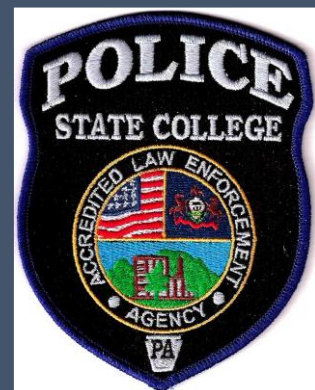


**Report 19-001:**  
Conduct and  
Procedures Review of  
Deadly Force





*"A Home Rule Municipality"*

## STATE COLLEGE POLICE DEPARTMENT

243 South Allen Street

Phone 814-234-7150  
Fax 814-231-3070

State College, PA 16801  
www.statecollegepa.us  
police@statecollegepa.us

John F. Gardner  
Chief of Police



---

### **CONDUCT AND PROCEDURES REVIEW OF DEADLY FORCE** **19SC04228 and 19SC04265**

**Conduct and Procedures Review of Deadly Officer Involved Shooting as per following State College Police Department policy sections:**

#### **1.3.6 A.5 Conduct and Procedures Review Board**

The Conduct and Procedures Review Board shall convene and review the circumstances of each discharge of a firearm by a Department Member.

The Conduct and Procedures Review Board will evaluate, in explicit and fact-finding fashion, each aspect of an officer involved shooting. Such evaluation will include:

- 1) A thorough review of the criminal investigation report
- 2) A thorough review of the internal affairs report
- 3) Hearing of direct testimony, if necessary, from officers and witnesses

#### **1.3.6 A.6 The Conduct and Procedures Review Board will develop findings and make recommendations to the Chief of Police in the following areas:**

- 1) Whether the shooting was within policy, inconsistent with policy, or accidental
- 2) Tactical considerations
- 3) Training considerations
- 4) Quality of supervision
- 5) Discipline considerations
- 6) Quality of the post-shooting investigative process
- 7) Quality of the post-shooting personal services

## **PRELIMINARY REVIEW DIRECTIONS FOR Conduct & Procedures Review 19-001**

On Thursday June 27, 2019 at 5:00 p.m., the Conduct and Procedures Review Board convened to discuss the upcoming review of the deadly Force incident reference SCPD incident numbers 19SC04228 and 19SC04265.

The Board, chaired by Captain Christian Fishel, consisted of: a lieutenant, sergeant and two officers. Investigator Assistant Chief Matthew Wilson provided the board members with the following materials and direction to be completed before the date of the internal review:

- 1) Board members were provided a review of department policy sections 1.3.6 A.5 and 1.3.6 A.6 that give the board authority to review such incidents as well as provides guidance on what recommendations the board may make to the Chief of Police.
- 2) Board was provided the “Message to Conduct and Procedures Review Board” authored by Assistant Chief Wilson.
- 3) Board members were provided all potentially pertinent policy sections and advised to read sections before the date of the review. The board was also requested to provide the chairman and investigator any other department policies they may be aware of that should be considered as part of this review.
- 4) Board members were directed to read the entirety of SCPD incidents 19SC04228 and 19SC04265.
- 5) Board members were directed to read the entirety of the District Attorney’s report regarding State College Police Shooting (On-line)
- 6) Board members were provided a digital copy of *Officer-Involved Shootings – A guide to Law Enforcement Leaders* and directed to read for information on best practices (Department of Justice) (International Association of Chiefs of Police).
- 7) Board members were directed to visit the hallway outside apartment G3, 1013 Old Boalsburg Road.

## **TABLE OF CONTENTS**

- 1. Message to Conduct and Procedures Review Board**
- 2. Related Policy Sections**
- 3. Synopsis of Police Reports**
- 4. List of Follow-up internal interviews**
- 5. Use of Taser and Deadly Force**
- 6. Tactics**
- 7. Training**
- 8. Supervision**
- 9. Post Shooting Investigation Process**
- 10. Post-Shooting Personal Services**
- 11. Closing**
- 12. Attachments (Not included in Public Document)**

# **1. MESSAGE TO CONDUCT AND PROCEDURES REVIEW BOARD**

Notwithstanding the State Police criminal investigation and District Attorney decision that the use of force was reasonable and justified, this board is charged with reviewing State College Police Department Policy and Procedure as it relates to this event. This includes reviewing officer actions leading up to the final interaction with Osaze Osagie (hereafter referred to as Mr. Osagie) as they relate to department policy. The board owes a thorough and thoughtful review of the facts and circumstances to those officers directly involved, the department, the Osagie family and the community we serve. The board should review all applicable policies and officer actions and consider potential improvement of responses and policy to minimize, if possible, the chance our officers and community is faced with such a circumstance in the future.

As noted in policy section 1.3.6 A.6 and included at the beginning of this report, the board is charged with making numerous rulings and potential recommendations related to this event. If the board makes a finding that specific department personnel were in fact in violation of department policy, a separate internal affairs investigation, or minimal corrective action may be recommended by the board.

The design of this review and subsequent attachments is such so that the board can focus on each aspect of this review in an independent fashion. This review board simply needs to determine in each section (1) whether department policy was followed and if not provide a recommendation for accountability and, (2) was policy adequate and if not, provide policy recommendations. The board may also make a recommendation for further investigation if this report is insufficient to make proper conclusions and decisions.

## **2. RELATED POLICY SECTIONS**

### **1.3.0 Use of Force**

#### **1.3.01 Definitions**

#### **1.3.0.2 Testing on Use of Force Policy**

#### **1.3.1 Authorized Use of Force Options and Their Appropriate Application**

#### **1.3.2 Use of Deadly Force**

#### **1.3.3 Prohibited Use of Weapons**

#### **1.3.4 Electro-Muscular-Disruption Devices Conducted Electrical Device (Taser)**

#### **1.3.5 Medical Aid After Use of Force**

#### **1.3.6 Investigations and Written Reports Required**

#### **1.3.7 A Administrative Leave**

- 1.3.7 B Psychological Services
- 1.3.7 C Personal Services After Shooting
- 1.3.9 Demonstrated Proficiency required to Carry Approved Weapons
- 1.3.10 Use of Force In-Service and Weapons Proficiency Training
- 1.8.1.12 Use of Alcohol/Drugs on duty or in Uniform
- 1.8.3 Biased Based Policing
- 1.10.5 In -Service Training
- 2.2.1.14 Centre County Crisis Negotiation Team
- 2.7.4 Civil Process – Requires Sworn Service
- 2.7.8 A Mental Health/Intellectual Disability
- 5.5.0 Command Notification Procedure
- 7.1.05 On-duty Handgun and Equipment

### 3. SYNOPSIS OF POLICE REPORTS 19SC04228 / 19SC04265

**\*\*synopsis taken solely from filed police reports\*\***

#### 19SC04228

On March 19, 2019 at approximately 9:55 p.m. Mr. Osagie’s father came to the police station with concerns regarding his 29-year-old son. Two State College patrol officers met with the father and learned that his son, Mr. Osagie, was currently missing from his apartment at G3, 1013 Old Boalsburg Road. Mr. Osagie’s father reported that Mr. Osagie has a history of anxiety and schizophrenia and was most likely off his medication. This fact concerned the father believing that Mr. Osagie may be suicidal.

Mr. Osagie’s father showed the officers recent text messages that his son had sent him. The most concerning messages were as follows: **“Shoot, God is dead in this country, and soon I hopefully will be dead also. My fast-approaching deep sleep will result from a struggle between God and evil. Any poor soul whose life I take today, if any poor soul at all, may God forgive his sins if he has any.”** The father was supposed to meet Mr. Osagie for dinner however he received a last text from Mr. Osagie stating, **“Good bye”**. The father attempted to call his son however received no answer.

Two officers went to Mr. Osagie’s apartment at G3, 1013 Old Boalsburg Road at 10:16 p.m.; however, did not make contact. They spoke to Mr. Osagie’s roommate who had not seen him since 2:00 p.m. that day. He was unsure where Mr. Osagie might be.

An officer then contacted Centre County Can Help (crisis intervention service hotline) and learned that their agency had not had recent contact with Mr. Osagie. That officer was put in touch with Mr. Osagie's Strawberry Fields case manager who also advised he had not had recent contact with Mr. Osagie. The officer was unable to find Mr. Osagie by pinging his phone and checking known hang outs. That officer then took the father to the Mount Nittany Medical Center Emergency Department so that he could meet with a Can Help crisis worker. Mr. Osagie's father shared his concerns with the crisis worker and a 302 warrant was completed. The 302 warrant was given to the State College Police Department to serve.

Since Mr. Osagie was not immediately found by patrolling officers at that time, the investigating officer entered Mr. Osagie as a missing endangered person in NCIC as well as put out a local bolo and placed information regarding this situation on the SCPD hot sheet specifically for following shifts to review.

The following morning, March 20, 2019, the case was assigned to a detective. That detective followed up with Mr. Osagie's father confirming he had not heard from Mr. Osagie. The detective also attempted to call Mr. Osagie's roommate with negative results as well as attempted pings of Mr. Osagie's phone. All pings were found to be old.

At the same time, a daylight patrol officer was also following-up on this case. That patrol officer also called Mr. Osagie's father and attempted to call Mr. Osagie's roommate. At approximately 9:24 a.m. a lieutenant and that officer attempted to contact Mr. Osagie at G3, 1013 Old Boalsburg Road. There was no answer at the apartment. The officer re-contacted Mr. Osagie's father and learned of other potential locations his son might be at. The officer also had contact with Mr. Osagie's roommate and confirmed he had not seen him since the previous day. Patrol officers continued to search for Mr. Osagie expecting him to be somewhere in the vicinity.

## **19SC04265**

On March 20, 2019, at approximately 1:48 p.m. State College Officers received information from the Centre County Emergency Communications Center that Mr. Osagie's case worker from Strawberry Fields had spotted Mr. Osagie leaving the Weis grocery store and appeared to be headed back to his apartment. The caseworker was requesting that officers attempt to contact Mr. Osagie. Officer #1 was assigned the case and responded with Officer #2 assisting. The officers did not locate Mr. Osagie in the area, so they responded to his apartment. Officer #3 had also been looking for Mr. Osagie and he responded to assist in locating him.

All three officers ended up at Mr. Osagie's apartment at approximately 1:59 p.m. Officer #3 confirmed the apartment number as well as the existence of a hard copy of the 302 warrant with the assigned detective. Officer #1, Officer #2 and Officer #3 approached the basement apartment from a small stair well. Officer #1 (uniform) was at the door in the hallway, Officer #2 (uniform) was on the first step and Officer #3 (plainclothes) was further up the steps. Officer #1 knocked on the door and a voice from within stated he was coming. Once the door was opened, Officer #1 asked the resident if he was Mr. Osagie. The male indicated that he was. Officer #1 asked to come inside the apartment to talk. Mr. Osagie denied entry so Officer #1 asked Mr. Osagie if he was willing to step out into the hallway. It was at this time that Officer #1 observed that Mr. Osagie had a knife in his hand. Officer #1 immediately drew his duty weapon and ordered Mr. Osagie to drop the knife. Officer #2 drew his Taser as Officer #3 was requesting, he do so. Mr.

Osagie ignored commands to drop the knife and briefly backed into the apartment while stating he wanted to die. Mr. Osagie specifically told Officer #1 to kill him. Mr. Osagie then charged out of the apartment toward the officers still holding the knife in his right hand in front of him. Officer #2 activated his Taser while only approximately 3-4 feet away. Officer #1 fired several shots at Mr. Osagie as he attempted to retreat.

Both Officer #2 and Officer #1 fell back onto the steps with Mr. Osagie falling at their feet. Observing that Mr. Osagie was seriously injured, Officer #2 requested a medical kit. Officer #3 notified the communications center that “shots had been fired” at approximately 2:03 p.m. He requested an ambulance as well as began making command notifications and request for State Police Assistance.

A patrol lieutenant arrived on scene with numerous other responding officers. That lieutenant took over care of Mr. Osagie. It was apparent Mr. Osagie had lost a large amount of blood. He had no signs of life as evaluated by the lieutenant. A Centre Life Link Emergency Medical Services unit took over care and confirmed that Mr. Osagie was dead.

## **4. LIST OF FOLLOW-UP INTERVIEWS**

<b>Initial responding Officer –</b>	<b>5/22/19 at 7:30 p.m.</b>
<b>2<sup>nd</sup> Initial Responding officer –</b>	<b>6/6/19 at 7:30 p.m.</b>
<b>Night Shift Patrol Lieutenant –</b>	<b>6/6/19 at 8:00 p.m.</b>
<b>Day Shift Patrol Lieutenant –</b>	<b>5/29/19 at 7:00 p.m.</b>
<b>Day Shift Patrol Officer –</b>	<b>5/29/19 at 1:22 p.m.</b>
<b>SCPD Detective Investigator –</b>	<b>5/23/19 at 12:14 p.m.</b>
<b>SCPD Officer #1 –</b>	<b>6/12/19 at 10:00 a.m.</b>
<b>SCPD Officer #2 –</b>	<b>6/7/19 at 10:30 a.m.</b>
<b>SCPD Officer #3 –</b>	<b>5/31/19 at 9:30 a.m.</b>
<b>State Police Investigator –</b>	<b>6/6/19 at 10:30 a.m.</b>
<b>Centre Life Link medic –</b>	<b>6/5/19 at 1:16 p.m.</b>
<b>Mr. Osagie’s father –</b>	<b>6/26/19 (Attorney representing family stated that he was going to advise his clients against speaking with me.)</b>



## **5. USE OF DEADLY FORCE**

### **1.3.0 Use of Force**

#### **1.3.01 Definitions**

#### **1.3.1 Authorized Use of Force Options and Their Appropriate Application**

#### **1.3.2 Use of Deadly Force**

#### **1.3.3 Prohibited Use of Weapons**

#### **1.3.4 Electro-Muscular-Disruption Devices Conducted Electrical Device (Taser)**

The board must determine whether the use of force in this circumstance was within department policies. The board shall review in their entirety involved officer reports from Officer #1, Officer #2 and Officer #3 as well as the District Attorney report and pertinent excerpts from the Pennsylvania State Police Investigative report PA 2019-354397. Also included for board review and analysis are the Centre County Communication Center dispatch recordings as well as scene photos.

Each involved officer did review their State College Police department report and answered clarifying questions from this investigator. Those responses are woven throughout this report in the related and appropriate review sections. Regarding the encounter with Mr. Osagie, I found nothing in my interviews that turned up contradictory information to submitted officer department reports and Pennsylvania State Police officer interviews. Specifically, the limited dialogue with Mr. Osagie and the amount of time the final encounter encompassed was consistent throughout reports, evidence and follow-up interviews. Following are notes from my interviews with all three directly involved officers.

Officer #3 recalled going to the scene to simply help as support. He mentioned wanting to find Mr. Osagie as fast as he could as he recalled from previous incidents that Mr. Osagie would go missing for a lengthy period of time. Once they entered the apartment building, Officer #3 stood on the steps behind Officer #2. Officer #1 knocked on the door and Officer #3 could hear someone from inside say “I’m coming”. When the door was eventually opened, Officer #3 could only see the top of Mr. Osagie’s head and nothing else. Mr. Osagie denied the officers entry. Officer #1 then invited Mr. Osagie into the hallway. Suddenly, Officer #3 saw Officer #1 draw his weapon and begin commands telling Mr. Osagie to drop the knife. Officer #3 could not see the knife himself, nor could he hear what Mr. Osagie was saying due to echoing in the hallway. He did direct Officer #2 to draw his Taser. Officer #3 attempted to call for back-up at this time.

Unfortunately, within seconds Officer #2 deployed the Taser, and shots were fired by Officer #1. Officer #3 mentioned that had he had the time, he would have told Mr. Osagie to go back inside and instruct the officers to leave. Unfortunately, it seemed like he only had a few seconds. Officer #3 recalled that the Taser and gunshots were right on top of each other, quite nearly simultaneous. Officer #3 and I did go back to the scene and he showed me where he stood as well as where Officer #2 and Officer #1 were in the hallway. Scene photos were taken by a detective at my request.

Officer #2 was standing on the first step behind Officer #1. Officer #2 confirmed the same facts as provided by Officer #3. Once the knife was observed, Officer #2 unholstered his Taser and armed it. Mr. Osagie stepped into the apartment out of view stating, “no I want to die”. He either did this upon seeing the red dot or hearing Officer #3 tell Officer #2 to get his Taser. Shortly after

concealing himself, Mr. Osagie then ran from the apartment directly at Officer #2 and Officer #1 with the knife in hand, pointed at the officers. Officer #2 immediately fired his Taser as it was what he had in his hand at the time and there was no opportunity to switch to his firearm. Officer #2 agreed that the Taser and gunshots were right on top of each other and almost simultaneous. Officer #2 advised the entire incident was 30 seconds maximum from the time Officer #1 knocked on the door until the Taser was deployed and shots were fired.

Officer #1 reported that there was no spoken plan made for the contact. The call or supplement was assigned to him, so he was the contact officer and knocked on the door. The circumstances seemed routine at that time. Officer #1 reported that Mr. Osagie seemed irritated at the on-set. Mr. Osagie was quick to say “no” when Officer #1 requested to enter the apartment to talk. Once the knife was observed and positively identified by Officer #1, he unholstered his duty weapon and gave Mr. Osagie direct commands to drop the knife. While doing so he backed up almost as far as the hallway would allow him and was essentially right next to Officer #2 with his left hand on Officer #2. Officer #1 characterized his commands as being “loud and commanding in tone”. Officer #1 reported that Mr. Osagie yelled back “shoot me, kill me”. Officer #1 reportedly said “no” to this and told him to drop the knife repeatedly. Mr. Osagie stepped out of the doorway, and into the apartment briefly concealing himself. He then came back into view within seconds rushing the officers. Officer #1 did not recall seeing Officer #2 unholster his Taser nor did he recall hearing it, but he did remember seeing it deploy just before he fired his duty weapon as Mr. Osagie charged them. Officer #1 agreed that the Taser deployment and his decision to fire were right on top of each other and nearly simultaneous.

Due to the crime scene and the criminal investigation of this case being totally handed off to the State Police, all physical evidence was processed solely by the State Police. Ultimately the District Attorney determined that the physical evidence obtained by the State Police supported the statements provided by the involved officers. The physical findings are included in the District Attorney report; however, I will summarize a few key findings at this point.

The hallway is extremely small as I realized when I visited the scene. The measurements are approximately 3 feet by 7 feet long. Mr. Osagie’s apartment door opens outward, making the space smaller. The Pennsylvania State Police did recover a 5” steak knife from the hallway and apartment scene. The involved officers estimated that Mr. Osagie was within 2 to 3 feet with the knife and closing when Officer #2 fired the Taser. The Taser probe spread was found to be approximately 6 inches on Mr. Osagie’s body. It takes a minimum of 7 feet for an X26P 25’ cartridge probe spread to open up to 12 inches. The 6-inch probe spread supports the officer’s statements regarding how close Osagie was when the Taser was fired. Furthermore, it also illustrates why the Taser seemed ineffective. Without a minimum probe spread of 12 inches, neuro-muscular incapacitation was not achieved, and most likely Mr. Osagie only felt some localized pain from the Taser probes. There was also not a lot of time to be able to assess the ultimate effectiveness of the Taser due to the close proximity of Mr. Osagie. Officer #1 fired 4 shots with 3 shots striking Mr. Osagie. Gunshot residue tests on Mr. Osagie’s clothing determined the 3 shots that struck Mr. Osagie were all from ranges determined to be greater than 6 inches and less than 36 inches. Again, this demonstrates how close Mr. Osagie was to the officers when force was deployed.

Timing of the incident was obtained from dispatch recordings and the Taser download. The involved officers all estimated the total time of the incident at the door as being roughly 25 to 30

seconds and that included the time it took Mr. Osagie to get to the door. Dispatch records show that the officers reported on scene at 13:59:02 hrs. The officers indicated that they needed other units at 14:02:56 and at 14:03:07 called out that shots were fired. Also, of note, the Taser download indicated that the Taser was armed for 10 seconds before it was deployed. As reported, the Taser was not pulled from the holster and armed until the knife was identified in Mr. Osagie's hand. This indicates the officers had approximately 10 seconds time from when the knife was observed until when the Taser and firearm were discharged. Furthermore, the total time at the door, to include the time it took for Mr. Osagie to open the door supports the facts that there was no time for extended dialogue or negotiation, as reported by Officer #3, Officer #2 and Officer #1 before force was used.

### **1.3.5 Medical Aid After Use of Force**

Regarding duty to render care, Officer #3 immediately attempted to arrange for medical care by calling for an ambulance and attempted to obtain a medical bag. The day shift patrol lieutenant arrived on scene and his medical bag was obtained. The Lieutenant assessed Mr. Osagie and observed no signs of life coupled with a large amount of blood loss. A Centre Life Link medic arrived and placed a monitor on Mr. Osagie. Shortly afterward, the medic advised that Mr. Osagie was dead. I interviewed the medic and she confirmed that due to Mr. Osagie's injuries there was nothing that could have been done regarding life saving measures.

### **1.8.3 Biased Based Policing**

The board must also understand that in the aftermath of this incident, several community members voiced concern or suggested that the decision to use deadly force was based on Mr. Osagie being African-American. These concerns were raised primarily in several community meetings and Borough Council meetings held after the incident. This public accusation implies a violation of the department's biased based policing policy and cannot go without inquiry and addressing the matter. The District Attorney also made a request for information in reference to this community concern. That information was provided to the District Attorney and is included in this report. Upon completion of the Pennsylvania State Police investigation and at the public announcement of the investigation results, the District Attorney and State Police Sergeant of the Heritage Affairs Section indicated that Mr. Osagie's race had nothing to do with the officers' actions in this incident.

In an effort to answer the District Attorney's inquiry as well as further address or respond to this community concern, I obtained Officer #1's email, car to car Instant Messaging, and work phone text messaging records. I located nothing referencing this incident or anything related to racial bias or anything inconsistent with department policy. I researched past complaints against Officer #1 and found only one Use of Force complaint that was subsequently un-founded in the preliminary investigation process. That complaint came from a white college age male and did not involve injury. Furthermore, I found no documented complaints regarding violations of the department's biased based policing policy in Officer #1's overall delivery of police services. I also tracked Officer #1's application of force since being hired as a State College Police Officer. I also compiled arrest data since date of hire for Officer #1. The data showed Officer #1 has made 1,283 total arrests since hired as a State College Police Officer. Arrest and Use of Force data clearly shows that Officer #1 has dealt mostly with white subjects during career with SCPD. Furthermore, referenced in this review are the last two years of department bias-based policing reports. The

conclusions in both reports indicate that the department as a whole is not in violation of the bias-based policing policy.

Despite no evidence nor indication whatsoever race played a role in the officers' actions in this incident, I still discussed this with all three officers present at this final encounter. None of them indicated that Mr. Osagie's being African American had anything to do with how they responded to this incident. Specifically, Officer #3 advised he had no concerns nor felt more in jeopardy due to Mr. Osagie's race. He was quite confident going to the apartment, that if not the other two officers, he was going to be able to talk Mr. Osagie to go to the hospital and that was the expectation. I asked Officer #1 if Mr. Osagie being African American played any role whatsoever in his decision to use deadly force and he advised "not at all". The board should offer its opinion on this matter using the facts of this particular case and supplied historical data concluding as to whether Mr. Osagie's race had potentially anything to do with the handling of this incident and the ultimate decision to use deadly force.

## **6. TACTICS**

### **2.7.4 Civil Process – Requires Sworn Service**

#### **2.7.8 A Mental Health/Intellectual Disability**

##### **2.2.1.14 Centre County Crisis Negotiation Team**

The initial responding officer met with Mr. Osagie's father at the police department on March 19, 2019. That officer took the initial report from Mr. Osagie's father. The initial responding officer confirmed that he and a 2<sup>nd</sup> officer went to the apartment with the father present. Mr. Osagie's father apparently needed to go with them as he did not know the exact apartment number where Mr. Osagie lived. The officers attempted to make contact at the door while Mr. Osagie's father stood at the top of the steps. The initial responding officer also confirmed that he and the 2<sup>nd</sup> officer did attempt to call Mr. Osagie at some point; however, the phone went immediately to voicemail. The initial responding officer did advise that this report felt a "little more than normal" referring to the validity or seriousness of the threats. That officer did have an elongated conversation with the father while waiting for Can-Help to meet with them at the hospital. He advised that he only remembered letting Mr. Osagie's father know that our department would contact him once we located his son. There was no conversation regarding advising Mr. Osagie's father before making direct contact with Mr. Osagie at the apartment. This question was asked of all the officers that had contact with Mr. Osagie's father. In a State College.com article dated May 8, 2019, Mr. Osagie's father is quoted as saying "he had been driving around looking for his son and wasn't notified that police were going to enter his apartment." The quote infers that officers were supposed to contact Mr. Osagie's father before going to the apartment. As noted in the interviews section, I was unable to interview Mr. Osagie's father and discuss this statement for this review.

The 2<sup>nd</sup> responding officer advised he assisted simply due to the type of call. He recognized Mr. Osagie's name from past incidents. The officer recalled that the roommate took an elongated time to come to the door. While waiting, Mr. Osagie's father suggested that they get apartment maintenance to assist them gaining entry to the apartment. The officer advised that he recalled no mention of Mr. Osagie's father being told we would contact him before attempting further contacts with Mr. Osagie. The officer did mention that there was another gentleman with the father that night. This officer also advised the report Mr. Osagie's father made did have a "weird feel" to it

but otherwise it was not out of the normal for a mental health type call. The officer explained that the clarity of the text messages did concern him. The officer also felt that they did everything they could to locate Mr. Osagie that night.

The night shift patrol lieutenant also stopped by the apartment and briefly met with Mr. Osagie's father. He obtained a synopsis of the investigation and rechecked the apartment with the officers to make sure Mr. Osagie was not present. The lieutenant also advised that there was nothing said regarding contacting Mr. Osagie's father before contacting his son. The lieutenant advised that he did very intentionally evaluate whether they were doing enough that night based on the text messages and circumstances involved. The lieutenant also advised that based on the amount of people we deal with that say such things; this case did not seem to him to be out of the ordinary. He also considered the past contacts we have had with Mr. Osagie, having positive outcomes, so he felt they were on the right track with what was being accomplished.

Regarding passing off information to daylight platoon, the initial responding officer advised that he believed night shift patrol lieutenant passed the incident information off to the day shift patrol lieutenant. The officer did not believe the photographed text messages with specific threats were included with the 302 paperwork. The night shift patrol lieutenant confirmed the photographed text messages were a part of the 302-warrant packet on the hot sheet and were available to the daylight platoon. He spoke to the day shift patrol lieutenant about the incident that morning as well as left the case open with a notation to the Lieutenant in charge of the Detective Section

The day shift patrol lieutenant assigned the case to a dayshift patrol officer at briefing. That officer immediately began following up on the case by re-contacting Mr. Osagie's father and confirming that he had not heard from his son. The officer also attempted to follow-up with Mr. Osagie's roommate with negative results.

Both the lieutenant and officer attempted contact at Mr. Osagie's residence later in the morning with negative results. The lieutenant advised that he nor the patrol officer attempted a call to Mr. Osagie before attempting contact. The lieutenant advised he did read the 302 Affidavit narrative and did not recognize it as anything more serious than had been dealt with in the past. This lieutenant was aware of some of Mr. Osagie's past; however, did not think he was necessarily capable of what he later did. The lieutenant did look in the windows of the apartment and advised that he really thought the apartment was wrong as it looked unfurnished. Later, the daylight patrol officer assigned the case had contact, a second time, with Mr. Osagie's father and then made positive contact with the roommate. The officer remembered that Mr. Osagie's father advised that he thought Mr. Osagie's phone was off as text messages were not going through. The officer did not recall if he/she ever attempted to call Mr. Osagie. The officer did not recall anything from Mr. Osagie's father requesting the police not contact Mr. Osagie before letting him know.

A detective was assigned the case to begin immediate follow-up due to knowledge of past incidents. The detective began working the case by collecting the pertinent information off the hot sheet. This included the 302 warrant and attached photo of the specific text messages. The detective also contacted Mr. Osagie's father and attempted to contact the roommate. The detective confirmed with Mr. Osagie's father that he still had not located his son. There was no mention in this conversation that the father wanted notified before his son was contacted. The detective attempted another ping of Mr. Osagie's cellphone and only received a location from approximately 1:00 a.m. that morning. That detective did not remember attempting to call Mr. Osagie. The

detective did not necessarily know exactly what the day shift lieutenant and patrol officer assigned the case were doing but did hear them on the radio and it sounded like they were also looking for Mr. Osagie, so the detective provided them the last cellphone ping location.

Officer #3 did check Hamilton Plaza on his own based on the old cellphone ping provided by the assigned detective. Upon hearing the call from Can-Help, Officer #3 responded from the department to assist. He hoped to locate Mr. Osagie near Weis. Once Mr. Osagie was not located, Officer #3 responded to the apartment.

Officer #3 advised they used contact and cover with the two uniforms first and Officer #3, in plainclothes without a vest, operating in a support role. Officer #3 felt that the brief interaction at the door was non-confrontational by the police. As example, when Mr. Osagie denied entry to the officers, Mr. Osagie was provided an alternative to step outside the apartment until the knife was observed. Officer #3 felt that Mr. Osagie dictated the physical actions at the door by running out in the hallway with the knife giving the officers no other choice but to defend themselves. Officer #3 also advised their actions were consistent with training as a crisis intervention team officer and crisis negotiator. The involved officers' intentions were to get Mr. Osagie talking. Officer #3 advised that although the police department has had numerous incidents with Mr. Osagie over the years, he had never proven to want to fight the police, therefore there seemed to be little justification to utilize alternate tactics when attempting to make contact at the apartment.

Officer #2 responded to back Officer #1 on the call. Officer #2 was aware of the situation from briefing that morning; however, was not made aware of the specific text messages. Officer #2 agreed with Officer #3 regarding this being a routine contact and 302 service. There was no specific plan, but they used standard contact and cover principles with Officer #1 at the door since it was his call. Once the door was opened, the incident quickly became anything but ordinary. Officer #2 remarked that Officer #1's tone was normal and pleasant until the knife was observed. Officer #2 also stated it seemed Mr. Osagie's mind was already made up when the door was opened. Officer #2 also stated, based on Mr. Osagie's demeanor, the officer didn't think it mattered who was at the door, and that included Mr. Osagie's father.

Officer #1 felt the same as Officer #3 and Officer #2. Officer #1 was aware of the 302 warrant for Mr. Osagie. He was not aware of the specific text messages that Mr. Osagie made to his father. Officer #1 took the lead at the door since the call was assigned to Officer #1. Officer #1's intention was to make contact and talk Mr. Osagie to go to the hospital for help. Officer #1 did cover the peep hole in the door. He did not want Mr. Osagie to know that the police were outside the door until the door was opened.

At the moment the threat (knife) was observed, Officer #1 was able to recognize the threat, draw his duty weapon and alerted Officer #2 and Officer #3 to the threat per training. Once the threat was alerted, Officer #2 drew his Taser. Officer #2 remembered that Officer #3 said to draw the Taser as Officer #2 was deciding to do so. Officer #2's thought process was to draw the Taser so that there was not only a lethal force option but also a less lethal option present. When the Taser was activated and the red dot was on Mr. Osagie, he backed into the apartment not allowing for a clear shot from the Taser. At this time, Officer #3 in a support role and on the steps, immediately attempted calling for back-up from additional police officers. Actually, what came over the radio was Officer #1 calling for back-up and announcing "10-33". When Mr. Osagie ran out of the apartment doorway with the knife, both Officer #2 and Officer #1 feared for their life and had to

make a split-second decision to discharge their weapons and both did so striking Mr. Osagie. The Taser probes struck Mr. Osagie but were found to be too close to be effective as discussed earlier in this review. Officer #1 fired 4 shots, striking Mr. Osagie 3 times at close range, effectively neutralizing the threat before officers were assaulted with the knife wielded by Mr. Osagie.

During various community meetings, some citizens expressed concern that the peep hole was covered when the officers knocked on the door, there was no mental health expert with the officers and the officer in plainclothes was not at the door making contact as he would have appeared less threatening. Furthermore, some citizens questioned why, given the layout of the apartment hallway, the officers chose to make contact at that location. Many of the concerns brought up by the community are commonly and professionally accepted police tactics. Nonetheless, the board should consider this community feedback along with the totality of circumstances and information known by the officers at the time (not 20/20 hindsight) to consider, if anything, tactically different should or even could have been done, before attempting to contact this individual suffering from mental health to the degree that a 302 warrant has been issued.

## **7. TRAINING**

### **1.3.0.2 Testing on Use of Force Policy**

### **1.3.4 Electro-Muscular-Disruption Devices Conducted Electrical Device (Taser)**

### **1.3.9 Demonstrated Proficiency required to Carry Approved Weapons**

### **1.3.10 Use of Force In-Service and Weapons Proficiency Training**

#### **1.3.10.5 In-service training**

#### **2.7.8 A Mental Health/Intellectual Disability**

A review of all department training was completed as a result of this incident. This was in part due to questions from the community specifically centered around mental health training as well as cultural diversity training within the State College Police Department. Complete training records for Officer #1, Officer #2 and Officer #3 are provided, with specifically related trainings highlighted. Aside from specific specialized training, the included training transcripts are indicative of overall department training.

In summary, all three of the officers involved in this incident have had Crisis Intervention Team training. Officer #3 is also a certified crisis negotiator. The department has spent considerable time on cultural diversity training since 2015. All three officers recently received a four (4) hour block of Surviving Verbal Conflict (de-escalation) training. Besides CIT training, the last department-wide mental health specific training was a two (2) hour block at in-service in 2017. All three officers are currently up to date with Mandatory In-service Training (MIST) training. Furthermore, State College Officers receive a review of critical policies on an annual basis. That policy review includes but is not limited to bias-based policing, deadly force and mental health procedures. All three officers attended 2019 department in-service training and received critical policy review.

Included in this review is the 2018 Firearms report and 2019 Winter shoot. All three (3) officers were up to date on the Pennsylvania firearms certification requirements at the time of this incident. The department has spent considerable time training officers with specific emphasis on mental health, cultural diversity, and de-escalation in the past several years. The department has also expanded the firearms program to include more qualification dates and instructors. The board

should review involved officer training transcripts through the lens of this incident and consider emphasis on any future training that could aid officers to be better prepared for such a circumstance in the future.

## **8. SUPERVISION**

### **1.3.6 Investigations and Written Reports Required**

### **5.5.0 Command Notification Procedure**

Department supervisors were involved and provided direction throughout this incident. As stated earlier, the night shift lieutenant was present at the apartment and briefly met with Mr. Osagie's father the night prior. He provided the initial responding officer with direction regarding obtaining a 302 Warrant as well as provided ideas to locate Mr. Osagie to include using phone pings. That lieutenant personally briefed the day shift lieutenant on the situation at shift change.

The day shift lieutenant assigned the case to a patrol officer at briefing as well as assisted that officer with an attempt to make contact at the apartment. Officer #3 was alerted to the missing person / Mental Health investigation by both patrol supervisors. Later at another briefing, Officer #3 recognized that the involved individual was Mr. Osagie. Remembering from past incidents that Mr. Osagie often goes missing for days, Officer #3 requested that the incident be assigned to a detective as well so that a detective could continue phone pings and immediately pick up the case if the assigned patrol officer did not immediately locate Mr. Osagie that day. Officer #3 and Officer #2 were present backing Officer #1 attempting to contact Mr. Osagie after the report from Can-Help. Before contact, Officer #3 verified the 302 warrant and apartment number. Once Officer #1 observed Mr. Osagie holding a knife and drew his firearm, Officer #3 advised Officer #2 to get the Taser ready. Officer #3 then attempted to call for back-up however Mr. Osagie ran out of the apartment toward the officers with Officer #2 firing the Taser and Officer #1 firing the officer's duty weapon. As documented, this event occurred approximately 10 seconds after the knife was observed by Officer #1. Once the shooting took place, Officer #3 made notifications and began the process of securing the crime scene. Both Officer #3 and Officer #2 took over responsibility of the scene from Officer #1. Officer #2 checked on Officer #1 as well as searched the apartment and provided direction to a responding officer to take Mr. Osagie's roommate back to the police department. The day shift patrol lieutenant was aware of the warrant service attempt and that Officer #2 was assisting Officer #1 with the call. That lieutenant was currently assisting officers at another location securing for a search warrant. Hearing what took place, the lieutenant immediately responded to the scene in emergency fashion and assisted with medical care to include checking on the wellbeing of Officer #1, Officer #2 and Officer #3. Command was notified by Officer #3 and I responded to the scene.

The actual shooting occurred in seconds; however, the board should consider the role of the supervisors before the shooting event (attempting to locate Mr. Osagie) and after the event to include support and direction provided to the officers.



## 9. POST SHOOTING INVESTIGATION PROCESS

### 1.3.6 Investigations and Written Reports Required

#### 1.8.1.12 Use of Alcohol/Drugs on duty or in Uniform

#### 7.01.05 On-duty Handgun and Equipment

This investigation was turned over to the Pennsylvania State Police as per department policy. Officer #3 immediately notified the State Police and Centre County District Attorney requesting assistance. Once further State College Officers responded to the scene, an officer was placed in control of the scene and began a crime scene log.

Officer #1 was released from the scene and transported to station. Officer #1 was later transported to the hospital. While at the hospital, Officer #1 did submit to a blood test. Although not specifically in policy, this test and the results were requested by the Chief of Police. No illegal substances or alcohol were found in Officer #1's system.

While at the scene, Officer #3 took Officer #1's firearm. Officer #3 then turned over Officer #1's firearm to Pennsylvania State Police investigators at the scene. The Pennsylvania State Police made several requests for evidence items beyond the incident scene on March 20, 2019 and March 21, 2019. Those requests were as follows:

- 1) **Officer #2's and Officer #3's firearms**
- 2) **Any Available Car Camera Footage**
- 3) **Uniforms worn by Officer #2 and Officer #1**
- 4) **Taser Download**

The lead Pennsylvania State Police Investigator was interviewed regarding the State College Police Department assistance with the criminal investigation. He advised that all three officers were interviewed several days after the incident consistent with State Police procedure allowing the officers proper time to decompress. Officer #3 was interviewed on Thursday March 23, 2019 and Officer #1 and Officer #2 were interviewed on Monday March 25, 2019. The state police investigator advised that all three officers provided accounts that were consistent with their SCPD police reports. There were no major conflicts between officer recollections and as reported by the DA, the physical evidence supported officer reports. The only thing that the investigator mentioned was that Officer #1 thought he fired 3 rounds and he did not recall calling the Centre County Communications Center himself. The investigator did remark that all officers interviewed in this investigation to include Officer #3, Officer #2 and Officer #1 were extremely courteous, forthcoming and professional in the interviews and interactions with all State Police investigators.

This internal review did not begin in earnest until the criminal investigation was completed and the DA released his findings and report. This final internal report for review by the board relied primarily on the SCPD reports, follow-up interviews, and SCPD information/statistics. The public DA report and PSP investigative report were used to supplement this investigation particularly regarding physical evidence findings. State Police interview transcripts were used to cross check internal review information and confirm there were no conflicting statements made by involved officers. One piece of feedback provided by several officers that were re-interviewed for this report included that this internal review lagged too far behind the criminal investigation. The board should look at how this investigation unfolded and look for potential improvements in policy and procedure to provide an improved road map for future investigations of this kind.

## 10. POST SHOOTING PERSONAL SERVICES

### 1.3.6 Investigations and Written Reports Required

#### 1.3.7 A Administrative Leave

#### 1.3.7 B Psychological Services

Both Officer #1 and Officer #2 were briefly checked out for injuries by the responding Centre Life Link emergency personnel. Officer #1 was transported to the station. Centre Life Link continued to monitor Officer #1 outside of the State College Municipal Building (243 South Allen Street). A patrol officer remained with Officer #1 as well as his wife responded from work. Eventually it was decided to have Officer #1 change to his civilian clothing and be taken to the hospital as a precaution. Officer #1 was accompanied by another officer and his wife. The union attorney responded to the hospital from Harrisburg and provided Officer #1 legal representation. The borough attorney was not involved in providing legal representation.

All three officers met with a counselor from the Employee Assistance Program (EAP) on Thursday 3/21/19. This was followed up with a scheduled appointment with a licensed clinical psychologist. Those appointments were made separately and at the involved officer's convenience. Officer #1 continues to remain on paid administrative leave. Officer #2 was taken off duty immediately following the incident and then was on administrative leave through March 30<sup>th</sup>, 2019 when the officer returned to a restricted duty status. Officer #2 was cleared medically, and once the DA provided his findings, Officer #2 was placed back in full duty status on May 13, 2019. Officer #3 was placed on a restricted duty status while this officer finished up some critical work on March 20<sup>th</sup> and 21<sup>st</sup>. Officer #3 had one administrative leave day on Friday March 22<sup>nd</sup>. Officer #3 then returned to restricted duty on Monday March 25<sup>th</sup>. Officer #3 was cleared medically and once the DA provided his findings, Officer #3 was placed back in full duty status on May 13, 2019.

## 11. CLOSING

The District Attorney has declared the shooting of Mr. Osagie as justifiable, and a reasonable amount of force given the circumstances the officers faced in that moment. That determination being made, the board still has the tremendous responsibility of reviewing all actions and related policies in an intentionally and critical fashion to determine whether the officers acted within department policy and if so, decide whether our policy is appropriate and sufficient. This tragic event is unprecedented as it has never occurred before in our department's 103-year history. That being the case, we are applying some department policies that have never been tested and navigating strong emotions while doing so. It is the duty of this board to ensure that we learn everything we can from this event through a detailed and all-encompassing review. Such a thorough analysis of the entirety of the events surrounding this incident will greatly benefit the safety of our officers and the community as well as enhance our departments professional image and the public's trust.

# ATTACHMENTS

(Not included in Public Document)

- A. Policy Sections to consider**
- B. Incident report 19SC04228**
- C. Incident report 19SC04265**
- D. Centre County District Attorney report**
- E. CCECC records of phone conversations and dispatch of officers**
- F. Scene photos of 1013 Old Boalsburg Rd**
- G. DA Correspondence**
- H. Officer Use of Force**
- I. Officer #1 arrest by race breakdown**
- J. Department biased policing reports from 2017 and 2018 / Dolan Consulting Research Brief**
- K. Prior Osaze Osagie contacts with synopsis**
- L. Officer training records**
- M. 2018 Firearms report and 2019 Winter shoot**
- N. Officer #1 Lab results from 3/20/19**
- O. Miscellaneous emails and documentation**
- P. State Police Investigative report PA 2019-354397**
- Q. Officer-Involved Shootings: A guide for Law Enforcement Leaders (US Department of Justice & IACP)**

Report completed by:

Captain Matthew E. Wilson #3296  
Assistant Chief State College Police Department

## Internal Review Board Review and Findings

On Monday, July 8, 2019 at 8:00 a.m., the Internal Review Board convened to conduct a review per policy of Incidents 19SC04228 (Health and Safety) and 19SC04265 (Assault). The review was concluded at 7:10 p.m.

The Internal Review Board, chaired by Captain Christian Fishel, consisted of one Lieutenant, one Sergeant, and two Officers. The material and information were compiled and presented to the board by Assistant Chief Matthew Wilson.

The following are the related policy sections the Internal Review Board considered, the Board's findings, and summary highlights supporting the Board's findings:

### **A. USE OF FORCE AND DEADLY FORCE:**

- 01.03.00 Use of Force
- 01.03.00.1 Definitions
- 01.03.01 Authorized Use of Force Options and Their Appropriate Application
- 01.03.02 Use of Deadly Force

Upon careful consideration and review of all evidence, information, and statements presented during this inquiry, the board voted on the sections as outlined below:

**Section A Policies – Use of Force and Deadly Force:** The board was unanimous in its decision (**4-0 vote**) that the officer's actions were **Within Policy** regarding these policy sections.

In reaching their conclusion, the Internal Review Board noted the following:

The District Attorney's conclusion and analysis: the officer had no other option than to shoot in self-defense and in defense of the 2<sup>nd</sup> officer at the time Mr. Osagie charged the officers with a knife (page 26).

Section 508 (a) of Title 18, the Pennsylvania Crimes Code. Deadly force is justified in defense of human life, or in defense of any person in immediate danger of serious bodily injury.

Based on the Totality of the Circumstances to include the following:

- Mr. Osagie's text messages.
- Mr. Osagie's assault with a deadly weapon.
- Forensic evidence.
- Officer statements and reports
- Radio transmissions
- Taser download

## **B. MEDICAL AID AFTER USE OF FORCE:**

Upon careful consideration and review of all evidence and statements presented during this inquiry, the board voted on the sections as outlined below:

**Section B Policies – Medical Aid After Use of Force:** The board was unanimous in its decision **(4-0 vote)** that the officer’s actions were **Within Policy** regarding this policy section.

In reaching their conclusion, the Internal Review Board noted the following:

Officers called for medical aid at an appropriate time period after the shooting when Officer #3 requested medical aid (“Code 3”).

Officers cleared the knife, cleared the apartment, and obtained a medical bag to administer aid.

The Daylight Patrol Lieutenant arrived to assist with medical aid. He noted no signs of life.

The responding paramedic noted no opportunity to preserve life.

## **C. BIASED BASED POLICING:**

01.08.03      Biased Based Policing

Upon careful consideration and review of all evidence and statements presented during this inquiry, the board voted on the sections as outlined below:

**Section C Policies – Biased Based Policing -** The board was unanimous in its decision **(4-0 vote)** that the officer’s actions were **Within Policy** regarding this policy section.

In reaching their conclusion, the Internal Review Board noted the following:

All evidence and indications are that the officer’s actions were based on Mr. Osagie’s actions, circumstances, prior knowledge and evidence. Specifically, Mr. Osagie attempted to commit an assault with a deadly weapon, the public safety function of a 302 MHID warrant was initiated on the father’s determination of a threat to self or others, and officers were directed to Mr. Osagie’s presence by the Strawberry Fields case worker.

Assistant Chief Matthew Wilson conducted a review of the race of Officer #1’s career contacts / arrests and found no indication of bias.

On May 8, 2019, Sergeant William Slaton of the Pennsylvania State Police Heritage Affairs Unit announced publicly that race had nothing to do with the outcome.

## **D. TACTICAL CONSIDERATIONS:**

- 02.07.04 Civil Process – Requires Sworn Service
- 02.07.08A Mental Health / Intellectual Disability

Upon careful consideration and review of all evidence and statements presented during this inquiry, the board voted on the sections as outlined below:

**Section D Policies – Tactical Considerations:** The board was unanimous in its decision (**4-0 vote**) that the officer's actions were **Within Policy** regarding this policy section. While the board found the actions to be Within Policy, they did make several recommendations on additional tactics that may be considered in the future.

In reaching their conclusion that the officer's actions were Within Policy, the Internal Review Board noted the following:

Per policy 02.07.04, Civil Process – Requires Sworn Service, the service (civil warrant) shall be done by sworn police officers of the Department and sufficient resources shall be requested to maintain order and provide for the safety and security of the serving officers.

All involved officers shared information appropriately to keep Department members informed of the circumstances, completed required reports, assigned the case for follow up to a detective, and contacted Mr. Osagie's father three (3) times to find out if he had any contact with his son.

**Section 02.07.08 - Mental Health / Intellectual Disability -** The board was unanimous in its decision (**4-0 vote**) that the officer's actions were **Within Policy** regarding this policy section.

In reaching their conclusion, the Internal Review Board noted the following:

The board noted that the officers followed policy in regard to serving 302 warrants per state law and policy regarding 02.07.08 A (1) and 02.07.08 A (2).

02.07.08 A (1) states When an MHID 302 warrant is issued, an officer will be dispatched to the scene of the incident to assist in serving the warrant or stabilizing the person or situation until a crisis worker arrives on scene.

02.07.08 A (2) (b) states in some cases there are incidents in which the person to be picked up may be a danger to him or herself or others. This individual may require immediate police action prior to the arrival of the crisis worker with the warrant.

The officers went to the apartment to serve the warrant. Officer #1 attempted to engage Mr. Osagie in conversation and de-escalate him until he showed the knife; and eventually attacked the officers. These actions precluded any attempts to serve a warrant, stabilize the scene or await a case worker. The actions of charging the officers created the exigent circumstance.

Three (3) separate teams of officers at three different times over an approximate 16-hour period of time attempted contact with Mr. Osage after his father provided the information necessary to declare the warrant by proceeding to his apartment and attempting contact with the subject.

#### **E. TRAINING CONSIDERATIONS:**

- 01.03.00.2     Testing on Use of Force Policy
- 01.03.09       Demonstrated Proficiency Required to Carry Approved Weapons
- 01.03.10       Use of Force In-service and Weapons Proficiency Training
- 01.10.05       In-service Training

Upon careful consideration and review of all evidence and statements presented during this inquiry, the board voted on the sections as outlined below:

**Section E Policies Training Considerations:** The board was unanimous in its decision (**4-0 vote**) that the officer's actions were **Within Policy** regarding these policy sections. While the board found the actions to be Within Policy, they did make several recommendations on continued and additional training.

In reaching their conclusion that the officer's actions were Within Policy, the Internal Review Board noted the following:

The board found that the officers completed all training recommended by the Department and mandated by the Commonwealth.

All officers completed state mandated and Department firearms training and qualification.

All officers completed Critical Policies training and exam as part of the Department's accreditation program of best practices in law enforcement.

All officers completed Crisis Intervention Training (CIT) and De-escalation training. One officer completed CIT training, one officer completed CIT training and is a CIT presenter, and one officer completed CIT training and is a certified Crisis Negotiations Team member by the National Tactical Officers Association and the Phoenix Consulting Group in both Basic and Advanced Crisis Negotiations.

#### **F. SUPERVISION:**

- 01.03.06       Investigations and Written Reports Required
- 05.05.00       Command Notification Procedure

Upon careful consideration and review of all evidence and statements presented during this inquiry, the board voted on the sections as outlined below:

**Section F Polices, Supervision:** The board was unanimous in its decision (**4-0 vote**) that the supervision was **Within Policy** regarding these policy sections and the supervisors provided guidance and supervision.

In reaching their conclusion, the Internal Review Board noted the following:

The board reviewed the supervision BEFORE the incident on Old Boalsburg Road and found the following:

Night Platoon Lieutenant facilitated contact with Mr. Osagie's father and also passed on the information to Daylight Platoon to include the issuance of the 302 Warrant and text message content.

Daylight Platoon Lieutenant reviewed the 302-warrant information with all platoon officers.

Due to the nature of the call, the daylight Lieutenant assisted an officer in an attempt to contact Osagie at the beginning of the daylight platoon.

Detective Lieutenant assigned follow up to a detective since the incident had the element of a missing endangered person.

The board reviewed the supervision UPON ARRIVING at the incident location and found the following:

Officer #2 was the on-duty field supervisor and teammate in the contact and cover concept.

Officer #3 was the senior supervisor on scene but was serving a support role related to the officer's negotiator specialty.

The board reviewed the supervision AFTER the shooting and found the following:

Officer #3 called for emergency medical assistance, then ensured the investigation process was initiated and made command notifications.

Officer #2 cleared the knife of the immediate area, conducted a cursory search of the hallway and apartment, ensured medical assistance was requested, and checked Officer #1 for officer wellness.

Daylight Platoon Lieutenant responded to the scene, assisted with the medical assessment, started a crime scene log, and ensured preservation of the crime scene.

The Platoon Commander or Shift Supervisor is required by policy to perform certain functions following an officer involved shooting of which Daylight Platoon Lieutenant completed. The functions are as follows:

Proceed to the scene, secure the scene, conduct a preliminary investigation and notify the supervisor's chain of command, render command assistance, assist the involved officer, and submit a written report



## **G. POST SHOOTING INVESTIGATION PROCESS:**

- 01.03.06 Investigations and Written Reports Required
- 01.08.1.12 Use of Alcohol / Drugs on Duty or in Uniform On-duty Handgun and Equipment
- 07.01.05 On-duty Handgun and Equipment

Upon careful consideration and review of all evidence and statements presented during this inquiry, the board voted on the sections as outlined below:

**Section G Policies, Post Shooting Investigation Process:** The board was unanimous in its decision (**4-0 vote**) that the investigation process of preserving the scene for the Pennsylvania State Police Crimes Unit was **Within Policy**. While the board found the actions to be **Within Policy**, they did make several recommendations on ways to enhance this policy.

## **H. POST SHOOTING PERSONAL SERVICES:**

- 01.03.06 Investigations and Written Reports Required
- 01.03.07A Administrative Leave
- 01.03.07B Psychological Services

Upon careful consideration and review of all evidence and statements presented during this inquiry, the board voted on the sections as outlined below:

**Section H Policies, Post Shooting Personal Service:** The board was unanimous in its decision (**4-0 vote**) that the personal services provided was **Within Policy**. While the board found the actions to be **Within Policy**, they did make several recommendations on ways to enhance this policy.

Board findings report completed by:

Captain Christian D. Fishel #3277  
Patrol Division Commander