

Vancouver Police Department Taser Use Follow-Up Audit

Simon Demers, Audit Manager Vancouver Police Department

June 2009

Vancouver Police Department 312 Main Street Vancouver, British Columbia V6A 2T2

PR2009-1004 Taser Use Follow-Up Audit June 2009

This document is the property of the Vancouver Police Department and may contain proprietary or sensitive information. This document shall not be duplicated, disseminated, disclosed or reclassified without prior consent of the Vancouver Police Department. This document may be used by the authorized recipient solely for purposes related to law enforcement.

r8hqo430945

Table of Contents

<u>1</u>	EXECUTIVE SUMMARY	4
<u>2</u>	INTRODUCTION AND BACKGROUND	5
<u>3</u>	FINDINGS	6
	FINDING 1: COMPLIANCE WITH THE REPORTING POLICY HAS IMPROVED BUT TASER USAGE CONTINUES TO BE UNDER-REPORTED.	6
	FINDING 2: MEDICAL ATTENTION IS USUALLY PROVIDED IN ACCORDANCE WITH THE POLICY.	9
	FINDING 3: TASER SPARK TESTS ARE USUALLY CONDUCTED IN ACCORDANCE WITH INTERNAL TRAINING GUIDELINES.	10
	FINDING 4: TASER USAGE HAS DECLINED.	11
	FINDING 5: TASER DISCHARGES HAVE BECOME LESS COMMON.	11
	FINDING 6: TASER-RELATED PRIME REPORTS HAVE IMPROVED NOTICEABLY	12
<u>4</u>	CONCLUSION	14
<u>5</u>	APPENDIX – RPM POLICY 1.2.1	16

1 Executive Summary

1.1 In May 2009, the Audit Unit initiated a Taser Use Follow-Up Audit. The primary objective of the follow-up audit was to confirm that Taser usage continues to be tracked and monitored in accordance with the applicable VPD policies.

1.2 Although compliance with the Taser reporting policy improved between 2007 and 2008, Taser usage continues to be under-reported. Under-reporting by ERT reflects the fact that ERT maintains its own use of force records and downloads its own Taser data in-house after a Taser is discharged. This sometimes creates a gap in the use of force documentation held by the Force Options Training Unit because the CEW Coordinator is not always notified when a Taser is discharged by an ERT operator. The Force Options Training Unit and ERT have already taken steps to ensure that the Force Options Training Unit's CEW Coordinator is properly notified whenever a Taser incident occurs.

1.3 Although regular Taser spark tests appear to be conducted in accordance with internal training guidelines and Taser International's recommendations, no spark test was conducted before at least four incidents where a Taser was discharged. Taser operators should be reminded that a spark test must be conducted at the beginning of each shift or before a Taser is deployed in the field.

1.4 Taser usage has declined significantly in 2008 and preliminary data suggests it may decline further in 2009. As a proportion of all Taser incidents, Taser discharges have also become less common. This would be consistent with the idea that the Taser has progressively become a more effective deterrent and officers are therefore forced to use the Taser less often as a pain compliance tool or an incapacitation device.

2 Introduction and Background

2.1 In January 2008, the Audit Unit initiated a Use of Force Audit (PR2007-1001). The main purpose of the Use of Force Audit was to confirm that VPD members comply with all applicable laws, standards, policies and procedures related to use of force reporting and documentation. A draft audit report was presented to the audit stakeholders in August 2008 and the final audit report was accepted by the Executive Committee in October 2008.

2.2 In May 2009, the Audit Unit initiated a Taser Use Follow-Up Audit to confirm that Taser usage continues to be tracked and monitored in accordance with the applicable VPD policies. The follow-up audit focused specifically on the Taser because the Use of Force Audit showed that the beanbag (less-lethal) shotgun is rarely discharged and its usage is usually reported in accordance with the applicable policies.

2.3 Based on a risk assessment, the follow-up audit consisted of an examination of the documentation provided for each incident that involved a Taser during the period between April 2008 and March 2009 inclusively. The Force Options Training Unit provided the list of all Taser incidents reported during this period as well as detailed usage data downloaded directly from each Taser device. The Audit Unit compiled an exhaustive list of Taser incidents by searching in the PRIME Records Management System (RMS) system for keywords such as TASER (including variations like TAZER, TAZOR, ENERGY WEAPON, CEW and ECD). A cursory review of the Computer-Aided Dispatch (CAD) data did not yield any undocumented Taser incidents. Private and invisible case files in RMS could not be reviewed by the Audit Unit and were therefore excluded.

2.4 The Audit Unit would like to thank all of the audit stakeholders for their assistance. The contribution of practicum student Darlene Lau is gratefully acknowledged.

2.5 This follow-up audit was conducted in accordance with the *International Standards for the Professional Practice of Internal Auditing* and the Code of Ethics of the Institute of Internal Auditors.

3 Findings

3.1 The findings of the Audit Unit are summarized below.

FINDING 1: Compliance with the reporting policy has improved but Taser usage continues to be under-reported.

3.2 According to the RPM policy 1.2.1, members shall complete and submit to the Force Options Training Unit a VPD840 Use of Force Report when they discharged a Taser during an incident or when they aimed a Taser at a non-compliant subject without firing. Members shall also document the incident in their notebook and submit a General Occurrence (GO) report.

3.3 Between the second quarter of 2008 and the first quarter of 2009 (April 2008 to March 2009 inclusively), the overall reporting rate for Taser incidents was approximately 58.8%. Based on the documentation available, a VPD840 Use of Force Report was submitted for 20 of the 26 incidents where a Taser was discharged (76.9%) and 27 of the 54 incidents where a Taser was presented to a non-compliant subject but not discharged (50.0%).

3.4 Patrol members were responsible for most of the unreported incidents where a Taser was presented but not discharged. However, Emergency Response Team (ERT) members appear to have been involved in four of the six incidents where a Taser was discharged but no VPD840 Use of Force Report was received by the Force Options Training Unit

3.5 Under-reporting by ERT reflects the fact that ERT maintains its own use of force records and downloads its own Taser data in-house after a Taser is discharged. Although this allows Taser devices to be returned to ERT operators more quickly after they are discharged, it also creates a gap in the use of force documentation held by the Force Options Training Unit because the CEW Coordinator is not always notified when a Taser is discharged by an ERT operator. This explains many of the discrepancies

between the data compiled by the Audit Unit and the summary usage reports by the Force Options Training Unit.

3.6 In one case (<u>222(2)(b)</u>), the ERT officer who discharged the Taser added an electronic use of force report to the main GO report but the Force Options Training Unit does not appear to have been notified because the incident was not included in the CEW Coordinator's 2008 annual report. In another case <u>22(2)(b)</u>, a cursory review by the ERT Taser Master Instructor indicated that a VPD840 Use of Force report was completed, although the incident was not included either in the CEW Coordinator's 2008 annual report (suggesting the VPD840 report was either misplaced or lost).

3.7 The following table contains the list of incidents where a Taser was discharged between the second quarter of 2008 and the first quarter of 2009. The incidents for which no VPD840 report could be located are in **bold**.

Event	Taser Usage	Event	Taser Usage		Taser Usage
2.2.(3.).(b.)	Probe Mode	<u>22(3)(b)</u>	Contact Stun	<u>22(3)(b)</u>	Contact Stun
	Probe Mode		Probe Mode and		Probe Mode
	Probe Mode	Contact Stun		Contact Stun	
	Contact Stun		Probe Mode		Probe Mode and Contact Stun
	Probe Mode		Probe Mode		
	Contact Stun				Accidental Discharge Probe Mode
	Probe Mode		Probe Mode and Contact Stun		Contact Stun
	Contact Stun		Contact Stun		Probe Mode
	Probe Mode		Probe Mode		26 INCIDENTS
	Probe Mode		Probe Mode		20 REPORTS (76.9%)

Table 3-1 Taser Discharged Between 2008 Q2 and 2009 Q1

3.8 The following table contains the list of incidents where a Taser was presented but not discharged between the second quarter of 2008 and the first quarter of 2009. The incidents for which no VPD840 report could be located are in **bold**.



Table 3-2 Taser Presented Between 2008 Q2 and 2009 Q1

3.9 Taking into account the data compiled as part of the Use of Force Audit, compliance with the mandatory reporting process appears to have increased in 2008. The reporting rate when a Taser was discharged would have increased from 53.5% in 2007 to 78.8% (26 out of 33) in 2008.

3.10 When a Taser was presented but not discharged, the reporting rate would have increased from 10.0% in 2007 to 55.2% in 2008 (37 out of 67). This was expected since these cases did not need to be reported using the VPD840 form before 2008.

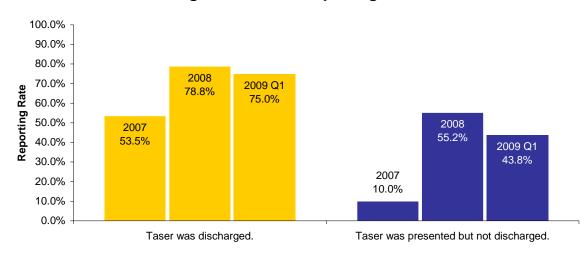


Figure 3-1 Taser Reporting Rate

3.11 Although the preliminary data for the first quarter of 2009 suggests a decrease in the overall reporting rate, the change does not appear to be statistically significant and it remains too early to tell whether the downward trend will continue throughout the year.

3.12 Taser incidents need to be properly documented in order to detect training gaps, malfunctions, identify defective investigate equipment equipment, maintain accountability and manage liability issues (i.e. place injuries resulting from use of force incidents into the proper context). Weak compliance with the formal reporting process reduces the quality and quantity of the data supporting the decision-making process as it relates to use of force in general and Taser usage in particular. Under-reporting may also distort the Early Warning System maintained by the Professional Standards Section because Taser incidents that are not officially reported in accordance with the policy are more likely to remain unnoticed and therefore cannot be weighted in the model.

3.13 Of note, most incidents where a Taser was discharged since October 2008 appear to have been reported publicly by the Public Affairs Unit regardless of whether a VPD840 form was submitted to the Force Options Training Unit or not. This is most likely because the Public Affairs Unit relies on different internal communication channels that do not depend on the VPD840 form being filled out. Among the exceptions, one accidental Taser discharge on 2009-01-24 and one ERT incident on 2009-03-03 were not reported publicly by the Public Affairs Unit.

FINDING 2: Medical attention is offered in accordance with the policy.

3.14 According to the RPM policy 1.2.1, Emergency Health Service (EHS) should attend each incident where a Taser was discharged.

3.15 In all cases where a Taser was discharged, notes or remarks in the report confirmed that the subjects involved had the opportunity to receive medical attention either at the scene (from EHS) or at the hospital (from medical staff).

3.16 Providing medical attention after a Taser is discharged minimizes the risks associated with non-visible trauma and ensures that obvious injuries are treated and properly documented.

FINDING 3: Taser spark tests are usually conducted in accordance with internal training guidelines.

3.17 According to the Taser X26E Operating Manual provided by Taser International, a spark test should be conducted by Taser operators prior to the start of each shift and when a Taser device has been dropped or has been exposed to water. Taser operators at the VPD are trained to perform a one-second spark test prior to or at the beginning of each shift. As part of the spark test, officers fire the Taser in contact stun mode and look for proper arching between the contact points.

3.18 The primary purpose of the spark test is to minimize the risk of a weapon failure during field deployment by verifying that the Taser device is working properly and the battery is adequately charged. The secondary goal of the spark test is to energize or "condition" some of the internal components, including the internal spark gap. Some laboratory experiments have suggested that unconditioned Taser devices may output abnormally high current during the initiation pulse or may not fire as quickly when the trigger is pulled (see *Analysis of the Quality and Safety of the Taser X26 Devices Tested for Canadian Broadcasting Corporation*, National Technical Systems, Test Report 41196-08.SRC, pages 6-8).

3.19 Based on the Taser download data provided by the Force Options Training Unit, spark tests appear to be conducted at the beginning of most shifts. However, it appears that no spark test was conducted before at least four incidents where a Taser was discharged 22(3)(b). In one case 22(3)(b) the Taser discharged accidentally in probe mode while it was being re-holstered and the last spark test was dated 30 hours prior. In the other cases, the last spark tests were dated 6 to 30 days prior to the Taser being discharged.

JUNE 2009

FINDING 4: Taser usage has declined.

3.20 Based on the data assembled as part of the audit, Taser usage has declined significantly in 2008. Extrapolating based on the first quarter of 2009, Taser usage would be expected to decline further in 2009.

3.21 The number of incidents where a Taser was discharged decreased by 61.6% from 86 in 2007 to 33 in 2008. Over the same period, the number of incidents where a Taser was presented decreased by 16.3% from 80 to 67.

3.22 The number of incidents where a Taser was discharged also decreased by 63.6% from 11 in the first quarter of 2008 to 4 in the first quarter of 2009. Over the same period, the number of incidents where a Taser was presented decreased by 44.8% from 29 to 16.

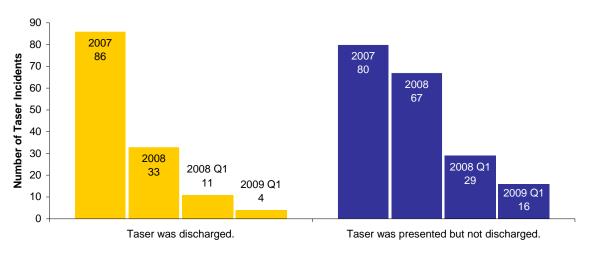


Figure 3-2 Number of Documented Taser Incidents

FINDING 5: Taser discharges have become less common.

3.23 As a proportion of all Taser incidents, Taser discharges have become less common.

3.24 In 2007, a Taser was discharged in up to 51.8% of all Taser incidents (86 out of 166). As shown by Figure 3-3, this proportion decreased to 33.0% in 2008 (33 out of 100) and 20.0% in the first quarter of 2009 (4 out of 20).

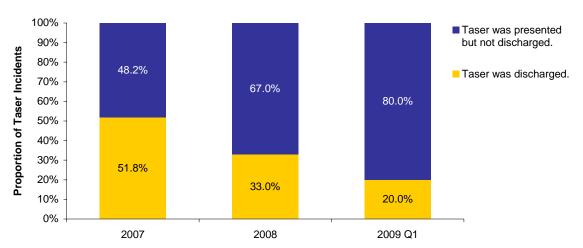


Figure 3-3 Proportion of Taser Incidents Where Taser is Discharged

3.25 By comparison, approximately 50.9% of all Taser incidents reported by the RCMP in 2008 resulted in a Taser being discharged according to the Commission for Public Complaints Against the RCMP (see *RCMP Use of the CEW – 2008*, Commission for Public Complaints Against the RCMP, March 31, 2009, Graph 4).

3.26 Overall, this would be consistent with the idea that the Taser has become a progressively more effective deterrent, a conclusion also reached by the Commission for Public Complaints Against the RCMP. Subjects appear to comply more often when they are confronted or challenged with a Taser. In turn, officers use the Taser less often as a pain compliance tool or an incapacitation device.

FINDING 6: Taser-related PRIME reports have improved noticeably.

3.27 Anecdotally, the quality of the Taser-related PRIME reports reviewed by the Audit Unit appears to have improved since 2007.

3.28 PRIME reports now appear more likely to contain very precise and comprehensive details about the context associated with, the justification for and the outcome of each Taser incident. The involvement of the Forensic Identification Unit, Force Options Training Unit, Duty Officer and EHS also seem more likely to be documented as part of the main PRIME report. Examples of well-documented incidents include _-----

JUNE 2009

3.29 Because the PRIME report often forms the basis of the VPD840 Use of Force report that is forwarded to the Force Options Training Unit, proper documentation in PRIME is essential. Proper PRIME documentation provides supervisors, managers and other stakeholders the opportunity to review more thoroughly and potentially learn from each documented Taser incident. Compliance with the RPM policy 1.2.1 can also be asserted more easily using each PRIME report.

4 Conclusion

4.1 Although compliance with the Taser reporting policy improved between 2007 and 2008, Taser usage continues to be under-reported. Under-reporting partially reflects the fact that ERT maintains its own use of force records and downloads its own Taser data in-house after a Taser is discharged. This sometimes creates a gap in the use of force documentation held by the Force Options Training Unit because the CEW Coordinator is not always notified when a Taser is discharged by an ERT operator. The Force Options Training Unit and ERT have already taken steps to ensure that the Force Options Training Unit's CEW Coordinator is properly notified whenever a Taser incident occurs.

4.2 Although regular Taser spark tests generally appear to be conducted in accordance with internal training guidelines and Taser International's recommendations, no spark test was conducted before at least four incidents where a Taser was discharged. The Force Options Training Unit has already taken steps to remind Taser operators that a spark test must be conducted at the beginning of each shift.

4.3 Taser usage has declined significantly in 2008 and preliminary data suggests it may decline further in 2009. As a proportion of all Taser incidents, Taser discharges have also become less common. This would be consistent with the idea that the Taser has progressively become a more effective deterrent and officers use the Taser less often as a pain compliance tool or an incapacitation device.

4.4 The Force Options Training Unit is currently participating in the development of an electronic use of force report called the Subject Behavior-Officer Response (SB-OR) template that could be integrated with the existing RMS system. The SB-OR template is designed to electronically record structured data about use of force by police. This new electronic template has the potential to standardize and streamline use of force reporting at the VPD. Ultimately, this may improve the Taser reporting rate. It also has the potential to improve the quality of the data supporting the decision-making process as it relates to use of force in general and Taser usage in particular. For example, the

SB-OR data could be used to determine whether a reduction in Taser usage coincided with an increase in other force options and control tactics.

4.5 This report is presented for information. The current RPM policy 1.2.1 on use of force is included as an appendix.

4.6 The Audit Unit will continue to work with the Force Options Training Unit in order to monitor compliance with Taser policies.

THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY.

5 Appendix – RPM Policy 1.2.1

1.2 Use Of Force

1.2.1 Use of Force - Justification

(Effective: 2008.10.22)

POLICY

Police members may be required to use force in the execution of their duties. The member must endeavour to use a reasonable level of force in the circumstances facing them, given the use of force model of the Vancouver Police Department.

When using force in the course of their duties, members shall be guided by, and shall comply with, the provisions of the Criminal Code and the Use of Force Regulation (B.C. Reg 203/98) passed pursuant to the Police Act (the "Regulation").

A member who uses force in the course of their duties is legally responsible for the force so applied and cannot rely on an administrative direction or order issued by the Vancouver Police Department or any officer or supervisor within it to protect the member from such scrutiny and legal responsibility. The member may be required to justify their actions afterward in various legal forums, including criminal court, civil court and in the context of an investigation and/or adjudication in a Police Act proceeding.

PROCEDURE

Firearms/Lethal Force

- 1. Members may discharge their firearms if it is reasonable and necessary to do so and in accordance with the protections and authorizations provided by Section 25 of the Criminal Code (Canada).
- 2. The seriousness of the offence does not in itself justify the use of firearms in the pursuit of suspects, unless:
 - a. the member is, or is about to be, or has been fired upon, or the suspect has already killed or wounded someone;
 - b. the member is satisfied nothing less than deadly force will stop the fugitive or prevent their escape; and
 - c. the lives or safety of innocent persons will not be jeopardized.
- 3. Members shall not discharge a firearm at a vehicle in an attempt to disable it. Members are justified with using an appropriate level of force, including deadly force, against the occupant(s) of a vehicle if it is to prevent grievous bodily harm or death to himself or herself or another person, and it is the least violent means available.
- 4. The discharge of a firearm as a warning shot is prohibited.

NOTE: None of the forgoing is intended in any way to convey the impression that members must unnecessarily risk their personal safety. In potentially dangerous situations, such as entering premises where there may be armed criminals, DRAWING OF THE SIDEARM AND HAVING IT "AT THE READY" IS QUITE PROPER AND IS RECOMMENDED.

- 5. In every instance where a member discharges a firearm while on duty, the member shall:
 - a. notify their Supervisor of the incident;
 - b. verbally report the incident through their Supervisor to the Duty Officer;
 - c. submit a detailed written report through their Supervisor to the Chief Constable;
 - d. turn the firearm used in the incident, used casings, and live ammunition over to their Supervisor or an investigating officer; and
 - e. obtain a replacement pistol, if required, from the Firearms Training Supervisor, or from a person designated by the Inspector i/c of the Training and Recruiting Section.
- 6. A Supervisor receiving notification that a member has discharged their firearm, shall:
 - a. investigate the reason for the discharging of the firearm;
 - b. seize the member's firearm, ammunition and any used casings unless already seized by an investigating officer (Refer to Section 1.6.17(ii) Seizing of a Member's Firearm);
 - c. obtain detailed reports from all members involved in the incident;
 - d. notify the Firearms Training Supervisor; and
 - e. submit a full report to the Chief Constable, which may include recommendations.
- 7. A Duty Officer receiving a report that a member has discharged their firearm shall ensure that all requirements of subsection 5 have been met and record the incident in the Duty Officer's Log.
- 8. In the event that the discharge has caused an injury, the Duty Officer shall notify Major Crime Section-Homicide who will be responsible for the investigation. In all other cases, the Duty Officer shall notify Major Crime Section-Robbery who will be responsible for investigating firearm discharges where no injury has resulted.
- 9. The Chief Constable or his designate, upon receipt of a full report concerning a member discharging their firearm shall:
 - a. conclude the matter forthwith; or
 - b. cause disciplinary proceedings and/or corrective action to be taken.

Use of Intermediate Weapons

10. The Vancouver Police Department supports the use of intermediate weapons by members who are qualified and/or certified to use them when lower levels of force (including other specific intermediate weapons) have been ineffective and/or inappropriate, and the use of higher levels of force (including other specific intermediate weapons) may not be justified and/or appropriate. The Conductive Energy Weapon (CEW), commonly known as TASER; Beanbag Shotgun; ARWEN Gun; Penn Arms SL-65; Baton; and Oleoresin Capsicum (OC) Spray are intermediate weapons that are authorized for use by members upon successful completion of the required training and having been qualified or re-qualified. (See Section 2.4.1 - Qualifying Standards - Firearms, Baton, Vascular Neck Restraint and Oleoresin Capsicum Spray)

Procedures for CEW/Beanbag Shotgun Deployment

- 11. When the CEW is drawn and aimed (but not discharged) at a non-compliant subject, members shall complete a VPD840 Use of Force Report.
- 12. When members discharge a Beanbag Shotgun and/or a CEW (contact stun or probe discharge) at an incident they shall:

- a. ensure that the requirements of subsection 22 have been met;
- b. complete a VPD840 Use of Force Report;
- c. ensure that the Emergency Health Service is notified and attends to the person involved;
- d. ensure that the Forensic Indent Squad attends the incident; and
- e. notify the Duty Officer.
- In every instance where a member discharges the beanbag shotgun the member shall attempt to seize the discharged beanbag and tag the beanbag in the property office (See Section 1.6.17(i) - Seizing of Intermediate Weapons).
- 14. In every instance where a member deploys a CEW (contact stun or probe discharge) the member shall submit the CEW, and any associated cartridge and probes to the CEW Coordinator or Supervisor, Force Options Training Unit (FOTU). If the FOTU office is closed, the member shall:
 - a. Personal Issue CEW
 - i. Lock the CEW (also known as ECD) in the locker provided on the 2nd floor annex of 312 Main St. for the ECD coordinator to download and assess;
 - ii. obtain a replacement CEW from the Station NCO;
 - iii. forward a copy of the Use of Force Report to the FOTU Supervisor; and
 - iv. once the Supervisor of the FOTU has downloaded the microprocessor and function tested the CEW, the member will be notified by the FOTU to attend the Office of the Station NCO to return the replacement CEW and obtain their personal issue CEW.
 - b. "Pool" CEW
 - i. Lock the CEW (also known as ECD) in the locker provided on the 2nd floor annex of 312 Main St. for the ECD coordinator to download and assess; and
 - ii. forward a copy of the Use of Force Report to the FOTU Supervisor.

Vascular Neck Restraint

- 15. The Vascular Neck Restraint shall only be used when the following criteria are met:
 - a. the situation demands immediate control over a violent person;
 - b. no less violent means are available;
 - c. there is no reason to believe that the person being subdued will suffer any injury; and
 - d. the member has been trained to apply the hold correctly.

Use of an Intermediate Weapon Resulting in Death or Grievous Bodily Harm

- 16. A Supervisor receiving notification that a person died or was grievously injured following the application of an intermediate weapon shall:
 - a. immediately report the incident to the Duty Officer;
 - b. investigate the reason for the use of the weapon;
 - c. seize the weapon (Refer to Section 1.6.17(i) Seizing of an Intermediate Weapon);
 - d. obtain detailed reports from all members involved in the incident;
 - e. notify the FOTU Supervisor during regular daytime hours when the weapon involved is a CEW;

- f. notify the Firearms Training Supervisor during regular daytime hours when the weapon is not a CEW; and
- g. submit a full report including recommendations (if appropriate), to the Chief Constable.
- 17. A Duty Officer receiving a report that a person has died or was grievously injured following the application of an intermediate weapon shall:
 - a. ensure that the requirements of subsection 22 have been met; and
 - b. notify Major Crime Section-Homicide who will be responsible for the investigation.

Unintentional Discharge of an Intermediate Weapon resulting in Death or Injury

- 18. In every instance where a member unintentionally discharges an intermediate weapon following which death or injury occurs the member shall:
 - a. notify their Supervisor of the incident;
 - b. verbally report the incident through their Supervisor to the Duty Officer;
 - c. submit a detailed written report through their Supervisor to the Chief Constable; and
 - d. submit the weapon used in the incident, used casings, and live ammunition, if applicable, to their Supervisor or an investigating officer. (Refer to Section 1.6.17(i) -Seizing of an Intermediate Weapon).
- 19. A Supervisor receiving notification that a person has died or was injured following the unintentional discharge of an intermediate weapon shall:
 - a. immediately report the incident to the Duty Officer;
 - b. investigate the reason and/or circumstances for the use of the weapon;
 - c. seize the weapon (Refer to Section 1.6.17(i)- Seizing of an Intermediate Weapon);
 - d. obtain detailed reports from all members involved in the incident;
 - e. notify the FOTU Supervisor during regular daytime hours when the weapon involved is a CEW;
 - f. notify the Firearms Training Supervisor during regular daytime hours when the weapon is not a CEW; and
 - g. submit a full report including recommendations (if appropriate), to the Chief Constable.
- 20. A Duty Officer receiving a report that a person has died or was injured following an unintentional discharge of an intermediate weapon shall:
 - a. ensure that the requirements of subsection 16 have been met; and
 - b. notify Major Crime Section-Homicide who will be responsible for the investigation.

Unintentional Discharge of an Intermediate Weapon not resulting in Injury

- 21. In the event the discharge of the weapon was unintentional and no injury has occurred, the member shall:
 - a. notify their Supervisor of the incident;
 - b. verbally report the incident through their Supervisor to the Duty Officer;
 - c. submit a detailed written report through their Supervisor to the Force Options Training Unit Supervisor when the weapon involved is a CEW;
 - d. submit a detailed written report through their Supervisor to the Firearms Training Supervisor when the weapon involved is not a CEW;

- e. unload the weapon;
- f. keep the ammunition from the weapon separate from other ammunition seized; and
- g. contact the appropriate Supervisor (FOTU Supervisor or Firearms Training Supervisor), who shall determine if the weapon will be seized. In the event the appropriate Supervisor cannot be contacted, notify the Duty Officer who shall make this determination. (Refer to Section 1.6.17(i) Seizure of an Intermediate Weapon).

Member's Requirement to Report Use of Force and Provide Medical Attention

- 22. When a member has found it necessary to apply one or more of the following force options to gain physical control of a non-compliant subject:
 - o ARWEN gun
 - o Penn Arms SL-65
 - Beanbag Shotgun
 - Conductive Energy Weapon (CEW), also known as TASER
 - Oleoresin Capsicum (OC) Spray
 - A Baton that causes injury to a person
 - o A Vascular Neck Restraint
 - Any physical force to a person that causes injury and medical attention is required or requested

The member shall:

- a. notify their Supervisor;
- b. in the event of injury, report the incident through their Supervisor to the Duty Officer;
- c. consider whether it is appropriate for an assault, assault peace officer and/or obstruction charges against the non-compliant subject;
- d. offer medical assistance or aid. A member shall have the Emergency Health Service (ambulance) attend if the person requests medical attention or if the member believes it is appropriate (See Section 1.2.2 Use of Force to Provide Medical Aid). If the member believes that medical attention is required, that member will have Emergency Health Service attend even if the subject initially refuses such aid;
- e. document the incident in their notebook, and submit a GO report. If charges are requested, the member(s) shall document the force used on a Vancouver Jail Arrest Report and submit a GO report for Crown Counsel;
- f. complete and submit a VPD 840 Use of Force Report following the use of the CEW or Beanbag Shotgun; and
- g. ensure that reports include the following information:
 - A description of the incident which led up to the necessity of force being applied;
 - Type of force applied;
 - Type of injury, if any, received by the non-compliant subject, or member; and
 - Whether medical attention was requested and the result of the medical attention received.