdf>

Such a formal process would support unit staffing, supervision, and consistency in the level of experience of selected personnel.

Recommendation 3.3: The department should research and consider available external resources that will assist them as the agency continues to assess and improve upon their capacity to conduct investigations. In addition to POST, the U.S. Department of Justice (DOJ), Bureau of Justice Assistance (BJA) National Resource and Technical Assistance Center (NRTAC) for Improving Law Enforcement Investigations provides free technical assistance to departments on a wide range of topics related to conducting high-quality investigations.¹⁰⁹ NRTAC also provides webinars to law enforcement agencies on various investigative topics.¹¹⁰ Resources like NRTAC provide a low-cost opportunity for the APD to continue developing and institutionalizing the quality of their investigations.

Lesson Learned 4: During the initial investigation, APD first responding officers did not have the training, personnel, and equipment necessary to carry out sufficient crime scene management and evidence collection needs. With crime scene processing and evidence collection responsibilities spread throughout the APD, first responding officers did not have access to the trained personnel and specialized equipment necessary to thoroughly manage crime scene and evidence collection needs.

Recommendation 4.1: The department should ensure all staff have the training and equipment necessary to carry out their responsibilities and protect themselves during incidents. Equipping department members with the training and tools to carry out their initial crime scene management responsibilities would better prepare them to respond to critical incidents. A system of regularly scheduled inspections of inventory should be implemented to ensure readiness of all essential equipment.

Lesson Learned 5: APD first responding officers did not have tactical medical equipment that could have been helpful as part of their initial first aid efforts. Tactical emergency medical training can prepare first responders to take immediate and critical life-saving actions.¹¹¹

Recommendation 5.1: The department should consider providing officers tactical emergency medical training and equipment. Such training and equipment could be used to render aid to severely injured victims and colleagues.¹¹²

[strengthening-homicide-investigations.pdf](#)

¹⁰⁹ National Resource and Technical Assistance Center for Improving Law Enforcement Investigations. (n.d.). Retrieved from <https://centerforimprovinginvestigations.org/>

¹¹⁰ National Resource and Technical Assistance Center for Improving Law Enforcement Investigations. (2019). NRTAC Webinars. Retrieved from <https://centerforimprovinginvestigations.org/nrtac-webinars/>

¹¹¹ International Association of Chiefs of Police. (2013, October 23). Tactical Emergency Medical Training for Law Enforcement Personnel. Retrieved from <https://www.theiacp.org/resources/resolution/tactical-emergency-medical-training-for-law-enforcement-personnel>

¹¹² Straub, F., B. Cowell, J. Zeunik, and B. Gorban. (2017). *Managing the Response to a Mobile Mass Shooting: A Critical Incident Review of the Kalamazoo, Michigan, Public Safety Response to the February 16, 2016, Mass Shooting Incident*. Washington, DC: National Police Foundation. Retrieved from <https://www.policefoundation.org/publication/managing-the-response-to-a-mobile-mass-shooting/>

Organizational Leadership, Supervision, and Command and Control

Proficient incident management begins at the executive level of a public safety organization. Strong leadership ensures that systems, regional relationships, and protocols are in place to mitigate problems and properly prepare for and respond to major incidents. Adequate supervision and command and control of the response and the investigation are essential to properly managing major incidents as well. The NPF assessment team found that inadequate leadership and organizational preparation, as well as lack of supervision and command and control, left the department unable to thoroughly manage the initial response and investigation.

Notifications and Response Protocols

During the response to the April 15, 2017 incident, in accordance with APD policy, and due to the lone dispatcher focused on priority emergency traffic and operations, the APD AWC attempted to make notifications of the incident to the APD lieutenant (the next officer in the chain of command), but was initially unable to locate his number. Approximately 45 minutes after the initial dispatch, around 3:46 a.m., the AWC did notify the operations lieutenant and detective sergeant. The operations lieutenant was called and reported that he was on a scheduled vacation approximately three hours away and unable to respond in a timely manner. The department made no provisions for another commanding officer to be on call should one be needed, other than the chief of police.

The operations lieutenant did not respond to the APD call-out during the initial stages of the investigation. Following protocol, the operations lieutenant notified the chief, shortly after receiving the call from the AWC. He made a follow-up call to the chief of police between 7:00 a.m. and 8:00 a.m., to advise that a suspect was in custody. His decision not to respond, indicated an inability to understand the responsibility of his command, especially in light of the lack of resources he dedicated to the investigative unit. Only one detective sergeant with prior homicide experience was assigned to the case, with no other detectives or crime scene technicians assigned to the investigative unit. The resources, cross-training, and availability of equipment was the specific responsibility of the operations lieutenant.

The detective sergeant who took over investigative and supervisory duties from the AWC arrived at the hospital, responding directly from his home approximately 40 minutes away. The sergeant called additional officers to assist in the investigation, including the newly assigned detective. The detectives responding to the incident each responded to different locations: the newly appointed detective went to the crime scene on Spear Avenue and to the police department. The sergeant in charge of the case went to Mad River Community Hospital where the AWC and victim were located. The detective sergeant did not visit the crime scene in the hours after the incident, nor did he view any of the digital photographs prior to conducting interviews, including his 15-minute interview of the arrested subject.¹¹³

¹¹³ NPF assessment team interview with sergeant, APD, August 14, 2018.

Incident Command and Leadership

The responses and actions by officers on scene were conducted independently, indicating that no overall supervision or incident command was in place. From the moment she arrived on scene, the APD AWC was focused on lifesaving efforts for the victim. The AWC provided strong guidance and delegation to others during the initial response to provide lifesaving efforts and manage the crowd.¹¹⁴ However, she then attempted to delegate crime scene security and evidence collection tasks to available personnel beyond what they were prepared to effectively accomplish at the time, and did not provide the same level of supervision to address these tasks. Additional supervisors from other agencies were present and management of the crime scene could have been delegated to a mutual aid supervisor from another agency allowing for better management of that critical location.

The first officer on scene took custody of the suspect, per witness statements. The second officer to arrive and the AWC were directly involved in lifesaving efforts of the victim. The APD had command of the scene and although an HSUPD sergeant had arrived on scene, the APD did not request the sergeant assume any command function such as scene control or witness coordination. No established protocols were in place to enable another agency supervisor to assume any aspect of command of the scene while the AWC was engaged with the victim. As a result, command and control of the scene, evidence, witnesses, and investigation was insufficient. After the victim was transported to the hospital, the secondary crime scene at the hospital was also left inadequately secured, allowing for the loss of potential physical evidence.¹¹⁵

Specific tasks were assigned to each investigator without knowledge of the crime scene or the information that had been collected or received in statements provided to the initial responding officers. The AWC did not hold a debriefing with the officers at the Spear Avenue scene to gain and disseminate information before delegating tasks.¹¹⁶ In this incident, a debriefing would have been especially important because of the chaotic and violent nature of the incident and the lack of a structured incident command component. A debriefing may have also provided the AWC with additional information relative to the contacts and interviews that were conducted, resulting in her being able to prioritize assignments differently and to identify appropriate priorities in the transition of the investigation to the detective sergeant. Consequently, officers acted independently without coordination or the advantage of full situational awareness. As an example, the first officer on scene (who took the suspect into custody) was unaware that other officers had been engaged in CPR until 34 minutes into the call.

Security, control, and oversight of the primary crime scene was left to an underexperienced officer. The primary crime scene perimeter was too small and poorly secured, allowing for the suspect's vehicle and other potential items of evidentiary value to be removed. Potential witnesses or

¹¹⁴ The AWC would later note that she believed her gender helped her to avoid some confrontation with witnesses and de-escalate the situation in this emotionally charged environment enough to be able to render first aid to the victim. NPF assessment team interview, AWC, APD, August 15, 2018.

¹¹⁵ After the victim was pronounced dead, the body was cleaned for family viewing rather than secured for the preservation of possible physical evidence. The NPF assessment team interview with sergeant, APD, August 14, 2018; hospital employee witness statement, police report, reviewed by NPF assessment team, August 2018-May 2019.

¹¹⁶ A debriefing serves to collect and disseminate information among the team of officers engaged in the incident.

accomplices were also directed to leave the area without sufficient vetting. The officer who was delegated the responsibility to document and collect the photographic, video, and physical evidence would have also benefitted from assistance from an experienced officer or supervisor. The processing of the crime scene was further compromised by the arriving investigative supervisor's decision not to request assistance from other tenured APD staff or to make use of resources within the county, including the HCDA Office Investigations team.

The former APD chief of police and operations lieutenant acknowledged that the operations lieutenant was not engaged in the initial investigation and into the months following the April 15, 2017 incident.¹¹⁷ According to the operations lieutenant, he did not make a follow-up call to the investigative sergeant until the Monday following the incident. During this period, there was no "running whiteboard" outlining the progress of the case. The lieutenant never went to the scene and he had not viewed any of the crime scene pictures.¹¹⁸ The operations lieutenant had not resumed functional supervision of the investigation or taken the time to review the case file or to visit the scene before the arrival of the NPF assessment team in August of 2018.¹¹⁹ The operations lieutenant had served as the detective sergeant prior to his promotion to his current rank. He managed the investigations unit and had been engaged in previous homicide and high-profile investigations for eight years. His knowledge, experience, and assistance would have been a valuable asset in the homicide investigation, especially considering that the former chief did not have extensive investigative experience or training.

The former chief was also not properly engaged in the supervision of the Lawson homicide investigation. The former chief delegated the command of the investigation to the detective sergeant and received periodic updates on the progress of the investigation.¹²⁰ No hands-on command or oversight of the investigation was provided and the department did not engage outside investigative resources from any other regional agencies for assistance until complaints from the victim's family and community members led the city to engage a pro bono investigator. The former chief noted to the NPF assessment team that he had confidence in the lead investigator, but that the investigator could have benefited from additional supervisory assistance.¹²¹ However, the former chief also indicated that he did not ensure that the necessary supervision had been provided by the operations lieutenant.

Crime Scene Investigation and Evidence Management

Once the victim was transported from the scene, patrol officers were underprepared to investigate the incident. Based on audio recordings of her discussion of plans to identify and photograph the crime scene, the AWC did not understand requirements for the collection and preservation of evidence—particularly considering the severity of the victim's injuries. The entire driveway area should have been designated as a crime scene and cordoned off to limit contamination and entry by individuals.

¹¹⁷ NPF assessment team interview, operations lieutenant and former chief, APD, August 14-15, 2018.

¹¹⁸ NPF assessment team interview, operations lieutenant, APD, August 14, 2018.

¹¹⁹ NPF assessment team interview, former chief, APD, August 15, 2018.

¹²⁰ NPF assessment team interview with former chief, APD, August 15, 2018.

¹²¹ NPF assessment team interview with former chief, APD, August 15, 2018.

The AWC directed HSUPD officers to tape off a small area of the driveway within the cul-de-sac, which she believed constituted the crime scene, approximately 40 minutes after the incident. The crime scene was hastily identified as the AWC showed the second officer, "It's from there to there." The AWC assumed that the crime scene was limited to the width of the driveway area and that the stabbing had occurred where she observed a pool of blood. However, the stabbing had not occurred in the driveway, but on the adjacent lawn area. The actual location of the stabbing was important information that was overlooked in the early stages of the investigation and caused significant misdirection in the follow-up investigation by the detectives.

Numerous people had unfettered access to the crime scene after the ambulance and the victim's friends left the scene. No attempt was made to secure a large enough area around the crime scene, although the AWC did discuss the need to search the area for the knife. The AWC located a knife under one of the vehicles parked in the driveway area. Her initial reaction was that it was the weapon used in the assault, but later, she debated with other officers on the scene as to the probability of it being the weapon used in the assault because she said, "there's no blood on it."¹²²

The knife was collected at the scene by one officer who then gave it to a second officer at the scene. The second officer then drove to and spent time at the hospital with the victim before transporting the knife to the APD and giving it to the arresting officer who booked the knife into evidence.¹²³ Based on the NPF assessment team review of the audio recordings, it does not appear that the officers on the initial scene, nor the detectives who were engaged in the initial investigation, considered or discussed the possibility that the knife had been wiped off or moved by a third party. Investigative interviews later determined that at least one subject had retrieved items of the suspect's belongings from the area of the fight and subsequent fatal assault, before the crime scene was secured. The suspect's vehicle was also driven away from the scene by the mother of one of the suspect's associates, who had been called to the scene by her daughter. This is supported by MAV footage.¹²⁴

Two separate crime scene diagrams were produced over the course of the investigation. The newly promoted detective made an initial crime scene diagram, but the detective sergeant deemed that it was inadequate to capture necessary information, leading to the creation of a second diagram. However, with limited oversight and lack of clarity around tasks that still required follow up, a second crime scene diagram was not prepared and submitted by the detective sergeant with the assistance of the former evidence technician until seven days after the incident.

Witness Interviews

APD officers conducted brief interviews with subjects at the scene of the incident. The NPF assessment team reviewed videos showing that officers on scene were concerned with clearing people from the chaotic scene, rather than identifying witnesses. They did not delegate

¹²² APD AWC MAV recording, April 15, 2017.

¹²³ This transportation of evidence is notable for chain of custody issues.

¹²⁴ APD AWC MAV recording, April 15, 2017.

responsibility to gather and identify witnesses and triage for the most critical, to other officers who were present. They also did not secure the crime scene and call in trained investigators to assess the scene and collect evidence. Minimal attempts were made to detain or identify parties that may have been involved in the altercation or who may have witnessed the incident.¹²⁵ Key witnesses and potential suspects were allowed to leave the scene or communicate with one another.

Initial interviews conducted in the field and at the hospital by the first responding officers in the early morning hours after the stabbing yielded several conflicting statements from persons associated with the victim and with the arrested suspect. Significant statements made by both witnesses and suspects were not recognized or were overlooked as a result of the lack of investigative, supervisory, and critical incident experience of APD personnel involved in the investigation.

While still parked at the scene, the arresting officer interviewed the suspect in the back of the patrol vehicle after the suspect waived his Miranda rights.¹²⁶ The suspect had been secured in the patrol vehicle parked on the street while individuals leaving the party walked by and hit the patrol car.¹²⁷ The suspect's female associates also came and stood next to the patrol vehicle, talking freely to him and amongst themselves.¹²⁸ The first and second responding officers conducted informal interviews of the female associates at different times at the scene on Spear Avenue. It does not appear that the officers coordinated efforts or communicated any of the information received with one another. No attempt was made to preserve the integrity of their statements, by separating the women or having them transported to the police department for interviews, despite their indication that they had been involved in the altercation.

No concerted effort appeared to be made to utilize experienced personnel to conduct organized, controlled, and thorough interviews. Probative formal questioning of witnesses and potential suspects involved in the assaults did not occur until several days after the incident. Many subsequent interviews of significant persons were conducted in informal settings. Some occurred while walking outdoors and others in a coffee shop. Portions of the recordings were inaudible.

Several witness interviews were summarized in reports. A review of the audio recordings during this assessment confirmed that some reports were inaccurate or reported incomplete witness interviews. Information in the reports was, at times, taken out of context or unrecognized as vital to the investigation and appeared to be left out of other reports.¹²⁹ For example, one witness associated with the arrested subject told an officer that she saw the stabbing and that she saw a black man attack the suspect who attempted to wrestle the knife from him.¹³⁰ According to her statement, the man then stabbed the victim and walked away.¹³¹ The statement was captured on the MAV recording; however, the officer's report only indicated that the witness said the arrested

¹²⁵ APD MAV recordings of officers at the scene, April 15, 2017. Reviewed by NPF assessment team August 2018-June 2019.

¹²⁶ APD first arriving officer MAV recording, April 15, 2017.

¹²⁷ Ibid.

¹²⁸ Ibid.

¹²⁹ APD first arriving officer MAV recording, April 15, 2017; APD first arriving officer's police report, April 15, 2017.

¹³⁰ APD first arriving officer MAV recording, April 15, 2017.

¹³¹ APD first arriving officer's police report, April 15, 2017.

suspect never had a knife and never stabbed anyone.¹³² The same witness had called 9-1-1 and was one of the first callers to report the incident via a cellular phone. She was initially connected to the CHP dispatch center. CHP transferred the call to the APD, and the CHP dispatcher indicated that the caller was reporting a stabbing and that someone had a gun.¹³³ Furthermore, reports indicated that recordings had been booked into evidence. In at least one instance during the NPF assessment team's review, the recordings could not be located or were not included in APD's case management system.

The APD supervising detective assigned to the investigation wrote a report in which he attempted to summarize the case and investigation. His summary included information obtained from the same witness by another officer within minutes of the first interview, which indicated that she had not seen the stabbing. The same witness was interviewed by a detective two additional times. Each time the witness provided a different statement about the incident and their involvement. The witness had been involved in the altercations and had used a pepper spray product on the victim and other subjects. The witness's statements were summarized, and the inconsistencies were not addressed.

A crucial interview—one significant in the District Attorney's decision to file the charges in the early stages of the investigation before all the analysis and reports were completed—was reported inaccurately. An APD detective summarized an interview that indicated the witness had identified the arrested suspect by name as the person who had stabbed the victim. At the preliminary hearing, the court determined that the detective had erred in his summarization. In addition to the incorrect summation, the review of the interview audio recording revealed that the detective did not ask substantive follow-up questions of what appeared to be a key witness. The appropriate follow-up questions would have included a detailed description of everything the witness saw and did not see.

The APD investigator prepared a report summarizing the incident, in which he indicated one witness stated that he observed the suspect stab the victim, and two other persons that stated they saw the suspect with an object in his hand shortly after the stabbing. Transcripts of preliminary hearing testimony show that some witness statements conflicted with each other, demonstrating that investigators did not complete a thorough investigation before the preliminary hearing. The credibility of statements provided to officers, some of which were recorded by officer audio recorders and were summarized by officers early in the investigation and continue to be called into question.

Suspect Interviews

The detective sergeant took the arrested suspect to APD headquarters and reread him his Miranda rights, which the suspect waived again. The arrested suspect was cooperative and answered the detective sergeant's questions. The interview could have yielded significant information, but it lasted only approximately 15 minutes and was curt instead of exploratory.¹³⁴ The arrested suspect did not refuse to answer additional questions.

¹³² APD first arriving officer MAV recording, April 15, 2017.

¹³³ APD CAD incident report, April 15, 2017.

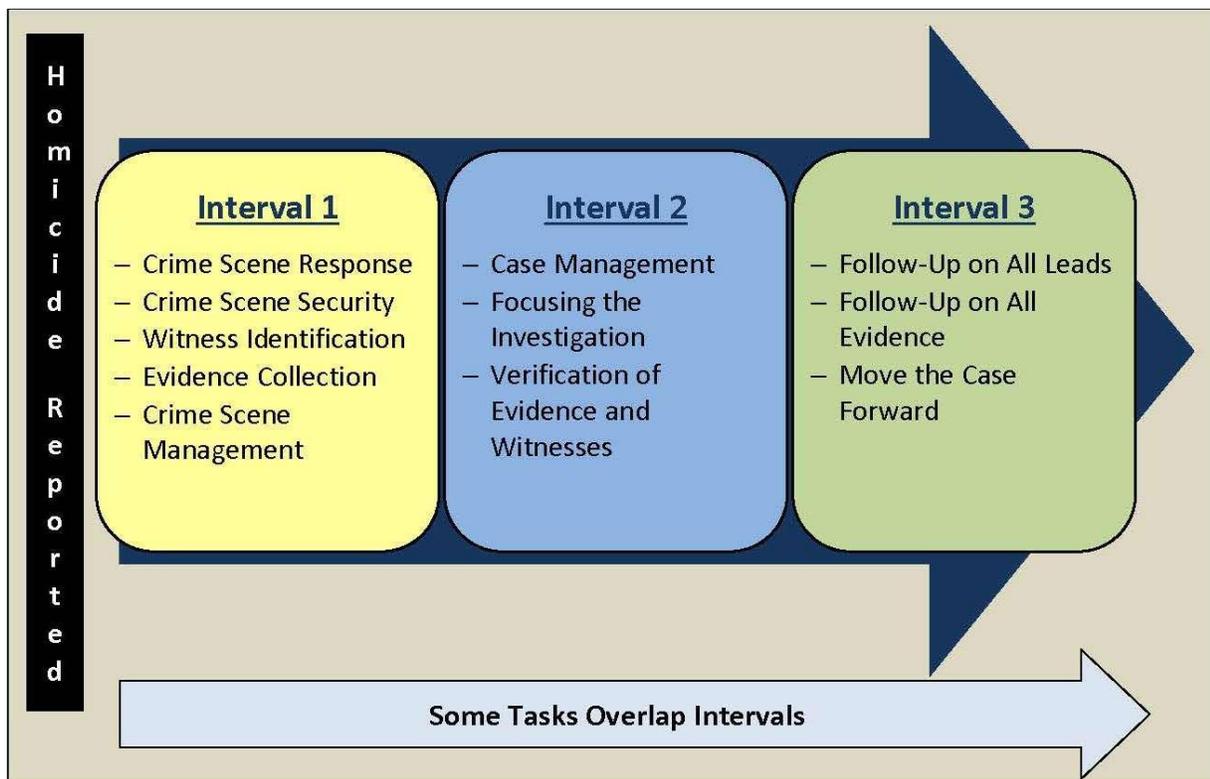
¹³⁴ Audio recording of the interview with the suspect, April 15, 2019. Reviewed by NPF assessment team August 2018-May 2019.

The arrested suspect was booked on homicide charges.

Homicide Investigation Process Best Practices

As a U.S. Department of Justice, Bureau of Justice Assistance (BJA) best practices report on homicide process mapping explains, when patrol units initially arrive at the scene of a homicide, their first responsibilities are determining whether aid must be rendered and apprehending the suspect if still at the scene.¹³⁵ After these initial steps, several critical tasks must be conducted in the first 48 hours by patrol officers, investigators, crime scene investigators, intelligence analysts, supervisors, the medical examiner investigator, department personnel responsible for public information, the DA if appropriate, and others.¹³⁶

Figure 6: Functions of Each Time Interval in the First 48 Hours



Source: Carter, D. L. (2013). *Homicide Process Mapping*.

Figure 6 displays the main tasks during the first 48 hours of a homicide investigation in three intervals. Interval 1 focuses on crime scene management over approximately the first eight hours; interval 2 moves into a focus on the suspect and case development over approximately the next 16 hours; and, interval 3 involves follow-ups on case development, after developing a clear

¹³⁵ Carter, D. L. (2013). *Homicide Process Mapping: Best Practices for Increasing Homicide Clearances*. Washington, DC: Bureau of Justice Assistance. Retrieved from https://www.iir.com/Documents/Homicide_Process_Mapping_September_email.pdf

¹³⁶ Ibid.

understanding of the evidence and facts, over approximately the remaining 24 hours.¹³⁷ Since each of the steps demands sufficient time and resources to conduct, collaboration between agencies and appropriate supervision throughout the process is key to thoroughly fulfill investigative responsibilities in the first few days.

Case Review and Quality Control

External oversight by tenured staff should occur at all phases of the response to, and investigation of, a major incident. This did not happen during the April 15, 2017 homicide of Josiah Lawson. As a result, inconsistent statements and accounts were not clarified nor were they deconflicted prior to being presented to the HCDA. The statements were ultimately presented in court as accurate. This lack of basic review reflected poor decision-making on the part of the APD.

The operations lieutenant did not engage in any meaningful case review, nor did he assist in relieving the detective sergeant of any of his collateral assignments during the subsequent investigation and preparation to present the case to the HCDA for consideration of charges. The former chief did not make other arrangements for the case review and oversight at the command level. That critical functional piece of command and management oversight was not conducted during the early weeks of the investigation, nor before the case was presented to the HCDA Office recommending charges be filed, nor did it resume after the unsuccessful preliminary hearing in May 2017.

The former chief said during interviews with the NPF assessment team, that he believed the case to be fairly straightforward and within the scope of his department to complete satisfactorily. He later realized that the case was more complicated than he initially believed. In retrospect, he understood both he and the operations lieutenant should have been more involved in the oversight of the investigation at the beginning saying, "I should have been more in the weeds."¹³⁸

As a result of the lack of command oversight, insufficient case review of the investigation was completed prior to submitting the case and requesting charges be filed by the HCDA. A list of tasks to be reviewed and analyzed for quality of effort was not conducted to ensure the accuracy of information presented to the HCDA Office.

The HCDA Office became involved in the case four to five days into the investigation. The chief and the HCDA experienced significant pressure from members of the community to have the case filed quickly. Despite not conducting a case review, the chief felt that there was sufficient evidence to have the suspect held to answer in the preliminary hearing. The chief only later realized, "in hindsight, we weren't ready."¹³⁹

Lessons Learned and Recommendations

Lesson Learned 6: APD first responders were challenged to make timely notification of the

¹³⁷ Ibid.

¹³⁸ NPF assessment team interview with former chief, APD, August 15, 2018.

¹³⁹ Ibid.

incident up their chain of command and did not receive adequate support to manage the crime scene and investigation. Lack of resources created some challenges for APD first responders to notify APD supervisors in a timely manner. As a small department, the APD only had one dispatcher available to coordinate communications for the critical incident. Thus, in accordance with APD policy, the AWC notified the operations lieutenant and detective sergeant. The operations lieutenant notified the chief. The AWC was unaware of the operations lieutenant's duty status. Even after supervisors were notified, on-scene personnel were not allocated appropriate resources to manage an incident of this magnitude.

Recommendation 6.1: Protocols for emergency notifications up the chain of command should be updated regularly and posted with on-duty dispatch and patrol commanders. Notifications should be made as early as practical to the authorized on-call commander. Following notification, the commander should ensure that appropriate resources are allocated to the scene. Once supervisors were notified, these commanders should have been responsible for ensuring that personnel at the scene had the resources needed to manage the crime scene and investigation and reaching out to other agencies for support as necessary.

Lesson Learned 7: The department did not have sufficient quality assurance and management processes in place to handle the case review. A proper review of this investigation did not take place at the command or executive level. No follow-up was conducted with assisting agencies to assess the effectiveness of mutual aid protocols. Likewise, no review of reports completed by officers the night of the incident was conducted at the command level. The NPF assessment team's interviews indicated that no secondary level of review was conducted with the operations lieutenant absent.

Basic supervisory auditing components should have been followed as early as the first morning to assess the effectiveness of the initial response to this incident.¹⁴⁰ Once the command staff learned of difficulties at the crime scene in following established protocols, additional layers of supervision and oversight should have been initiated to ensure a proper investigation going forward. The information that was provided to APD commanders was sufficient to warrant a closer examination of the actions taken in this early crucial portion of the investigation. However, this did not occur and led to further complications that continue.

Recommendation 7.1: The APD and HCDA Office should develop a formal case review processes and protocols that include layers of command. The APD has a responsibility to conduct thorough investigations with proper documentation and quality assurance. The HCDA Office additionally has a responsibility to evaluate and verify the information provided to them by the APD to the extent possible.

Lesson Learned 8: Case files related to this incident were disorganized and incomplete. The incident report itself was unstructured and inaccuracies were not identified early in the review

¹⁴⁰ Carter, D. L. (2013). *Homicide Process Mapping: Best Practices for Increasing Homicide Clearances*. Washington, DC: Bureau of Justice Assistance. Retrieved from https://www.iir.com/Documents/Homicide_Process_Mapping_September_email.pdf

process, nor were they corrected. This led to preliminary statements that were not challenged and corrected before the case was submitted to the HCDA Office for filing. During the incident, this APD command position was vacant and others in the position to provide this oversight did not assume responsibility to do so.

Recommendation 8.1: The department should consider assigning an additional supervisor on a collateral basis, if needed, in the early stages of an investigation to assist with report review or other tasks as needed until the case stabilizes. A fresh set of eyes can be helpful to the case and can develop the expertise of the supervisor involved. It should be the job of the Investigations Unit commander to ensure such reviews are accomplished.

Lesson Learned 9: The APD did not appropriately separate and delineate investigative and supervisory functions to ensure case integrity and provide for supervision through the chain of command throughout the investigation.

Recommendation 9.1: The APD should develop a written policy and protocol outlining the duties and responsibilities of every function during the investigative process. That protocol should outline layers of supervision and quality assurance processes. Investigative and supervisory responsibilities must be distinct functions in a major investigation. It was unreasonable to expect that the primary investigator would take full responsibility for actively participating in every investigative task while providing the required objective oversight and review of the entire investigation. Written protocols identifying areas of responsibility for personnel would help to clarify duties and responsibilities for different individuals involved.

APD relies on Lexipol, a comprehensive and broad-based policy and training platform, as the foundation for their policy manual. Lexipol is utilized by many law enforcement agencies.¹⁴¹ The Lexipol model allows agencies to stay current with best practices in police policy. Yet, to be effective, departments must adapt departmental policies, using the framework of Lexipol policies, to the specific needs of each individual organization. The APD would be well-served to conduct such a policy review to align Lexipol policies to clearly articulate responsibilities and expectations for APD personnel in an APD operations policy manual. Specific attention should be provided regarding major incident protocol to ensure every member throughout the chain of command is aware of expectations. Best practices from national guides like BJA's *Homicide Process Mapping* or from similarly small departments can also help to develop their protocols.¹⁴²

Lesson Learned 10: The APD had an insufficient system of accountability throughout the organization. During the initial investigation of the incident, APD members were not held accountable when follow-up tasks were missed or inappropriately prioritized.¹⁴³

¹⁴¹ Lexipol. (n.d.). Lexipol. Retrieved from <https://www.lexipol.com/>

¹⁴² For more, see: Carter, D. L. (2013). *Homicide Process Mapping: Best Practices for Increasing Homicide Clearances*.

¹⁴³ NPF assessment team interviews, AWC and command staff, APD, August 13-16, 2018.

Recommendation 10.1: APD leadership should ensure that the APD’s system of accountability is reevaluated to reinforce performance expectations of members at all levels of APD operations. The new leadership of the APD has an opportunity to identify and implement a system of values and expectations for the department moving forward. APD leadership must reestablish a system of accountability throughout the organization. Standards of performance are irrelevant without accountability for adhering to the standards. A written performance evaluation system would assist the chief in setting performance goals, recognizing quality performance, and providing a foundation for correcting behavior. All members of the command and supervisory ranks should be committed to ensuring that the highest levels of customer service are provided to the residents of Arcata and to each other.

Lesson Learned 11: The APD had not prioritized continual organizational learning, personnel performance, and accountability systems.

Recommendation 11.1: The department should establish a culture of learning by regularly debriefing and analyzing performance as part of an overall effort to continually improve performance and identify deficiencies. Until this independent review process began, the APD had not taken the opportunity to debrief this incident internally to glean learning points that could be incorporated throughout the department. An opportunity was missed to carefully examine the challenges presented in this investigation and learn from them. Chief Ahearn has indicated his interest in focusing on continuous quality improvement throughout the organization. The department can advance this internal cultural shift by developing an environment in which personnel can freely discuss strengths and weaknesses of their and the agency’s performance in the spirit of learning.

Recommendation 11.2: The department should establish protocols within the chain of command for thorough and ongoing critical reviews of their performance in major incidents and investigations. Continuing to conduct after-action reviews (AARs) to examine and learn from incidents is critical to cultivate a culture of learning within the department that will improve response to incidents and investigations at all levels of the organization over time.¹⁴⁴ AARs should be part of a continuous quality improvement plan for the department in the future. AARs can help identify some of the primary challenges, including the lack of adequate safeguards to ensure quality control and oversight and the disjointed methodology for preparing the case.

Regional Coordination and Mutual Aid

Regional coordination, cooperation, and mutual aid are critical to ensuring public safety, particularly during responses to major incidents. Most law enforcement agencies do not have the resources to

¹⁴⁴ The forthcoming U.S. Department of Justice and NPF *Critical Incident Response Review Guidebook* and Virginia Center for Policing Innovation (VCPI) *After-Action Review and Reporting* online training explain the step-by-step process for conducting an AAR. AARs do not seek to assign fault or blame but use the review process as a learning opportunity that can be applied to strengthen future responses and guide agencies as they prepare for future incidents.

respond to catastrophic events involving multiple victims and witnesses independently. Particularly in Arcata, where violent crime is rare, many APD officers had limited practical experience in handling major crime scenes. Early in the investigation, other Humboldt County agencies offered to assist the APD. While the APD was used to working with mutual aid agencies on responses to major incidents, all of these offers of assistance were rejected. The APD chief at the time believed the investigation was within their capacity, given that a suspect had been identified and was in custody.

Regional Communications

The interoperability of regional public safety communications systems and processes is valuable to facilitate interagency communication, coordination, and response. Each of the Humboldt County emergency service agencies' dispatch centers has separate staffing, radio hardware, and software.¹⁴⁵ While some of the agencies monitor each other's radio frequencies and regularly transfer 9-1-1 calls to each other, limitations to interoperability can add valuable seconds to dispatch and public safety response time. According to the National Fire Protection Association, the time needed to transfer a call from one Public Safety Answering Point (PSAP) to another should not exceed 30 seconds for at least 95 percent of all alarms processed.¹⁴⁶ This still adds valuable seconds during responses to events that rely on the ability to exchange time-sensitive and important information between callers and responding agencies.

Lack of Coordination with the District Attorney

Lack of early coordination with the HCDA Office additionally challenged the investigation. Within several hours of the homicide, after learning of the incident from a news broadcast, the HCDA chief investigator contacted the APD chief to offer assistance. This offer was declined. The former chief reportedly based his decision on an erroneous belief that he had enough experienced resources and his reluctance to abrogate control of the investigation to another agency.¹⁴⁷ During interviews with the NPF assessment team, the HCDA indicated that efforts have since been made to improve relationships and the HCDA Office is now called in approximately 90 percent of the homicide cases throughout the county.¹⁴⁸

During interviews with the NPF assessment team, the former APD chief indicated that he was unaware of any APD policies that required notification of the HCDA's Office of homicide incidents. The HCDA Office reported that they had previously attempted to develop a major crimes response protocol with the Humboldt County law enforcement agencies, without success. The Humboldt County Major Crimes Investigation Team Memorandum of Understanding (MOU) was developed "to promote coordination and cooperation between participating Humboldt County law enforcement agencies in the investigation of major crimes, where the rapid response and

¹⁴⁵ Arcata-Mad River Ambulance, Inc., letter to Measure Z Committee, February 14, 2017, provided to the NPF assessment team, reviewed August 2018-May 2019.

¹⁴⁶ National Fire Protection Association. (2010). NFPA Standards. Retrieved from <https://files.nc.gov/ncdit/documents/files/NFPA-Standards.pdf>

¹⁴⁷ NPF assessment team interview with former chief, APD, August 15, 2018.

¹⁴⁸ NPF assessment team interviews, HCDA Office, August 13-16, 2018.

deployment of combined resources will assist in solving crime.”¹⁴⁹ Signatory commitments were obtained from the majority of county law enforcement agency leadership, including the APD, in July 2018. The NPF assessment team found that the APD did not fully implement the protocol on the next homicide, which occurred on October 25, 2018. The APD has since reported participating in the Major Crimes Investigation Team and utilizing portions of the mutual aid provided through this MOU on subsequent responses.¹⁵⁰

Lessons Learned and Recommendations

Lesson Learned 12: Humboldt County public safety agencies do not have an interoperable public safety communications system. During the April 15, 2017 incident, dispatch centers in Humboldt County had separate staffing, radio hardware, and software.¹⁵¹ Call takers were required to transfer calls to other PSAPs, adding valuable time to each of the initial emergency 9-1-1 calls. Furthermore, the system placed significant dependence on the lone APD call taker and dispatcher working at the time, which could have been alleviated with joint staffing.

Recommendation 12.1: Public safety agencies in the Humboldt County area should consider establishing a consolidated communications center or otherwise update their communications centers with more contemporary equipment, protocols and processes that would better enable interaction with the systems of other agencies. A consolidated communications system may have significant costs and require regional leadership to implement and manage but could improve interoperability of communications systems and relieve reliance on lone call takers and dispatchers.

In 2017, local agencies, including the Humboldt County Sheriff’s Office and Arcata-Mad River Ambulance, Inc., recommended a needs assessment and feasibility study that would explore the creation of a Joint Emergency Communications Center and County Emergency Operations Center.¹⁵² Such a study would be a first step in evaluating Humboldt County’s existing public safety communications system as compared to national best practices, as part of identifying the most appropriate system for the county to pursue in the future.

Lesson Learned 13: The APD and co-responding agencies did not have a multi-agency response protocol or regular training to update and exercise coordination and cooperation between agencies. A multi-agency response protocol could have provided the temporary delegation of tasks to a supervisor from another agency to stabilize the scene until long-term coordination was established.

Recommendation 13.1: Mutual aid protocols and training should be established in the region. Formal agreements should be implemented similar to the current MOU for tactical

¹⁴⁹ Humboldt County Major Crimes Investigation Team. “Memorandum of Understanding, 1. Purpose.” Reviewed by NPF assessment team, August 2018-May 2019.

¹⁵⁰ Comments from the City of Arcata. Received by NPF assessment team, October 9, 2019.

¹⁵¹ Arcata-Mad River Ambulance, Inc., letter to Measure Z Committee, February 14, 2017, provided to the NPF assessment team, reviewed August 2018-May 2019.

¹⁵² Ibid.

situations in the investigative and supervisory coordination of extraordinary events. Such a protocol requires leadership at the executive level of all the agencies in the region to effectively implement and execute.

Recommendation 13.2: APD and mutual aid partners should conduct regular scenario-based training and regional training and tabletop exercises. Training opportunities should involve personnel from different parts of the department, including dispatch, victim services, public information, and others, as well as city agencies and other relevant stakeholders.¹⁵³ Relationships should be established before a major incident occurs. Training protocols should not be limited to classroom lecture. Perishable skills require continual refresh and exercise; training should be scenario-based and conducted at regular intervals. Agencies should develop, and cities and the county should establish, budgets to support this critical public safety function. Agencies can take advantage of regional expertise, POST, and academic institutions in developing lesson plans and conducting regional training and exercises, as well as tabletop exercises.

Training should not be limited to patrol and investigative staff. As an after-action review of the Orlando Pulse nightclub shooting found, dispatchers who answer calls and relay information to responding officers and make requests for mutual aid to other law enforcement, fire and EMS personnel should also be involved.¹⁵⁴ Similarly, public information officers (PIOs), city officials, and other personnel that engage with the community or play a role in providing support and resources during major incidents should be involved and understand their roles and responsibilities before an incident occurs.¹⁵⁵

Recommendation 13.3: The APD should develop relationships with local hospitals and establish protocols for responding to, and supporting, security at hospitals during high-profile and high-intensity incidents. This should include training with hospitals to practice coordination. The large crowd and high emotions in the Mad River Community Hospital around this event challenged hospital staff and officers to remain calm and focused as they attempted to accomplish live-saving tasks, create a safe environment, and secure physical evidence. The APD and other Humboldt County agencies should develop protocols for coordination with hospital staff and train accordingly.

Lesson Learned 14: The APD rejected offers for assistance by other law enforcement agencies that could have provided support to the investigation. Several agencies offered resources to the APD during the response and investigation; however, the then-APD chief believed the investigation was within the APD's capacity to handle, given that a suspect had been identified, was in custody, and a

¹⁵³ Straub, F., J. Cambria, J. Castor, B. Gorban, B. Meade, D. Waltemeyer, and J. Zeunik. (2017). *Rescue, Response, and Resilience: A Critical Incident Review of the Orlando Public Safety Response to the Attack on the Pulse Nightclub*. Washington, DC: Office of Community Oriented Policing Services. Retrieved from

<https://www.policefoundation.org/wp-content/uploads/2017/12/Orlando-Pulse.pdf>

¹⁵⁴ Straub, F., et al. (2017). *Rescue, Response, and Resilience*.

¹⁵⁵ Braziel, R., F. Straub, G. Watson, and R. Hoops. (2016). *Bringing Calm to Chaos: A Critical Incident Review of the San Bernardino Public Safety Response to the December 2, 2015, Terrorist Shooting Incident at the Inland Regional Center*. Washington, DC: Office of Community Oriented Policing Services. Retrieved from

<https://www.policefoundation.org/wp-content/uploads/2016/09/Bringing-Calm-to-Chaos-Final-1.pdf>

weapon was recovered. The failure to identify, accept support as needed, and deploy adequate resources to complete investigative duties limited the progress of this case. Other agencies could have provided valuable resources to assist with the identification of witnesses, evidence collection, crime scene documentation, and other critical tasks that needed immediate attention in the early stages of the investigation.

Recommendation 14.1: The APD should not only accept assistance where appropriate but should invoke assistance from other agencies early in major investigations to maximize resources to support the response and continued service across the region. Other agencies could have provided resources to assist with the identification of witnesses and other critical tasks that needed immediate attention in the early stages of the investigation. The APD should partner with other Humboldt County agencies in their major incident response team protocol. These relationships and protocols should be established and practiced prior to major incidents so that agencies have situational awareness of the resources available to them. Roles, responsibilities, and resource allocation should be formally agreed upon, defined, and exercised regularly.

Recommendation 14.2: All public safety agencies in the region should sign and adhere to the provisions within the Humboldt County Major Crimes Investigation Team Memorandum of Understanding. All public safety agencies in the region should sign on to this policy and be provided the resources, training, supervision, and a budget necessary to ensure a successful implementation. Management oversight of this protocol should be monitored and evaluated at the executive level of the Humboldt County Law Enforcement Executive Leadership group. Executive level commitment to adhere to the policies, once formalized, is necessary to ensure readiness on behalf of all Humboldt county law enforcement agencies in preparation for unanticipated major incidents. The stark reality is that major incidents can and do occur anywhere and law enforcement needs to prepare.

Lesson Learned 15: Lack of collaboration and coordination between the APD and the HCDA Office negatively impacted the case review. The decision to file charges in this case, within days of the incident and without proper coordination, resulted in the Superior Court of Humboldt County ruling there was insufficient evidence presented by the prosecution to support the homicide charges. This result may have been mitigated with a closer review by both agencies. Strained relationships between the HCDA Office and the APD highlighted the continued need for improved communication and coordination between the two agencies.

Recommendation 15.1: The APD should consider the development of a case management protocol with the HCDA Office to provide a critical case review before a case is filed. This type of review did not occur between agencies during the homicide investigation. Cooperation between law enforcement and the DA is critical in major incidents. Major investigations continue long after a department submits an investigation for prosecution. Numerous contributing factors influence the successful outcome of an investigation that can be better served with early involvement of the DA. The judicial process in major cases is long and time-consuming. The APD continues to experience investigative difficulties in this case due to decision-making that occurred early in the response to, and investigation of, this

incident. The opportunity to resolve issues at an early stage can be beneficial for all as the process moves forward.

Public Information and Support Services

During high profile incidents, law enforcement agencies face a delicate balance between informing the public about what is taking place, protecting victims and officers, and ensuring the integrity of the response.¹⁵⁶ In the aftermath of the homicide of Josiah Lawson, misinformation and misperceptions have been pervasive, particularly around the actions and intent of emergency service responders from the APD and AFD. The rumors of APD and AFD inaction spread through the HSU student body and the community over the next 72 hours and continue to go unchecked.

In contrast, the review of the video footage supports the APD and AFD account of their significant efforts towards saving Josiah Lawson's life. MAV audio recording indicates that the AWC and second officer on scene engaged in both CPR and efforts to control the bleeding for approximately four to five minutes until the firefighter paramedic team arrived and took over.¹⁵⁷ Once the fire truck arrived, fire personnel were seen on the MAV immediately running from their vehicles with their equipment into the area where Josiah Lawson was found.¹⁵⁸ Audio from the MAV recorders indicated that APD officers and AFD firefighters provided life-saving efforts at the scene while being circled closely by people watching.¹⁵⁹

While APD and AFD personnel were attending to the victim, other first responders appropriately attended to the suspect and attempted to manage the crowd, enabling the others to attend to the victim. The first officer on scene arrested and remained in the proximity of the detained suspect throughout the incident to ensure the suspect's safety in a situation with heightened tensions. After AFD paramedics arrived, the APD AWC and a second officer on scene engaged in crowd control efforts to prevent possible interference in lifesaving efforts and called for backup from other agencies when needed.

Family Notification and Support

Misinformation around the public safety response to the homicide of Josiah Lawson also complicated relations with family members of the victim, immediately after the incident and since. After the incident, although APD and AFD members provided first aid to the victim, friends of the victim told his mother that officers failed to provide first aid. The victim's mother was inaccurately told by then-Chief Chapman shortly after her son's death, that the delay in the fire and ambulance response was due to them staging outside the area until officers felt it was safe for them to enter. Although one initial CAD entry noted that fire would be staging, the review of the NPF assessment team indicated that, upon dispatch, AFD members responded directly to the scene and immediately ran to Josiah Lawson's side without staging. Furthermore, the AFD captain saw the seriousness of

¹⁵⁶ Straub, F., et al. (2017). *Rescue, Response, and Resilience*.

¹⁵⁷ Second arriving officer MAV recording, 5:50-9:50.

¹⁵⁸ Firefighter arrival was recorded at approximately 7:46 on the first arriving officer's MAV.

¹⁵⁹ Second arriving officer MAV recording, 5:50-10:00.

the victim's injuries as APD officers were conducting CPR and directed the victim be moved from under the bushes to a surface and location more conducive to rescue efforts. The captain directed the ambulance to "load and go" after the attempt to use an AED device because they recognized the severely injured victim required immediate transport to the hospital in order to facilitate the best chance to save his life. Thus, misinformation without immediate correction from the APD enabled those on social media and other platforms to influence the public narrative around the response, portraying the first responders to the incident as uncaring and unprofessional.¹⁶⁰ These allegations and questions around the first responders actions and intentions have continued since the incident.¹⁶¹

Uncoordinated support services provided to the victim's family after the initial death notification further complicated relations with the family. Mrs. Lawson was initially advised of her son's death by his girlfriend. The AWC made the formal police department notification to the victim's mother by phone early that morning while at the hospital. The then-APD chief and city manager quickly contacted the victim's mother offering condolences and tried to provide helpful information to her as the case progressed. Both were thrust into the role of serving as the department liaison to the Lawson family for the first time. With the best of intentions, both made themselves available to the grieving family. This was not necessarily their administrative role, nor their area of expertise and their efforts were uncoordinated; each had a different understanding of the status of the case and what could be shared with the family. Release of information was inconsistent, contributing to the sense of confusion that led the victim's mother to believe she was being purposely misled, and resulted in a loss of trust in the chief. The HCDA Office followed their victim/witness coordination protocol, and staff met and provided services to the victim's mother upon her arrival in Humboldt County five days after the incident.

Public Information

After the incident, the then-APD chief heard from a variety of sources informing him of the criticisms being leveled against his staff. Several HSU staff advised him soon afterward that the emphasis of the story was now focused on the APD response and not on the suspect and circumstances of the encounter. The AFD chief also heard criticism from the local HSU Lumberjack newspaper.

The former APD chief chose not to respond publicly to the concerns being raised. He felt he had a strong relationship with the university and the community and thought people would understand that the allegations were so outrageous no one would believe them. The chief indicated during interviews with the NPF assessment team that, in retrospect, he was not prepared for the criticism to continue to focus on him and the department. The chief continued, "I thought the trust in our community would know the allegations being made were inaccurate. We were great at not addressing our side. I'd never seen anything like this. We didn't think things would continue to escalate."¹⁶² The chief was asked by several other leaders to respond publicly to the criticism. He

¹⁶⁰ Mann, P. (2017, April 26). Eyewitness alleges police, EMT racism.

¹⁶¹ Hamlin, C. (2018, April 12). Justice for Josiah: HSU Students Lead Powerful Protests For Slain Black Classmate. *NewsOne*. Retrieved from <https://newsone.com/3792358/justice-for-josiah-lawson-humboldt-protest-case-stabbing-death/>

¹⁶² NPF assessment team interview with former chief, APD, August 15, 2018.

declined, thinking, “it will go away.”¹⁶³

The failure to respond to criticism, unfortunately, has contributed to the spread of misinformation that went unchecked. A videotaped interview of a witness by a local news channel was aired and later posted on YouTube alleging officers did not help the victim.¹⁶⁴ Individuals present at the scene have alleged that the APD’s initial response and the actions taken by law enforcement and emergency responders at the scene were inadequate.¹⁶⁵ In media articles, and other public statements, some have questioned the proficiency and motivation of the responding officers and of the subsequent investigation of the incident.¹⁶⁶ In addition, some in the community allege that the first aid and lifesaving efforts conducted by the first arriving officers were insufficient.¹⁶⁷ Friends and family members of the victim also allege that the response by paramedics and the ambulance was delayed due to the victim's race.¹⁶⁸

The misinformation and allegations of bias have continued to foster distrust of the APD by some members of the Arcata community. Errors in the APD’s investigation of the case have additionally contributed to this distrust. Following the preliminary hearing, the community criticized the management of the crime scene and the subsequent investigation conducted by the APD. The suspect’s release from custody brought additional concerns by family and friends about the management of the investigation by the APD.

Feelings of distrust among community members continues to hamper the ability of the APD to investigate and solve this case, perhaps even discouraging community members who may have information relevant to the case from coming forward. These enduring challenges demonstrate the need for the APD to consistently cultivate community trust, actively counter false narratives, and take proactive steps to rebuild trust and community relations.

Lessons Learned and Recommendations

Lesson Learned 16: The APD was unprepared to provide support services to the victim’s family following this incident. While the Arcata city manager and then-APD chief attempted to provide support to the victim’s family, they were not prepared through training, experience, or authority to do so.

Recommendation 16.1: The APD should designate a family liaison and coordinate efforts in conjunction with established victim/witness resources staff located within the HCDA

¹⁶³ Ibid.

¹⁶⁴ YouTube. (2017, April 18). HSU: David Josiah Lawson Stabbing Death.

¹⁶⁵ Did police and EMT response contribute to Humboldt State student’s death. (2017, April 27). *Bay View*. Retrieved from <https://sfbayview.com/2017/04/did-police-and-emt-response-contribute-to-humboldt-state-students-death/>

¹⁶⁶ “We need to talk about the murder of HSU student Josiah Lawson.” (2018, March 30). *AfroPunk*. Retrieved from <https://afropunk.com/2018/03/need-talk-murder-hsu-student-josiah-lawson/>

¹⁶⁷ Mann, P. (2017, April 26). Eyewitness alleges police, EMT racism.

<https://www.scribd.com/document/346236699/MadRiverUnion-4-26-17edition-reviSED>

¹⁶⁸ Burns, R. (2017, April 19). ‘He Was the One’: Josiah Lawson, Humboldt State Student and President of Brothers United, Remembered at Campus Prayer Service. *Lost Coast Outpost*. Retrieved from <https://lostcoastoutpost.com/2017/apr/19/prayer-service-david-josiah-lawson/>

Office. Victim/Witness assistance services are housed and coordinated through the HCDA Office. The APD's designee should coordinate roles and responsibilities for information sharing with the investigative supervisor and those specialized services. This case illustrated the need for departments to designate family liaisons and support services as quickly as possible and to keep information lines open throughout the life of the investigation.

Recommendation 16.2: The APD should research and identify specialized support resources within the community for victims and their families in the aftermath of a traumatic event. For example, a comprehensive list of support resources to share with victims and their families following traumatic events would provide them with the ability to quickly reach out to services. An opportunity exists for the APD to develop a robust chaplaincy referral network to be available to families when needed. Having a comprehensive list of clergies, mental health providers, and university counselors that can be available to victims and their families should be part of the standard response to traumatic events.

Lesson Learned 17: APD officers demonstrated a primary focus on lifesaving measures for the victim and the arrest of the suspect in the interest of public safety. Allegations have been made questioning first responding officers' compassion for the victim and their willingness to provide aid.¹⁶⁹ Their actions have been described in the media and by some in the community as 'lackluster and uncaring.'¹⁷⁰ A videotaped interview of a witness by a local news channel that was aired and later posted on YouTube alleged that officers did not help the victim.¹⁷¹ Despite these narratives, review of audio and video evidence from police cars at the scene by the NPF assessment team, as well as independent statements and reports of arriving police and fire department personnel do not support, and could dispel, these accounts. Audio and video evidence, as well as interviews with witnesses, indicate that the initial actions by first responders demonstrated an appropriate focus on lifesaving measures and public safety. The NPF assessment team found that the initial arriving officers made remarkable efforts to fulfill law enforcement's primary mission—to provide immediate life-saving efforts and first aid to the victim and arrest the suspect identified by witnesses at the scene—in the interest of public safety.

Recommendation 17.1: The department should clearly and publicly recognize first responders' efforts made on scene to save the victim's life. While organizational deficiencies contributed to a number of failures during the response and investigation, first responders on-scene executed their duty to attempt to save the victim and keep the scene safe to the best of their ability. In addition, the AWC showed strong leadership skills in the initial response and attempts to save the victim, a commitment to public safety, and compassion to all involved under difficult circumstances.

¹⁶⁹ Did police and EMT response contribute to Humboldt State student's death? (2017, April 27). *Bay View*. Retrieved from <https://sfbayview.com/2017/04/did-police-and-emt-response-contribute-to-humboldt-state-students-death/>

¹⁷⁰ Mann, Paul. (2017, April 26). Eyewitness alleges police, EMT racism. Retrieved from <https://madriversonion.com/eyewitness-alleges-police-emt-racism-2/>

¹⁷¹ YouTube. (2017, April 18). HSU: David Josiah Lawson Stabbing Death. Retrieved from <https://www.youtube.com/watch?v=CkfOnGgmBU>

The APD should clarify the record regarding the lifesaving measures of public safety personnel on scene. New leadership in the APD has brought a renewed sense of urgency to bring this case forward. Correcting the misperceptions regarding the response of Arcata police and fire personnel on the night of April 15, 2017, and acknowledging lessons learned from the response and investigation, can serve to assist city leadership and members of the community to encourage potential witnesses to come forward.

Lesson Learned 18: The then-APD chief did not provide coordinated, accurate incident information, nor did he correct misinformation spreading among community members. The then-APD chief also did not proactively counter the media narrative around the case.

Recommendation 18.1: The APD should work to develop processes and protocols to allow as much current and accurate information known to be made available to the family and the community, with appropriate limits. With careful consideration to withhold sensitive investigative information and information that could jeopardize a case, agencies should be prepared to share information with the public to dispel rumors and engage with their communities. Various agencies involved should also coordinate on the appropriate response to avoid competing and confusing messages. Following the 2016 attack on the Pulse nightclub in Orlando, Florida, public information officers (PIOs) from multiple responding agencies and city and state stakeholders coordinated with each other to determine the appropriate media strategy toward a unified message.¹⁷² Their cohesive messaging during and after the response to the incident helped to dispel inaccurate information while successfully keeping the public informed.

Recommendation 18.2: The department should develop a social media presence and designate a member(s) of the department to be responsible for public information, to share public safety and general departmental messages when possible and appropriate. Opportunities to build trust and restore confidence in the department were missed in the decision not to address media concerns and conflict. The strategy to remain silent in the face of intense scrutiny is rarely effective in 21st century policing communications. Rumors and innuendo rapidly take hold and spread, which allows those without the facts to control the narrative of the incident. This not only creates confusion, but also allows fear to spread and in highly charged incidents can jeopardize the safety of officers and the public. In Minneapolis, Minnesota;¹⁷³ Charlotte, North Carolina;¹⁷⁴ and Ferguson, Missouri, information similarly spread and went unchecked during mass demonstration incidents.¹⁷⁵

¹⁷² Straub, F., et al. (2017). *Rescue, Response, and Resilience*.

¹⁷³ Straub, F., H. Aden, J. Brown, B. Gorban, R. Monroe, and J. Zeunik. (2017). *Maintaining First Amendment Rights and Public Safety in North Minneapolis: An After-Action Assessment of the Police Response to Protests, Demonstrations, and Occupation of the Minneapolis Police Department's Fourth Precinct*. Washington, DC: Office of Community Oriented Policing Services. Retrieved from <https://www.policefoundation.org/wp-content/uploads/2017/03/Maintaining-First-Amendment-Rights-and-Public-Safety-in-North-Minneapolis.pdf>

¹⁷⁴ Straub, F., J. Brown, R. Villaseñor, J. Zeunik, B. Gorban, B. Norton, and E. Reyes. (2018, February). *Advancing Charlotte: A Police Foundation Assessment of the Charlotte-Mecklenburg Police Department Response to the September 2016 Demonstrations*. Washington, DC: Police Foundation. Retrieved from <https://www.policefoundation.org/publication/advancing-charlotte-a-police-foundation-assessment-of-the-charlotte-mecklenburg-police-department-response-to-the-september-2016-demonstrations/>

¹⁷⁵ Institute for Intergovernmental Research. (2015). *After-Action Assessment of the Police Response to the August 2014 Demonstrations in Ferguson, Missouri*. Washington, DC: Office of Community Oriented Policing Services. Retrieved from <https://ric->

The narrative cultivated fertile ground for additional fear, anger, and confusion to flourish in these incidents—and for escalation to continue. The era of social media requires departments to be engaged in a new level of information sharing. These platforms need to be a part of every organization’s communication strategy, particularly one serving a large population of young people.

Furthermore, the connection to social media outlets can be an essential source of information, assisting law enforcement agencies in community outreach and investigative objectives.¹⁷⁶ The APD should proactively develop a more comprehensive media relations protocol and policy that is actively engaged with social media platforms. Collateral responsibilities can be assigned to interested officers to serve as PIOs. Such a plan can be helpful in efforts to bring investigations to closure through outreach and engagement with the community and to witnesses who have been reluctant to come forward with information.

The department should consider developing a collateral social media outreach team. The team should be comprised of sworn and civilian personnel. Such a program has an additional benefit associated with recruitment and retention of staff by providing broader opportunity to participate in innovation and building a model that advances community outreach showcasing the organization.

Recommendation 18.3: The APD should research and take advantage of opportunities to leverage external expertise in communications to build internal APD capacity in public relations and communications strategies. Many agencies have begun outreach to specialized communications strategists. The California Police Chiefs Association (Cal Chiefs) offers referrals to such expertise for agencies facing high impact, low-frequency incidents such as this.¹⁷⁷ Cal Chiefs has also offered regional training for chiefs and their seconds in command to help develop a communications strategy, including for crisis communications.¹⁷⁸ Chief Chapman advised that he contacted a California Police Chief’s Association media consultant regarding his case. As the International Association of Chiefs of Police has highlighted, a department’s public relations strategy should be proactive, carefully planned, and involve the right personnel.¹⁷⁹ Given the importance of messaging during crisis communications, involving key personnel and communications professionals, such as a collateral APD communications team made up of supervisors and officers trained in media relations can be beneficial to ensure appropriate messaging.¹⁸⁰ The APD should take

zai-inc.com/Publications/cops-p317-pub.pdf

¹⁷⁶ Law Enforcement Policy Center. (2019, May). *Considerations Document: Social Media*. International Association of Chiefs of Police.

¹⁷⁷ For more information, see: California Police Chiefs Association. (n.d.). Free Crisis Communication Consulting Service for Chiefs. Retrieved from

<https://www.californiapolicechiefs.org/assets/crisis%20communications%20consulting%20service-use%20this.pdf>

¹⁷⁸ California Police Chiefs Association. (n.d.). Having a Communication Strategy that Works in Your Community. Retrieved from <https://www.californiapolicechiefs.org/regional-communication-training>

¹⁷⁹ Parker, J. (2019). Hiding and Hoping is Not a PR Strategy. *Police Chief*. Retrieved from

<https://www.policechiefmagazine.org/hiding-and-hoping-is-not-a-pr-strategy/>

¹⁸⁰ Ibid.

the opportunity to research these and other communications opportunities and strategies and apply them to APD policy and operations.

Recommendation 18.4: The APD should consider policies that improve transparency by sharing mobile auto video (MAV) and body worn camera (BWC) video with the public as soon as is appropriate. The release of police video footage is a complex evolving issue particularly during response to major or high-profile incidents. The decision to release footage should be evaluated in the context of the benefits that the release of specific footage would have on advancing public trust by correcting misperceptions regarding officer conduct against the harmful effects the release could have on the investigative process. Consultation with the DA's Office should always precede any release of footage during an active investigation. Each case should be evaluated based upon the circumstances. The APD and the HCDA Office should share the rationale for their decision with the community. The APD may be able to improve their relationship in building trust within the community through this process.

As BJA's *Body-Worn Camera Toolkit* explains, "video and audio recordings from BWCs can be used by law enforcement to demonstrate transparency to their communities."¹⁸¹ The fact that the APD deploys MAV and BWCs affords it the ability to share the conduct of their officers with the community. BWCs may support the professionalism of their staff.¹⁸² Conversely, when misconduct is observed, it should be acknowledged and corrected by the APD and the department should be transparent with the investigation and disciplinary process within the guidelines of emerging California Statutes.

Community-Police Relations and Trust in Arcata

Strong relationships between the police and the community are critical to supporting public safety. As the U.S. Department of Justice has noted, mutual trust is necessary, as law enforcement agencies rely on community members to provide information about crime in their area and work with the police to address public safety issues.¹⁸³ In Arcata, the homicide of Josiah Lawson has further distanced community members and the police.

Arcata Demographics and Community Perceptions

The City of Arcata and its residents have had a complicated relationship with changing demographics and perceptions of race that have created divisions within the community. NPF assessment team interviews and open source media indicate that some in the Arcata community have perceived an increase in African American residents over recent years, largely driven by shifts in HSU demographics.

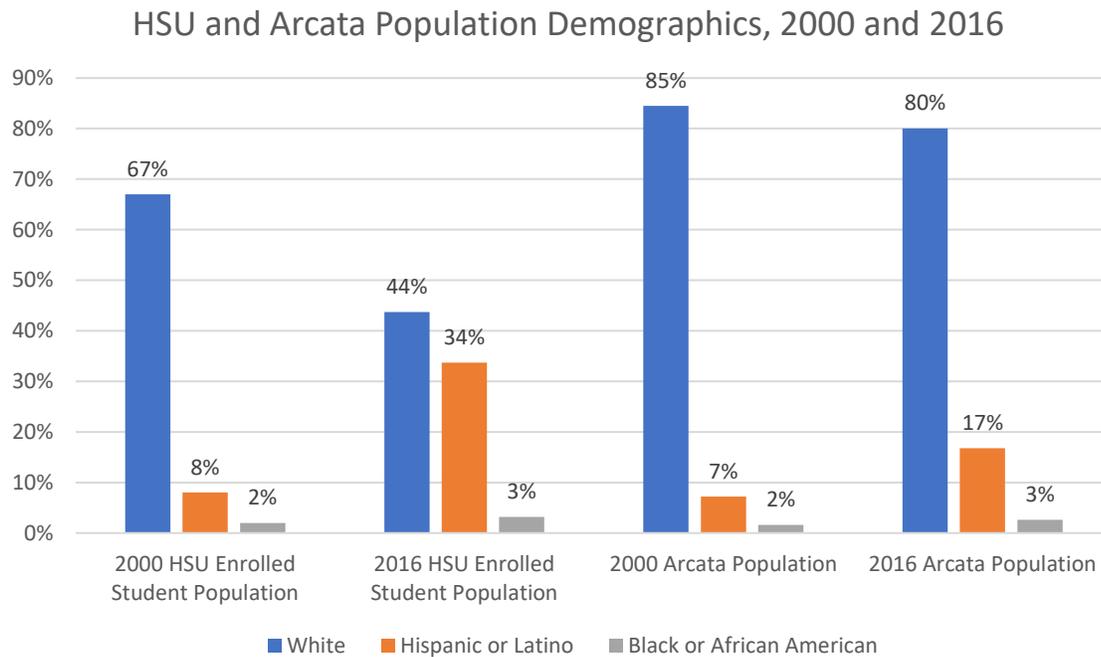
¹⁸¹ Bureau of Justice Assistance. (2015). *Body Worn Camera Toolkit: Body-Worn Camera Frequently Asked Questions*. Retrieved from https://www.bja.gov/bwc/pdfs/BWC_FAQs.pdf

¹⁸² Ibid.

¹⁸³ U.S. Department of Justice. (n.d.). *Importance of Police-Community Relationships and Resources for Further Reading*. Retrieved from <https://www.justice.gov/crs/file/836486/download>

However, as Figure 7 shows, from 2000 to 2016, while the City of Arcata’s population did have a marginal increase in the number of African American residents, the city remains predominantly white. Furthermore, much of the shift in demographics at HSU and within the City of Arcata has been the result of an increase in the Hispanic or Latino population rather than the black or African American population.

Figure 7: HSU and Arcata Population Demographics, 2000 and 2016



Note: HSU enrolled student population demographics are shown as a percentage of the total HSU enrolled student population during each year shown. Arcata population demographics are shown as a percentage of the total Arcata population during each year shown.

Sources: American Factfinder. ACS Demographic and Housing Estimates: Arcata city, California, retrieved from <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>; Greenson, T., Recruit Then Retain: Who’s coming to HSU and too many aren’t staying, *North Coast Journal*, retrieved from <https://www.northcoastjournal.com/humboldt/recruit-then-retain/Content?oid=5864208>; Data USA, Humboldt State University, retrieved from <https://datausa.io/profile/university/humboldt-state-university/>

University Community Police Relations

Like many other cities across the U.S., the Arcata community had been engaged in discussions around police-community relations—especially with diverse communities—based on incidents that occurred nationwide, particularly in Ferguson, Missouri; Baltimore, Maryland; New York City; and, Charlotte, North Carolina, prior to the homicide of Josiah Lawson. In acknowledgement of issues of racial equity and inclusion prior to April 2017, the City of Arcata and HSU developed programs focused on addressing racial equity and inclusion in Arcata. HSU has held Campus and Community Dialogue on Race events for 20 years. These week-long events are designed for student, faculty, staff, and community members to present and attend programs related to racial justice. Students can earn a unit of college credit for their participation.¹⁸⁴ On October 6, 2016, HSU hosted a Black

¹⁸⁴ Humboldt State University. (n.d.). Campus & Community Dialogue on Race. Retrieved from <http://dialogue.humboldt.edu/>

and Blue Dialogue forum to specifically discuss race and policing, police de-escalation, and racism on campus. The forum hosted a 13-person panel including the APD chief, the Eureka Police Department chief, HSUPD chief, members of the African American Center for Academic Excellence, and campus faculty.¹⁸⁵ Just two days before the forum, HSU President Lisa A. Rossbacher, acknowledged that, "members of our University community had been subjected to racial bias as well as racially motivated acts of violence."¹⁸⁶

This information provides important context to the environment that existed on April 15, 2017. Despite efforts by the City and its police department to engage in dialog to improve community relationships, those efforts did not curb the volatility of distrust that was enlivened in the days and months following. Existing tensions within the Arcata community, including between newly arriving HSU students and long-time residents, prior to the incident created challenges around the incident response and subsequent community healing.

Perceived Bias

The homicide of Josiah Lawson, allegedly by a white man at a local party, and the public safety response to the incident, deepened perceptions of racial bias and distrust of the local police by some in the community. While it is clear to the NPF assessment team, upon review of all available audio, video, and other materials, that the chaotic scene did not interfere with lifesaving efforts conducted by first responders, perceptions of inaction created challenges for police, fire, and hospital staff during the response to this incident. These perceptions and misinformation cultivated chaos at the scene of the stabbing and at the hospital, provided fertile ground for false narratives and lack of communication regarding APD's response to the incident, and created an environment that may have discouraged witnesses and others with factual information from coming forward with information. The narrative about the incident has also enlivened the emotions and perspectives of racial bias in the community in a way that continues to challenge healing.

Recognizing the importance of race in this incident, and its continued impact on the community, the NPF assessment team was made aware of local media reports and statements—along with anecdotal assertions—of mistreatment of people of color by members of the APD prior to and in the aftermath of the homicide of Josiah Lawson. The NPF assessment team searched for reports or complaints of racial bias that were formally reported to or investigated by the APD and found none. Many residents express support for and trust in the men and women of the APD. Former Chief Chapman relied on this perception of broad community support as his rationale for not responding directly to the criticism that grew about the conduct of APD staff in this case. Still, the fact that the APD had no documented hate crime reports for that period and had no allegations of bias in the conduct of their officers is not indicative of the feelings expressed by some students and other community members both prior to and after the homicide of Josiah Lawson. The NPF assessment team did not conduct follow up into any of the anecdotal allegations of bias as they were outside

¹⁸⁵ Rojas, J. (2016, October 7). Starting the conversation: HSU forum focuses on race, police. *North Coast Journal*. Retrieved from <https://www.northcoastjournal.com/NewsBlog/archives/2016/10/07/starting-the-conversation-hsu-forum-focuses-on-race-police>

¹⁸⁶ Hubel, S. (2016, October 17). #POCNORMHSU: Students respond to ignorant letter from university president. *Odyssey*. Retrieved from <https://www.theodysseyonline.com/pocnormhsu>

the scope of this review.

Lessons Learned and Recommendations

Lesson Learned 19: The APD must re-commit to a culture of community policing. Police departments who view every interaction with the community through a lens of procedural justice take steps toward securing legitimacy in the police and can begin to partner with the community to improve public safety. As the U.S. Department of Justice 2015 President’s Task Force on 21st Century Policing has noted,

“Building trust and nurturing legitimacy on both sides of the police/citizen divide is the foundational principle underlying the nature of relations between law enforcement agencies and the communities they serve. Decades of research and practice support the premise that people are more likely to obey the law when they believe that those who are enforcing it have authority that is perceived as legitimate by those subject to the authority. The public confers legitimacy only on those whom they believe are acting in procedurally just ways. In addition, law enforcement cannot build community trust if it is seen as an occupying force coming in from outside to impose control on the community. Pillar one seeks to provide focused recommendations on building this relationship. Law enforcement culture should embrace a guardian – rather than a warrior – mindset to build trust and legitimacy both within agencies and with the public. Toward that end, law enforcement agencies should adopt procedural justice as the guiding principle for internal and external policies and practices to guide their interactions with rank and file officers and with the citizens they serve. Law enforcement agencies should also establish a culture of transparency and accountability to build public trust and legitimacy. This is critical to ensuring decision making is understood and in accord with stated policy.”¹⁸⁷

Recommendation 19.1: The APD must renew and continue efforts to build open and trusting relationships throughout all segments of the Arcata community and specifically with people of color. Organizational engagement efforts should be established as part of the overall culture within the APD, as opposed to singular events and programs. Weaving community into the fabric of the organization is beyond the capacity of the chief to engage in solely. The department should embrace the philosophy that community engagement is the responsibility of every member of the agency, and that it is integral to successful public safety in Arcata.

Trust-building cannot be built in a vacuum and cannot be sustained through one, or even a series of, engagement events or activities. Rather, it is a systemic process that is part of the culture of the police department and includes ongoing efforts on the part of APD to request community involvement, productive responses from the department on community concerns, ongoing evaluation of community sentiment and follow-through and feedback

¹⁸⁷ President’s Task Force on 21st Century Policing. (2015). *Final Report of the President’s Task Force on 21st Century Policing*. Washington, DC: Office of Community Oriented Policing Services. Retrieved from https://cops.usdoj.gov/pdf/taskforce/taskforce_finalreport.pdf

from APD back to the community on how community input is used to develop and change departmental policy.¹⁸⁸

As a Policing Project report on police-community engagement found, there are multiple opportunities for police departments to build community trust including hosting community meetings, using social media, and engaging the public to weigh in on department policies and procedures.¹⁸⁹ Similarly, the U.S. Department of Justice, Office of Community Oriented Policing Services identifies collaborative partnerships between law enforcement agencies and communities as a key to increase trust in police.¹⁹⁰ Ongoing efforts, reevaluated over time, are necessary to develop these partnerships and build trusting relationships throughout the community.

Recommendation 19.2: The APD should train and implement the principles of community policing, procedural justice, implicit bias, and police legitimacy. Promoting a culture of community policing and engagement within APD requires that all personnel are trained on relevant principles and philosophies.¹⁹¹ Community policing is a concept, supported by evidence, that describes a way to strengthen community police relationships. Community policing is defined as a philosophy adopted by every member of an organization that promotes organizational strategies that support the systematic use of partnerships and problem-solving techniques to proactively address the immediate conditions that give rise to public safety issues such as crime, social disorder and fear of crime.¹⁹²

Recommendation 19.3: Community engagement should be part of the agency's performance evaluation process, using data and metrics to evaluate both overall organizational health in this area, as well as officer performance. These metrics should be included as prerequisites for promotion. Incorporating community perspectives into department metrics can enable law enforcement to measure progress toward a variety of indicators beyond crime enforcement while creating a mechanism for community members to actively collaborate with law enforcement in the co-production of public safety.¹⁹³

The chief should make a practice of routinely reviewing the agency's and officers' performance to ensure community members are treated fairly. Such efforts should be recognized and celebrated throughout the organization. The department should also consider non-traditional means of evaluation. In addition, the chief and command staff should be routinely looking at departmental data on various indicators to make sure they are aware of any information regarding engagement of community that could be cause for

¹⁸⁸ Ibid.

¹⁸⁹ *Beyond the Conversation: Ensuring Meaningful Police-Community Engagement*. (2018). New York, NY: Policing Project. Retrieved from <https://www.policingproject.org/beyond-the-conversation-report>

¹⁹⁰ *Community Policing Defined*. (2014). Washington, DC: Office of Community Oriented Policing Services. Retrieved from <https://ric-zai-inc.com/Publications/cops-p157-pub.pdf>

¹⁹¹ National Initiative for Building Community Trust & Justice. (n.d.). Implicit Bias. Retrieved from <https://trustandjustice.org/resources/intervention/implicit-bias>

¹⁹² US Department of Justice. *Community Policing Defined*. Retrieved from <https://cops.usdoj.gov/RIC/Publications/cops-p157-pub.pdf>

¹⁹³ CompStat360. (n.d.). Welcome to CompStat360. Retrieved from <https://www.compstat360.org/#learnmore>

alarm, as well as ways to recognize individual efforts in this area.

Recommendation 19.4: The APD should examine and engage in ways to regularly gauge community sentiment and opinions of the department’s performance, such as through community surveys. Community surveys and other similar means of collecting community feedback, conducted regularly, can help agency leaders to assess their department from multiple perspectives. The NPF-administered National Law Enforcement Applied Research and Data Platform (“the Platform”) offers law enforcement agencies community surveys, which are intended to measure their community’s perceptions of the department and police-community interactions. The Platform provides an opportunity for agencies to benchmark their results against departments of similar size, and geographic location. Agencies can use the survey data to inform their internal operations and their community outreach and engagement strategies.¹⁹⁴

Lesson Learned 20: Although the APD has a positive relationship with many in the university community, more can be done to work with students and faculty—particularly those who have reported perceptions of disparate treatment.

Recommendation 20.1: The department should engage the Arcata and HSU communities regarding the APD policy on fair and equitable policing and work to improve transparency, reporting, and investigations of violations of that policy. Additionally, the department should develop a process to communicate the results of investigations to the public as part of efforts to build trust. Regular community forums and dialog can provide opportunities to bridge gaps. The restoration of trust is a long term and ever-evolving process.

Recommendation 20.2: The APD should develop internship programs with HSU and the College of the Redwoods. Opportunities exist to initiate APD internship programs with students, which can be valuable to building relationships with the community, gain broader community perspective, and open opportunities for recruitment. An open house with the APD and ride along programs can similarly be valuable recruiting tools, in addition to building mutual respect between officers and the public. Many agencies have developed more informal programs to connect the department with the community including social engagements.

¹⁹⁴ National Police Foundation. (2019). National Law Enforcement Applied Research & Data Platform. Retrieved from <https://www.nationallawenforcementplatform.org/>

Conclusion

A Path Forward

The City of Arcata retained the services of the National Police Foundation (NPF) to analyze the Arcata Police Department (APD) response to the homicide of Josiah Lawson on April 15, 2017, and the subsequent investigation. The review revealed that while Arcata first responders operated remarkably in their lifesaving efforts, responding APD officers had limited experience and training in securing chaotic events and no experienced supervisor was available to provide direction. The department lacked the availability of an experienced evidence technician to assist with processing the crime scene and collecting critical evidence appropriately. The department also did not deploy sufficiently trained personnel with appropriate oversight, nor request such mutual aid support, to manage the initial crime scene management, evidence collection, identification of witnesses, and other critical investigative tasks.

In addition, while the APD currently dedicates resources to relationship-building with the community, more can be done. Relationship-building efforts and communication between the police and all segments of the community are valuable to develop a foundation of trust, counter misinformation, and support information gathering prior to and following a critical incident. While members of the APD are well-regarded in much of their community, renewed commitment to building a broader sphere of trust beyond their existing support network is a worthy endeavor. Some steps to do this include initiating positive non-enforcement activities to engage communities that typically have high rates of investigative and enforcement involvement with government agencies, tracking and analyzing the level of trust communities have in police, and creating a workforce that encompasses a broad range of diversity to improve understanding and effectiveness in dealing with all communities.¹⁹⁵ References to specific opportunities directly related to the circumstances of this incident are included in this report, and the chief has already begun exploring new opportunities for further outreach.

The NPF assessment team acknowledges the forthrightness of current and former members of the APD to share their perceptions and experiences related to supporting this independent review process and providing an opportunity for others to learn from their actions. The APD's willingness to acknowledge shortcomings and the commitment to improving their performance throughout the highlighted areas of this review can serve as a demonstration to both the department and the community that the mistakes of the past will not be repeated. The commitment to conduct an in-depth review can also be an effective tool for APD leadership to advance overall organizational performance. Reinvestment in communications, training, adherence to a systematic chain of command, and a renewed sense of dedication to their mission can improve the APD's capacity to work with the Arcata and HSU community toward improved public safety and trust.

Incorporation of the lessons learned contained in this report can strengthen the APD's continual

¹⁹⁵ President's Task Force on 21st Century Policing. (2015). *Final Report of the President's Task Force on 21st Century Policing*. See also, US Department of Justice. *Community Policing Defined*. Retrieved from <https://cops.usdoj.gov/RIC/Publications/cops-p157-pub.pdf>

organizational development and work toward forging a path forward. The APD chief has an opportunity to institute a culture of ongoing evaluation of the department's performance—especially in critical incidents or unusual responses. This is how organizations grow, evolve, learn, and improve. Training must be provided for members at all levels of the department—including the chief—to ensure the department sets and maintains high standards adhering to national best practices. Arcata's leadership has begun this process of identifying deficiencies and working with police and city staff, university leadership, and the residents of Arcata to implement needed improvements. These efforts have great promise for the growth of the department that will support improved public safety in Arcata. As these advancements are made, it is the hope of the NPF assessment team then that the Arcata community will engage in this process and provide support and a renewed spirit of cooperation to build relationships and to bring this case to justice.

David “Josiah” Lawson

David “Josiah” Lawson came to Humboldt State University from the Southern California community of Moreno Valley in the fall of 2015. He was a nineteen-year-old sophomore at the time of his death.¹⁹⁶ Josiah Lawson was a Criminal Justice major with the goal of becoming a lawyer. He was keenly interested in the workings of the criminal justice system and was described by those who knew him as a caring and charismatic young man.¹⁹⁷ He was the president of a Humboldt State University club known as, “Brothers United,” a club that seeks to “assist and navigate towards graduation, maturity, and success through Brotherhood . . . through scholarship, philanthropy, fundraising, social events and to create a safe haven for all males in campus.”¹⁹⁸ Friends described him as being a natural leader; one statement from a friend described him as “the best of us all!”¹⁹⁹

The NPF assessment team’s condolences go out to Josiah Lawson’s family and friends on the loss of this young man. The NPF assessment team’s sincere hope is that both members of the Arcata community and the men and women of Humboldt County law enforcement remember the loss of this vibrant and promising young man and are motivated to renew their commitment to working together to bring this case to justice.

¹⁹⁶ Durham, J. (2018, September 21). Additional resources for Lawson case. *Mad River Union*. Retrieved from <https://madriverrunion.com/additional-resources-for-lawson-case/>

¹⁹⁷ NPF assessment team interview with family member of victim, October 23, 2018.

¹⁹⁸ Clubs & Activities. (n.d.). Humboldt State University. Retrieved from <https://clubs.humboldt.edu/categories/all-clubs>

¹⁹⁹ Witness statements related to the investigation of the homicide of Josiah Lawson, reviewed by the NPF assessment team, August 2018-March 2019.

Appendix A: Methodology

In May 2018, at the request of the City of Arcata, the National Police Foundation (NPF) assembled a team of subject matter experts with extensive experience in public safety incident response and investigations. From August 2018 through March 2019, the NPF assessment team conducted interviews; reviewed materials including incident reports, policies and procedures, and audio and video recordings from the night of the incident; examined open source media relating to the Arcata Police Department (APD) response to the incident and the investigation; researched national and international promising practices and resources; and, studied after-action reports from previous homicide incidents. Based on the analysis of this body of information, the NPF assessment team developed the lessons learned contained in this report.

The assessment approach involved four methods of information gathering and collection: (1) open source media review, (2) on-site data collection, (3) resource review, and (4) off-site data collection and research. Each method is described in more detail below.

Open Source Media Review

Throughout the life of the review, the NPF assessment team reviewed and referenced open source media. The assessment team read dozens of news articles, watched videos, and reviewed social media posts related to the incident. This review provided context for the assessment team's interviews, informed the report writing, and provided direction for additional research.

On-Site Data Collection

The NPF assessment team conducted site visits to Arcata, California. This included a visit to the scene at 1120 Spear Avenue, where the homicide incident occurred. During site visits, the assessment team conducted interviews with local and county personnel and community members. Individuals interviewed included the following:

- Arcata Police Department command staff, including the former chief of police, interim chief of police, current chief of police, and lieutenant and personnel at the scene;
- Humboldt State University (HSU) Police Department chief of police;
- Arcata Fire Department district chief and staff who responded to the scene;
- Arcata city manager;
- Humboldt County district attorney and chief investigator;
- Other Humboldt County law enforcement executives and personnel;
- Mother of the victim; and,
- Eureka Chapter NAACP representative.

Attempts were made to contact HSU Student Services staff including the interim dean of students and other HSU administrative personnel. They declined to return our calls requesting an interview.

Resource Review

The assessment team collected and reviewed APD policies, procedures, incident reports, relevant audio and video recordings, and other documents and materials provided by the APD. Each resource was reviewed to better understand the department's preparation, response, and investigation of the homicide incident. Materials reviewed included the following:

- Review of the 911 calls to Arcata Police Dispatch Center, Fire and EMS;
- Review of the Computer Aided Dispatch logs and response times;
- Review of the APD crime reports, crime scene photographs, crime scene diagrams, and audio and video recordings of all interviews with involved parties;
- Review of 2015 APD Homicide investigation report;
- Review of APD Internal Affairs Logs 2013 –2018;
- Review of APD Crime Statistics 2013 –2017;
- Review of APD Response Time statistics 2017, and 2018;
- Review of APD sworn officer roster with tenure;
- Review of APD Organizational Chart;
- Review of investigative consultant reports dated July 31, 2018, and August 1, 2018;
- Review of Interim Chief of Police's recommendations to City Manager memorandum dated August 2, 2018;
- Review of Investigative Updates/Task Log July 6, 2018 – August 8, 2018;
- Review of California Highway Patrol Incident Detail Reports (911 caller information);
- Review of autopsy report dated March 2, 2018;
- Review of audio and video recordings from APD mobile vehicle video and audio devices;
- Review of the Arcata Fire District Response report;
- Review of the police reports prepared by Humboldt State University Police Officers;
- Review of Humboldt County District Attorney Forensic Report;
- Review of California Department of Justice Bureau of Forensics Services Reports (dated August 2, 2017, February 22, 2018, March 23,2018);
- Review of California Department of Justice Bureau of Forensic Services, Eureka Regional Criminalistics Laboratory Field Investigations Report dated August 2, 2017;
- Review of State of California, Department of Justice Bureau of Technical Services Physical Evidence Submission Forms (dated June 26, 2018, and July 13,2018);
- Review of Mad River Community Hospital medical records and violence reporting forms;
- Review of State of California Certificate of Death;
- Review of court transcripts of the Preliminary Hearing held in Humboldt County Superior Court, May 5-8, 2017;
- Review of APD Lexipol Policies and Procedures;
- Review of the City of Arcata adopted budget proposals and personnel allocation;
- Review of the District Attorney's Memorandum of Understanding Humboldt County Major Crimes Investigation Team;
- Review of Humboldt County Sheriff's Department records related to the arrested subject.

Off-Site Data Collection and Research

In addition to the information collected from Arcata, and to ground the incident review in national standards, model policies, and best practices, the assessment team researched and reviewed the literature regarding incident response and homicide investigations. The team also conducted research in other relevant topics published by researchers from academia and from organizations including the following:

- U.S. Department of Justice
- International Association of Chiefs of Police
- Police Executive Research Forum
- National Police Foundation

Analysis and Application of Lessons Learned and Recommendations

The assessment team used the totality of the information available to them to conduct a gap analysis, which focused on identifying key areas to develop a set of lessons learned for the APD and the larger public safety field. The team began by reviewing APD policies and procedures for responding to and investigating homicide incidents. Based on this information as well as on recognized promising practices, the team produced a series of lessons learned for the response and investigation of future homicide incidents involving multiple parties and multiple witnesses. The lessons learned are not only intended for Arcata-area emergency response and investigative agencies, but also applicable to communities across the nation faced with responding to similar scenarios.

Appendix B: About the Assessment Team

Chief (ret.) Walter Tibbet retired as chief of the Fairfield Police Department in March 2015 after more than 40 years of law enforcement experience. He began his career in 1972 with the Alameda Police Department. In 1980, he joined the San Jose Police Department where he served for 26 years advancing through the ranks to captain. In July 2006, he returned to the Alameda Police Department as its chief of police. During his four years as chief, he restructured the department, increased efficiencies in departmental operations, and improved training opportunities for members of the department. He also enhanced the department's presence in the community through various outreach efforts. He was named chief in Fairfield in 2010. While a member of the San Jose Police Department, he completed a wide range of assignments in each of the department's four bureaus. He served as commander of various units within the department including the Special Operations Division's Narcotics Enforcement Team, the Gang Investigations Unit, Community Services Division, and the Bureau of Technical Services where he was charged with the implementation of emerging technologies throughout the department. He worked extensively in developing community and business collaborations and served as the co-chair of the mayor's Gang Prevention Task Force. Chief Tibbet was awarded the San Jose Police Department's Medal of Valor, a Hazardous Duty Award, and two city council commendations. He was also a recipient of the National Exchange Club's Blue and Gold Wounded in Service Award.

Chief Tibbet is a past chairman of the Solano County Law Enforcement Administrators Association, a board member for the California Police Chiefs Association and Fight Crime—Invest in Kids organizations, and an advisory board member for the Fairfield-Suisun Unified School District's Public Safety Academy.

He holds a M.S. in Counseling Psychology from California State University, Hayward, with an emphasis of study including Organizational Development, Cross-Cultural Consultation, and Substance Abuse prevention and treatment. He has a B.A. in Management from St. Mary's College of Moraga, California. Chief Tibbet is also a graduate of the FBI National Academy.

Vaughan Edwards' law enforcement career has spanned over 32 years serving with two agencies, the San Jose Police Department and the Santa Clara County District Attorney's Office. He has held a variety of assignments and received numerous promotions with increasing responsibilities. Mr. Edwards retired as captain of police – division commander from the San Jose Police Department in June 2010. His assignment as a division commander was multi-faceted and included geographical responsibility of police services and community issues for approximately 100 square miles of the City of San Jose, an urban/rural area with approximately 250,000 residents.

During his tenure as a police lieutenant, Mr. Edwards held the following three commands: investigations commander of the General Assaults, Juvenile, and Missing Persons Units, commander of the Santa Clara County Auto Theft Task Force, and commander of Patrol Watch. In addition to providing investigative and operational leadership as a Bureau of Investigations commander, Mr. Edwards oversaw the re-design of the department's Investigative Incident Command Center and the development of the Incident Command Tracking Database.

As a District Attorney's Office investigator, police sergeant, and police officer, Mr. Edwards was assigned to the following units: Office of the Chief of Police, Internal Affairs Unit, Homicide Investigations, Special Operations-MERGE (SWAT – Mobile Emergency Response Group and Equipment), Covert Investigations, Sexual Assault Investigations, Training Unit as an instructor, and Bureau of Field Operations. Mr. Edwards was also an instructor in Homicide Investigations and Internal Affairs Investigations for the San Jose State University Administration of Justice Bureau.

Mr. Edwards holds a Bachelor of Science degree from California State University, Long Beach. He is a graduate of the California Police Officers' Standards and Training Sherman Block Supervisory Leadership Institute as well as the California Police Officers Standards and Training Executive Command College.

About the National Police Foundation

The National Police Foundation is America's oldest non-membership, non-partisan police research organization. We were founded in 1970 by the Ford Foundation to advance policing through innovation and science. We integrate the work of practitioners and social scientists to facilitate effective crime control and the progress of democratic policing strategies. We have a wide breadth of projects throughout the U.S. and Mexico. Among other efforts, we conduct scientific evaluations of policing strategies, organizational assessments, critical incident reviews, police data projects and issue timely policing publications critical to practitioners and policymakers. We also have a strong interest in officer safety and wellness, preventable error in policing and helping policing enhance community trust and confidence, especially in the area of police use-of-force.



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