

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF THE VIRGIN ISLANDS**

UNITED STATES OF AMERICA,)
)
) C.A. No. 3:08-CV-158
)
 Plaintiff,)
)
 v.)
)
)
 THE TERRITORY OF THE VIRGIN ISLANDS)
 and THE VIRGIN ISLANDS POLICE)
 DEPARTMENT,)
)
)
 Defendants.)
)
)

IMT Third Quarter 2024 Status Report

Comes now Sydney R. Roberts, Independent Monitor, and submits the IMT's third quarter Status Report for 2024.

Dated: November 15, 2024

Respectfully submitted,

s/ Sydney R. Roberts
Independent Monitor

CERTIFICATE OF SERVICE

I hereby certify that on November 15, 2024, a copy of the Independent Monitors' third quarter Status Report for 2024 was filed electronically on November 15, 2024, using the CM/ECF system, which will send electronic notification of this filing to all counsel of record.

s/ Sydney R. Roberts

Sydney R. Roberts

Independent Monitor

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Third Quarter 2024 Final Report

November 15, 2024





November 15, 2024

Honorable Judge Robert A. Molloy
Chief Judge
District Court of the Virgin Islands
Ron de Lugo Federal Building
5500 Veterans Drive, Room 310
St. Thomas, VI 00802

Dear Honorable Judge Robert A. Molloy:

Pursuant to Consent Decree Case No. 3:08-CV-158 ¶196, the Independent Monitor submits its quarterly report for the period ending November 1, 2024.

Sincerely,
Virgin Islands Police Department Monitor Team



Sydney Roberts, JD
Monitor

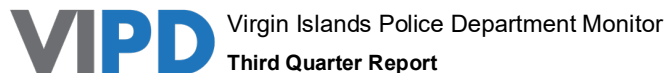


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Executive Summary

The Independent Monitoring Team (IMT) is pleased to submit its third quarter 2024 (Q3 2024) report. This report encompasses our evaluation of the Virgin Islands Police Department's (VIPD) efforts between June 1, 2024, and August 31, 2024 (i.e., the assessment period). The IMT concludes the VIPD continues to demonstrate VIPD's sustained compliance with all Consent Decree (CD) paragraphs except for Use of Force (UOF) paragraph 37 and Management and Supervision (M&S) paragraphs 64 and 71.¹ Consistent with previous quarters, VIPD has demonstrated partial compliance with these three paragraphs and continues to make incremental progress.

The IMT concluded administrative investigations were generally thorough, and the findings reached were supported by the facts and evidence uncovered during the investigation. In addition, we continue to see instances wherein commanding officers have conducted meaningful reviews of completed investigations and identified necessary corrections and additional investigative steps when warranted. Nevertheless, in two completed complaint investigations assessed, additional evidence or witnesses were identified, but the investigative report is void of any indication that the investigator followed up on the additional information or concluded that it lacked evidentiary value. At this time, the IMT finds VIPD remains in substantial compliance with the Citizen Complaint section notwithstanding these investigative lapses. However, the IMT does have concerns about whether VIPD is devoting sufficient attention to the quality of its investigative reports. In its October status report to the court, the VIPD reported it hosted a two-day Level 1 Investigative Interviewing Techniques Training Course for supervisors in both districts. The training was the result of a VIPD request to the Department of Justice's Office of Community Oriented Policing Services and facilitated by the Collaborative Reform Initiative Technical Assistance Center (CRI-TAC). VIPD has also begun researching additional training opportunities. This quarter, the Compliance and Change Management Unit (CCMU) completed all outstanding quarterly audits from 2023, and it is current with all 2024 quarterly audits. VIPD, in consultation with the IMT, has modified its auditing methodology and is positioned to maintain the timely completion of its audits moving forward.

VIPD has made progress in investigative timeliness, particularly relative to the closure of some of its oldest UOF investigations. Of note, VIPD was successful in reducing the overall number of pending cases for the third consecutive quarter. The IMT is encouraged by the evidence of VIPD imposing accountability measures for the untimely completion and/or review of investigations; however, corrective action has been intermittent and inconsistent. We remain steadfast in our belief and recommendation to VIPD that an effective accountability structure and disciplinary process require swift and consistent action. To facilitate organizational compliance with the timeliness mandates under paragraphs 37 and 71, VIPD must be vigilant and unwavering in its commitment to holding personnel accountable for violating the timelines set forth in VIPD policy.

In regard to the analysis of its risk data, as required under paragraph 64, the VIPD has not made progress. The IMT and VIPD engaged in several discussions over the past quarter to identify challenges related to technology, process and personnel, and the path forward. To assist VIPD in addressing these challenges,

¹ See Appendix B for full reading of paragraphs 37, 64 and 71.

the IMT has added a subject matter expert in data analysis to its team to provide technical assistance. The IMT is optimistic that VIPD will resume analyzing this data in Q4 2024.

In consultation with the IMT and the Parties, VIPD plans to hold a two-day Consent Decree Summit in St. Thomas on December 10-11, 2024. Attendees will include VIPD sergeants and above. The intent of the summit is to identify obstacles to achieving compliance and develop strategies to overcome them. The summit will provide a forum for VIPD to identify challenges to compliance, to collectively develop solutions to address those challenges, and, importantly, to facilitate the commitment of VIPD's supervisors and leadership to work in earnest to achieve substantial compliance with paragraphs 37, 64 and 71.

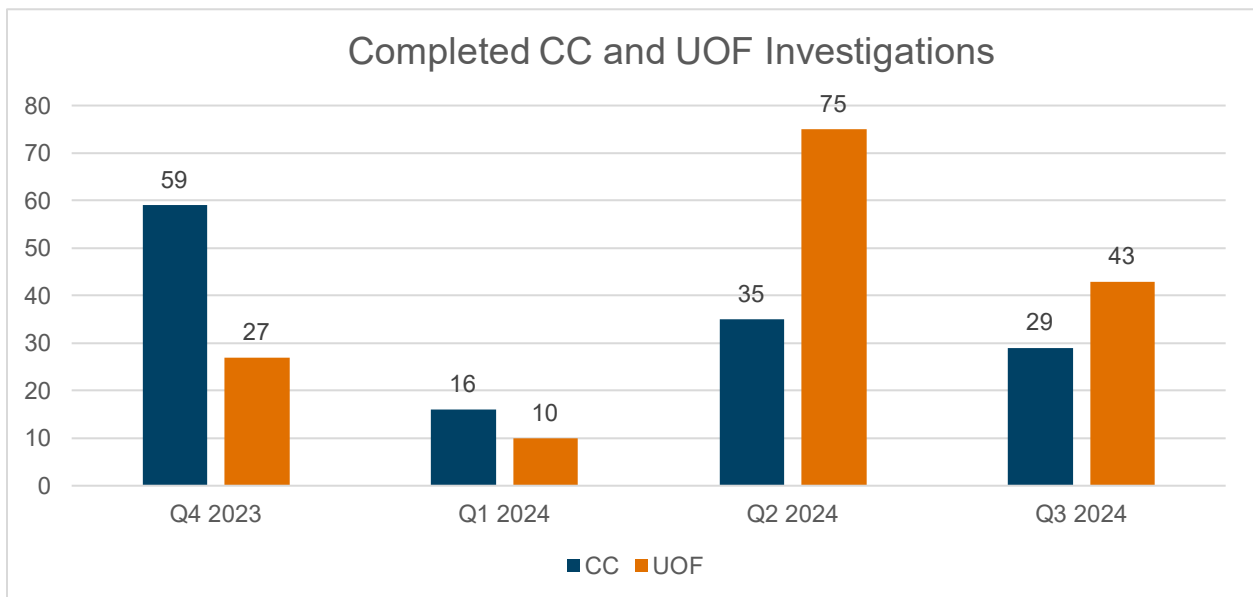
The key to achieving substantial compliance with paragraphs 37, 64 and 71 is an inspired commitment, driven by the Acting Commissioner and reinforced throughout the organization, that prioritizes completing administrative investigations in a timely manner, analyzing risk data and ensuring accountability when standards are not met. Successful compliance with the remaining paragraphs is within reach and can be realized if approached strategically, buttressed with realistic benchmarks, and given the full and active support of VIPD leadership.

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Territory Timeliness, Oversight and Accountability

Completed Internal Investigations

The IMT analyzed VIPD’s administrative investigation case closure performance in terms of the total number of investigations closed over the last four quarters to assist in our assessment of VIPD’s compliance with paragraphs 37 and 71 and to identify recommendations for the path forward. As reflected in Chart TTOA1, below, there is considerable volatility in the number of citizen complaint (CC) and use of force (UOF) cases VIPD closes each quarter. In Q3 2024, a total of 72 cases were closed, versus 110 in Q2 2024, 26 in Q1 2024 and 86 in Q4 2023. Stated another way, there was a 70% reduction in cases closed in Q1 2024 compared to Q4 2023, an over 400% increase in cases closed in Q2 2024 compared to Q1 2024, and a 35% decrease in closed cases in Q3 2024 compared to Q2 2024.

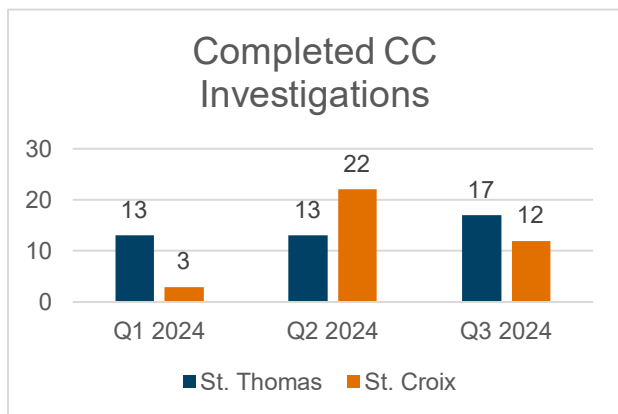


TTOA1: Number of CC and UOF cases closed each quarter since Q4 2023.

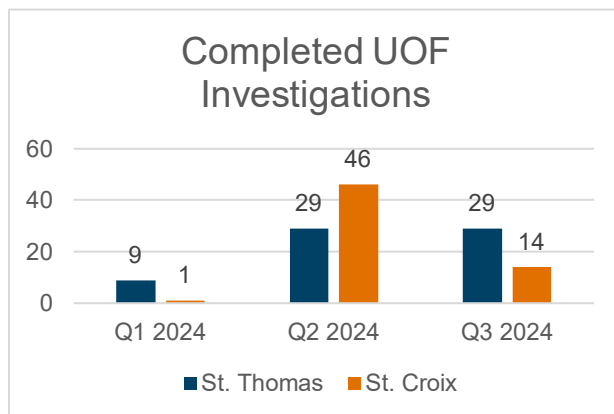
The IMT encourages VIPD leadership to engage in data analysis and discussions to determine possible contributing factors for the significant fluctuations in case closure performance. Once potential obstacles to closing cases on a consistent basis are identified, a strategy to mitigate them should be developed and implemented. For example, if events such as Carnival, military deployments or planned medical leaves negatively impact case closure, the VIPD should integrate case closure strategies for such foreseeable occurrences. It is incumbent upon those tasked with case management oversight to maintain situational awareness and to take action to prevent investigations from untimely resolutions. An excellent venue in which to discuss the conditions that cause these fluctuations is the Quarterly Pattern and Trend meetings required under VIPD Policy 6.2 that were adopted to advance VIPD’s compliance under subparagraphs 64d, 64i and 64k. Notwithstanding the foregoing, VIPD’s efforts are having an overall positive impact on its

pending caseload; for the third quarter in a row, the department has reduced the total number of pending investigations.

Below, Charts TTOA2 and TTOA3 reflect the investigations completed over the first three quarters of 2024 by island and investigation type. During this time period, St. Thomas closed 12 more cases than St. Croix. While St. Croix closed significantly more cases than St. Thomas in Q2 2024, St. Thomas has generally remained more consistent than St. Croix in terms of its case completion numbers. St. Thomas completed four more investigations in Q3 2024 compared to Q2 2024 (46 versus 42), while St. Croix completed 42 fewer cases in Q3 than in Q2 (26 versus 68). Identifying the cause(s) of these shifts may prove helpful in building stability in performance and enhancing investigative timeliness. In total, VIPD concluded 42% of the UOF and 62% of the CC investigations this period that were older than six months.



TTOA2: Number of CC investigations completed on each island each quarter since Q1 2024.

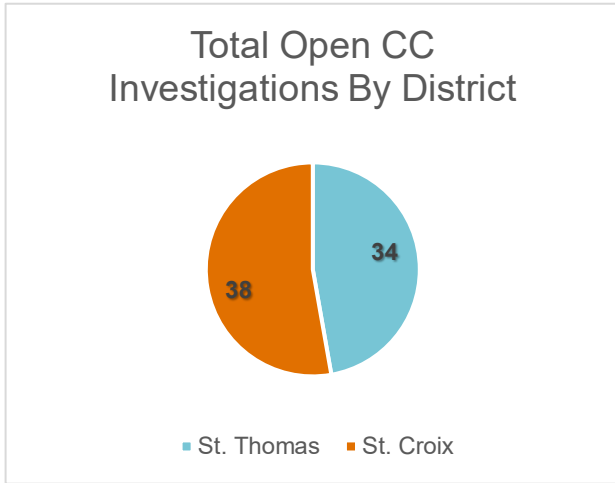


TTOA3: Number of UOF investigations completed on each island each quarter since Q1 2024.

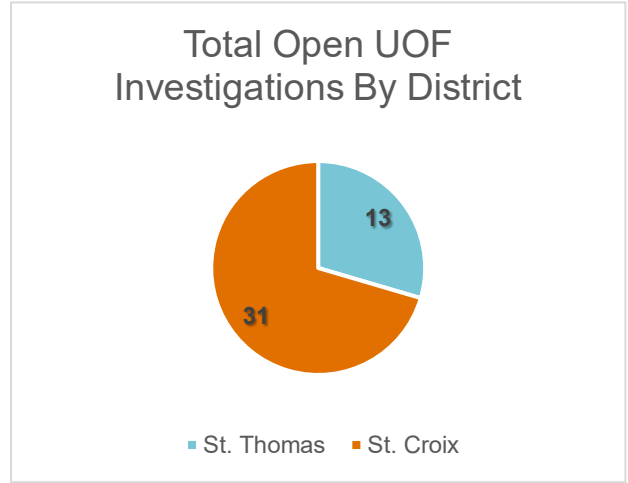
Incomplete Internal Investigations

The VIPD had a total of 116 open CC and UOF investigations on August 31 (i.e., the end of the assessment period for this quarter). Of these open investigations, St. Croix had 69 cases, while St. Thomas had 47 cases. This signifies a positive trend, representing a 23% decrease from the total number of open cases (151) recorded at the end of Q2 2024. At the conclusion of the assessment period, the proportion of total open cases assigned in St. Thomas is 41%, while St. Croix is responsible for 59%.

Further, as shown on the following page in Charts TTOA4 and TTOA5, at the end of this quarter, there were fewer pending UOF investigations (44) than CC investigations (72). When compared with the prior quarter, VIPD has reduced the number of pending CC and UOF investigations; specifically, at the end of Q2 2024, there were 67 pending UOF investigations and 84 pending CC investigations.

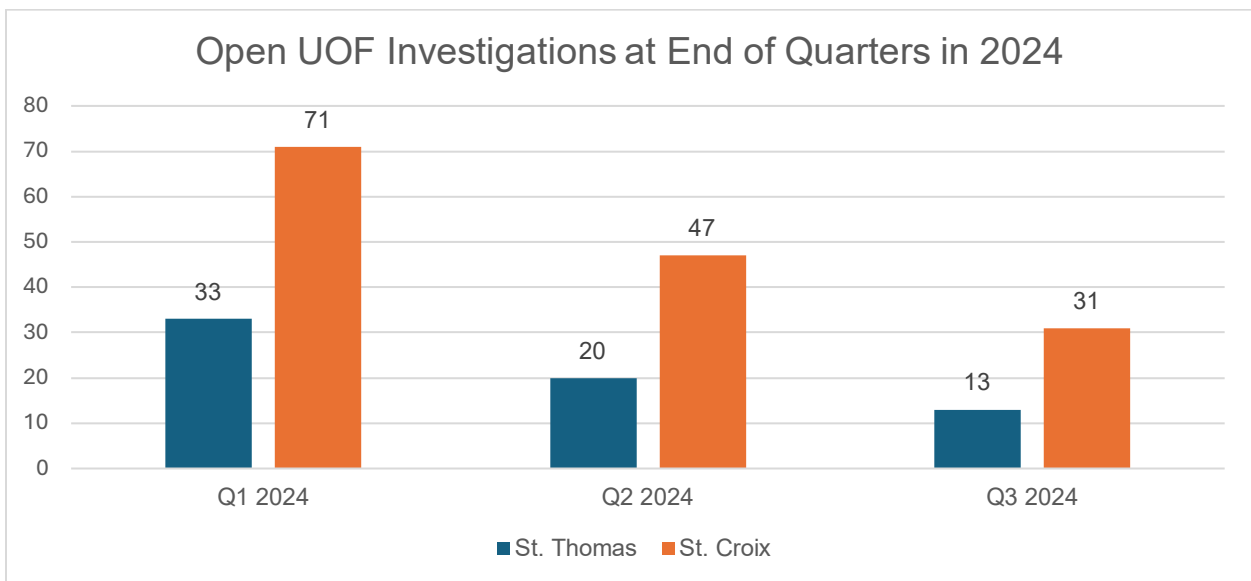


TTOA4: Number of open CC investigations on each island at the end of Q3 2024.



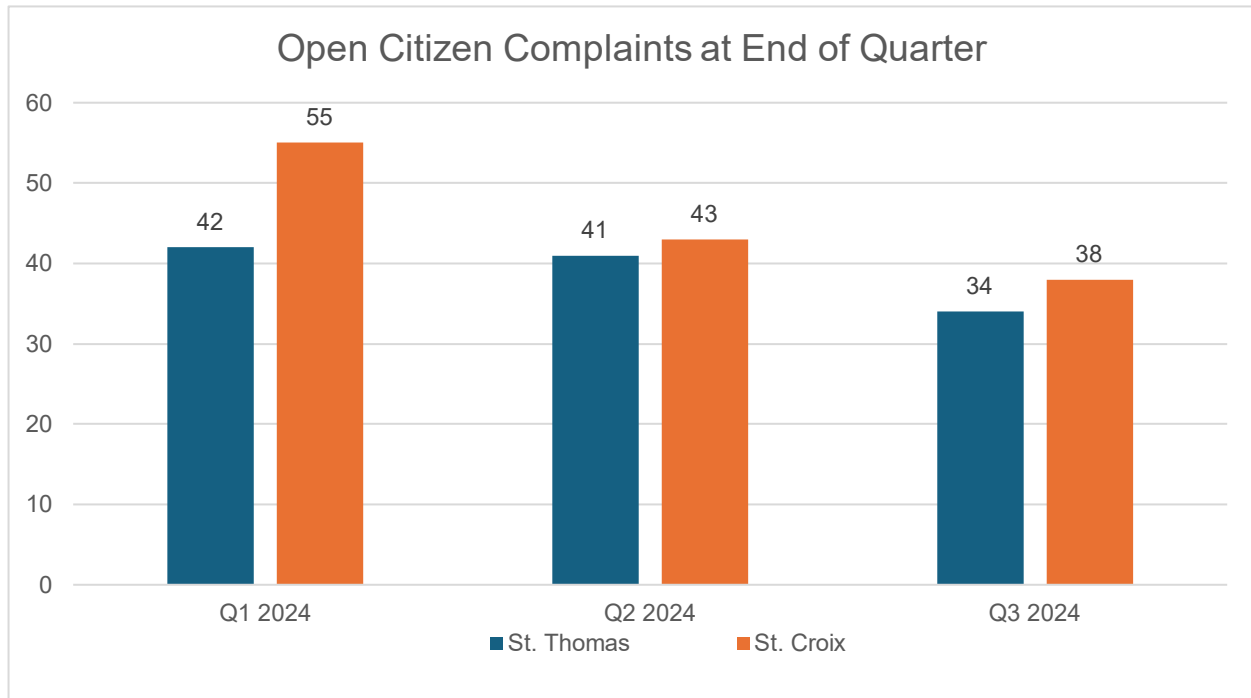
TTOA5: Number of open UOF investigations on each island at the end of Q3 2024.

As illustrated below in TTOA6, St. Thomas reduced its total number of pending UOF investigations by seven this quarter, while St. Croix reduced its pending UOF cases by 16. Overall, VIPD reduced the total number of pending UOF investigations from 67 at the conclusion of Q2 2024 to 44 at the end of Q3 2024, representing 34% fewer open cases. This period, St. Thomas completed 29 UOF investigations, while St. Croix completed 14. Of note, 20 of the 44 UOF pending investigations were opened prior to 2024, with its oldest three incidents occurring in 2022. The quarter-to-quarter reduction in the number of pending UOF investigations has been consistent in each evaluation period this year.



TTOA6: Open UOF investigations at the end of each quarter since Q1 2024 on St. Thomas and on St. Croix.

Chart TTOA7 below reflects the CC investigations that remained incomplete at the end of Q3. St. Thomas (17) and St. Croix (12) closed a combined 29 CC investigations this quarter, and both were successful in reducing the number of pending cases at the quarter's end when compared to Q2. St. Thomas realized a reduction of seven cases while St. Croix had a reduction of five cases. Both islands have reduced the number of pending CC investigations in each of the three quarters this year. Of the 72 pending CC, 30 were opened prior to 2024.

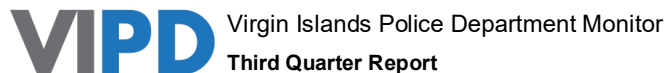


TTOA7: Open CC investigations at the end of each quarter since Q1 2024 on St. Thomas and on St. Croix.

The data reflect that of all incomplete cases, CC investigations carry over year to year more often than UOF investigations. Of the 72 pending CC investigations, 54 (75%) are from 2023 or older, 12 of which occurred in 2016. In comparison, out of the pending use of force investigations, only three are older than 2023, and these occurred in 2022. As noted earlier, VIPD should devote attention to identifying why CC investigations remain open longer and implement strategies that will improve performance and advance compliance with paragraph 71.

IAB-Assigned Incomplete Internal Investigations

This quarter, the IMT highlights VIPD's CC complaints investigated by the Internal Affairs Bureau (IAB). This assessment period, the IMT notes that IAB is responsible for the investigation of 35 CC cases, none of which have been completed. The IMT draws attention to the fact that some of these cases are among VIPD's oldest open investigations, and some of the assigned investigators as noted within VIPD's risk



management system, IAPro, left the department's employ years ago. At the end of the assessment period (i.e., August 31), these cases were not reassigned for investigation.

There is a combined total of 17 incomplete CC investigations from 2016, 2017 and 2018; IAB personnel are the assigned investigators for 12 of them. Of the remaining five, three are not assigned to an investigator, one is assigned to an employee who left the organization, and one is the responsibility of a member of Operations. IAB is responsible for almost half of the incomplete St. Thomas CC investigations (15 of 34); on St. Croix, IAB personnel are responsible for over 50% of open CC investigations (20 of 38). Lastly, of the 13 UOF cases pending, seven are Level 1 incidents assigned to IAB.

To ensure accountability, VIPD leadership should analyze the incomplete investigations assigned to IAB members. Cases assigned to investigators who no longer work for VIPD should be audited to determine the steps required and prioritized for closure. IAB's role in supporting compliance with the CD department-wide cannot be overstated. To this end, IAB's legitimacy to hold others to account for timely and thorough investigations is undermined by its failure to close the department's oldest cases in a timely manner.

Summary of Internal Investigations Observations

The IMT commends VIPD for reducing the overall number of incomplete cases for the third consecutive quarter. Additionally, the closure of 36 cases that were older than six months demonstrates a continued focus on reducing the backlog. VIPD should be encouraged by the progress and realize it can successfully eliminate the entire backlog. As a point of reference, if VIPD's productivity during Q2 2024 was replicated in the year's final quarter (Q4 2024), the result would be 50% fewer incomplete CC investigations and zero open UOF cases at the end of the year.

Oversight and Accountability

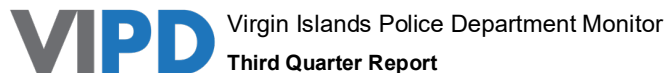
CD paragraph 37 establishes that all UOF investigations will be reviewed. If the review identifies deficiencies, the case is to be sent back to the investigating supervisor for corrections. The paragraph explicitly states:

"Supervisors will be held accountable for the quality of their reviews. Appropriate non-disciplinary corrective action and/or disciplinary action will be taken when a supervisor fails to conduct a timely and thorough review..."²

These duties are reiterated in VIPD Policy 3.2, which states, "All use of force incidents, as designated herein, shall be reported, investigated, and reviewed in a timely, complete and accurate manner as prescribed by this policy."

CD paragraph 71 also mandates that complaint investigations be completed within the timeframe established by VIPD Policy 7.3 IV (F).

² See Appendix A for a full reading of paragraph 37.



To advance compliance with these two sections of the CD and promote adherence to VIPD's corresponding policies, each territorial chief holds a weekly Commander Call with subordinate supervisors for the express purpose of discussing and receiving updates on the status of all open citizen complaint and UOF investigations.

To VIPD's credit, the territorial chiefs sometimes set deadlines for supervisors to bring open investigations to a close. Also, the VIPD has occasionally relied on the disciplinary process and imposed accountability for not meeting timelines, as established by the CD and VIPD policy. The IMT has observed documented counseling memoranda and instances where supervisors have received formal discipline. However, accountability measures are employed inconsistently. For example, a partial audit of supervisors responsible for untimely investigations, absent the presence of a valid stay or waiver, provided evidence of investigators receiving documented counseling after a single incident of failing to complete a case on time, while others involved with multiple untimely investigations have nothing in their file documenting the corrective action. The department's efforts must be consistent to ensure the effectiveness of the accountability structure and disciplinary process and to improve the timeliness of these investigations.

In the last two years, the VIPD has implemented strategies to improve the timeliness and quality of investigations. Two efforts that have had the greatest impact on improving the quality of reviews and timeliness are the Commissioner's directive issued in December 2023 and the Q2 2024 Chief's Workshop facilitated by the VIPD Deputy Commissioner. The workshop focused on improving the format of Commander Calls to enhance oversight of open investigations and drive accountability for completing them in accordance with VIPD policy. Other initiatives included providing the territorial chiefs and deputy chiefs with a list of outstanding cases and opportunities for supervisors to receive remedial IAPro training.

The innovation and agility in modifying approaches to promote compliance with the CD, specifically paragraphs 37 and 71, is admirable. However, while we have seen positive changes among some individual commanders, territorial chiefs and deputy chiefs, adherence to administrative investigative timelines or accountability is not an organizational priority.

Commander Calls

This is the fifth quarter the IMT has been observing weekly VIPD Commander Calls for St. Thomas and St. Croix. Either the chief or a deputy chief conducts the call virtually. The participants include supervisory personnel and zone commanders from the respective islands, as well as the citizen complaint investigations inspectors (CCIIs), force investigation inspectors (FIIs), Internal Affairs Bureau (IAB) staff, and Compliance and Change Management Unit (CCMU) members. A total of 21 Commander Calls were conducted this quarter, and the IMT observed 19.

In June 2024, the VIPD's Deputy Commissioner led a Chief's Workshop, which was aimed at implementing a consistent format for the Commander Calls. The objective is for the format to enhance the chief and deputy chief's situational awareness of incomplete citizen complaint and use of force investigations to drive timely completion. The strategy discussed in the workshop was implemented. However, the IMT has

observed fidelity to the process has waned in subsequent months, as the calls have reverted to being driven by the participants, rather than the chief or deputy chief chairing the meeting.

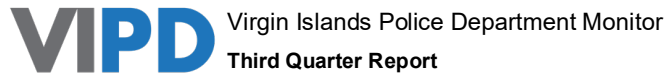
Although there has been an improvement in the level of awareness regarding incomplete investigations among chiefs and deputy chiefs, they do not have a comprehensive understanding of all outstanding cases. The IMT's observations suggest the chief or deputy chief facilitating the calls does not use a master list of all incomplete investigations. IAB regularly provides each command with a list of all outstanding cases, but the meeting facilitators rely solely on self-reporting by investigating supervisors, and investigators do not always provide updates on all incomplete investigations. The FII and CCII routinely call out the investigators for unaddressed cases, meaning the CCII and/or FII are holding the investigator to account. This highlights the chief or deputy chief's ineffectiveness in ensuring accountability and ownership of incomplete investigations within their command.

While Commander Calls have been used to promote VIPD's efforts to clear older cases from the backlog, it appears the momentum is beginning to stall. CCMU members, CCII and FIIs have expressed frustration with the slow pace of completion and the lack of progress from week to week. CCMU, FII and CCII personnel consistently inform call participants they are available for questions and encourage supervisors to contact them if they are uncertain about any of the processes surrounding citizen complaint and use of force investigations.

Of note, this was the first quarter wherein the IMT observed Operations personnel express frustration that their peers were not completing assigned investigations in a timely manner. In the past, the CCII and FII were the only people addressing investigators for untimely or incomplete investigations. During one call, an Operations commander commented, "We look at facts and hold people liable for crime, but we cannot do the same and hold people accountable for not doing their job." In another call, a supervisor said, "Why take it [completing investigations timely] serious if no one [is] ever terminated or seriously suspended for not doing it?" and suggested there is a "need to make [an] example of those not doing their job."

Disciplinary Actions and Proceedings

The IMT requested documentation of examples where supervisors were held accountable for failing to complete thorough and timely investigations. The VIPD submitted a report from its risk management system (IAPro) that included supervisors subject to counseling and/or discipline since 2021. For assessment purposes, only the cases completed during the first three reporting periods of 2024 (i.e., December 2023 through August 2024) were reviewed. Of the 27 cases analyzed, nine were associated with untimely UOF and citizen complaint investigations. Of these nine, eight resulted in completed counseling forms, five on St. Thomas and two on St. Croix. Of the eight counseling forms issued for untimely investigations, one supervisor received three, all of which were issued on the same day and by the same superior officer (SAT2024-18, SAT2024-0019, SAT2024-0020). Notably, the supervisor who received the counseling forms is assigned to IAB and refused to sign the forms, rebuking the mild form of accountability he was subjected to, despite being a supervisor in the bureau primarily tasked with ensuring organizational legitimacy and integrity.



As noted in previous IMT reports, this quarter's assessment of disciplinary proceedings identified two instances wherein the untimeliness of the investigation prevented the VIPD from imposing discipline for the underlying allegations.

In DHT2024-0020, an officer failed to activate his body-worn camera (BWC) before taking enforcement action. Based on the provided documentation, it appears the charge against the officer was undisputed, but the investigation was not completed in a timely manner, and as a result, the hearing officer did not sustain the allegation. The commissioner overruled the hearing officer's recommendation by sustaining the charge but was unable to impose discipline based on the collective bargaining agreement (CBA). In this instance, the involved officer was the subject of a sustained charge for the same violation in the past and would have been subject to progressive discipline if the investigation had been conducted in a timely manner. A search of IAPro also indicated the supervisor responsible for the late investigation did not receive any type of formal discipline, counseling or remedial training.

DHT2024-0024 involved two officers who responded to a disturbance call for service, which resulted in a use of force. One of the involved officers did not activate his BWC, while the other officer activated the BWC but held it in their hand, as opposed to attaching it to the uniform. The hearing officer did not sustain either charge, concluding the investigation was not completed in a timely manner. The commissioner concurred with the hearing officer's findings. Similar to DHT2024-0020, a search of IAPro indicated the supervisor responsible for the late investigation did not receive formal discipline, counseling or remedial training.

A significant example of VIPD's failure to drive accountability for willful non-compliance is reflected in the department's approach to DHX2024-0017. In this case, a deputy chief directed a lieutenant to complete seven outstanding personnel investigations (four UOF cases, two citizen complaints and one vehicle accident) by a specific date. The lieutenant failed to complete the investigations and was given a second deadline to complete the investigations. When the cases remained incomplete, a command investigation was initiated, and the lieutenant was determined to have violated Category B:39- Refusal to obey any lawful order or directive. During the subsequent disciplinary hearing, it was determined that four of the cases had been completed and forwarded for review after the established deadline. The three other cases, which are all UOF investigations from 2023, and remain incomplete as of October 31, 2024. Although the lieutenant did not complete the seven investigations as directed, the island's police chief served as the hearing officer and did not sustain the charge. The justification for not sustaining the charge was that the charging document used one word from an outdated VIPD policy; the current version of VIPD Policy 7.1 had been modified to read "failure to obey" instead of "refusal" to obey a lawful order. Thus, the charging document should have read "failure to obey any lawful order or directive" as opposed to "refusal to obey any lawful order or directive." The Acting Commissioner concurred with the hearing officer's findings.

Thanks to the tenacity and initiative of the Deputy Commissioner and the St. Croix deputy chief, the charges were refiled in SAX2024-0014. While the Commissioner sustained the charges, the charged officer was only ordered to serve a one-day suspension without pay and a two-day suspension held in abeyance for a period of six months.

The hearing officer and the Acting Commissioner's decisions to dismiss this violation during the initial disciplinary hearing process undermine the efforts of the deputy chief and others throughout VIPD who are

working diligently to obtain compliance with the CD, particularly those in St. Croix, which has nearly twice the number of incomplete investigations as St. Thomas. Moreover, at the time of the Acting Commissioner's ruling, the charged officer had still not completed three of the seven outstanding cases.

The skills required to comply with the investigative mandates in the CD and VIPD policy have been trained, reinforced, and when executed, specifically addressed in the IMT quarterly reports. Despite these employed strategies, cases continue to be completed outside of the CBA and VIPD-established mandates, resulting in officers and supervisors evading the disciplinary process for actions clearly in violation of policy, including offenses that could result in termination of employment. To bring about meaningful change, the supervisors responsible for untimely investigations must be held accountable, especially when retraining has not resulted in improved performance or enhanced organizational commitment. Appropriate disciplinary and/or non-disciplinary action should be taken every time a supervisor fails to conduct a timely and/or thorough investigation.

Until supervisors are consistently held accountable for ensuring investigations are completed thoroughly and in a timely manner, deadlines will continue to be viewed as only suggestions. This is problematic for several reasons but particularly burdensome to creating a culture of accountability and a functional disciplinary process. Organizational progress is hindered when obvious policy and directive violations occur but involved employees are not held accountable because investigations are undermined or completed in an untimely fashion. It is imperative VIPD take consistent action now to ensure the accountability structure and disciplinary process are effective.

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Use of Force³

Level 1 Uses of Force

Closed Level 1 Investigations - Status

From June 1, 2024, through August 31, 2024, the VIPD closed five Level 1 use of force investigations:

- UOFT2021-0091
- UOFT2022-0002
- UOFT2022-0078
- UOFX2022-0054-0058
- UOFT2024-0028-0035

Compared to the prior two quarters, wherein just one Level 1 investigation was closed in each quarter, closing five Level 1 investigations is a significant improvement. With the closure of the above 2022 Level 1 cases, one 2022 case remains open (UOFX2022-0114-0115). VIPD's most recent Level 1 incident occurred on July 13, 2024, with no reported injuries (UOFT2024-0088).

As reflected in Chart UOF1 on the following page, two Level 1 investigations took more than two years to close (UOFT2021-0091-0092 and UOFT2022-0002), two took more than one year to close (UOFT2022-0078 and UOFX2022-0054-0058) and one was closed in less than one year; UOFT2024-0028-0035, which involved a senior VIPD official, was investigated by an external entity and was completed in 147 days.

³ See Appendix B for a list of all UOF paragraphs under the CD.

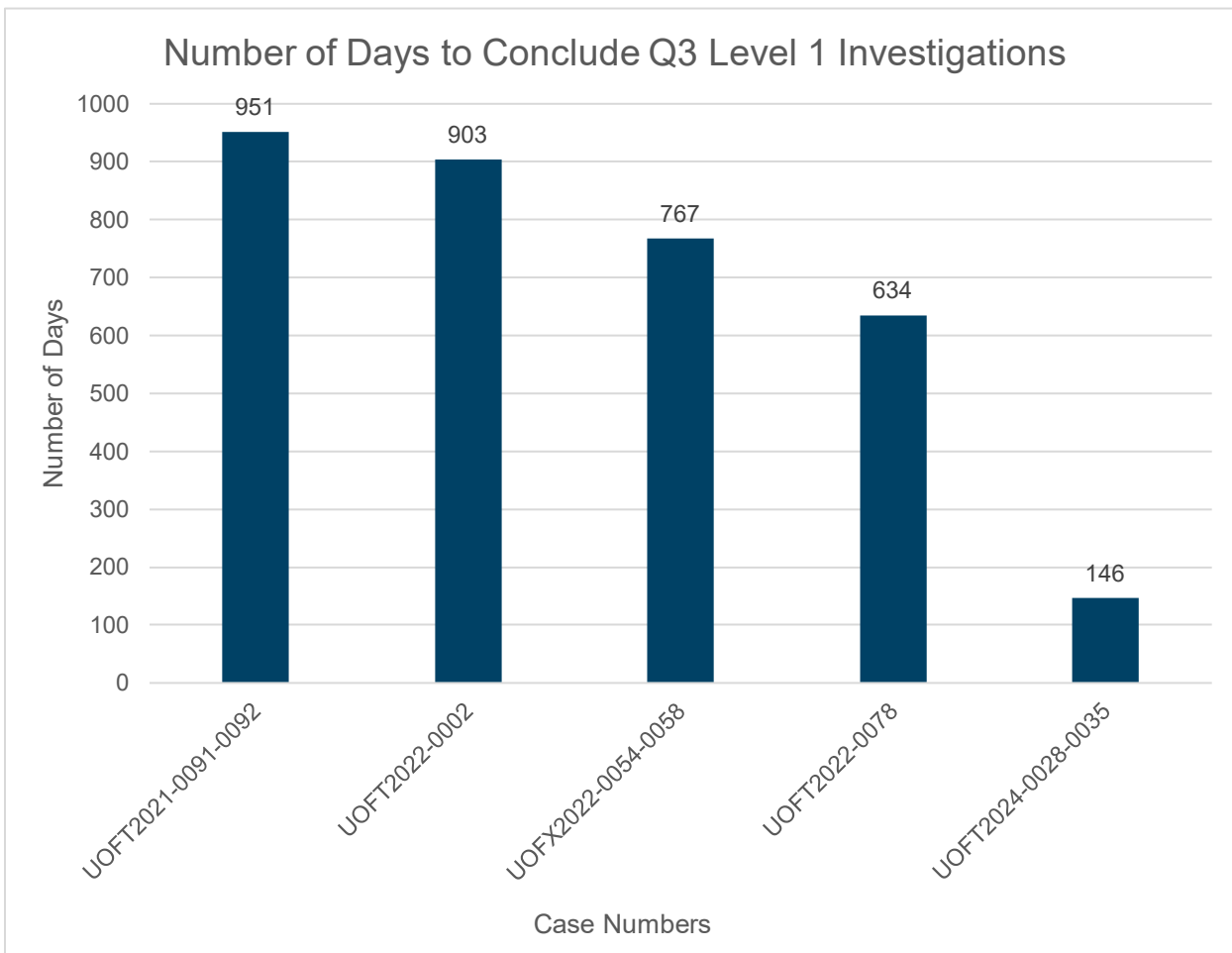


Chart UOF1: The number of days it took to close each UOF investigation closed in Q3.

In accordance with VIPD Policy 3.2, Reporting, Investigation and Review of Force, Section IV(e), Level 1 investigations must be completed within 120 days, which may be extended by a non-renewable extension of 35 days, for a total of 155 days for the Force Investigation Team (FIT) to complete the investigative report. Following the completion of the FIT investigation, Policy 3.3, Use of Force Review Board (FRB) allows an additional 45 days for the completion of the FRB report. Based on these timelines, the maximum number of days to conclude a Level 1 investigation is 200 days. However, since Q3 2023, with the exception of UOFT2024-0028-0035, which was investigated by an external entity, the VIPD has not concluded a Level 1 investigation within the timeframe set by VIPD policy.⁴

Upon reviewing the Level 1 investigations concluded this quarter, we found the completed investigative reports (IRs) were submitted to the FRB in a timely manner. However, there were considerable delays between the receipt of the FIT investigation and the FRB hearing, as well as from the FRB hearing to the

⁴ In Q3 2023, the IMT conducted its first compliance assessment for the purpose of assessing VIPD’s compliance with the CD.

completion of the FRB report and approval by the Commissioner.⁵ In UOFX2022-0054-0058, the FRB hearing was held 36 days after the IR was forwarded to the FRB, but it took an average of 58 days for the other three FRB hearings to be held. Moreover, on average, it took an additional 66 days before the FRB report was submitted to the Commissioner for review and approval. This delay is directly attributed to the fact that it took an average of 56 days following the FRB hearing for the hearing officer, usually a chief or deputy chief, to complete the FRB report. The Commissioner generally signed the FRB report within several days; however, in UOFX2022-0054-0058, 42 days elapsed before the Commissioner signed the FRB report. In this case, the FRB report was completed on May 21, 2024, but was not signed by the Commissioner until July 2. No explanation was noted within the case file to explain the delay in the Commissioner's signature.

VIPD Policy 3.3, Use of Force Review Board, sets forth the following:

- Section C.1.a. states the Force Review Board shall commence its review of an incident within 25 days after the receipt and acceptance of the FIT investigation.
- Section C.1.b. states the Force Review Board will have 20 days to complete its review [of the FIT investigation] and forward a Force Review Board Report, which documents their findings and any recommendations, to the Police Commissioner.

The IMT recognizes that VIPD is focused on concluding its older cases and that the time to complete these cases has surpassed the timelines set by VIPD. However, it is within VIPD's control to complete the post-investigation review process in a timelier manner, specifically the scheduling of the FRB hearing and the completion of the FRB report, in accordance with VIPD policy. The IMT noted similar issues of non-compliance with Policy 3.3 Section C in its Q4 2023 report.⁶ While IAB is referring completed IRs to the FRB in a timelier manner, we have not observed an improvement in the timeliness of the FRB process (i.e., scheduling of the FRB hearing and completion of the FRB report). While VIPD Policy 3.3 is silent on the timeframe in which the Commissioner must sign the FRB report, these reports should be reviewed and signed in a timely manner.

The IMT recommends VIPD address this void within policy. The IMT also recommends VIPD's executive leadership provide meaningful oversight of its Territorial Chiefs to ensure timely completion of the post-investigative review process of its most serious use of force incidents.

Chart UOF2 below depicts VIPD's nine pending Level 1 investigations by the number of days elapsed from the date of the incident through August 31 (i.e., the end of the assessment period for this quarter). Four have been open for more than one but less than two years, and five have been open for less than one year, including UOFT2024-0088, which occurred on July 14, 2024, and is still being investigated.

⁵ Due to the external investigation associated with UOFT2024-0028-0035, an FRB hearing was not held; however, a memorandum was drafted by the Deputy Commissioner of Professional Standards addressing findings and recommendations by the external investigator discussed in this report's section on Force Review Board Hearings and Reports.

⁶ IMT Q4 2023 Final Report, page 15.

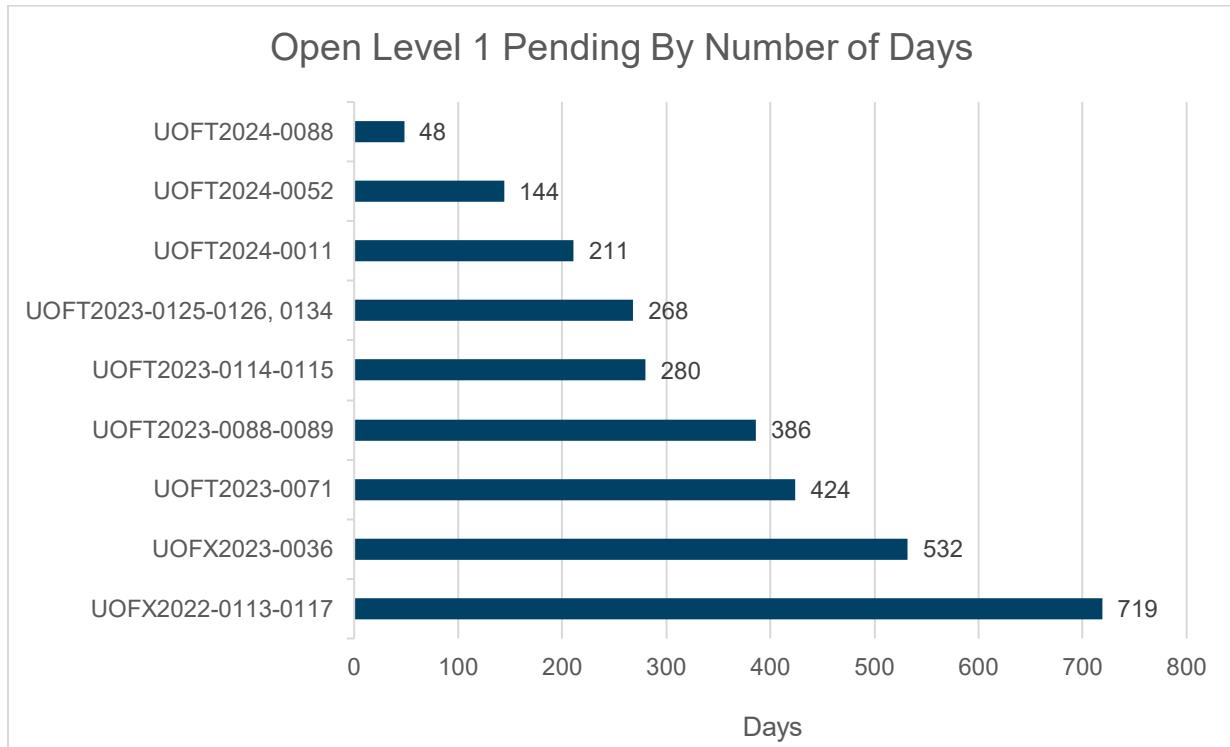


Chart UOF2: How long each Level 1 investigation has been open as of August 31.

At the end of the quarterly assessment period, the following reflects the status of the nine open Level 1 investigations:

- Three have been pending completion of the IR since Q2: UOFX2022-0113-0117, UOFX2023-0036 and UOFT2023-0071. The criminal investigations in these cases were completed in January, February and April 2024, respectively. The Attorney General's decision not to seek criminal charges in UOFX2022-0113-0117 was issued in March of this year; the Attorney General's decisions not to seek charges in the other two cases were issued in May 2024.
- Four are pending completion of the IR and the Attorney General's decision: UOFT2023-0088-0089, UOFT2023-0114-0115, UOFT2023-0125-0126, 0134 and UOFT2024-0052. Of these four cases, two have been pending a decision from the Attorney General since June of this year (UOFT2023-0088-0089 and UOFT2023-0125-0126, 0134), and two have been pending since July 2024 (UOFT2023-0114-0115 and UOFT2024-0052).
- Two are pending completion of the criminal investigations: UOFT2024-0011 and UOFT2024-0088.

The IMT reiterates that completing the IRs should not be reliant or contingent on the completion of the criminal investigation, nor should they depend on the Attorney General's decision to pursue charges.

If the VIPD is to adhere to VIPD Policies 3.3 and 3.2 and to advance compliance with the CD in this regard, it must devote greater effort and resources to the completion of the department's most serious use of force incidents.

Data and Data Analysis

Description of Cases Closed this Review Period

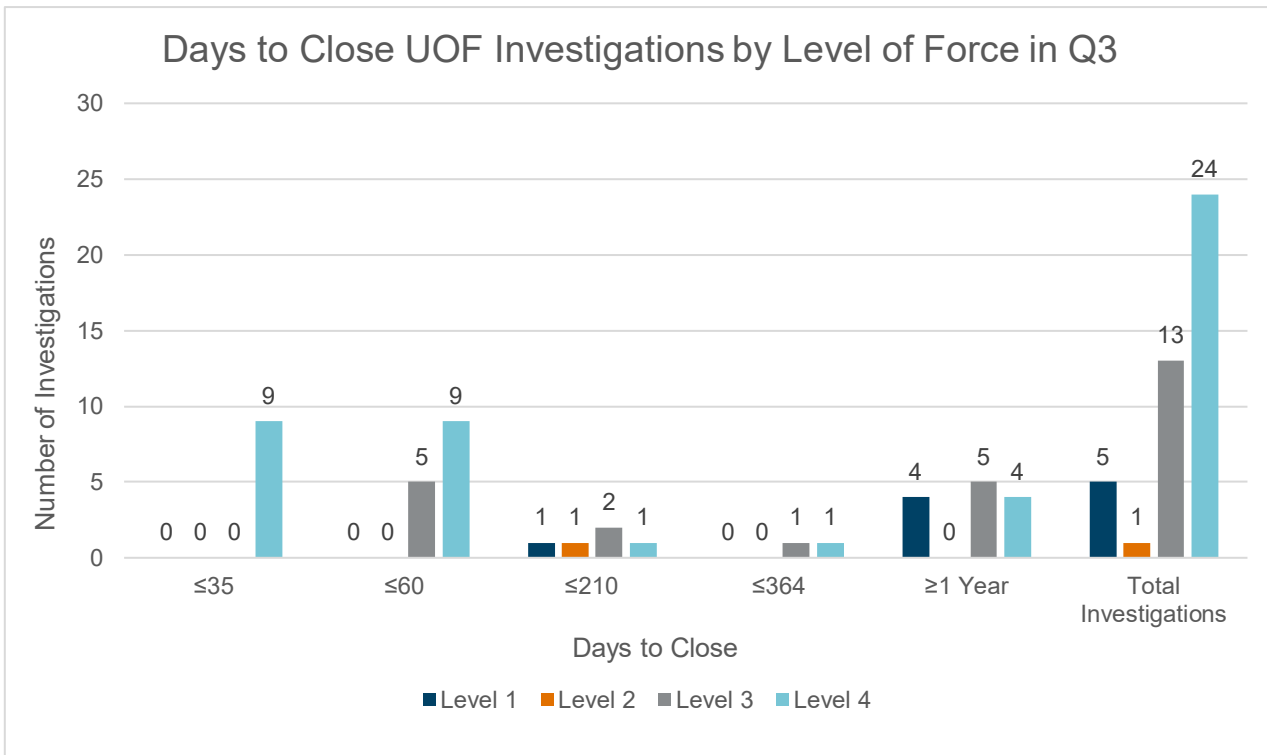
Between June 1, 2024, and August 31, 2024, the VIPD closed 43 use of force (UOF) investigations arising from 97 reportable applications of force by VIPD officers. Compared to Q2 of this year, the number of investigations closed decreased by 42% (75 in Q2 versus 43 in Q3).

Of the 97 reported uses of force, 62 occurred in St. Thomas, and 35 occurred in St. Croix. The investigations completed in St. Thomas included five Level 1, one Level 2, 19 Level 3 and 37 Level 4 applications of force. UOF investigations closed on St. Croix involved one Level 1, two Level 2, four Level 3 and 28 Level 4 applications of force.

Chart UOF3 on the following page illustrates the number of days to case closure by the level of force used. The total elapsed days to close a case includes any stays or waivers granted with each investigation and is intended to provide a better trend analysis moving forward.

This quarter, the VIPD continued to devote significant time and resources to closing its older cases. In total, 26% of the investigations closed this quarter involved incidents that occurred in Q3 2024; 37% of the cases closed this quarter involved UOF incidents that occurred in Q2, and 35% involved incidents that occurred before Q1 2024.⁷ Of note, six of the 43 incidents closed dated to 2016. These 2016 cases presented unique challenges for the VIPD, as the investigative files were compromised by the impact of Hurricanes Irma and Maria and the loss of data from the 2019 ransomware attack.

⁷ Percentages do not total 100% due to rounding.



UOF3: The number of days to close investigations based on the level of force used in Q3 2024.

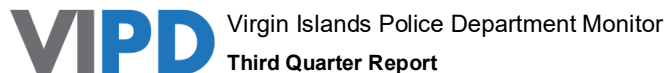
Of the 43 cases closed in Q3, nine were closed within 35 days of occurrence, 14 were closed between 36 and 60 days, while 13 took a year or more to close. Of the total investigations closed, 53% were closed within 60 days. Of the cases that took over one year to close, six were from 2016, two from 2021, three from 2022, and five from 2023.

In accordance with VIPD Policy 3.2, the maximum allowable days to complete a Level 4 investigation is 35 days.⁸ A comparison of Level 4 UOF case closures between Q3 2024, Q2 2024 and Q3 2023 offers evidence that there has been an improvement in the efficiency and timeliness of closing cases.

In Q3 2024, VIPD closed 24 Level 4 investigations. Of these 24 investigations, nine were closed within 35 days (37%), compared with just 6 of 46 last quarter (13%). Another 9 investigations took more than 35 days but were closed within 60 days (37%), one more than was closed in Q2 (17%). Additionally, in Q3 2024, 83% of all cases closed were finished within 210 days, compared to 67% completed in Q2 2024.

Looking at the number of Level 4 cases closed in both Q2 and Q3 of this year compared to the number closed in Q3 2023, it is clear that VIPD has put significant emphasis and effort into more timely case disposition. The IMT expects to see this trend continue moving forward as VIPD continues to close its older cases. In order to sustain this trend, it is imperative that VIPD redouble its efforts in closing out cases within

⁸ The 35-day total includes a maximum 20-day waiver and five days to submit to IAB for closure.



prescribed policy guidelines to prevent the type of backlog that has impacted its ability to achieve substantial compliance with paragraph 37 of the CD.

Pursuant to VIPD Policy 3.2, the maximum allowable days to complete a UOF investigation involving a Level 2 or 3 type of force is 60 days. This quarter, VIPD closed 47% of its Level 3 cases in less than 60 days, compared to 18% in Q2 2024. That said, VIPD closed a higher number of older cases in Q2; this is a positive sign of progress, and VIPD should continue to focus on closing these older cases.

The lone Level 2 case in Q3 was closed within 210 days; however, VIPD closed a total of six Level 2 investigations in Q2.

As discussed earlier in this report, the VIPD is not bringing its most serious UOF cases to a conclusion in a timely manner. With the exception of the Level 1 investigation involving a high-ranking member of the VIPD, which was outsourced to an external entity to investigate, Level 1 UOF investigations take more than a year to conclude. Of the nine pending Level 1 investigations, three have been open for more than a year (UOFT2023-0088-0089, UOFT2023-0071 and UOFT2023-0036), and one has been open for almost two years (UOFT2022-0113-0117). All four of these cases are still pending completion of the IR.

While the IMT acknowledges the efforts VIPD has made to bring its oldest pending cases to a conclusion, the department must direct continued attention and resources toward these investigations.

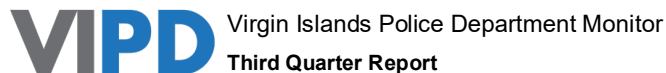
Case Review and Assessment of Completed Cases

The IMT's Q3 2024 case assessment included 25% of all non-Level 1 UOF incidents closed during the assessment period (June 1, 2024, through August 31, 2024), as well as all concluded Level 1 cases. This resulted in an analysis of 30 UOF investigations stemming from 12 force incidents and five concluded Level 1 incidents.

Force Review Board Hearings and Reports

In Q3 2024, the IMT assessed four FRB hearings and reviewed the associated final reports. The hearings were thorough and well-organized, with case presentations that included reviews of the FIT investigative reports, relevant statements, audio/visual recordings and forensic evidence, when applicable. Deliberations were handled in accordance with VIPD Policy 3.3, allowing all participants to voice their opinions and pose appropriate questions. A VIPD UOF subject matter expert was present during all hearings and deliberations to answer board member questions and to offer an opinion on the objective reasonableness of the force in question. Final dispositions were based on a scripted set of questions provided in Appendix A of Policy 3.3, Force Review Board Standard Operating Procedure, ensuring due consideration was given to policy, training, the evaluation of the force applied in each case and any issues that may justify revisiting departmental training or policies.

Regarding FRB hearings and reports, VIPD continues to struggle with timeliness. In three of the cases, FRB final written reports were submitted well beyond the 20-day limit prescribed by VIPD Policy 3.3 (UOFT2021-0091-0092, UOFT2022-0002 and UOFT2022-0078), while another was not approved by the Commissioner



within 10 days of completion (UOFX2022-0054-0058). VIPD does not close UOF investigations until the FRB hearings and reports are complete. These delays contribute to VIPD's struggles with timeliness, despite recent improvements.

FRBX2024-0001

FRBX2024-0001 (UOFX2022-0054-0058) was held on April 17, 2024. The incident occurred on May 27, 2022, and the FIT submitted its report for the FRB on March 12, 2024. The FRB report was completed on May 21, 2024, and received final Commissioner approval on July 2, 2024.

According to Policy 3.3, the FRB report must be completed within 20 days of the conclusion of the FRB hearing and receive final approval from the Commissioner within 10 days. While the FRB report was completed within the prescribed timeframe, the Commissioner's approval was not, as it was not approved for 42 days after completion; the FRB hearing was held approximately one year and 11 months after the incident occurred.

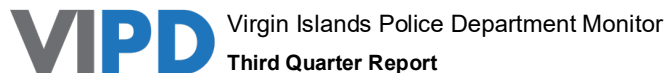
The case involved a head strike, which is categorized as a Level 1 use of force pursuant to VIPD Policy 3.2, that occurred at the Wilbur H. Francis Command Police Station parking lot in St. Croix.

According to the FIT report, the officer who is the subject of the investigation (subject officer) arrived at the parking lot to drop off items for a retirement celebration. This was also Civilian Day, meaning the civilian staff, which includes Records Bureau staff, had the day off. There were no signs posted on the station door to inform the public that the station was closed, so one of the other officers present notified people looking to conduct business that the Records Bureau was closed for the day.

A male subject walked up to the station and was informed the Records Bureau was closed for the day because the civilian employees were having a Civilian Day celebration. Upon hearing this, the subject became upset and began yelling and swearing. The officer explained that the civilian staff ran the Records Bureau and had nothing to do with the police. Not satisfied, the subject continued to yell obscenities.

Hearing the disturbance, the subject officer looked over and observed the male subject cursing and walking away, only to return and confront the other officer as if he wanted to fight. The male party charged directly at the officer, pointing in his face and yelling obscenities, before subsequently striking the officer in the face. The two men continued to struggle, and the subject officer ran over to their location to assist. The two men engaged in the altercation had a hold of each other's shirt, and the male party refused orders to let go. The subject officer struck the male subject several times on the arms and legs with a baton to make him let go of the officer he was fighting with. During the fight, the male party lunged forward, and one of the baton strikes hit his head. The baton strikes were ineffective, and the male party continued to fight with the officer and refused to obey commands to stop.

The subject officer then called out for assistance from yet another officer and instructed them to deploy their Taser to stop the fight. This caused the subject to fall, and with the assistance of several officers, the male party was secured in handcuffs and taken into custody. Supervisory personnel were notified of the use of



force in a timely manner, and the party was transported for medical treatment. He sustained a laceration on his head from the baton strike and two puncture wounds from the Taser prongs.

The officer involved in the fight with the subject sustained a torn bicep and was also transported for medical treatment.

The FIT investigation reviewed surveillance cameras, a video/audio recording of the scene walk-through, and all documentation and relevant evidence collected by the VIPD Forensic Unit. The FIT investigation did not uncover any policy or criminal violations pertaining to the actions of the subject officer.

Based on the evidence presented, the FRB found the force used was objectively reasonable and was not excessive considering the actions of the male party involved. Based on the totality of the circumstances, the FRB found that lesser force options were not available and/or practical. Furthermore, the board found that proper tactics were deployed when the male party was inadvertently struck in the head with a baton by the subject officer, and the strike to the head was not deliberate.

The final disposition of this case was that the force used was justified and within department policy.

FRBT2024-0002

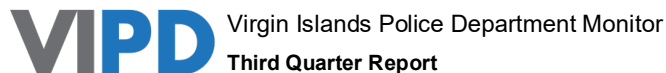
FRBT2024-0002 (UOFT2022-0002) was held on May 9, 2024. The incident occurred on January 19, 2022, and the FIT submitted its report for FRB review on March 12, 2024. The FRB report was completed on July 10, 2024, and received final Commissioner approval on July 12, 2024.

According to VIPD policy, the final FRB report is to be completed within 20 days of the FRB hearing. In this case, the report was submitted for approval after 62 days, a violation of VIPD policy.

The incident involved a fatal firearm discharge, which is categorized as a Level 1 use of force pursuant to VIPD Policy 3.2. The incident occurred on January 19, 2022, at Emanuel Bar in St. Thomas.

According to the FIT report, the officer involved was off duty at Emanuel Bar on Julian Jackson Drive. He was standing outside of the bar and speaking with another individual when he heard gunfire. The officer pushed the individual out of the way, ducked and drew his department-issued Glock 22, .40-caliber handgun and ran toward the area where the gunshots originated. The officer observed an individual wearing dark clothing and a black hoodie standing next to a light-colored vehicle discharging a firearm toward him and other patrons in the courtyard of the bar. When the officer returned fire, the subject got into the vehicle, which then headed directly toward the officer, who was standing in the roadway. The officer continued to discharge his weapon at the individual inside of the vehicle. Once the vehicle left the area, the officer ran back to his personal vehicle and notified Central Dispatch that shots were fired at his location. The officer also relayed that EMS was needed at the scene for several gunshot victims.

Backup officers en route to the area discovered a silver Toyota Corolla parked in the roadway obstructing traffic. Upon further inspection, officers observed bullet holes in the driver's side of the vehicle and blood on the exterior of the driver's door, driver's seat and on the guardrail next to the car. Approximately 40 feet



from the vehicle, a responsive male was found lying on his stomach beyond the guardrail. The individual had a gunshot wound to his left forearm and blood on his torso. EMS was notified and responded to the scene at approximately 11:54 p.m. to render aid to the wounded party. At 12:17 a.m., the injured party died. VIPD's Forensic Unit and the Department of Justice Medical Examiner's Office were on the scene when the individual's body was removed from the scene and transported to the morgue.

The FIT investigation reviewed surveillance cameras, video/audio recordings of the FIT scene walk-through, and other documentation and relevant evidence collected by the VIPD Forensic Unit. The FIT investigation determined that there were no policy or criminal violations related to the actions of the involved officer.

After deliberation, the FRB provided findings based on the UOF analysis questions included in the FRB SOP. Specifically, the FRB determined the officer's actions were objectively reasonable in the context of *Graham v. Connor*. Further, the officer's actions were not excessive given he was responding to an active shooting situation involving gunfire directed at him. Lesser force options were not available or practical, nor was there any opportunity to attempt to de-escalate the situation.

The final disposition was that the involved officer's actions were justified and within department policy. There were no recommendations for training or non-disciplinary or disciplinary actions. The board recommended that the officer be awarded the Combat Cross for his valor and dedication to protecting the Virgin Islands community.

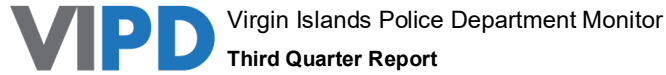
The FRB determined the FIT was thorough and in compliance with VIPD Policy 3.2.

FRBT2024-0003

FRBT2024-0003 (UOFT2021-0091,0092) was held on May 9, 2024. The incident occurred on December 4, 2021; however, the FRB report indicates it took place on January 12, 2022. The IMT reconciled the date through documents contained within the investigative files, confirming the December 4 incident date. It is concerning that this investigation was reviewed and approved by numerous members of the VIPD executive leadership team, including the Commissioner, and the error with the date of the incident was not noted nor corrected prior to closure. The IMT cannot stress strongly enough the importance that VIPD personnel conduct meaningful and thorough reviews of all force incidents and particularly those involving the highest level of force.

The FIT submitted the case for FRB review on March 12, 2024. The final FRB report was completed on July 10, 2024, and received approval from the Commissioner on July 12, 2024. The final FRB report was submitted 62 days after the FRB hearing, in violation of VIPD Policy 3.3, which requires report completion within 20 days.

According to the FIT report, two VIPD officers (Officer 1 and Officer 2) were on duty attending firearms qualifications when they heard a radio transmission reporting an armed robbery that had occurred at Havensight Mall, and two individuals had been shot. The 911 call center relayed that the subjects had fled the area and provided a vehicle description.



Officers 1 and 2 left the firing range and responded to the area to assist in locating the suspect vehicle. While conducting a search of the area for the suspect vehicle, the officers observed a dark-colored Nissan Versa and noticed the driver and the front passenger were not wearing seatbelts. Based on this, the officers decided to initiate a traffic stop of the vehicle for not wearing seatbelts.⁹ Before activating their blue lights, the vehicle came to a stop, and a rear passenger got out of the vehicle. Upon seeing this, the officers activated their blue lights to affect the stop. When the officers approached the vehicle, the rear passenger who had gotten out of the vehicle immediately began running away. The operator of the suspect vehicle immediately drove off at a high rate of speed. The two officers got back into their vehicle and pursued the vehicle to effectuate the stop.

The vehicle came to a stop, and officers observed the driver pulling on a backpack that appeared to be stuck. As the driver exited the vehicle, Officer 1 observed the back of a rifle protruding from the half-opened backpack. Officer 2 yelled, "Watch out, he has a gun!" Officer 1 then drew his department-issued firearm and ordered the man to drop the weapon. He did not comply and proceeded to run. Officer 1 pursued him on foot. During the foot chase, the man reached into the backpack and attempted to retrieve the rifle. Officer 1 discharged his firearm toward the subject, hitting the sidewalk. The subject then dropped the bag containing the rifle and continued running. Officer 1 ordered the fleeing subject to get on the ground, and the subject subsequently complied.

The subject was taken into custody and escorted back to Officer 1's police unit. A supervisor was asked to come to the scene due to the firearm discharge, along with a VIPD Forensic Unit. There were no injuries associated with this incident.

The FIT investigation was conducted in accordance with VIPD policy. Facts and evidence, as presented, disclosed no policy or law violations.

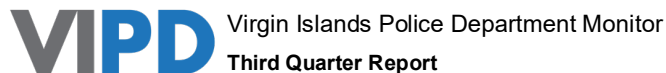
FRB deliberations were conducted in accordance with FRB SOPs and yielded the finding that the UOF was justified and within policy. Further, the FRB unanimously agreed that the force used was objectively reasonable and that lesser force options were available or practical given the circumstances.¹⁰

FRBT2024-0004

FRBT2024-0004 (UOFT2022-0078) was held on May 10, 2024. The incident occurred on October 22, 2022. The FIT submitted the case for FRB review on March 12, 2024. The final FRB report was completed on July 15, 2024, and received approval from the Commissioner on July 17, 2024. The final FRB report was submitted 66 days after the FRB hearing in violation of VIPD Policy 3.3, which requires report completion within 20 days.

⁹ There were no connections drawn between the initial suspect vehicle described by dispatch and the stop of this vehicle for a traffic violation referenced in FIT investigation report nor during the FRB hearing other than to lay the foundation for what brought the involved officers to the area where the traffic stop was initiated.

¹⁰ The disposition in this case was based solely upon the facts and circumstances that transpired following the officers activating their blue lights for purpose of effectuating a traffic stop for the seatbelt violation.



The incident involved a use of force consisting of firearms discharges by a VIPD officer and another officer with the Virgin Islands Department of Licensing and Consumer Affairs (DLCA).

According to the FIT report, a VIPD officer assigned to the Special Operations Bureau (Officer 1) and another officer (Officer 2) were on patrol when their attention was drawn to a black Honda Accord that appeared to have improperly tinted windows. Based on that, the officers initiated a traffic stop of the vehicle. Both officers exited the patrol car and approached the vehicle. Upon approach, Officer 1 noticed the driver rolled down both the vehicle's front windows.

An officer with the Department of Licensing and Consumer Affairs Police (DCLA) was working in the area under the authority of VIPD's Special Operations Bureau on "Operations Overwatch." Upon overhearing the announcement of the traffic stop over the radio, he drove to the vicinity to provide backup to the officers already on scene. The DLCA officer positioned his patrol vehicle in front of the suspect vehicle, exited and monitored the stop from his forward position. While standing outside of the patrol vehicle, the DLCA officer reported hearing an officer's raised voice saying something to the vehicle operator.

Officer 1 approached the driver's side of the vehicle and smelled marijuana coming from inside the vehicle. He then asked the operator to provide his license, registration and proof of insurance, which was then handed to the officer. Officer 1 observed that the window tint on the windshield extended below the Automotive Safety Standard 1 (AS-1) Line.¹¹ Officer 1 then asked the operator if he had any marijuana in the vehicle. He replied, "Nah." The officer then informed the driver that he could smell a strong odor of marijuana coming from the vehicle. At that point, two additional officers arrived on scene and confirmed they could also smell marijuana coming from the vehicle. The operator was instructed to turn off his vehicle and step out so that a search of the car could be conducted. The vehicle operator claimed, "I ain't got nothing in here."

During the interaction, the vehicle operator placed his hand on the gear shift and was told by a Department of Planning and Natural Resources (DPNR) Officer to remove his hand from the gear shift. He ignored the DPNR Officer's directions, put the car in gear and drove off at a high rate of speed. Officer 1 then unholstered his department-issued firearm, yelled "shoot," and discharged five rounds at the vehicle. Simultaneously, the DLCA officer raised his issued HK UMP .40-caliber rifle and opened fire at the vehicle, striking the vehicle with several rounds. Officer 2 called in to report shots fired, and along with Officer 1, ran back to the patrol vehicle to pursue the suspect vehicle that was fleeing from the scene. The officers lost sight of the vehicle and conducted a search of the area to locate it, but their efforts were unsuccessful.

The suspect vehicle was found abandoned a short time later with multiple bullet holes in its left side. The operator of the vehicle was apprehended a short time later at his mother's residence and taken into custody. He was charged with possession of a firearm, possession of ammunition, reckless endangerment, unauthorized possession of cocaine and crack cocaine with intent to distribute, interfering with officers discharging their duties, and reckless driving. None of the parties involved in the incident sustained injuries.

¹¹ The AS-1 Line is the dark dotted line made by car manufacturers at the top of the windshield. The AS-1 line marks the minimum swept area for windshield wipers to clear; window tint is not permitted below that line.

The FIT investigation was conducted in accordance with VIPD policy. All material evidence was collected and properly processed. The investigation concluded Officer 1's discharge of a firearm was not justified and not within policy. The FIT determined that, given the totality of the circumstances, the officer's actions were not objectively reasonable. Specifically, the FIT determined that both officers violated Policy 3.1, Use of Force: Section IV, Procedures: D. Deadly Force restrictions, for shooting at a moving vehicle, creating a risk to innocent bystanders, and drawing and pointing a firearm at a person absent an objectively reasonable determination that deadly force would be authorized.

The FRB report did not specifically address the firearms discharge by the DLCA officer since they were not an employee of the VIPD; however, the FRB discussed that discharge and determined that it was not justified under VIPD policy. Considering this, the VIPD Commissioner issued a letter to the DLCA Commissioner advising him of the shooting and FRB's findings. Further, he informed the DLCA that the involved officer was no longer authorized to work any assignments with the VIPD.

The FRB's deliberations unanimously concurred with the FIT investigation findings. They determined the VIPD officer's use of force was not objectively reasonable. Further, the officer's actions were excessive considering he was not involved in an active shooter incident and did not observe the subject with a firearm. In the FRB's opinion, the officer discharged his weapon solely because the operator drove away after being ordered to turn off his vehicle.

The FRB's final recommendation was that the VIPD officer involved should face disciplinary charges because of the serious nature of the incident.¹²

Timeliness and Accountability

Our review continues to reflect the improvement in VIPD's UOF investigative and accountability processes, which have helped bring about the downward trend in the amount of time necessary to close UOF investigations. The cases, dispositions and number of days until closure are listed in Appendix C, "UOF Cases in Q3."

To determine compliance under paragraph 37, the IMT assessed the extent to which VIPD concluded its UOF investigations in accordance with the requirements set forth in VIPD Policy 3.2. This policy sets forth defined timelines to complete investigations into each type of force level, establishes criteria when the timelines may be extended and lays out the process by which an extension may be sought (i.e., a request and approval for a stay or waiver).

Our assessment of investigative timeliness this quarter is different than prior quarters in two respects. First, the IMT assessed timeliness based on the amended timelines issued pursuant to a waiver and/or stay. Secondly, our assessment of the timeliness of each UOF level is set by the highest level of force used in the incident. For example, if a Level 4 use of force was associated with a Level 1 use of force, the total number of days to conclude both the Level 4 and the Level 1 is 210 days, the allowable days permitted for a

¹² The outcome of the disciplinary hearing process has not concluded.

Level 1. The IMT finds this shift in methodology affords a fuller and more accurate depiction of VIPD's timeliness and accountability practices. The IMT will continue to use this metric for assessing investigative timeliness moving forward, while also employing enhanced oversight over the process for approving a stay or waiver and the subsequent status of these cases for the purpose of assessing compliance with paragraph 37.

Upon reviewing the cases assessed this period, we found 82% (14 of 17) were closed in accordance with the timelines established in VIPD policy or with the timelines permitted under an authorized stay and/or waiver. The remaining 18% were not closed within time limits prescribed by policy, nor had a stay or waiver been issued.

The six cases (three in St. Thomas and three in St. Croix) that VIPD closed within the prescribed time limits set forth under policy, without an associated stay or waiver, included the following:

- St. Thomas: UOFT2024-0078, UOFT2024-0093-94, UOFT2024-0028-0035¹³
- St. Croix: UOFX2024-0047-0050, UOFX2024-0061-64, UOFX2024-0073-74

The eight cases (seven in St. Thomas, one in St. Croix) that were closed within the prescribed time limits pursuant to the issuance of a stay or waiver included the following:

- St. Thomas: UOFT2016-0081-0082, UOFT2016-86-87, 97, UOFT2016-0093-94, 96, UOFT2021-0091-92, UOFT2022-0002, UOFT2022-0078, UOFT2024-0041-0044
- St. Croix: UOFX2023-0004-5, 0015

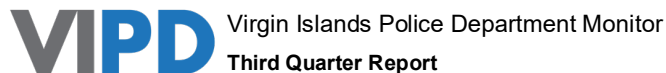
The three cases (two in St. Thomas and one in St. Croix) that were not concluded within the timelines or procedures set by policy included the following:

- St. Thomas: UOFT2024-0061-62, UOFT2024-0095
- St. Croix: UOFX2022-0055-58

The IMT notes the 2016 UOF case files that had been compromised as a result of Hurricanes Irma and Maria and the loss of records associated with a data breach in 2019 have been closed. The VIPD took a strategic approach to concluding these cases that ensured a thorough review and vetting of the investigative files and where applicable, permitted these cases to be closed administratively. The IMT, in consultation with the Parties, reviewed the processes associated with the closure of these cases and supported the strategy adopted by the VIPD. At the end of this assessment period, VIPD's oldest UOF incident dates to 2022.

Of the cases completed outside policy time constraints, two illustrate an ongoing obstacle that is hindering VIPD's substantial compliance with paragraph 37: the amount of time that cases sat waiting to be reviewed in the case management system (IAPro). For example, in UOFT2024-0061,0062, a total of 36 days were lost when cases were sent back and forth for review because they went unopened by the reviewer. VIPD

¹³ This case involved a Level 1 use of force and was investigated by an external entity.



requires that personnel check their email daily, as this is how they are notified of pending Blue Team cases. In this instance, either the employee failed to check Blue Team as required and/or ignored their obligation to bring this matter to closure. Moreover, there was no indication in the case file that anyone was held accountable for the seemingly unnecessary delays.

In UOFT2024-0095, the case sat in the queue without being reviewed for 13 days. Unlike the previous example, however, a ranking officer stepped in, completed the case review and closed the case. The sergeant was issued a letter of counseling for their lack of responsiveness/timeliness. Although this case was completed outside of policy time limits, it is a positive example of accountability for not meeting case review/closure expectations.

The IMT strongly recommends that VIPD set timelines for conducting periodic reviews of the stays granted for individual investigations. This will enable the VIPD to monitor cases under a stay on an ongoing basis to ensure that any cases that are ready to process are not sitting indefinitely without being reviewed. This will provide leadership with increased awareness of the status of outstanding case investigations and help them determine what additional resources or processes may be needed to move the case forward. The increased accountability may aid in bringing cases to closure in a timelier manner.

Along with monitoring stays, the IMT recommends that VIPD establish a process to reevaluate cases once they have been open for more than six months. Such a process will aid VIPD in determining if the cases should be prioritized, reassigned or administratively closed. Furthermore, it could help VIPD avoid recreating the present situation where old cases create a backlog that hinders the department's ability to focus on current investigations.

The IMT will continue to monitor VIPD's progress, hold it accountable for its efforts to achieve substantial compliance with the CD and offer technical assistance when appropriate to assist in overcoming remaining obstacles.

Concluded Case Qualitative Assessment

Regarding the 12 non-Level 1 incidents reviewed this quarter, the IMT found each investigation to be thorough, the finding supported by the facts and evidence, and compliant with all UOF section paragraphs except paragraph 37.

All non-Level 1 cases reviewed in Q3 2024 were found by the VIPD to be "Justified, Within Department Policy," except UOFX2022-0056. This case involved an accidental discharge of a Taser. After one officer deployed their Taser in a justifiable manner, they handed the Taser to another officer so that they could assist in controlling and handcuffing the subject. The prongs were still attached to the subject when the second officer inadvertently pulled the trigger on the Taser, causing the subject to receive a second shock. The UOF review process properly identified this issue as an unjustified use of force, and retraining was recommended.

The IMT also highlights UOFT2024-0028-0035, which involved a Level 1 use of force with exceptional circumstances that warranted investigation by an external entity. This incident occurred on March 5, 2024, at Hull Bay/Paradise Beach and involved firearm discharges by two members of the VIPD. One of the involved officers is a first-line supervisor who discharged his firearm once. The other officer was a high-ranking senior officer, who fired two rounds from his firearm.¹⁴ Given a high-ranking officer was involved, an external investigative body investigated this incident to remove any appearance of bias or impropriety. The external body submitted its report, findings and recommendations for review and approval to the VIPD Governor instead of the VIPD Force Review Team. The IMT and the Parties supported the decision to refer this matter for external investigation and review. Since VIPD did not investigate this incident, the IMT's assessment of this investigation focused on VIPD's protocols for referral, oversight and after actions pursuant to the resulting findings and recommendations.

The external body found credible the involved officers' statements that their discharges were warning shots to compel the suspect to comply with officer commands, specifically to drop his weapon and surrender. However, each officer was found to have violated VIPD Use of Force Policy 3.1, specifically Section IV, subsection D1, which prohibits the firing of warning shots. There were additional findings reached for responding officers who did not use force. All other uses of force that occurred within this incident, including five Level 3 uses of force and one Level 4 use of force, were found to be justified and within department policy.

The external body found additional violations not related to a use of force. It was determined that several officers violated Use of Force Policy 3.1, Section IV, subsection D1, which requires officers to secure their firearms and ensure no other person will have access to them; this is because the officers left their firearms unattended as they entered the water to assist other personnel with the apprehension of the suspect. Finally, the investigation uncovered two instances where VIPD personnel deactivated their BWCs, in violation of VIPD BWC Policy 6.5, Section IV, subsection D, which requires that BWCs remain activated until the conclusion of an event. The officers involved claimed they were instructed by other officers to turn them off; however, no other witness officers heard the instruction.

The external investigating body said one hindrance in their investigation was the lack of a VIPD policy requiring officers to give witness statements. After reviewing recorded interviews of VIPD witnesses, the IMT observed that several of them asserted their Fifth Amendment rights and did not provide statements. The IMT concurs with the external investigators: VIPD should consider strengthening its policy on this issue when witness officers are not the focus of the investigation.

The external entity also made the following recommendations:

- Amend VIPD policy to ensure officers involved in Level 1 uses of force are subject to urinalysis for alcohol consumption.
- Mandate sending immediate notifications to the dispatcher of shots fired incidents.
- Require all officers to dock BWCs at the station to ensure they are fully charged for duty.

¹⁴ The high-ranking senior officer resigned from the department in June 15, 2024.

VIPD has already begun to address some of these recommendations.

After reviewing this matter, the IMT discovered during its discussions with the VIPD that the department had no written protocols to guide the selection and oversight of an outsourced investigation to ensure compliance with VIPD policy, nor to facilitate the implementation of recommendations made by the external body. The IMT provided technical assistance with drafting protocols to define what types of investigative matters are appropriate for a third party to conduct and outline VIPD's duty to ensure the investigative entity acts in alignment with policy. Of paramount importance, VIPD bears the ultimate responsibility of ensuring all investigations are conducted in accordance with VIPD policy, including those investigations conducted by an external entity. For this reason, protocols must not only address when it is appropriate to use outside resources but should also include the process by which VIPD reviews the final investigative report for policy compliance and investigative quality. Further, the IMT recommends that policy describe the process and feedback mechanisms necessary for VIPD to address any issues of concern it may have with the investigation.

The importance of this step became apparent during this case. Based on the third party's investigative report, VIPD investigators recommended disciplinary action for a witness VIPD officer. However, after an internal command review of the evidence, it was determined that disciplinary action was not appropriate. Had VIPD relied solely on the third-party investigative report, the department would have unjustly disciplined an officer. This highlights the importance of the VIPD conducting its own review at the conclusion of an outside investigation.

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Citizen Complaints

Pursuant to the review and assessment of citizen complaint investigations completed this assessment period, the IMT continues to find the VIPD to be in substantial compliance with all citizen complaint paragraphs – paragraphs 42 through 58 – of the CD.¹⁵

Case Review and Assessment of Completed Cases

Case Selection and Review Protocol

The VIPD made available to the IMT a list of all citizen complaint investigations completed between June 1, 2024, and August 31, 2024. A total of 27 citizen complaint investigations were completed during this review period: 14 were investigated by operations supervisors in St. Thomas, 11 were investigated by operations supervisors in St. Croix, and two citizen complaints were completed by the Internal Affairs Bureau (IAB). This represents a 31% decrease in the number of closed citizen complaint investigations than reported in Q2, wherein 39 complaint investigations were closed.

The IMT used a sample size of 25% for this review of citizen complaint investigations.¹⁶ Using a random selection process, we identified four St. Thomas investigations and three St. Croix investigations to include in the assessment sample.

The seven cases in the sample were identified to the VIPD and the U.S. Department of Justice (DOJ). The VIPD uploaded the investigative files to DOJ's records management system (BOX), for review by the IMT. In addition to the DOJ records management system (BOX), the IMT members utilized direct access to VIPD's risk management system (IAPro), and body-worn camera (BWC) systems to further facilitate the reviews.

The cases selected for assessment this quarter were:

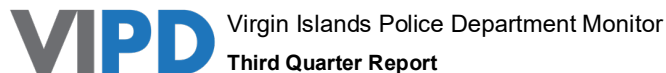
- CCT2023-0051, CCT2024-0010, CCT2024-0013, CCT2024-0015, CCX2023-0013, CCX2024-0007, CCX2024-0008

Closed Citizen Complaint Cases

Of the 27 citizen complaint investigations closed during this review period, there were 37 respondents. Seventeen of the complaints involved allegations against a single VIPD respondent, seven involved allegations against two VIPD respondents, two involved three or more VIPD respondents, and one involved an unidentified respondent(s). The closed cases comprised eight complaints involving a single allegation, 12 complaints involving two allegations and seven complaints with three or more allegations. In total, there were 67 allegations investigated from the 27 citizen complaints against the 37 respondents.

¹⁵ See Appendix B for a list of data points captured in CD paragraph 64.

¹⁶ An IMT member, who was not involved in reviewing or evaluating citizen complaint investigation files, was assigned to generate the sample.

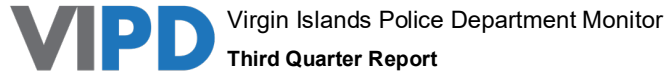


The complaints resulted in the following allegations:

- Category A/Level 1: Offenses alleged against one respondent.
 - A22: Failure to operate official vehicles in a careful and prudent manner, and obeying laws and/or all departmental orders pertaining to such operation.
- Category B/Level 2: Offenses alleged against 24 respondents.
 - B9: Using rude, violent, profane, vulgar, or insulting language or conduct to the public and/or any other officer.
 - B10: Failure to assist any person requesting information, advice, making complaints by telephone or in person.
 - B12: The recording of any person (audio/video) without notifying the individual, unless it is within the scope of an assignment.
 - B16: Failure to direct and/or control or effectively supervise a command, section, unit, squad, etc.¹⁷
 - B26: Failure to be tactful, control temper, and exercise patience and discretion while performing one's duties.
 - B27: Failure to prepare a departmental report when required.
 - B28: Failure to take appropriate action on the occasion of traffic violations and misdemeanors.
 - B32: Failure to take appropriate action on the occasion of traffic violations and misdemeanors.¹⁸
 - B39: Refusal to obey any lawful order or directive.
 - B40: Failure to obey a department policy or procedure.
- Category C/Level 3: Offenses alleged against 10 respondents.
 - C16: Improper handling, misuse, and/or display of firearms contrary to department training and policy.
 - C25: Failure to take appropriate action on the occasion of felony, domestic violence, or other condition deserving police attention.
 - C35: Performing any act or omission not specifically covered in the rules and procedures, charges, and specification, which may be prejudicial to the good order and efficiency of the Department, or which will discredit the reputation of the department, or its employees.
- Category D/Level 4: Offenses alleged against 11 respondents.

¹⁷ The involved complaint is case number CCT2022-0011 and reflects that Category B designation for this allegation in VIPD Policy 301 in 2022.

¹⁸ The involved complaint is case number CCT2021-0039 and reflects that Category B designation for this allegation in VIPD Policy 301 in 2021.



- D2: Bullying through the following, but not limited to, hostile intent, imbalance of power, personal threats, derogatory comments, public humiliation, verbal abuse, and harassment or intimidation of a citizen, department, or government employee.
- D18: Intentionally make an arrest, search or seizure that is not in accordance with the law and department procedure.¹⁹
- D18: Knowingly join or participate in any organization that advocates, incites, or supports criminal act, criminal conspiracies, or hate crime activities.
- D34: Racial profiling / civil rights type violations (enforcement based solely on race, color, nationality origin, sex, religion, sexual orientation, or economic status).
- D37: Intentionally failing to cooperate in any internal administrative investigation conducted by this department.²⁰
- D38: Unprofessional conduct where evidence of a felony is met, regardless of whether the employee was prosecuted or convicted.
- D43: Performing any act or mission not specifically covered in the rules and procedures, charges and specification.²¹

The dispositions²² for the 27 citizen complaint investigations closed this period are reflected below in Table CC1, “Citizen Complaint Investigations Closed in Q3 2024,” and Chart CC1, “Dispositions of Closed Investigations by Type.”

Dispositions of Allegations in Citizen Complaint Cases Closed in Q3 2024

Disposition	Category A Offenses	Category B Offenses	Category C Offenses	Category D Offenses	Personal Conduct Policy 4.5
Not Sustained	0	16	8	7	0
Sustained	0	23	2	3	0
Unfounded	1	4	0	1	0
Exonerated	0	2	0	0	0

Table CC1: Allegation Dispositions - All Closed Cases this Period.

19 The involved complaint is case number CCT2021-0039 and reflects that Category B designation for this allegation in VIPD Policy 301 in 2021.

20 The involved complaint is case number CCT2021-0034 and reflects that Category D designation for this allegation in VIPD Policy 301 in 2021.

21 The involved complaint is case number CCT2021-0034 and reflects that Category D designation for this allegation in VIPD Policy 301 in 2021.

22 There were no cases concluded this period with an Administrative Closure disposition.

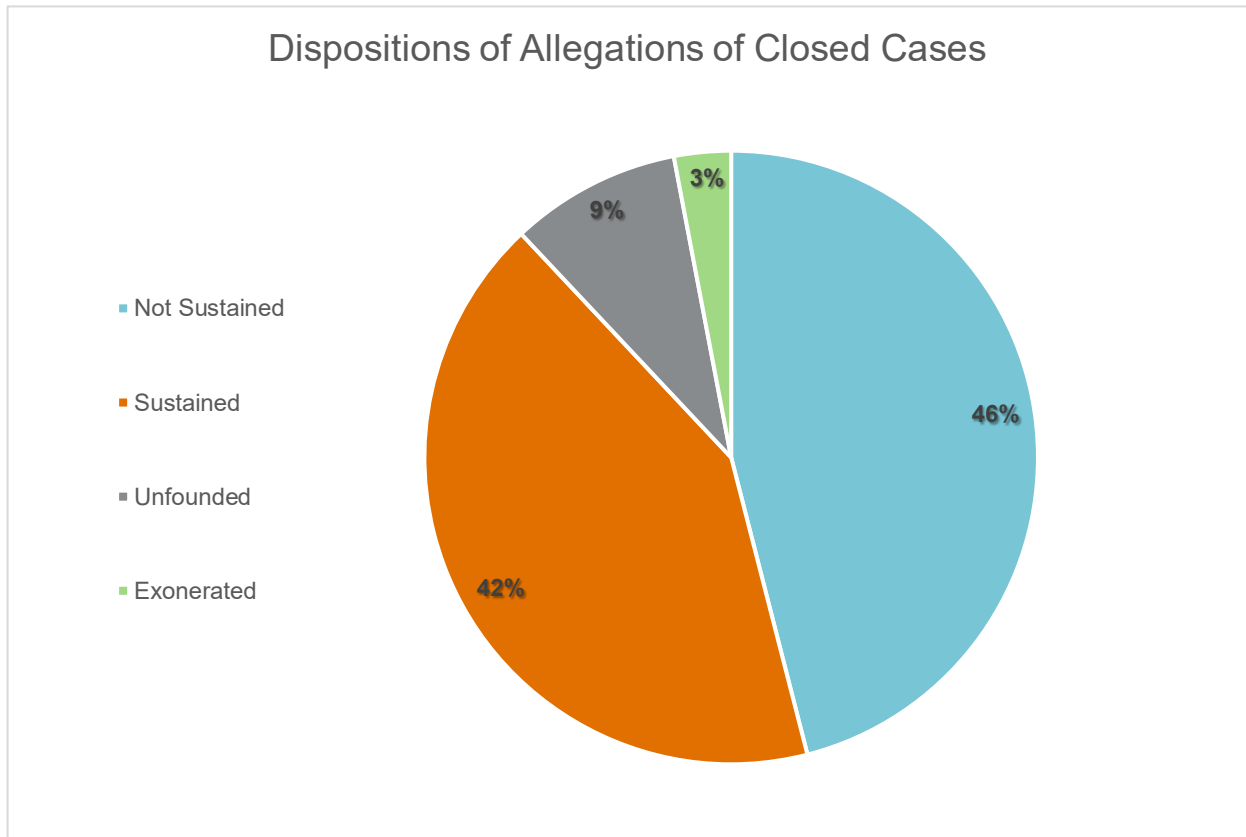


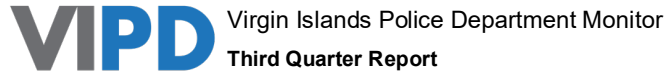
Chart CC1: Dispositions of Allegations - All Closed Cases this Period.

Assessed Citizen Complaint Cases

The IMT sample for assessment contains four St. Thomas investigations and three St. Croix investigations. They comprise two complaints with a single allegation, four complaints with two allegations and one complaint with three or more allegations. Five of the complaints involved allegations against a single VIPD respondent, while one involved allegations against two respondents and one involved allegations against three or more respondents.

The investigations from the seven complaints included the following allegations:

- Category B/Level 2: Offenses alleged against eight respondents.
 - B9: Using rude, violent, profane, vulgar, or insulting language or conduct to the public and/or any other officer.
 - B10: Failure to assist any person requesting information, advice, making complaints by telephone or in person.
 - B26: Failure to be tactful, control temper, and exercise patience and discretion while performing one's duties.



- B27: Failure to prepare a departmental report when required.
- B28: Failure to take appropriate action on the occasion of traffic violations and misdemeanors.
- B40: Failure to obey a department policy or procedure.
- Category C/Level 3: Offenses alleged against two respondents.
 - C25: Failure to take appropriate action on the occasion of felony, domestic violence, or other condition deserving police attention.
- Category D/Level 4: Offenses alleged against three respondents.
 - D2: Bullying through the following, but not limited to, hostile intent, imbalance of power, personal threats, derogatory comments, public humiliation, verbal abuse, and harassment or intimidation of a citizen, department, or government employee.

There were 17 allegations (offenses) investigated from the seven citizen complaints against the 10 respondents. The dispositions²³ of the cases examined in this review period are reflected below in Table CC2, “Dispositions of Citizen Complaint Cases Assessed in Q3,” and Chart CC2, “Dispositions of Assessed Cases by Type.”

Dispositions of Allegations in Citizen Complaint Cases Closed in Q3

Disposition	Category A Offenses	Category B Offenses	Category C Offenses	Category D Offenses
Not Sustained	0	8	2	3
Sustained	0	2	0	0
Unfounded	0	0	0	0
Exonerated	0	2	0	0

Table CC2: Allegation Dispositions of Citizen Complaint Cases Closed in Q3.

²³ There were no cases concluded this period with an Administrative Closure disposition.

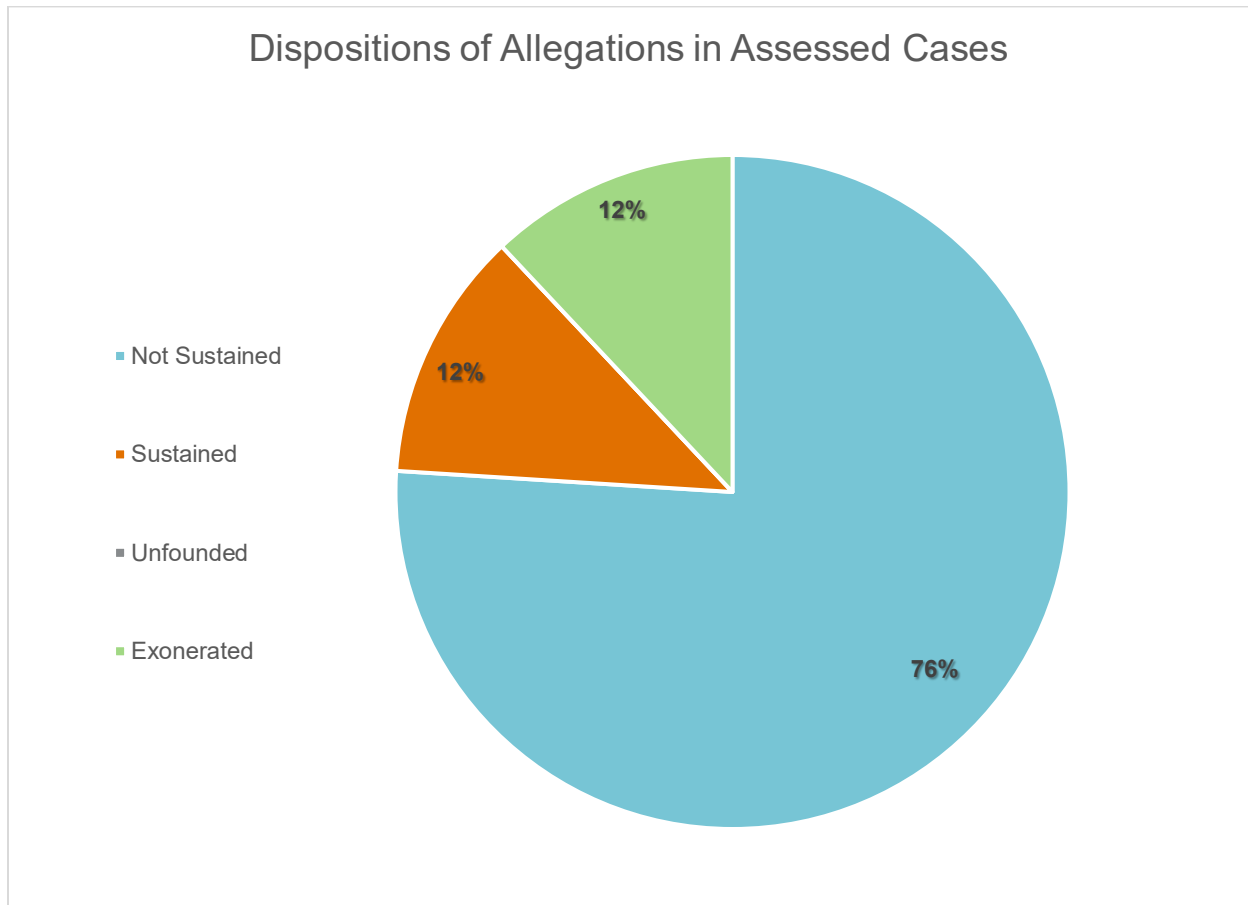


Chart CC2: Dispositions of Allegations in Citizen Complaint Cases Assessed in Q3 2024.

Assessment Observations

For the seven cases randomly selected for assessment, the IMT did not identify deficiencies that would impact overall compliance under the citizen complaint section of the CD. Our assessment revealed commanders continued to engage in reviews of completed investigations. However, a greater focus must be placed on ensuring investigators fully document all investigative actions taken to interview additional witnesses, follow up on evidence uncovered during the investigation and, importantly, to document these actions within the body of the investigative report.

The assessed cases are as follows:

- CCT2023-0051, CCT2024-0010, CCT2024-0013, CCT2024-0015, CCX2023-0013, CCX2024-0007, CCX2024-0008

Identifying Additional Witnesses and Evidence

In CCT2024-0015, an officer responded to a call that a vendor attempted to hit a customer in a tourist area near docked cruise ships. During the officer's investigation of the incident, the vendor made a complaint against the officer, alleging the officer disrespected her and her husband by accusing them of something they did not do. The complainant also alleged the officer told her customers not to purchase goods from her. The complainant suggested the officer was biased toward the tourists and sided with them.

The complaint investigator conducted recorded interviews of the complainant and her husband. Another witness was also interviewed but refused to be audio recorded. The complainant stated she only engaged the citizen who was holding her merchandise, asking her if she intended to purchase the item. The complainant's husband denied that any disturbance occurred. During the interview, the complainant's husband shared a personal video he took that shows some of his interaction with the responding officer. This video is not included in the investigation file, nor did the investigator document in the investigation report whether it was reviewed as part of the investigation and what, if any, evidentiary content it included.

In addition, the complainant and her husband pointed out to the investigator the location of a security camera on a nearby building that would have captured both the incident and the officer's response to the incident. The investigator inquired about gaining access to the video with an employee of the building but was unsuccessful in obtaining it.

In this investigation, the officer failed to activate their BWC, which was subsequently addressed as an additional allegation. The lack of BWC footage underscores the importance of identifying, obtaining, reviewing and analyzing any digital evidence that could shed light on the allegation.

The IMT believes the complainant's husband's personal video should have been addressed in the investigative report. Specifically, the report should have mentioned whether the video was provided to the investigator and, if so, whether it was reviewed and held evidentiary value related to the allegation. It is unknown if the investigator viewed it and was able to determine there was nothing on it relating to the allegations, or if the investigator requested a copy of it and the complainant's husband refused. It is also possible the investigator failed to act on the additional information. The investigator's reconciliation of this information is important and pertinent to the investigative process and should always be documented in the investigative summary report (ISR). Moreover, if it was made available. The video should also have been contained in the investigation file. Finally, the IMT believes the investigator should have made additional efforts to obtain access to the security camera, such as speaking with a manager or supervisor at the facility. As noted above, several scenarios are possible: he could have requested the video but was refused; the security camera could have been found to not cover the exact location where the incident occurred; the camera may have been inoperable at the time of the incident; or the camera footage could have already been deleted. Regardless, the investigator should have then documented the results of those efforts in the investigation report. Again, that information is important and pertinent to the investigative process and should always be documented in the ISR. If it was made available, the video should also have been contained in the investigation file.

In the investigation of CCX2023-0013, there was difficulty establishing the date of the alleged policy violation. The complainant said a civilian VIPD employee was following and watching her son's former girlfriend and the mother of her grandchild. The complainant alleged the employee had a history of harassing her and making disparaging comments. In one incident, the complainant alleged she was at her residence with a relative when they observed the employee parked outside of their building, watching and taking photographs of the complainant's vehicle. During the recorded interview of the employee, she denied following, harassing or making disparaging comments about the complainant and explained that she sometimes traveled to the area of the complainant's residence to visit her hairdresser, who was located there.

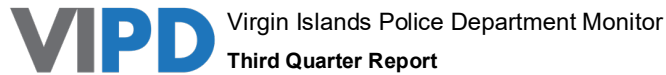
During the recorded interview of the complainant, she said she did not recall the date when the employee was at her residence but could later examine her cell phone to determine the date since she had taken photos, and then would report back to the investigator. The investigation report failed to document if the date was subsequently reported to the investigator, and if so, what the date was. The IMT also believes the investigator missed an opportunity to clarify with the complainant if the photos were of evidentiary value to the complaint investigation.

The IMT notes there was a separate complainant against the same employee regarding this same incident (CCX2023-0012). The complainant in CCX2023-0012 gave similar accounts of the allegation during her recorded interview and identified a third person who was present while the employee was outside of the residence. Neither report documents what, if any, actions were taken to locate and attempt to interview this witness, who could have shed light on the allegations. Each of these separate investigation files contained only recorded interviews of the complainant and the respondent employee. Although they are separate complaints about the same incidents, in which each complainant is a witness to the other's complaint, the IMT notes that neither case is linked in IAPro, a prudent practice when investigations are related to each other.

In the investigations of both CCT2024-0015 and CCX2023-0013, the complainants referenced additional evidence that may have been of evidentiary value in determining the outcomes of the investigations in which the allegations were Not Sustained. CCT2024-0015 identified video evidence, and CCX2023-0013 referenced photos that may have been available. However, the investigative reports are silent as to whether the investigator obtained, reviewed and/or considered this evidence.

In contrast, the IMT highlights CCT2024-0010, which depicts an investigator's initiative and efforts to identify additional witnesses and evidence beyond that laid out in the original complaint. In CCT2024-0010, the complainant alleged an officer harassed him over where he parked his vehicle. The complainant alleged the officer shouted at him to move his vehicle because of where it was parked even though he was entitled to park it there because it was private property. Two weeks later, the same officer issued a citation because his vehicle was parked in the same spot.

The investigator recorded the interviews of the complainant and the officer. The officer said she first approached the complainant as a citizen while she was off duty and politely asked him to move his vehicle, which was impeding traffic and blocking the access road, so she could pass by in her vehicle. She said she was professional and did not shout or curse. Days later, while on duty, she observed the vehicle parked in



the same place, again impeding traffic and blocking the access road. She issued a citation to the parked vehicle. The complainant insisted he was being harassed by the officer and had a right to park where he did given it was private property. He added that, when she asked him to move, he did not know she was an officer.

The investigator was tenacious in seeking to identify and obtain additional witnesses and evidence that would bring the investigation to a successful conclusion. In this instance, doing so was difficult. Since the interaction between the officer and the complainant occurred while the officer was off duty, no BWC footage existed, and no other officers were present as witnesses to shed light on the allegation. Therefore, more information would have to be located from other sources. The investigator canvassed the area to determine if anyone observed the interaction between the complainant and the officer on the date they interacted. This effort paid off with the identification of a witness -- a property manager -- who told the investigator he recalled the incident. He told the investigator the complainant was yelling at the officer, not the other way around. He also said the spot where the complainant had parked impeded access to the roadway.

The investigator also visited the site where the vehicle had been parked and took video of the location to include in the investigation file. Moreover, the investigator reviewed photos and land surveys that established the spot where the car was parked was not private property. Ultimately, the allegation was not sustained.

The investigation undertaken in CCT2024-0010 is an example of an investigator's efforts to identify witnesses and evidence beyond those identified in the original complaint. This investigation, like others IMT has assessed in past reports, affirms VIPD's ability to conduct thorough investigations, demonstrates the department's commitment to taking citizen complaints seriously and provides an example of professional investigative practices to complete investigations while bringing them to a successful conclusion.

The IMT recommends VIPD remind personnel conducting internal investigations and those reviewing them to ensure that all investigative leads are followed up on or to document why the investigator did not or could not pursue the investigative lead.

Also, the IMT recommends that VIPD consider concluding complaint investigation interviews with the following open-ended questions, which may elicit additional information, evidence or witnesses pertinent to the alleged incident from the interviewee. In many of the respondent and witness interviews conducted as part of citizen complaint investigations, the interviewer concludes without seeking information that may not have been addressed during the questioning. In an attempt to identify additional evidence or witnesses, a common practice in complaint investigation interviews is to conclude with the following:

- Is there anything not asked that you could add that would assist me with this investigation?
- Can you identify anyone else I can speak to who may have direct knowledge of this allegation?
- Sometimes following an interview, people may remember additional relevant information that they did not recall during the interview. Please contact me if you recall any additional information not discussed today.

Command's Engagement with Reviews

For investigations CCX2024-0007 and CCX2024-0008, the commander overseeing the investigation documented in the commander review memos the presence of grammatical errors and made other recommendations that were subsequently addressed by the investigator prior to closure. For investigation CCX2023-0013, there was no commander review memo or documentation in the file, nor a record that it was reviewed by a commander. In this investigation, an assistant commissioner served as the investigator, and the reviewer was the Acting Commissioner. Similarly, CCT2024-0010 did not contain a commander review memo on file and the investigator was a Captain and the reviewer was a Deputy Commissioner. The IMT recommends VIPD consider requiring that all reviewers, irrespective of rank, complete a review memo to document that the review was conducted.

The commander reviews assessed this period identified unaddressed allegations and dispositions that were inconsistent with the findings. For example, in CCT2024-0015 and CCT2023-0051, the commanders noted the investigators failed to identify and address uncovered allegations for failure to activate a BWC and using insulting language with the public, respectively. In CCT0023-0051 specifically, the commander identified an additional allegation and an incorrect disposition, all of which were investigated and corrected prior to closure. Additionally, in CCT2024-0013, the commander review included detailed commentary regarding some of the BWC evidence, reflecting how he reviewed the BWC during the investigation review.

The IMT also notes in the CCT2024-0015 ISR, the investigator recommended in the "Other Violations Uncovered During Investigation" section of the report that the respondent officer receive remedial instruction regarding the activation of the BWC. The commander's deficiency letter identified that the BWC charge and disposition was also not completed in that section of the report. Prior IMT assessments note similar instances are corrected by the completion of a supplemental report; however, in this case, it is unclear to the IMT if an updated investigative report or supplemental report was later completed to address the charge that did not get uploaded into the investigation file. IMT's review of IAPro also revealed that this additional charge and disposition was not found within VIPD's risk management system, IAPro.

Overall, however, the IMT is encouraged that this review demonstrated continued commitment at the operations level to engage in quality control of citizen complaint investigations with reviews. Most review memorandums and deficiency letters appropriately documented that the commander completed the investigation review in concert with the CCII. However, VIPD must ensure that ISRs include all investigative steps taken, as well as those not taken and the reason why and that all investigative dispositions are entered into VIPD's risk management system, IAPro.

Management and Supervision

Policy Review and Assessment

Risk Management Policies

This quarter, the IMT and VIPD held several meetings to discuss the finalization of Policy 6.2 Risk Management Protocol, which operationalizes the Early Intervention Program (EIP), and the value of updating Policy 6.1 Data Input Plan. Policy 6.1 identifies information that must be uploaded into VIPD's risk management system, IAPro, as well as the processes behind and the positions responsible for uploading that information. These data include each officer's personal identifiable information, employment history with the VIPD and other information identified under CD paragraphs 60 and 65.²⁴

VIPD Policy 6.2, while related to Policy 6.1, focuses on the use of that data by VIPD supervisors and commanding officers to identify patterns and trends in the performances of individuals, units and the department as a whole for monthly and quarterly review and analysis. Upon reviewing the updated draft of Policy 6.2, the IMT found it difficult at times to distinguish which sections addressed the early intervention process and which sections focused on the quarterly pattern and trend analysis. The draft also contained much of the same information included in Policy 6.1. Both policies appear to have been conceptually drafted before the implementation of IAPro and the EIP.

The IMT's review of Policy 6.1 identified outdated practices that warrant revision. For example, the performance indicator thresholds to trigger an early intervention alert outlined in Policy 6.1 are inconsistent with the performance indicators identified in Policy 6.2, which align with VIPD's current practices. Updating and amending Policy 6.1 is necessary to eliminate this conflict and to focus on the processes associated with data input more closely.

After engaging with the Parties to address these observations, the IMT recommended the VIPD update Policy 6.1 to align with its current practices for uploading data into its risk management system. Specifically, the policy should clearly identify the individuals and units responsible for uploading different data and the timelines for uploading such data to ensure all required information is imported appropriately. Secondly, the IMT has recommended that VIPD bifurcate Policy 6.2 to create one policy exclusively dedicated to the EIP and another policy covering the facilitation of quarterly pattern and trend analysis and meetings. Given the span of time since Policy 6.1 and 6.2 were implemented, updating the associated policies is a natural evolution as the department continues to reform. The IMT has provided technical assistance in this regard, and VIPD is reviewing the information provided.

Vehicle Collision Policy

VIPD finalized revisions to its Vehicle Collision Policy. While the CD does not expressly address this policy, VIPD sought the IMT's input, as vehicle accidents can trigger an EIP alert, which is expressly covered by

²⁴ See Appendix B for a list of data points captured in CD paragraphs 60 and 65.

the CD. The IMT's assessment found the updated edits align with best practices, providing clear direction on a supervisor's responsibility following an officer-involved vehicle accident.

However, the VIPD did not implement IMT's recommendation to integrate an accident review board "comprising specially trained department members, to analyze causal factors and identify trends in officer-involved collisions." The IMT reiterates its recommendation that the VIPD institute a process by which officer-involved vehicle collisions are subject to systemic reviews for the purposes of identifying any adverse or contributory trends that could be mitigated through training, new or updated equipment, or other non-punitive measures.

Early Intervention Program

The VIPD's mandates as they relate to the EIP are contained in CD subparagraphs 64e, 64f and 64g.²⁵

VIPD's Policy 6.1 includes a table identifying performance indicators and associated alert thresholds. However, in practice, the VIPD has been conducting alert meetings based on the employee performance thresholds in Policy 6.2, which has been in draft form for several years. According to the draft policy, the thresholds that, if exceeded, trigger an alert include the following:

- Anytime an employee:
 - Is the subject of a domestic violence allegation;
 - Is identified in a civil or criminal complaint;
 - Is directly involved with a Level 1 use of force;
 - Is involved in:
 - Vehicle pursuits and collisions (two or more during any consecutive 12-month period),
 - Citizen complaints (four or more during any consecutive 12-month period),
 - Level 2 uses of force (two or more during any consecutive six-month period), and
 - Level 3 uses of force (three or more within any consecutive six-month period).

Using IAPro, the IMT confirmed there were no triggering events to warrant an EIP meeting. This is the second quarter in a row where there were no officers whose behavior triggered an alert meeting. Moreover, the IMT confirmed the VIPD is current with all action plans from previous alert meetings.

Quarterly Audits, Pattern and Trend Meetings

Compliance and Change Management Unit

This quarter, VIPD's Compliance and Change Management Unit (CCMU) completed all outstanding audits, including those from Q2 2024, Q1 2024, Q4 2023 and Q3 2023. Importantly, several process changes helped VIPD complete these audits, a promising sign that subsequent audits will be completed in a timely

²⁵ See Appendix B for a list of data points captured in CD paragraph 64.

manner moving forward. Specifically, CCMU no longer conducts real-time audits of CC and UOF investigations. As noted in prior reports, CCMU's reviews of these audits were duplicative of the reviews conducted by operations supervisors, FIIs, CCII and IAB and encroached on the time needed to audit closed cases. Additionally, before completing its outstanding audits this quarter, VIPD modified its methodology to require auditing 25% of the completed CC and UOF investigations per quarter; CCMU's prior practice was to audit every third completed investigation.

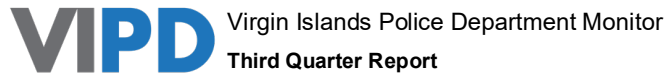
The IMT conducted a comparative analysis of IMT-assessed administrative investigations and CCMU-audited investigations to determine the thoroughness of CCMU's audits. First, our team identified IMT-assessed CC and UOF investigations that were also included in CCMU's audit sample. The IMT randomly selected four investigations: two UOF and two CC investigations from St. Croix and St. Thomas. The assessment determined the CCMU audits were consistent and complementary to those conducted by the IMT. In summary, the qualitative assessment of these audits found them to be thorough, objective and focused on compliance with the CD. The IMT commends the VIPD on its efforts, dedication and focus to advance and sustain the reform efforts sought through the CD. The IMT will continue to conduct comparative analyses of CCMU's audits in future quarterly assessments.

The procedural changes that helped drive the completion of these outstanding audits elevate the importance of finalizing VIPD's Audit and Inspection Policy, which has been pending internal review since Q1 2024. The IMT also notes CCMU's audits focus exclusively on compliance with CD paragraphs, not VIPD policy. As we enter the fourth quarter, the IMT will hold discussions with VIPD regarding transitioning CCMU's focus during compliance assessments from adherence to specific CD paragraphs to adherence with VIPD policy. As the entity identified within VIPD to ensure the reforms achieved under the CD continue after termination, the CCMU illustrates the importance of the VIPD beginning to evaluate itself against its own policies, which, as applicable, have incorporated the requirements of the CD. This will be an area of focus during the upcoming summit.

Quarterly Pattern and Trend Analysis

The VIPD did not conduct a Quarterly Pattern and Trend analysis meeting this quarter. VIPD last conducted a quarterly analysis of its risk data in Q2 2023. The failure to facilitate the analysis of this data is a key reason the department remains out of compliance with paragraph 64, which reads, in part:

- Subparagraph 64d: "The protocol will require that VIPD deputy chiefs, managers, and supervisors will review, on a regular basis but not less than quarterly, system reports, and will evaluate individual officer, supervisor, and unit activity."
- Subparagraph 64i: "The protocol will require that VIPD deputy chiefs, managers, and supervisors be evaluated on their ability to use the risk management system to enhance effectiveness and reduce risk."
- Subparagraph 64k: "The protocol will require regular reviews, at no less than quarterly intervals, by appropriate managers of all relevant risk management system information to evaluate officer performance territory-wide, and to evaluate and make appropriate comparisons regarding the performance of all VIPD units in order to identify any significant patterns or series of incidents."



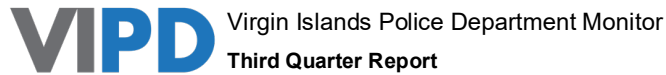
The IMT held several meetings with the VIPD to discuss potential implementation strategies geared toward the consistent facilitation of the quarterly meetings. The conversations included empowering chiefs and deputy chiefs with the ability to retrieve and analyze key data points from IAPro needed to maintain situational awareness of the patterns and trends impacting their areas of responsibility. Additional opportunities to promote compliance included continued technical assistance and an in-person collaborative discussion with subject matter experts from the IMT and key VIPD stakeholders.

The data needed to conduct the quarterly assessments is readily accessible in IAPro. The territorial chiefs will benefit from being able to extract the data necessary to drive enhanced leadership initiatives. Mandating ownership of the data and analysis will promote buy-in and drive a culture of accountability. Despite the foregoing, the VIPD is not taking the required actions to analyze this information. The IMT will continue to provide technical assistance in this regard, both virtually and during the upcoming summit.

Disciplinary Practices

Q3 2024 Disciplinary Hearing Assessments – Paragraphs 70 and 72

Hearing Number	Summary of Allegation	Investigation Finding	Hearing Officer Ruling	Commissioner Imposition
DHT2024-0020	An officer failed to activate his body-worn camera (BWC) prior to taking enforcement action.	Sustained finding violation of Category B:40- Failure to obey department policy or procedure.	Dismissed; based on the investigation exceeding established timeline.	Sustained; however, unable to impose discipline based on untimely investigation.
DHT2024-0021	An officer failed to make a timely entry into the Blue Team system regarding a use of force.	Sustained finding violation of Category B:27- Failure to prepare a departmental report when required.	Sustained; concurred with investigative findings and recommended one-day suspension with two additional days held in abeyance.	Sustained; imposed hearing officer's recommended discipline for offending officer.
DHT2024-0022	An officer was involved in a non-injury solo vehicle traffic collision.	Sustained finding violation of Category A:22- Failure to operate an official vehicle in a careful and prudent manner.	Not Sustained; hearing officer determined the vehicle had documented maintenance issues, which caused the collision.	Sustained; directed the officer receive a Written Reprimand.
DHT2024-0024	Two officers were involved in a use of force. One officer failed to activate his BWC,	Sustained finding violation of Category B:39- Refusal to obey department policy	Not Sustained; hearing officer determined investigation was untimely and did not find a policy violation.	Not Sustained; concurred with hearing officer's findings.



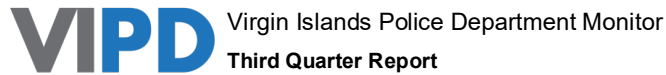
	and the other officer held the BWC in her hand.	and procedure against both officers.		
DHT2024-0027	An officer lost her department-issued BWC.	Sustained finding of Category B:5-Damage to or loss of department property.	Not Sustained; the officer found her BWC before the disciplinary hearing.	Not Sustained; concurred with hearing officer's findings.
DHT2024-0037	An officer called in sick for work during the St. John Carnival Festival but failed to provide a doctor's note.	Sustained finding of Category B:6-Failure to report for duty.	Not Sustained; hearing officer discovered that the investigating supervisor had also issued the involved employee a formal counseling for the same offense.	Not Sustained; concurred with the hearing officer's findings.
DHX2024-0011	A sergeant did not report his Level 4 use of force.	Sustained finding of Category C:11-Failure to prepare a Response to Resistance Report.	Sustained; recommended three-day suspension with seven additional days held in abeyance.	Sustained; imposed hearing officer's recommended discipline for offending sergeant.
DHX2024-0017	A lieutenant did not complete his assigned investigations in the timeframe directed.	Sustained finding of Category B:39-Refusal to obey any lawful order or directive.	Not Sustained; hearing officer found the charging title for Category B:39 had been changed from "Refusal to obey..." to "Failure to obey..." and did not sustain the charge based on the technicality of the antiquated wording used in the charging document.	Not Sustained; concurred with the hearing officer's findings.

Table MS1: Disciplinary Hearing Assessments.

Overview

The IMT analyzed the listed disciplinary cases to assess continued substantial compliance with CD paragraphs 70 and 72. In accordance with VIPD Policy 7.1, disciplinary hearings are conducted at the conclusion of personnel investigations that result in sustained findings.

The VIPD held eight disciplinary hearings this quarter, with four resulting in the imposition of discipline, which ranged from a written reprimand to suspension without pay. Six of the hearings involved personnel



from St. Thomas, and two occurred in St. Croix. Of the six hearings in St. Thomas, one was sustained for a supervisor's failure to make a timely entry of a use of force Blue Team report (DHT2024-0021). The sustained charge for St. Croix involved a supervisor's failure to complete a use of force response to a resistance form (DHX2024-0011). Our assessment of the above disciplinary matters affirmed VIPD's adherence to paragraphs 70 and 72. When discipline was administered, it was done so in compliance with the matrix attached to VIPD Policy 7.1.

However, as outlined below, we have identified opportunities for the VIPD to improve its handling of disciplinary matters.

Case Assessments

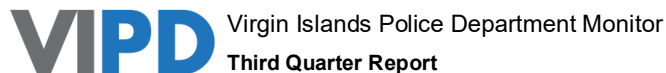
Overruling Hearing Officer Decisions

Transparency is critical to ensuring a fair and consistent discipline process and thus, subsequent decisions to overturn a finding and/or recommendation of the hearing officer should be sufficiently documented within the case file.

In DHT2024-0022, the commissioner disagreed with the hearing officer's recommendation and directed the hearing officer to issue the officer a written reprimand, in addition to remedial driver's training. This case involved an officer who was involved in a non-injury solo vehicle traffic collision and charged with violating Category A:22- Failure to operate an official vehicle in a careful and prudent manner. The investigation determined the officer exited his vehicle while it was running, and it rolled into a concrete barrier, resulting in minor damage. Evidence presented at the hearing indicated the vehicle had documented transmission issues. The hearing officer indicated the collision was possibly caused by a mechanical failure and found the allegation was not sustained. The reason the Commissioner deviated from the recommendation of the hearing officer was not documented.

In the absence of documentation to support the Commissioner's ruling, a reviewer is left without insight into what information the Commissioner relied upon in overruling the disposition of the hearing officer. The IMT encourages the VIPD to discuss the value of establishing a protocol requiring the Commissioner to document their rationale for altering the final disposition/discipline from the hearing officer's recommendation. Establishing a consistent practice of explaining the thought process behind the Commissioner's discipline decisions helps clarify organizational expectations and promote internal procedural justice.

Also, the IMT notes conflicting findings by the Commissioner between DHT2024-0020 and DHT2024-0024. In both of the above cases, there were sufficient facts to support a sustained finding; however, the Commissioner's rulings were not consistent. In DHT2024-0020, the Commissioner overruled the not sustained finding reached by the hearing officer and sustained the charges irrespective of the untimeliness of the investigation, noting that disciplinary action could not be taken. However, in DHT2024-0024, the Commissioner did the opposite, concurring with the not sustained finding of the hearing officer due to the untimeliness of the investigation. The IMT recommends the VIPD reach a consensus on the appropriate disposition for cases barred from disciplinary action pursuant to an untimely investigation. While the



collective bargaining agreement prohibits the imposition of discipline when investigations are not completed in accordance with established timelines, there should nonetheless be consistency in the findings on the merits.

Disciplinary Hearing Dispositions

In reviewing the documentation of the hearing officer and Commissioner, we note they almost always reach a finding of either “sustained” or “not sustained.” However, based on the definitions outlined in VIPD Policy 7.3, a finding of exonerated and/or unfounded may be more accurate in some cases.

For instance, DHT2024-0027 involved an employee who was unable to locate her BWC. The employee reported the lost BWC to her supervisor and, in accordance with policy, a personnel investigation was completed. The employee found their BWC after the investigation was complete (July 4, 2024) but before the disciplinary hearing (July 16, 2024). The hearing officer determined the employee should not be subject to discipline because the BWC had been found within a short period and was in good working condition. The hearing officer found the charges to be “not sustained” (i.e., there was insufficient evidence to prove one way or the other that the allegation occurred).

There was no question in this case that the employee was unable to locate her BWC by the time the investigation concluded. Based upon the definition of “not sustained” as defined in VIPD Policy 7.3, that finding is inconsistent with the facts of this case.

DHT2024-0037 offers another example wherein a finding of not sustained is inconsistent with the definition as defined in VIPD policy. In this case, the hearing officer issued a not sustained finding after it was determined that the employee had already been counseled for the same violation that was the subject of the disciplinary hearing. Contrary to VIPD’s definition of not sustained, this case did not reflect an inability to determine whether the employee had provided a doctor’s note; the employee had not. This was arguably an investigation that should not have been initiated and closed administratively.

The IMT recommends the VIPD revisit its disposition definitions with all supervisory personnel up to and including the Acting Commissioner to ensure the department is reaching findings that are consistent with VIPD policy. Furthermore, the IMT recommends the VIPD revisit Policy 7.3 to assess whether its administrative closure processes sufficiently address complaints and/or investigations opened in error.

Review and Assessment of Complaint Investigation Timeliness

Complaint Investigation Timeliness

IMT’s review of cases closed during this assessment period for the purpose of determining VIPD’s compliance with paragraph 71 continued to reveal that investigative timeliness remains a significant challenge for the VIPD; however, progress is being made.

For the 27 citizen complaint investigations closed by VIPD in Q3, the time between the receipt of a complaint and the closure of an investigation varied. The shortest investigation was closed in 23 days, while the longest was 1,136 days (a little over three years). The average length of time from the receipt of a complaint to investigation closure was 245 days, compared with 212 days to closure in the prior quarter. The IMT notes the VIPD closed two 2021, one 2022 and two 2023 complaint investigations, which skewed the overall average number of days to closure for this period. Of these older investigations, St. Thomas closed three and St. Croix closed two. Controlling for those five old cases, the average number of days to closure for this period is 109. Despite the adverse effect that concluding older cases has on VIPD’s overall timeliness, VIPD must continue to prioritize the closure of its oldest open cases in balance with the investigative priorities of its more recent cases.

The chart below highlights the quarterly differences in VIPD’s closure of its oldest cases. In Q3 2023, the VIPD did not close any cases that were between 180 and 364 days old, and it closed only one case that was over a year old. In comparison, in Q2 and Q3 2024, the VIPD achieved substantial increases in the number of closed cases older than 180 or 365 days.

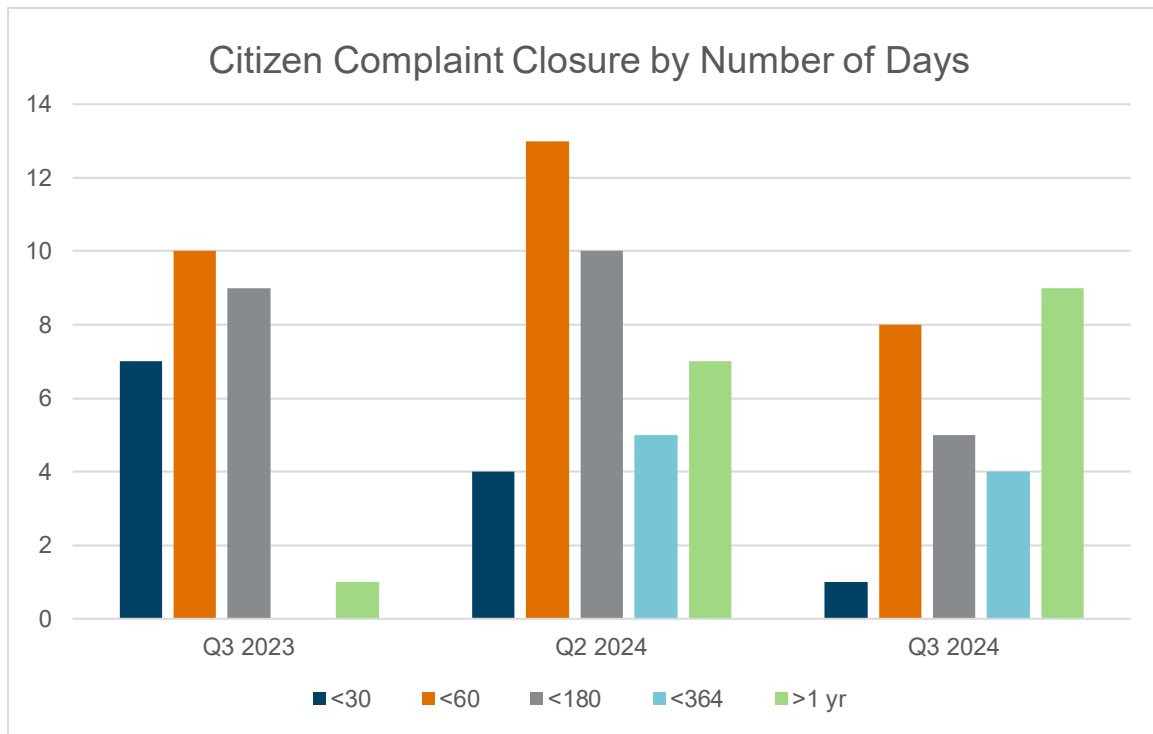


Chart MS1: Time to Close CC Cases.

The IMT continues to observe zonal differences in the amount of time taken to close investigations. In Q3, St. Thomas averaged 313 days to closure, compared to 239 days in Q2. Excluding the three older St. Thomas cases from the analysis, the average length to closure drops to 131 days this quarter, compared with 69 days the previous quarter. In St. Croix, investigations averaged 268 days to closure this quarter,

compared with 218 days the previous quarter. Excluding the older St. Croix cases from the analysis, the average number of days to closure falls to 213 in Q3, compared with 122 days in Q2.

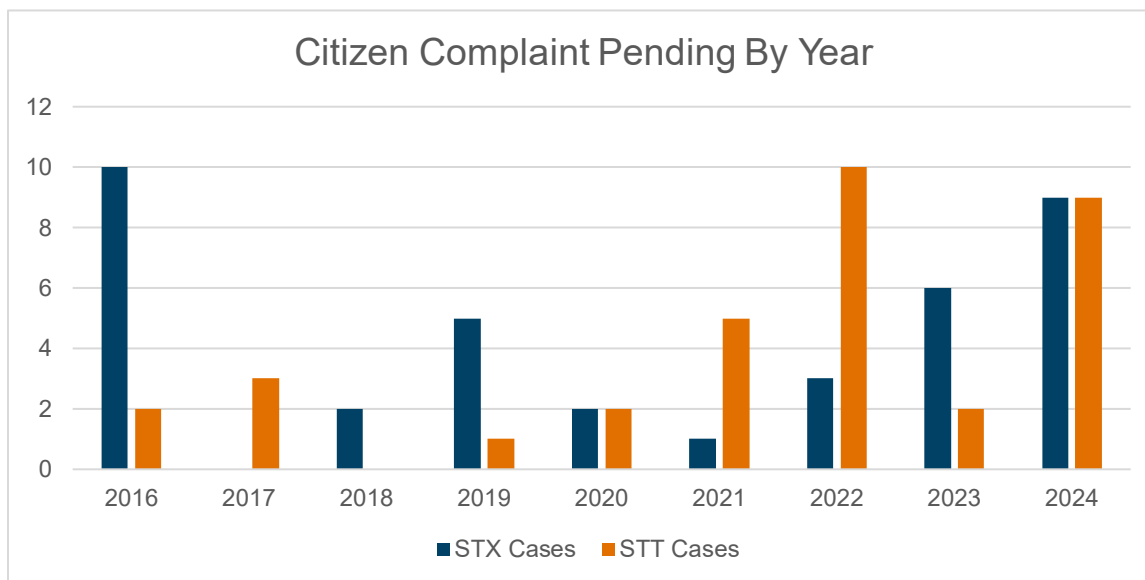


Chart MS2: Pending CC Cases.

At the end of Q3, VIPD had 72 pending citizen complaint investigations. Of those, more than half have been open for two years or more, and 15 have been pending since 2017.

To ensure the department continues to focus on concluding its oldest cases, the IMT recommends the VIPD set specific deadlines to conclude all cases that have been open for more than a year. For instance, the VIPD should set one deadline to conclude its pending 2016 cases, another deadline for its 2017 cases and so forth. Establishing benchmarks formalizes the department’s consensus and commitment to goals and objectives. Prioritizing the successful closure of older citizen complaint investigations can positively contribute to case management by helping reduce the total number of open active cases. Fewer active cases can place less demands on limited investigative resources.

On the following page and as highlighted earlier, Chart TTOA7 shows the number of open citizen complaint investigations in each of the past four quarters. It reflects small but consistent and gradual reductions quarter over quarter in caseload in both St. Thomas and St. Croix. Additionally, St. Croix carries a greater caseload than St. Thomas.

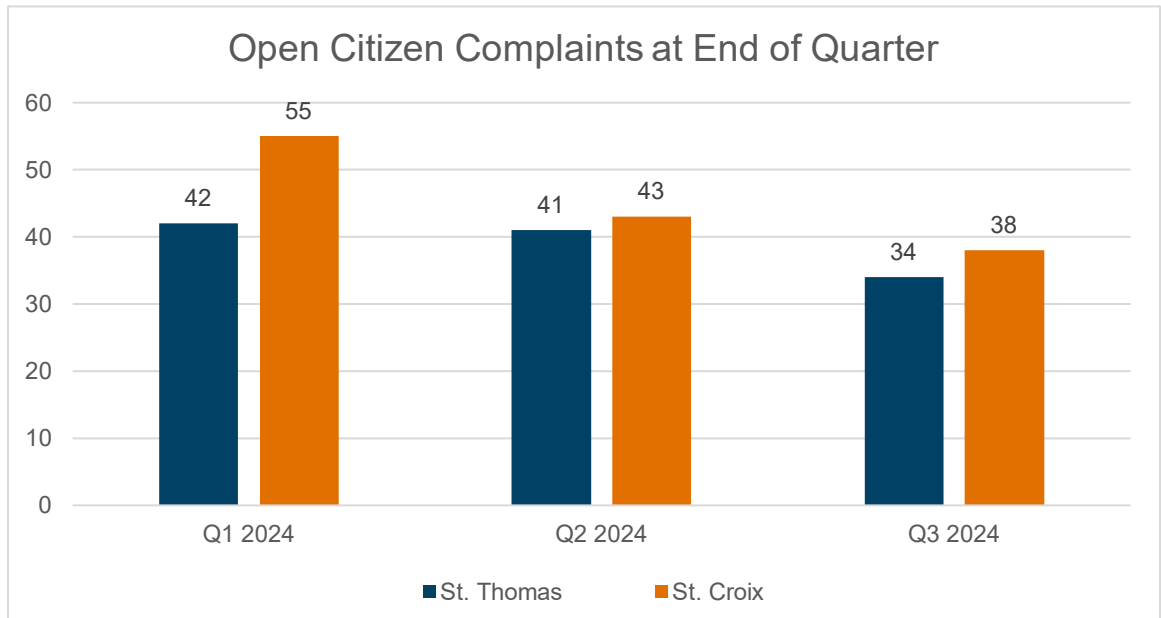


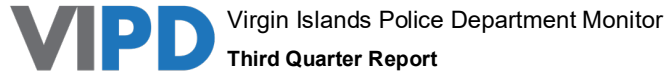
Chart TTOA7: Open Citizen Complaints by Island and Quarter.

Case Management Practices

This quarter, the IMT again found positive evidence of VIPD's use of IAPro to track the progress of open investigations. The IMT also continued to observe Commander Deficiency Review Memorandums included in investigations during this review period. These are noteworthy improvements that provide greater transparency than was available in the prior year, when files seldom contained data to document and track what, if any, reviews, corrections and deficiencies were completed by the commanders and deputy chiefs responsible for the review.

This quarter was the first time the IMT encountered an investigation file containing an "Untimely Submission" letter from a commander. While the investigator had completed the investigation before the due date, the commander noted, "However, the case folder inadvertently got misplaced with completed cases inside my secretary's office. I apologize for any inconvenience this may have caused." The commander's documentation of the reason the investigation closed after its due date and her ownership over the issue further contribute to transparency and accountability surrounding the completion of investigations.

Progress toward substantial compliance with paragraph 71 is directly tied to VIPD's institutionalizing effective and consistent case management protocols. Moreover, these protocols should be underscored by timely and meaningful oversight of pending cases by commanding officers.



Complaint Investigations – 35-Day Status Reports, Waivers and Stays

The documentation of waivers and stays (VIPD Policy 7.3 IV F) showed improvement based on the percentage of citizen complaint investigation case files we reviewed that submitted a timely 35-day status report this period versus the last period. Please see Table MS2: “Case Files and Documentation of Stays.”

Of the seven citizen complaint cases assessed this period, four had timely 35-day status reports, while one was submitted four days late and one was not completed; in one case, it was not required because a stay had been authorized prior to the 35-day status date. Three of the four that had timely 35-day status reports were closed later than their permitted due dates, which were generally 50 days after the submission of the 35-day status report, and three did not have stays issued.

The IMT examined the approved stay (CCX2023-0051) and found it adequately documented the reasons the investigation required additional time to complete. The stay request documented the respondent officer was not available to be interviewed, as he was on approved annual leave for a month and then called in sick on what was supposed to be his first day scheduled back. The officer still had not returned to work when the stay was requested.

While reviewing the citizen complaint files, the IMT also observed the use of a second waiver in an investigation (CCX2024-007) for the first time. The extenuating circumstances documented in the second waiver request included a delay in the availability of an evidence report related to the investigation and the absence of the reviewer, who was on vacation. The use of second waivers contributes to transparency and accountability regarding the timely completion of investigations.

Case Files – 35-Day Status Reports, Waivers and Stays

Case	Initially Assigned	35-Day Status Report	First Waiver (50 Days): New Case Due Date	Second Waiver (35 Days)	Stay	Complete	Within Policy
CCT 2023-0051	9/6/23	<p>Due: 10/10/23</p> <p>Submitted: None</p> <p>Recommended Disposition: NA</p>	None	None	9/29/23	6/28/24	Yes

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Case	Initially Assigned	35-Day Status Report	First Waiver (50 Days): New Case Due Date	Second Waiver (35 Days)	Stay	Complete	Within Policy
CCT 2024-0013	4/12/24	Due: 5/17/24 Submitted: 5/17/24 Recommended Disposition: Exonerated	7/6/24	None	None	6/7/24	Yes
CCX 2023-0013	3/6/23	Due: 4/10/23 Submitted: None Recommended Disposition: N/A	None	None	None	8/27/24	No ²⁶
CCX 2024-0008	3/5/24	Due: 4/9/24 Submitted: 4/9/24 Recommended Disposition: Not Sustained	5/29/24	None	None	6/11/24	No ²⁷
CCT 2024-0015	4/22/24	Due: 5/24/24 Submitted: 5/28/24 Recommended Disposition: Not Sustained	7/17/24	None	None	8/5/24	No ²⁸

26 There is no 35-day status report. The investigation was completed late.

27 The investigation was due on May 29, 2024, and completed on June 11, 2024.

28 The 35-day status report was late. The investigation was due on July 17, 2024, and completed on August 5, 2024.

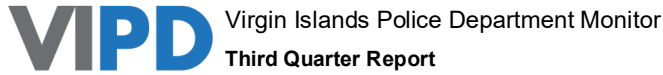
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Case	Initially Assigned	35-Day Status Report	First Waiver (50 Days): New Case Due Date	Second Waiver (35 Days)	Stay	Complete	Within Policy
CCT 2024-0010	3/18/24	Due: 4/22/24 Submitted: 4/22/24 Recommended Disposition: Not Sustained	7/11/24	None	None	8/30/24	No ²⁹
CCX 2024-0007	3/5/24	Due: 4/9/24 Submitted: 4/9/24 Recommended Disposition: Not Sustained	5/29/24	7/2/24	None	7/26/24	No ³⁰

Table MS2: Citizen Complaints – Stays and Waivers.

²⁹ The investigation was due on July 11, 2024, and completed on August 30, 2024.

³⁰ The May 28, 2024, waiver in the file is not signed by the approver.



Appendices

Appendix A: Compliance Status Summary

The below charts reflect a timeline presentation of VIPD’s compliance status regarding UOF, citizen complaints, and management and supervision. The period identified covers the first quarter of 2022³¹ (Q1 2022) through the third quarter of 2024 (Q3 2024).³²

The key is as follows:

- Green represents substantial compliance.
- Blue represents partial compliance.
- Yellow represents CD paragraphs placed in a warning status by the former Monitor.
- Red represents CD paragraphs that the former Monitor deemed not in compliance.

Compliance Status Summary Tables

	Para	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024
Use of Force	31	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
	32	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
	33	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
	34	Green	Green	Yellow	Blue	Blue	Blue	Green	Green	Green	Green	Green
	35	Green	Yellow	Red	Blue	Blue	Blue	Green	Green	Green	Green	Green
	36	Green	Yellow	Red	Blue	Blue	Blue	Green	Green	Green	Green	Green
	37	Red	Red	Red	Blue	Blue	Blue	Blue	Blue	Blue	Blue	Blue
	38	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
	39	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
	40	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
	41	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green

31 The current IMT began compliance assessments in Q4 2022 forward. Compliance status assessments prior to Q4 2022 were conducted by former monitor, i.e., the period covering Q4 2020 through Q3 2022.

32 Pursuant to the Court’s ruling in May 2021, terminating the training section of the CD, a compliance chart for training has not been included.

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	Para	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024
Citizen Complaints	42											
	43											
	44											
	45											
	46											
	47											
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	Para	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024
Management and Supervision	59											
	60											
	61											
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Appendix B: Compliance Assessment Status³³

Use of Force

The VIPD remains in substantial compliance with all paragraphs in the UOF section, except for paragraph 37.

Use of Force: ¶31

“The VIPD will review and revise its use of force policies as necessary to:

- a) define terms clearly;
- b) define force as that term is defined in this Agreement;
- c) incorporate a use of force model that teaches disengagement, area containment, surveillance, waiting out a subject, summoning reinforcements or calling in specialized units as appropriate responses to a situation;
- d) advise that, whenever possible, individuals should be allowed to submit to arrest before force is used;
- e) reinforce that the use of excessive force will subject officers to discipline, possible criminal prosecution, and/or civil liability;
- f) ensure that sufficient less lethal alternatives are available to all patrol officers; and
- g) explicitly prohibit the use of choke holds and similar carotid holds except where deadly force is authorized.

Once the DOJ has reviewed and approved these policies, the VIPD shall immediately implement any revisions.”

Use of Force: ¶32

“The VIPD will require all uses of force to be documented in writing. The use of force report form will indicate each and every type of force that was used, and require the evaluation of each use of force. Use of force reports will include a narrative description of the events preceding the use of force, written by a supervisor or by the designated investigative unit. Use of force reports also will include the officer(s)’ narrative description of events and the officer(s)’ statement. Except in cases of use of force involving the lowest level of force as defined in VIPD policy as approved by DOJ, the officer’s statement shall be audio- or video-taped.”

Use of Force: ¶33

“Officers shall notify their supervisors following any use of force upon the receipt of an allegation of excessive force. Except in uses of force involving the lowest level of force as defined in VIPD policy as approved by DOJ, supervisors will respond to the scene, examine the subject for injury,

³³ Refer to Appendix B for a full list of each paragraphs under the CD.

interview the subject for complaints of pain, and ensure that the subject received needed medical attention.”

Use of Force: ¶34

“Supervisors, or designated investigating officers or units, will review, evaluate, and document each use of force, and will complete the narrative description section of the use of force report. The narrative description will include a precise description of the facts and circumstances that either justify or fail to justify the officer’s conduct. As part of this review, the supervisor or designated investigating officer/unit will evaluate the basis for the use of force, and determine whether the officer’s actions were within VIPD policy. An officer who used force during the incident, whose conduct led to an injury, or who authorized conduct leading to the use of force or allegation of excessive force, or who was present during the incident, will not be eligible to review or investigate the incident.”

Use of Force: ¶35

“The parties agree that it is improper interview procedure during use of force investigations to ask officers or other witnesses leading questions that improperly suggest legal justifications for the officer’s conduct when such questions are contrary to appropriate law enforcement techniques. In each review/investigation, the VIPD will consider all relevant evidence including circumstantial, direct and physical evidence, as appropriate, and make credibility determinations, if feasible. The VIPD will make all reasonable efforts to resolve material inconsistencies between witness statements. The VIPD will train all of its supervisors and officers assigned to conduct use of force investigations in conducting use of force investigations, including in the factors to consider when evaluating credibility.”

Use of Force: ¶36

“Supervisors, or designated investigating officers or units, shall conduct an investigation of all uses of force or injury resulting from a use of force by any officer under their command. This requirement does not apply to uses of force involving the lowest level of force as defined in VIPD policy as approved by DOJ. In an investigation, supervisors or designated investigating officers or units, shall interview all witnesses to a use of force or an injury resulting from a use of force. Consistent with the requirements of the collective bargaining agreement or other applicable law, VIPD supervisors or designated investigating officers or units shall ensure that all officer witnesses provide a statement regarding the incident. Supervisors, or designated investigating officers or units, shall ensure that all use of force reports for all levels of force identify all officers who were involved in the incident or were on the scene when it occurred. Supervisors, or designated investigating officers or units, shall ensure that all reports for all levels of force indicate whether an injury occurred, whether medical care was provided, and whether the subject refused medical treatment. Supervisors, or designated investigating officers or units, shall ensure that all reports include contemporaneous photographs or videotapes taken of all injuries at the earliest practicable opportunity, both before and after any treatment, including cleansing of wounds.”

Use of Force: ¶37

“All investigations into use of force shall be reviewed by the Officer’s Commander and/or Director, or by a Commander and/or Director in the designated investigative unit, who shall identify any deficiencies in those reviews, and shall require supervisors, or designated investigative officers or units, to correct any and all deficiencies. Supervisors, and designated investigative officers or units, will be held accountable for the quality of their reviews. Appropriate non-disciplinary corrective action and/or disciplinary action will be taken when a supervisor, or designated investigative officer or unit, fails to conduct a timely and thorough review, or neglects to recommend appropriate corrective action, or neglects to properly implement appropriate corrective action. As provided by VIPD policy and approved by DOJ, designated command staff shall further review the Commander and/or Director’s reviews according to the level of force involved.”

Compliance Progress

- Status: Partial Compliance

The VIPD has partially complied with this paragraph. VIPD’s UOF-related policies include the requirements of this paragraph. In our review and assessment of completed cases, we saw enhanced engagement in the review and oversight of pending investigations by commanding officers. Investigative case files and disciplinary matters identified instances of accountability for untimely investigations. Investigative timeliness is also improving. Continued and consistent effort in this regard is required to demonstrate substantial compliance.

Use of Force: ¶38

“The VIPD will investigate all critical firearm discharges. The VIPD will ensure that the investigation accounts for all shots and locations of all officers who discharged their firearms. The VIPD will conduct all ballistic or crime scene analyses, including gunshot residue or bullet trajectory tests, as appropriate.”

Use of Force: ¶39

“VIPD shall complete development of a Use of Firearms policy that complies with applicable law and current professional standards. The policy shall prohibit officers from possessing or using unauthorized firearms or ammunition and shall inform officers that any such use may subject them to disciplinary action. The policy shall establish a single, uniform reporting system for all firearms discharges. The policy shall prohibit officers from obtaining service ammunition from any source except through official VIPD channels, and shall specify the number of rounds VIPD authorizes its officers to carry. The policy will continue to require that all discharges of firearms by officers on- or off-duty, including unintentional discharges, be reported and investigated.”

Use of Force: ¶40

“The VIPD shall revise its policies regarding off-duty officers taking police action to provide that off-duty officers shall notify on-duty VIPD or local law enforcement officers before taking police action, absent exigent circumstances, so that they may respond with appropriate personnel and resources to handle the problem; provide that, if it appears the officer has consumed alcohol or is otherwise impaired, the officer shall submit to field sobriety, breathalyzer, and/or blood tests.”

Use of Force: ¶41

“The VIPD shall continue to provide an intermediate force device, which is between chemical spray and firearms on the force continuum, that can be carried by officers at all times while on-duty. The VIPD shall continue its policy regarding the intermediate force device, incorporate the intermediate force device into the force continuum and train all officers in its use on an annual basis.”

Citizen Complaints

The IMT continues to find the VIPD in substantial compliance with paragraphs 42 through 58, the Citizen Complaints section of the CD. While we note opportunities to improve investigative skills in several areas impacting the CD and identified deficiencies in CCT2024-0007, these observations do not warrant changing the compliance status, and particularly paragraphs 47 and 51, which have been in substantial compliance since Q4 2020.

Citizen Complaints: ¶42

“The VIPD will develop and implement a program to inform persons that they may file complaints regarding the performance of any officer. This program will include distribution of complaint forms, fact sheets, informational posters, and public service announcements that describe the citizen complaint process.”

Citizen Complaints: ¶43

“The VIPD will make complaint forms and informational materials available at government properties such as VIPD district stations, substations, mobile substations, libraries, the Internet, and, upon request, to community groups and community centers. At each VIPD district station, substation, and mobile substation, the VIPD will permanently post a placard describing the complaint process and include the relevant phone numbers. These placards shall be displayed in both English and Spanish, and where deemed necessary, in French or French Patois, to account for diversity in the VI population. The VIPD will require all officers to carry informational brochures and complaint forms in English and Spanish, and where deemed necessary, in French or French Patois, in their vehicles at all times while on duty. If a citizen objects to an officer’s conduct, that

officer will inform the citizen of his or her right to make a complaint. Officers will not discourage any person from making a complaint.”

Citizen Complaints: ¶44

“Complaints may be filed in writing or verbally, in person or by mail, telephone (or TDD), facsimile or electronic mail. The duty officer at the front desk of each district station will be authorized to take complaints, including third-party complaints, which persons may file at any district station. Complaint intake officers may describe facts that bear upon a complainant’s demeanor and physical condition but may not express opinions regarding his/her mental competency or veracity. Each complaint will be resolved in writing. Upon receipt, each complaint will be assigned a unique identifier, which will be provided to the complainant. Each complaint will be tracked according to the basis for the complaint (e.g., excessive force, discourtesy, improper search, etc.)”

Citizen Complaints: ¶45

“Copies of all allegations of misconduct against the VIPD filed with the Zone Commands will be referred to Internal Affairs Unit (“IAU”) within five business days.”

Citizen Complaints: ¶46

“Complaints will be evaluated based on a preponderance of the evidence standard, for which the Territory will develop and implement appropriate training.”

Citizen Complaints: ¶47

“The VIPD will explicitly prohibit from investigating an incident any officer who used force during the incident, whose conduct led to the injury to a person, or who authorized the conduct that led to these reportable incidents.”

Citizen Complaints: ¶48

“The VIPD will investigate every citizen complaint. The VIPD will establish a clear policy and procedure regarding the intake of any complaint, including anonymous and confidential complaints, against a VIPD officer. This policy and these procedures will include instructions to an officer for taking a complaint and prompt delivery to a supervisor.”

Citizen Complaints: ¶49

“The VIPD will institute a centralized numbering and tracking system for all complaints, and each complaint will receive a tracking number as quickly as possible. The IAU will be designated as the primary and centralized agency to determine whether the investigation will be assigned to zone

(one of the seven zones located throughout the Virgin Islands), retained by the IAU, or referred for possible criminal investigation. If the IAU refers a complaint to a zone, copies of all documents, findings, and recommendations should be immediately forwarded to the IAU for tracking and monitoring. For complaints alleging the excessive use of force or violation of a person's constitutional rights, the Police Commissioner should be notified no less than twenty-four hours after receipt of a complaint."

Citizen Complaints: ¶50

"The VIPD will adopt a single policy concerning the investigation of misconduct complaints, regardless of whether the investigation is conducted by the IAU or a zone."

Citizen Complaints: ¶51

"The VIPD will establish policies and procedures and train all of its investigators on the factors to consider when evaluating complainant or witness credibility; examination and interrogation of accused officers and other witnesses; identifying misconduct even if it is not specifically named in the complaint; and using the preponderance of the evidence standard as the appropriate burden of proof. VIPD investigators will ensure that all officers on the scene of an incident provide a statement regarding the incident. The policy will require that all interviews be mechanically recorded using an audio or videotape."

Citizen Complaints: ¶52

"The policy will require that the investigative findings include whether: 1) the police action was in compliance with policy, training and legal standards, regardless of whether the complainant suffered harm; 2) the incident involved misconduct by any officer; 3) the use of different tactics should or could have been employed; 4) the incident indicates a need for additional training, counseling or other non-disciplinary corrective measures; and 5) the incident suggests that the VIPD should revise its policies, training, or tactics."

Citizen Complaints: ¶53

"The policy will provide clear guidance to all investigators regarding the procedures for handling criminal misconduct allegations, referring them to the Virgin Islands Attorney General's Office or other appropriate agency for possible criminal prosecution, and the entity or individual who should make the determination of whether the complaint should be investigated criminally. The policy shall continue to require the completion of an administrative investigation, irrespective of the initiation or outcome of criminal proceedings."

Citizen Complaints: ¶54

“In each investigation, the VIPD will consider all relevant evidence including circumstantial, direct and physical evidence, as appropriate, and make credibility determinations, if feasible. There will be no automatic preference for an officer’s statement over a non-officer’s statement, nor will the VIPD completely disregard a witness’ statement merely because the witness has some connection to the complainant. The VIPD will make efforts to resolve material inconsistencies between witness statements.”

Citizen Complaints: ¶55

“During an investigation, all relevant police activity, including each use of force (i.e., not just the type of force complained about) will continue to be investigated. The investigation will also evaluate any searches or seizures that occurred during the incident. The VIPD will not close an investigation simply because the complaint is withdrawn or the alleged victim is unwilling or unable to provide medical records or proof of injury or the complainant will not provide additional statements or written statements; rather, the investigating agency will continue its investigation as necessary to determine whether the original allegation(s) can be resolved based on the information, evidence, and investigatory procedures and techniques available. In each investigation, the fact that a complainant pled guilty or was found guilty of an offense will not be considered as evidence of whether a VIPD officer used or did not use a type of force, nor will it justify discontinuing the investigation.”

Citizen Complaints: ¶56

“The complainant will be periodically kept informed regarding the status of the investigation. Upon completion of the investigation, the complainant will be notified of its outcome, including an appropriate statement regarding whether any non-disciplinary corrective action or disciplinary action was taken.”

Citizen Complaints: ¶57

“Each allegation in an investigation will be resolved by making one of the following dispositions:

- a. Unfounded, where the investigation determines, by a preponderance of the evidence, that no facts to support that the incident complained of actually occurred.
- b. Sustained, where the investigation determines by a preponderance of the evidence that the person’s allegation is supported by sufficient evidence to determine that the incident occurred and the actions of the officer were improper.
- c. Not Sustained, where the investigation determines, by a preponderance of the evidence, that there are insufficient facts to decide whether the alleged misconduct occurred.

- d. Exonerated, where the investigation determined, by a preponderance of the evidence that the alleged conduct did occur but did not violate VIPD policies, procedures or training.”

Management and Supervision

The VIPD is in substantial compliance with all paragraphs in the Management and Supervision section, except for paragraphs 64 and 71.

Management and Supervision: ¶59

“The VIPD will develop and implement a risk management system to include a new computerized relational database or paper system for maintaining, integrating, and retrieving information necessary for supervision and management of the VIPD. Priority will be given to the VIPD obtaining any established program and system. The VIPD will regularly use this data to promote civil rights and best police practices; to manage risk and liability; and to evaluate the performance of VIPD officers across all ranks, units and shifts.”

Management and Supervision: ¶60

“The new risk management system will collect and record the following information:

- a. all uses of force;
- b. canine bite ratios;
- c. the number of canisters of chemical spray used by officers;
- d. all injuries to prisoners;
- e. all instances in which force is used and a subject is charged with “resisting arrest,” “assault on a police officer,” “disorderly conduct,” or “obstruction of official business;”
- f. all critical firearm discharges, both on-duty and off-duty;
- g. all complaints (and their dispositions);
- h. all criminal proceedings initiated, as well as all civil or administrative claims filed with, and all civil lawsuits served upon, the Territory and its officers, or agents, resulting from VIPD operations or the actions of VIPD personnel;
- i. all vehicle pursuits;
- j. all incidents involving the pointing of a firearm (if any such reporting is required); and
- k. all disciplinary action taken against officers.”

Management and Supervision: ¶61

“The new risk management system will include, for the incidents included in the database, appropriate identifying information for each involved officer (e.g., name, badge number, shift and supervisor) and civilian (e.g., race, ethnicity or national origin, if available).”

Management and Supervision: ¶62

“Within 120 days of the implementation of the new risk management system, or later with the agreement of DOJ, the VIPD will prepare, for the review and approval of DOJ, a plan for including appropriate fields and values of new and historical data into the risk management system (the “Data Input Plan”). The Data Input Plan will identify the data to be included and the means for inputting such data (direct entry or otherwise), the specific fields of information to be included, the past time periods for which information is to be included, the deadlines for inputting the data, and the responsibility for the input of the data. The Data Input Plan will include historical data that is up-to-date and complete in the risk management system. The VIPD and DOJ will together seek to ensure that the protocol receives final review and approval within 30 days after it is presented for approval.”

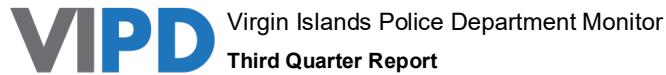
Management and Supervision: ¶63

“The VIPD will, within 120 days, prepare for the review and approval of DOJ, and thereafter implement, a protocol for using the risk management system. The VIPD will submit for the review and approval of DOJ all proposed modifications to the protocol prior to implementing such modifications.”

Management and Supervision: ¶64

“The protocol for using the risk management system will include the following provisions and elements:

- a. The protocol is comprised of the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation and audit.
- b. The protocol will require the automated system to analyze the data according to the following criteria: i) number of incidents for each data category by individual officer and by all officers in a unit; ii) average level of activity for each data category by individual officer and by all officers in a unit; and iii) identification of patterns of activity for each data category by individual officer and by all officers in a unit.
- c. The protocol will require the system to generate reports on a monthly basis describing the data and data analysis and identifying individual and unit patterns.
- d. The protocol will require that VIPD deputy chiefs, managers, and supervisors will review, on a regular basis but not less than quarterly, system reports, and will evaluate individual officer, supervisor, and unit activity.
- e. The protocol will require that VIPD deputy chiefs, managers, and supervisors initiate intervention for individual officers, supervisors and for units based on appropriate activity and pattern assessment of the information contained in the risk management system.
- f. The protocol will require that intervention options include discussion by deputy chiefs, managers, supervisors, and officers; counseling; training; and supervised, monitored, and documented action plans and strategies designed to modify activity. All



interventions will be documented in writing and entered into the automated system (appropriate intervention options will be employed based on the evaluation described in subsection (e) above).

- g. The protocol will specify that actions taken as a result of information from the risk management system be based on all relevant and appropriate information, including the nature of the officer's assignment, crime trends and crime problems, and not solely on the number or percentages of incidents in any category of information recorded in the risk management system.
- h. The protocol will require that VIPD deputy chiefs, managers, and supervisors will promptly review the risk management system records of all officers recently transferred to their sections and units.
- i. The protocol will require that VIPD deputy chiefs, managers, and supervisors be evaluated on their ability to use the risk management system to enhance effectiveness and reduce risk.
- j. The protocol will require that the system be managed and administered by the Internal Affairs Unit of the VIPD. The IAU of the VIPD will conduct quarterly audits of the system to ensure action is taken according to the process described above.
- k. The protocol will require regular reviews, at no less than quarterly intervals, by appropriate managers of all relevant risk management system information to evaluate officer performance territory-wide and to evaluate and make appropriate comparisons regarding the performance of all VIPD units in order to identify any significant patterns or series of incidents."

Compliance Progress

- Status: Partial Compliance

The VIPD remains in partial compliance with paragraph 64. The VIPD has become current with its outstanding quarterly audits and is currently amending VIPD Policy 6.2 Risk Management Protocol to more closely align with current practice. The VIPD had no triggering events that required facilitation of an EIP alert meeting and it is up to date on EIP action plans. However, the VIPD has not conducted a quarterly analysis of its risk management data since the second quarter 2024.

Management and Supervision: ¶65

"The VIPD will maintain all personally identifiable information about an officer included in the risk management system during the officer's employment with the VIPD for at least five years. Information necessary for aggregate statistical analysis will be maintained indefinitely in the risk management system. On an ongoing basis, the VIPD will enter information into the risk management system in a timely, accurate, and complete manner, and maintain the data in a secure and confidential manner." "Notwithstanding the foregoing, the VIPD shall not be required to upload any data dated prior to July 2017 into its electronic risk management system. Such data shall

continue to be retained in hard copy form consistent with the foregoing requirements of this paragraph.”³⁴

Management and Supervision: ¶66

“The new risk management system will be purchased off the shelf and customized by VIPD. Alternatively, the new risk management system may be developed and implemented according to the following schedule:

- a. Within 150 days of the effective date of this Agreement, subject to the review and approval of DOJ, the VIPD will issue a Request for Proposal (RFP).
- b. Within 270 days of the issuance of the RFP, or later with the agreement of DOJ, the VIPD will select the contractor to create the risk management system.
- c. Within 150 days of the effective date of this Agreement, the VIPD will submit the protocol for using the risk management system to DOJ for review and approval. The VIPD will share drafts of this document with DOJ and the Monitor (a position described in Section VII) to allow DOJ and the Monitor to become familiar with the document as it develops and to provide informal comments on it. The VIPD and DOJ will together seek to ensure that the protocol receives final approval within 30 days after it is presented for review and approval.
- d. Within 14 months of selecting the contractor, the VIPD will have ready for testing a beta version of the risk management system consisting of: i) server hardware and operating systems installed, configured and integrated with the VIPD’s existing automated systems; ii) necessary database software installed and configured; iii) data structures created, including interfaces to source data; and iv) the use of force information system completed, including historic data. DOJ and the Monitor will have the opportunity to participate in testing the beta version using use of force data and test data created specifically for the purposes of checking the risk management system.
- e. The risk management system computer program and computer hardware will be operational and fully implemented within 20 months of the selection of the risk management system contractor.”

Management and Supervision: ¶67

“Prior to implementation of the new risk management system, the VIPD will continue to use existing databases and resources to the fullest extent possible to identify patterns of conduct by VIPD officers or groups of officers.”

³⁴ Pursuant to the 2019 ransomware and virus attack to IAPro, the Court modified this paragraph by adding the last sentence. See Case: 3:08-cv-00158 Document #: 480, filed 10/29/20.

Management and Supervision: ¶68

“Following the initial implementation of the risk management system, and as experience and the availability of new technology may warrant, the VIPD may propose to add, subtract, or modify data tables and fields, modify the list of documents scanned or electronically attached, and add, subtract, or modify standardized reports and queries. The VIPD will submit all such proposals for review and approval by DOJ before implementation.”

Management and Supervision: ¶69

“The VIPD will develop a protocol for conducting audits. The protocol will be used by each officer or supervisor charged with conducting audits. The protocol will establish a regular and fixed schedule to ensure that such audits occur with sufficient frequency and cover all VIPD zones.”

Management and Supervision: ¶70

“The VIPD will continue to utilize a disciplinary matrix to take into account an officer’s violations of different rules, rather than just repeated violations of the same rule. The VIPD will further revise this matrix to increase the penalties for uses of excessive force, improper searches and seizures, discrimination, or dishonesty, to reflect the seriousness of those infractions. The revised disciplinary matrix will provide the VIPD with the discretion to impose any appropriate punishment when the VIPD believes the officer’s misconduct exhibits a lack of fitness for duty. This revised matrix will be subject to the review and approval of DOJ.”

Management and Supervision: ¶71

“VIPD policy will continue to identify clear time periods by which the various steps of a complaint adjudication process should be completed, from complaint receipt to the imposition of discipline, if any. Absent exigent circumstances, extensions will not be granted without the Police Commissioner’s written approval and notice to the complainant. In the limited circumstances when an extension is necessary, appropriate tolling provisions will be outlined in the policy.”

Compliance Progress

- Status: Partial Compliance


The VIPD remains in partial compliance with this paragraph. VIPD Policy 7.3 Investigating Misconduct and Citizen Complaints sets forth specific time periods for the complaint adjudication process and requires the Commissioner’s written approval and notice to a complainant for extensions. While progress has been made, continued focus to conclude its older cases while also addressing timely newly opened cases is required to achieve substantial compliance.

Management and Supervision: ¶72

“Absent exceptional circumstances, the VIPD will not take only non-disciplinary corrective action in cases in which the disciplinary matrix indicates the imposition of discipline. In a case where discipline has been imposed on an officer, the VIPD must also consider whether non-disciplinary corrective action is required.”

Appendix C: UOF Cases in Q3

Case Number	Level	Finding	Time (Days)	Case Number	Level	Finding	Time (Days)
UOFT2016-0081	3	Justified, W/I Policy	2,823	UOFT2024-0061	3	Justified, W/I Policy	54
UOFT2016-0082	3	Justified, W/I Policy	2,809	UOFT2024-0062	4	Justified, W/I Policy	54
UOFT2016-0086	3	Justified, W/I Policy	2,809	UOFT2024-0078	4	Justified, W/I Policy	25
UOFT2016-0087	3	Justified, W/I Policy	2,808	UOFT2024-0093	4	Justified, W/I Policy	25
UOFT2016-0097	3	Justified, W/I Policy	2,801	UOFT2024-0094	4	Justified, W/I Policy	25
UOFT2016-0093	4	Justified, W/I Policy	2,804	UOFT2024-0095	4	Justified, W/I Policy	30
UOFT2016-0094	4	Justified, W/I Policy	2,804	UOFX2022-0054	1	Justified, W/I Policy	773
UOFT2016-0096	4	Justified, W/I Policy	2,803	UOFX2022-0055	2	Justified, W/I Policy	773
UOFT2021-0091	1	Justified, W/I Policy	951	UOFX2022-0056	2	Not Justified, Not W/I Policy	773
UOFT2021-0092	4	Justified, W/I Policy	951	UOFX2022-0057	4	Justified, W/I Policy	772
UOFT2022-0002	1	Justified, W/I Policy	903	UOFX2022-0058	3	Justified, W/I Policy	773
UOFT2022-0078	1	Not Justified, Not Within Policy	633	UOFX2023-0004	4	Justified, W/I Policy	510
UOFT2024-0028	1	Justified, W/I Policy	147	UOFX2023-0005	4	Justified, W/I Policy	510


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UOFT2024-0029	4	Justified, W/I Policy	147	UOFX2023-0015	4	Justified, W/I Policy	476
UOFT2024-0030	3	Justified, W/I Policy	147	UOFX2024-0047	4	Justified, W/I Policy	26
UOFT2024-0031	3	Justified, W/I Policy	147	UOFX2024-0048	4	Justified, W/I Policy	26
UOFT2024-0032	3	Justified, W/I Policy	147	UOFX2024-0049	4	Justified, W/I Policy	26
UOFT2024-0033	3	Justified, W/I Policy	147	UOFX2024-0050	4	Justified, W/I Policy	26
UOFT2024-0034	1	Justified, W/I Policy	147	UOFX2024-0061	4	Justified, W/I Policy	40
UOFT2024-0035	3	Justified, W/I Policy	147	UOFX2024-0062	4	Justified, W/I Policy	40
UOFT2024-0041	4	Justified, W/I Policy	147	UOFX2024-0064	4	Justified, W/I Policy	40
UOFT2024-0042	4	Justified, W/I Policy	147	UOFX2024-0073	4	Justified, W/I Policy	15
UOFT2024-0043	4	Justified, W/I Policy	147	UOFX2024-0074	4	Justified, W/I Policy	15
UOFT2024-0044	3	Justified, W/I Policy	147				