VERMONT MENTAL HEALTH CRISIS RESPONSE COMMISSION

2019 Report to the Governor, General Assembly and Chief Justice, Vermont Supreme Court

DECEMBER 31, 2019

WILDA L. WHITE, ESQ., CHAIR
wildalwhite@gmail.com

Table of Contents

EXECUTIVE SUMMARY 3

I. ABOUT THE REPORT 13

II. BACKGROUND OF MENTAL HEALTH CRISIS RESPONSE COMMISSION 13

III. PURPOSE OF MENTAL HEALTH CRISIS RESPONSE COMMISSION 14

IV. COMMISSION MEMBERSHIP 14

V. COMMISSION MEETINGS 16

VI. ROOT CAUSE ANALYSIS 16

VII. COMMISSION'S PROCESS 17

A. Documentary Evidence Reviewed 17
B. Records requested/subpoenaed but not received 18
C. Witnesses Testifying before Commission 19
D. Informal Witness Interviews 20

VIII. OVERVIEW OF WHAT HAPPENED 20

IX. THE AFTERMATH 26

A. Taser Radio Story 26
B. Trauma to the Community 26
C. Changes adopted in the wake of Mr. Grenon's death 27
1. Burlington Police Department 27
2. Burlington Housing Authority 28
3. Howard Center 28

X. CONCLUSIONS – HOW AND WHY IT HAPPENED 29

XI. RECOMMENDATIONS – HOW FUTURE DEATHS IN SIMILAR SITUATIONS MIGHT BE PREVENTED 36

A. For community mental health agencies 36
B. For providers of public housing 37
C. For law enforcement 38
D. For communities 39

XII. OTHER VIEW (COMMISSIONER WHITE, JOINED BY COMMISSIONER PAQUIN) 39

A. PREVIOUS BPD KILLING 39
B. FAILURE TO FOLLOW BPD POLICIES DURING ENCOUNTER WITH PHIL GRENON 40
1. CONTAINMENT POLICY 41
2. TIME POLICY 42
3. EDGED WEAPON ZONE OF SAFETY POLICY 42
4. COMMUNICATIONS POLICY 43
5. CRISIS NEGOTIATION POLICY 45
6. COMMAND POST AND STAGING AREA POLICY 46
7. TASER POLICY 48
C. SIMILARITIES AND DIFFERENCES BETWEEN TWO BPD KILLINGS 50
D. STEREOTYPING AND DISPARAGING STATEMENTS 51
E. CONCERNS ABOUT ACTIONS TAKEN IN AFTERMATH OF PHIL GRENON'S DEATH 53
F. UNCONSCIOUS BIAS AND BPD'S KILLING OF PHIL GRENON 54
G. OTHER RECOMMENDATIONS 55

XIII. OTHER LAW ENFORCEMENT INVOLVED DEATHS OF INDIVIDUALS IN CRISIS 56

XV. APPENDIX A – 9-1-1 TRANSFER TO BURLINGTON POLICE DEPARTMENT 57

XVI. APPENDIX B – POLICE INTERVIEW OF NEIGHBOR WHO CALLED STREET OUTREACH 59

XVII. APPENDIX C – POLICE INTERVIEW OF 9-1-1 CALLER 60

XVIII. APPENDIX D – BPD INITIAL ENCOUNTER WITH PHIL GRENON 61

Executive Summary

The March 2016 death of Phil Grenon in his own home at the hands of law enforcement officers attracted widespread media coverage. However, his death is more than a headline. It represents a pervasive problem. In the United States, people with untreated, severe mental illnesses are at least 16 times more likely to be killed during a police encounter than other individuals.[1] In addition, this Commission has reason to believe that other Vermonters in a mental health crisis have been killed by Vermont law enforcement in the three years since Mr. Grenon's death.

The Mental Health Crisis Response Commission was created by the Vermont legislature in 2017 to investigate such deaths to learn how they can be prevented. The Commission selected the death of Phil Grenon as the subject of its first investigation.

The Commission spent two years investigating Mr. Grenon's death. The Commission reviewed documentary evidence, including medical records, tenant records, police body camera footage, and other video recordings; interviewed witnesses; heard witness testimony; and studied use of force policies and mental health laws.

By law, the Commission is required to report its conclusions and recommendations to the Governor, General Assembly and Chief Justice of the Vermont Supreme Court.

This is the report of the Commission's conclusions and recommendations.

Section XII is the report of Commissioner White, in which Commissioner Paquin joins. It is not the case that other commissioners disagree with all the facts or conclusions it contains. It is the case that it has not been edited and approved by the full commission.

Background

At the time of his death, Phil Grenon was a divorced, 76-year-old father of an adult daughter who lived in Arizona and an involved grandfather to six children, with whom he spoke by telephone weekly. Although trained as a college instructor, he had been a stay-at-home dad after age 40 when mental health challenges made it difficult for him to maintain full-time employment. At the time of his death he lived in a subsidized apartment owned by Burlington Housing Authority. He was also a client of the Howard Center, Chittenden County's community mental health agency. However, he had missed two of his last three appointments and ceased taking medication as prescribed in the three months before his death.

[1] Doris A. Fuller et al., Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters, Treatment Advoc. Ctr. 1, 12 (2015) https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf

On March 21, 2016, at 5:20 p.m., Burlington Police Department (BPD) Officers Durwin Ellerman and David Bowers responded to a 9-1-1 call from the resident manager of Mr. Grenon's South Square Apartments located in downtown Burlington. The resident manager reported that Mr. Grenon was "screaming and threatening" inside his apartment, saying "he wants to stab people." (A transcript of the 9-1-1 call is included in Appendix A to this report.)

About a week before the 9-1-1 call, Mr. Grenon had left a voice mail message for his Howard Center treating psychiatrist in which he threatened to protect himself with knives should the police come to his apartment door. He believed the police were coming to his apartment to kill him. The Howard Center did not notify BPD of the threat and did not contact Mr. Grenon to attempt to engage him in treatment. Mr. Grenon had also been served an eviction notice on March 15, 2016 because of escalating conflicts with his neighbors.

During the response to the 9-1-1 call, after Mr. Grenon did not acknowledge the officers' knocks on his door, the officers used the resident manager's key to unlock and open his door. Upon opening the door, the officers saw Mr. Grenon standing near the door holding a knife. They immediately aimed their firearms at Mr. Grenon and commanded Mr. Grenon to drop the knife. They also called for additional units. As the encounter unfolded, they came to recognize that Mr. Grenon was actually holding two knives, a 6 ½-inch boning knife in his left hand and a 10-inch carving knife in his right hand. (A transcript of the initial encounter between BPD Officers Ellerman and Bowers is included in Appendix D.)

Mr. Grenon failed to drop the knives despite repeated commands over two minutes to do so. While still holding the knives, Mr. Grenon moved his right hand forward to close the door. Officer Bowers then fired his Taser[2] at Mr. Grenon just as Mr. Grenon closed the apartment door.

Next, BPD tied Mr. Grenon's door closed and over the next three hours a crisis negotiator tried multiple times to reach Mr. Grenon by telephone and by knocking at his door. BPD officers also inserted a camera into Mr. Grenon's apartment; however, they were unable to see him. Former BPD Chief Brandon del Pozo then made the decision to enter the apartment because he was concerned that Mr. Grenon might take his own life. Officer Ellerman had reported to his supervisor that Mr. Grenon had threatened to kill himself.

A little less than four hours after the officers responded to the initial 9-1-1 call, BPD officers entered Mr. Grenon's apartment and within 10 minutes, found him hiding in the bathtub, still holding the two knives. After pepper balls failed to drive him out of the bathroom, BPD decided to use a Taser to subdue Mr. Grenon and remove him from the bathroom. However, the Taser did not subdue Mr. Grenon. Rather, after being struck by the Taser, Mr. Grenon, wielding a knife in each hand, started moving out of the bathtub and towards the bedroom where the officers were. As Mr. Grenon entered the bedroom, three officers managed to backtrack into

[2] A Taser is a brand name of a conducted electrical weapon considered less-lethal force. It fires two, small barbed darts intended to puncture the skin and remain attached to its target. The darts are connected to the main weapon by wires that deliver electric current designed to temporarily incapacitate the target.

the living room. Because of the bedroom's configuration, four other officers were unable to leave the bedroom as they were in Mr. Grenon's direct path. Instead, they retreated backwards, deeper into the small bedroom. When Mr. Grenon continued to advance, Officer Bowers fired six shots in Mr. Grenon's direction, striking him with four.

Paramedics who had been staged nearby transported Mr. Grenon to UVM Medical Center where he was pronounced dead at 10:01 p.m. According to UVM Medical Center records, "BPD adds that they believe [Mr. Grenon] wanted to be shot by the police." The medical examiner ruled the cause of death as gunshot wounds of torso and extremities. The manner of death was "homicide (shot by law enforcement)."

Aftermath

In his testimony before the Commission, former Chief del Pozo raised questions about the reliability of tasers in these situations.

The entire community has been traumatized by the manner of Mr. Grenon's death.

Both BHA and BPD implemented changes in programming, training and/or resources in the wake of Mr. Grenon's death. There was no evidence before the Commission that the Howard Center made any changes in policies, practices, and procedures as a result of Mr. Grenon's death.

Conclusions

While not unanimous, the majority of the Commission concluded that Mr. Grenon's death was the result of a breakdown in services and communication.

Mr. Grenon's mental health began to deteriorate at least one year before his death. At the time of his death, Mr. Grenon was likely experiencing psychosis. He believed that people, including the police, were coming to his apartment to kill him.

Mr. Grenon's treating psychiatrist consistently recommended an increase in anti-psychotic medication without ever recognizing that Mr. Grenon had stopped re-filling his prescription for anti-psychotic medication three months before his death.

The deterioration in Mr. Grenon's mental health in 2015 followed the loss of his long-time Howard Center case manager. While Mr. Grenon's treating psychiatrist recognized that changes in his care team could cause Mr. Grenon to discontinue treatment, the Howard Center did not have an adequate plan to support Mr. Grenon in advance of and during the departure of his case manager.

As his health deteriorated, Mr. Grenon left ever more angry, hostile, and threatening voice mail messages for his treating psychiatrist and others. Mr. Grenon's practice of leaving angry, voice

mail messages for his treating psychiatrist – messages which would not necessarily be listened to – was authorized by his treating psychiatrist and appeared to the Commission to be part of his treatment plan.

Mr. Grenon's neighbors complained to their landlord and the police that Mr. Grenon was disturbing them by talking to himself and screaming at the walls of his apartment. They assumed he was hallucinating. However, it is more likely that his neighbors were hearing Mr. Grenon leave ever more angry, hostile, and threatening voice mail messages for his treating psychiatrist and others.

At least three times between February and March 2016, the Howard Center actually warned or indicated that individuals and organizations should be warned of threats of harm made by Mr. Grenon in voice mail messages.

In exercising a mental health professional's "Duty to Warn" on those three occasions, the Howard Center explicitly determined that Mr. Grenon posed a serious risk of danger to others. To the Commission, patient behavior that triggers a mental health professional's "Duty to Warn," also meets the "danger of harm to others" criteria for involuntary treatment.

The Howard Center did not use any of the avenues available to it to treat Mr. Grenon involuntarily after it determined that he posed a serious risk of danger to others. The Howard Center medical records also do not indicate a treatment strategy to address the risk.

After Mr. Grenon refused to meet with the case manager assigned to him following the departure of his long-time case manager at the end of October 2015, Mr. Grenon's treating psychiatrist assumed the role of treating psychiatrist and case manager. When Mr. Grenon's treating psychiatrist left for a three-week vacation on March 4, 2016, Mr. Grenon was left without either a case manager or a treating psychiatrist familiar with his situation.

On March 12, 2016, Mr. Grenon left a voice mail message for his treating psychiatrist threatening to defend himself with knives should anyone come to his apartment door. The treating psychiatrist retrieved the message while on vacation and notified Howard Center staff of the threat. However, no attempts were made to contact Mr. Grenon or engage him in treatment. The Howard Center did not have an adequate plan to provide treatment to Mr. Grenon during the vacation of his treating psychiatrist.

BPD had false and incomplete information, and inadequate resources during its March 21, 2016 encounter with Mr. Grenon. Officer Ellerman incorrectly reported to his sergeant that Mr. Grenon had threatened to kill himself. The Howard Center did not inform BPD that Mr. Grenon held the belief that police officers were coming to his apartment to kill him and that he planned to defend himself with knives. In addition, BPD did not take into account how Mr. Grenon's mental illness affected his ability to comply with their commands or how his mental state might affect his reaction to pepper balls or Tasers. BPD also did not take advantage of the Howard Center's mobile crisis clinician who was standing by during the encounter. While four hours

elapsed before BPD entered Mr. Grenon's apartment, their incursions into Mr. Grenon's apartment began well before that. Given his mental state, each of their incursions likely heightened Mr. Grenon's sense that he was under attack.

Because of the number of officers in Mr. Grenon's small bedroom and the location of the bedroom's exit, four officers became trapped in the bedroom when after being struck by the Taser, Mr. Grenon left the bathroom and advanced into the bedroom, wielding the two kitchen knives. Without time and an unimpeded path out of the bedroom, Officer Bowers was compelled to use lethal force to protect his fellow officers and himself against the advancing and knife-wielding Mr. Grenon.

The Commission found no evidence to support the entry in the UVM Medical Center emergency department record that was attributed to BPD that Mr. Grenon "wanted to be shot by the police." To the contrary, Mr. Grenon likely thought he was acting in self-defense at the time he was killed.

BHA recognized the deterioration in Mr. Grenon's mental health months before he died. BHA did ask Mr. Grenon's Howard Center case manager as early as January 2016 to check in with Mr. Grenon, and also copied the Howard Center on notices of lease violation and the notice to vacate. But on those occasions when BHA received no reply from the Howard Center, no one followed up. All the communications from BHA to the Howard Center were by email or letter. The communications lacked the sense of urgency that the Commission believes the circumstances required. The telephone would have been more appropriate under the circumstances.

The Commission did not find that the BHA eviction notice itself caused Mr. Grenon to behave as he did. Any threats Mr. Grenon may have made inside the confines of his apartment while leaving voice mail messages overheard by his neighbors were likely part of the same psychotic process that triggered his earlier threats.

The community's trauma from Mr. Grenon's death, in many cases, has not been addressed or relieved.

Recommendations

The Commission recommends the following measures to prevent similar deaths in the future.

For community mental health agencies

1. When client/patient risk is identified, immediately develop and document treatment strategies and appropriate responses to address risk, up to and including coordination with relevant community providers and local law enforcement, as needed.

   If a client/patient will not attend appointments or respond to visits to his apartment, and emergency examination is appropriate, coordinate with law enforcement to intercept the client/patient when he is in public rather than in his home.

2. Adopt the best practice of accompanying the discharge of the common law "Duty to Warn" with a screening for an application for emergency examination.

3. Adopt internal and external communication protocols, particularly when client/patient risk is identified, to ensure that communications are received by all parties involved in the client's/patient's care.

4. Adopt a medical recordkeeping system that is able to retain and retrieve emails, snail-mail correspondence, and other written documentation pertinent to patient care in a timely manner.

5. Adopt practices to support clients/patients when assigned staff transition away from a client/patient, paying particular attention to individuals with a history of fractured relationships and develop interventions to support such individuals

6. Adopt best practices around how to engage clients/patients in treatment. Additionally, provide detailed documentation of attempts to engage clients/patients in treatment and include clients'/patients' response in the documentation.

7. Create comprehensive, individualized treatment plans that address the particular challenges of clients/patients. Comprehensive treatment plans include goals, measurable and attainable objectives, and specific interventions associated with the treatment. Interventions are more than just the services to be delivered. Interventions are the specific actions that will be engaged in within the services to be delivered. Plans should include an objective way to measure whether the clients/patients are progressing toward their goals.

   When the clients' needs change, insure that the treatment plans are updated to address the new needs. Updates should be done at least annually or sooner as indicated. Document progress towards treatment plan goals and objectives and if progress is not identified, consider changing treatment intervention, objectives and/or goals to best support the individual served.

8. Refrain from assigning treating psychiatrists the dual role of case managers.

9. Refrain from giving clients/patients permission to leave voice mail messages as a treatment intervention when the voice mail messages will not be listened to.

10. In conjunction with law enforcement, implement a training program for crisis clinicians to educate them how best to work with law enforcement during a crisis. The training should include a curriculum that teaches clinicians about police practices and how clinicians can best support law enforcement during interactions with people in extreme states.

For providers of public housing

1. Develop and implement a best practices housing retention services program. As a component of the housing retention services plan, adopt a compassionate eviction policy that includes the creation of a housing retention plan for tenants in danger of losing their housing because of conduct related to a mental health disability or episode.

2. Recognize a landlord's duty to address or obtain assistance in addressing, situations that involve complex tenant interactions that are beyond the housing authority's knowledge and capabilities. To this end, develop and implement a systematic protocol for collaborating with community providers to meet the needs of tenants whose behaviors or extreme mental states disturb the quiet enjoyment of other tenants. The protocol should include early identification of problems, rapid deployment of interventions, and close and intentional communication with community providers.

   Community partners might include the local community mental health agency, law enforcement, mental health peer workers, advocacy organizations, the local interagency team (LIT), etc.

   The protocol should hold staff accountable for achieving results rather than simply going through the motion of checking boxes off.

3. Adopt internal practices designed to ensure that communications to community partners about tenants in crisis are received and acted upon.

4. Employ mental health social workers onsite as a resource for tenants and housing authority staff. Bringing such knowledge in-house would allow the housing authority to identify mental health issues sooner, allay resident fears, and better manage relationships with the local community mental health agency and law enforcement.

5. Offer trained, peer workers free or reduced rent in exchange for offering intentional peer support to tenants. Peer workers are individuals with lived experience of mental health conditions, extreme states and/or the mental health system who are trained to offer emotional support, share knowledge, teach skills, provide practical assistance, and connect

people with resources, opportunities, communities of support, and other people. They often provide advocacy, education, mentoring, and motivation. They also work one-on-one as role models, mentors, coaches and advocates and support people in developing psychiatric advance directives and creating Wellness Recovery Action Plans (WRAP).

For law enforcement

1. Develop an arrest and detention protocol that accommodates an individual's known mental illness during arrests and detentions, Train officers in the protocol. Develop the protocol with input from community partners, including community mental health agencies, advocacy organizations, and people with lived experience of law enforcement interactions during extreme mental states. The protocol should include a system for working with mental health clinicians during an encounter.

2. If time allows, before confronting an individual in crisis, devise and role-play intervention strategies as well as an exit strategy to ensure officers do not become trapped and thus compelled to resort to lethal force for their protection. Determine if entry into an enclosed space is truly required. When confronting an individual in an extreme mental state in a small, enclosed space, use as few officers as is safe.

3. Refrain from assuming that interventions such as pepper balls or Tasers will work effectively or in a typical manner on people in crisis. Decide in advance what you will do if you do not achieve the desired effect from interventions such as pepper balls or Tasers and, where possible, maintain nonlethal options.

4. Obtain the best information available about the individual in crisis from as many sources as feasible. Assemble needed tools and equipment that will allow officers to maintain distance from and control over the individual in crisis. BPD's emergency response vehicle is an example of the types of tools and equipment that might be required in such situations.

5. When encountering individuals in a mental health crisis, make every effort to calm the atmosphere by reducing stimulation such as radio traffic, power drills, ringing telephones, ambient noise, etc.

6. Require every law enforcement officer to attend periodic, continuing education courses on best practices in mental health crisis response.

For communities

1. Educate families and friends about alternatives to obtain care or protection for individuals in crisis who are at risk of harming others, when a treating psychiatrist declines to apply for an emergency examination.

2. Offer community members traumatized by police shootings timely access to community resources to address their trauma.

3. Create a mechanism for all agencies involved in law enforcement interactions with people in crisis to debrief together after the legal process has concluded. The debrief should focus on lessons learned and how the agencies can work better together to obviate the need for law enforcement encounters with people in crisis.

Other View

Commissioner Wilda White, joined by Commissioner Paquin, is of the opinion that an unconscious bias against people with mental illnesses on the part of the City of Burlington, including the Burlington Police Department, was a root cause of Mr. Grenon's death.

This conclusion is based on the following: (1) Mr. Grenon's killing was the second killing by BPD of a person with a mental illness in fewer than three years and both deaths were directly related to BPD's failure to follow its own policies; (2) BPD officers and leadership made disparaging and/or stereotypical statements about people with mental illnesses, in general, and/or Mr. Grenon, in particular; (3) the changes BPD adopted in the aftermath of Mr. Grenon's death are heavily focused on investment in equipment to extract people in emotional crisis rather than engage with them; (4) BPD did not offer any credible, explanation as to why BPD did not adhere to its own policies and take the time to protect Mr. Grenon, accommodate his mental illness as the law requires and avoid putting BPD officers in harm's way; (5) the City of Burlington has rebuffed attempts by people with a history of mental illness to participate in activities to improve relations with BPD; and (6) despite two killings of people with mental illnesses in fewer than three years and a $270,000 payout in settlement of a lawsuit arising out of one of the deaths, the City of Burlington did not see fit to include people with a history of mental illness on its recently created use-of-force committee and when the omission was pointed out to the City Council, it took no action to rectify the omission.

Commissioner White, joined by Commissioner Paquin, make the following recommendations specifically for the City of Burlington and the Burlington Police Department:

I. Revoke the City of Burlington policy that prohibits people who disclose a history of mental illness from participating in police ride-alongs.

II. Amend the City of Burlington resolution pertaining to "Formation of a Special Committee to Review Community Policing Practices through a Robust Community Engagement Process," to include at least two members with a history of mental illness and an interest in improving community policing practices.

III. Audit current Burlington Police Department policies pertaining to encounters with people in mental or emotional crisis to ensure that they comply with the Americans with Disabilities Act.

IV. Develop and train officers in a wider array of options to avoid use of force involving people in mental or emotional crisis, including useful and effective alternatives to repeatedly shouting “drop the knife,” at people who are not complying.

V. Refrain from using tools on the recently purchased, $150,000 emergency response vehicle for forcible extraction before all peaceful resolution options have been exhausted.

I. About the Report

The Mental Health Crisis Response Commission hereby submits this report pursuant to 18 V.S.A. §7257a. All Commissioners participated in the drafting and review of this report, and all Commissioners have accepted the report as the report of the Commission.

Section XII is the report of Commissioner White, in which Commissioner Paquin joins. It is not the case that other commissioners disagree with all the facts or conclusions it contains. It is the case that it has not been edited and approved by the full commission.

Pursuant to 18 V.S.A. §7257a, subdivision (i), the Commission is required to report its conclusions and recommendations to the Governor, General Assembly and Chief Justice of the Vermont Supreme Court as the Commission deems necessary but no less frequently than once per calendar year. The report shall be available to the public through the Office of the Attorney General.

II. Background of Mental Health Crisis Response Commission

On May 23, 2017, Governor Phil Scott signed Act 45, a law relating to establishing the Mental Health Crisis Response Commission. The law is codified at 18 V.S.A. 7257a.

The Commission was created to review and improve law enforcement interactions with persons acting in a manner that created reason to believe a mental health crisis was occurring.

The creation of the Commission was proposed and advocated for by community members following the death of Ralph "Phil" Grenon, a Burlington native who was killed in his apartment by a Burlington police officer on March 21, 2016. At the time he was killed, Burlington police officers were aware that Mr. Grenon was in the midst of a mental health crisis.

Under Act 45, interactions resulting in death or serious bodily injury to any party to the interaction must be referred to the Office of the Attorney General by the relevant law enforcement agency within 60 days of the incident.[3] Other interactions, including those with positive outcomes, may be referred for optional review to the Commission.

"Serious bodily injury" means bodily injury that creates a substantial risk of death or that causes substantial loss or impairment of the function of any bodily member or organ or substantial disfigurement. (18 V.S.A. §1912.)

[3] In early 2018, the Commission mailed letters to every law enforcement agency in the State of Vermont to inform them of their reporting responsibilities under Act 45.

The proceedings of the Commission are confidential and are exempt from disclosure. The Commission's review process shall not commence until any criminal prosecution arising out of the incident is concluded or the Attorney General and State's Attorney provide written notice to the Commission that no criminal charges shall be filed.

The Act authorizes the Commission to issue subpoenas whenever the information sought cannot be obtained by a formal request.

The Commission must report its conclusions and recommendations to the Governor, General Assembly and Chief Justice of the Vermont Supreme Court as the Commission deems necessary, but no less frequently than once per calendar year.

III. Purpose of Mental Health Crisis Response Commission

In the course of conducting reviews of law enforcement interactions with persons acting in a manner that created reason to believe a mental health crisis was occurring, the Commission is also charged with:

1) Identifying where increased or alternative supports or strategic investments within law enforcement, designated agencies or other community services could improve outcomes;
2) Educating the public, service providers and policymakers about strategies for intervention in and prevention of mental health crises;
3) Recommending policies, practices and services that will encourage collaboration and increase successful interventions between law enforcement and persons acting in a manner that created reason to believe a mental health crisis was occurring;
4) Recommending training strategies for public safety, emergency or other crisis response personnel that will increase successful interventions; and
5) Making recommendations based on the review of cases before the Commission.

IV. Commission Membership

The statute designates the composition of the Commission by affiliation. The following table lists the membership categories designated by the statute and the names and affiliations of Commission members.

Statutory Designation	Designee
Attorney General or Designee	**David Scherr, Esq.** Assistant Attorney General

Statutory Designation	Designee
Commissioner of Mental Health or Designee	**Mourning Fox, LCMHC** Deputy Commissioner of Mental Health
Vermont State Police Member (Commissioner of Public Safety)	**Lt. Maurice Lamothe** Vermont State Police
Frontline Local Law Enforcement (Vermont Association of Police Chiefs)	**Chief Frank Koss** Hinesburg Police Department
Executive Director, Vermont Criminal Justice Training Council or Designee	**Cindy Taylor-Patch** Training Director
Designated Agencies Representative (Vermont Care Partners)	**Sandra Steingard, M.D.** Chief Medical Officer Howard Center
Disability Rights Vermont Director or Designee	**Ed Paquin** Executive Director Disability Rights Vermont
Person with Lived Experience (Vermont Psychiatric Survivors)	**Wilda L. White, Esq.** Former Executive Director Vermont Psychiatric Survivors
Family Member of Person with "Lived Experience" (National Alliance on Mental Illness)	**Laurie Emerson** Executive Director National Alliance on Mental Illness
Regionally Diverse At-Large Member (Governor)	**John Campbell, Esq.** Executive Director Department of State's Attorneys and Sheriffs
Regionally Diverse At-Large Member (Governor)	**Kristin Chandler, Esq.** Coordinator, Team Two

Sandra Steingard, M.D. was temporarily recused from the Commission on November 29, 2017 because of a conflict of interest pursuant to 18 V.S.A. § 7257a, subdivision (c)(3). She was temporarily replaced by Kate Lamphere, Director of Adult Services Division for Health Care & Rehabilitation Services (HCRS) in Windham County.

V. Commission Meetings

By statute, the Commission must meet "at such times as may be reasonably necessary to carry out its duties, but at least once in each calendar quarter." (18 V.S.A. §7257a, subdivision (d)(3).)

The following table lists the 2019 meeting dates and the status of commission members at each meeting.

LEGEND			
▒▒▒▒	= Active commission member	R = Recused	* = Resigned

Commissioners	01/9/2019	02/6/2019	03/15/2019	05/7/2019	06/6/2019	07/24/2019	08/14/2019	09/9/2019	11/1/2019	12/9/2019
Campbell, Esq., John	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
Chandler, Esq., Kristin	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
Emerson, Laurie	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
Fox, LCMHC, Mourning	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
Koss, Frank Chief	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
Lamothe, Maurice Lt.	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	*	*	*
Lamphere, MSW, Kate	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
Paquin, Ed	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
Scherr, Esq., David	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
Steingard, M.D., Sandra	R	R	R	R	R	R	R	R	R	R
Taylor-Patch, Cindy	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒
White, Esq., Wilda L.	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒	▒▒▒▒

For the convenience of witnesses, in 2019, the Commission met in Burlington on January 9, June 6, and July 24. The Commission met in Waterbury on November 1, 2019. All other meetings were held in Montpelier.

In 2019, the Commission re-elected Wilda L. White and Cindy Taylor-Patch as its Chair and Vice Chair, respectively.

Lt. Maurice Lamothe retired as Vermont State Police lieutenant in summer 2019 and resigned the Commission upon his retirement. No one was named to complete his term.

VI. Root Cause Analysis

The Commission sought to determine the root cause(s) of Mr. Grenon's death and how it could have been prevented. Root cause analysis is a method of problem solving that seeks to identify the underlying cause of an event, rather than symptoms of a problem. A factor is considered a

root cause if removing it prevents the problem from recurring. Several factors may constitute the root cause of an event. There can be more than one root cause. The goal of root cause analysis is to identify what happened, how it happened, and why it happened.

VII. Commission's Process

During its investigation of Mr. Grenon's death, the Commission requested and reviewed documentary evidence, took sworn testimony from witnesses, and studied Vermont's mental health laws and police use of force policies. The Commission's investigation spanned two years.

The Commission's inquiry focused primarily on seven areas: Mr. Grenon's life history; his residence at Burlington Housing Authority; the care he received at the Howard Center; his interactions with the Burlington Police Department; the week or so before his death; the final police encounter on March 21, 2016; and the aftermath of Mr. Grenon's death.

The Commission determined the facts based on a review of documentary evidence that included medical records, tenant records, police reports, police body camera footage and other video recordings, photographs, sworn statements, witness statements, and testimony before the Commission. When witness testimony or sworn statements conflicted with what was depicted in video recordings or other, contemporaneous documentary evidence, the Commission relied on the video recording or contemporaneous, documentary evidence.

A. Documentary Evidence Reviewed

Description of Documentary Evidence	Requested	Received
1. Vermont State Police investigation file regarding officer involved shooting of Phil Grenon	X	X
2. Howard Center medical records for Phil Grenon (1998; 2008 – 2009 and 2013 – 2016)	X	X
3. Burlington Housing Authority Phil Grenon tenant records (1998 – 2016)	X	X
4. Veterans Administration psychiatric records for Phil Grenon (1998 to 2009)	X	X
5. Lynn Martin correspondence re: Phil Grenon		X
6. Burlington Police Department policies and procedures re: interactions with people experiencing a mental health crisis	X	X

Description of Documentary Evidence	Requested	Received
7. UVM Medical Center records of Phil Grenon	X	X
8. Lakeside Pharmacy records of Phil Grenon	X	X
9. Chittenden County State's Attorney Use of Force Report		X
10. Vermont State Hospital medical records for Phil Grenon	X	X
11. Department of Mental Health records for Phil Grenon	X	X
12. Burlington Police Department reports relating to encounters with Phil Grenon between 2013 and 2016	X	X
13. Outreach Protocol developed by the Howard Center's Mobile Crisis Team	X	X
14. BPD Use of Force policy in effect as of March 21, 2016	X	X
15. Howard Center – BPD Burlington Outreach Interventionist Clinician Agreement	X	X

B. Records requested/subpoenaed but not received

Description of Requested Documentary Evidence	Response Received
1. Any new BHA written policies adopted after Mr. Grenon's death regarding interacting with persons with mental ill health.	"BHA has not adopted any new policies, practices or procedures specifically to 'address the needs of tenants experiencing mental ill health.'" – December 10, 2018, Attorney O. Whitman Smith, on behalf of the Burlington Housing Authority
2. Policies, practices and procedures of Howard Center's Mobile Crisis Team as of March 21, 2016	"At this point in time, agency personnel have not been able to locate the manual in effect as of the date indicated." – October 24, 2018, Attorney O. Whitman Smith, on behalf of the Howard Center
3. Policies, practices and procedures of Howard Center's Street Outreach program as of March 21, 2016	"As of now, it does not appear that the Street Outreach Program had separate policies and procedures in effect as of the date in question." October 24,

Description of Requested Documentary Evidence	Response Received
	2018, Attorney O. Whitman Smith, on behalf of the Howard Center
4. Any written agreements or memoranda of understanding between the Burlington Police Department and the Howard Center in effect on March 21, 2016.	"There does not appear to be any written agreements between the agency and the Burlington Police Department as of the date listed." October 24, 2018, Attorney O. Whitman Smith, on behalf of the Howard Center
5. Fairpoint/Consolidated Communications call log for Phil Grenon's home telephone from January 2016 to March 2016.	"We have no records responsive to the subpoena. This request is outside the data retention time frame." – March 25, 2019, Quinn Clemmons, Authorized Agent for Custodian of Records, Consolidated Communications
6. Any written agreements between BPD and BHA regarding police responses at BHA properties	BPD "doesn't believe there is any agreement between BPD and BHA."— January 15, 2019, Jannine Wright, Deputy Chief of Police, Burlington Police Department

C. Witnesses Testifying before Commission

Witness Name	Affiliation	Testimony Date
Bishop, Charles	BHA property manager	November 6, 2018
del Pozo, Brandon	Burlington Police Department former Chief of Police	June 6, 2019
Delphia, Pamela	BHA resident manager	November 6, 2018
Dion, Janet	BHA director of property management	November 6, 2018
Leddy, James	Phil Grenon friend	November 6, 2018
Marceau, Cory	Former BHA maintenance worker	November 6, 2018

Witness Name	Affiliation	Testimony Date
Martin, Lynn Ruth	Former Phil Grenon neighbor	December 4, 2018
Russell, Sarah	BHA director of housing retention and services	November 6, 2018
Steingard, Sandra M.D.	Howard Center Medical Director	January 9, 2019 and July 24, 2019
Toof, Hannah	Street Outreach worker	January 9, 2019

D. Informal Witness Interviews

The Commission's chair, Wilda White, conducted informal witness interviews with the following individuals.

Witness Name	Affiliation	Interview Date
Maxwell, Kyle PharmD, DPh, RPh	Owner, Lakeside Pharmacy	January 15, 2019
Siegel, Alan M.D.	Phil Grenon's nephrologist	January 15, 2019

VIII. Overview of What Happened

Phil Grenon was the father of an adult daughter for whom he had been a stay-at-home dad after mental health challenges at age 40 made it difficult for him to maintain full-time employment as a college instructor. When his daughter married, he traveled to Arizona to give her away and also traveled to Arizona for the birth of two of his six grandchildren. He was an involved grandfather and spoke weekly by telephone with his grandchildren. He was also an avid reader and an engaged citizen who followed public policy and commented frequently on current events.

At the time of his death, the 76-year old Mr. Grenon had lived in Burlington at South Square Apartments for more than 17 years. Owned by Burlington Housing Authority (BHA), South Square Apartments is a 65-unit apartment building for income-eligible individuals and households who are more than 62 years old or have a disability.

Mr. Grenon had also been a client of the Howard Center for 18 years. The Howard Center is a private, non-profit agency designated by the State of Vermont to provide community mental and developmental disability services in Chittenden County. At the time of Mr. Grenon's death, he was in the Howard Center's Community Rehabilitation and Treatment (CRT) program.

According to the Vermont Department of Mental Health, the CRT program "serves adults with the most serious mental illnesses such as schizophrenia, bipolar disorder, and major depression. Eligibility criteria includes the existence of a qualifying mental health diagnosis, a treatment history indicating a need for more intensive services, and severe functional impairment."[4]

About three months before his death, unbeknownst to his treating psychiatrist, Mr. Grenon stopped refilling psychiatric medication prescriptions. He later began to skip appointments with his psychiatrist and began to leave angry, obscene and threatening voice mail messages for several people in his life including his daughter and his treating psychiatrist. Mr. Grenon's neighbors also began to complain about his behavior to BHA, the Howard Center, the Burlington Police Department (BPD), and the Vermont Department of Disabilities, Aging and Independent Living (DAIL). BHA formally warned Mr. Grenon that if his behavior continued, he was at risk of eviction.

In February 2016, Howard Center staff, including a staff psychiatrist (who was not his treating psychiatrist) and Street Outreach[5] workers, and BPD officers visited Mr. Grenon's apartment several times in response to complaints, however, Mr. Grenon did not answer the telephone or respond to knocks at his door.

Mr. Grenon missed two of three scheduled appointments in January and February. After Mr. Grenon missed his February 29, 2016 appointment, his treating psychiatrist decided to wait to hear from him. The treating psychiatrist left for a three-week vacation on March 4, 2016.

On March 12, 2016, BPD again visited Mr. Grenon's apartment in response to a neighbor's complaint. Once again, the police were unable to make contact with Mr. Grenon. Later that same day, Mr. Grenon left a voice mail for his treating psychiatrist in which he threatened to protect himself with knives should the police or Street Outreach come to his apartment because he believed the police were coming to his house to kill him. The treating psychiatrist, who was out of the country at the time the voice mail message was left, notified certain Howard Center staff about the threat. Howard Center staff then notified Street Outreach and the BHA property manager about Mr. Grenon's threat. The Burlington Police Department, however, was not notified about Mr. Grenon's belief or Mr. Grenon's threat.

On March 15, 2016, BHA left a formal Notice to Vacate on Mr. Grenon's front door, notifying Mr. Grenon that BHA had decided to terminate his lease effective Monday, April 18, 2016 because of escalating conflicts with his neighbors and following several warnings.

---

[4] https://mentalhealth.vermont.gov/services/adult-mental-health-services/services-and-supports-adults/community-rehabilitation-and

[5] Street Outreach is a program under the auspices of the Howard Center. One of the job responsibilities of a street outreach worker is to respond with police or in lieu of police to community calls for intervention to help de-escalate situations.

On March 21, 2016, a Street Outreach worker who worked with BPD and attended the 5:00 p.m. roll call, asked the sergeant to assign an officer to accompany her to Mr. Grenon's apartment building in response to a neighbor's noise complaint about Mr. Grenon. The sergeant assigned two officers. However, as the officers were en route to the apartment, the resident manager of Mr. Grenon's apartment building called 9-1-1 to report that Mr. Grenon was "screaming and threatening" inside his apartment, saying "he wants to stab people." (A transcript of the 9-1-1 call is included in Appendix A.)

When officers arrived at Mr. Grenon's apartment building around 5:20 p.m., they spoke both to the neighbor who called Street Outreach with the noise complaint and also the resident manager who called 9-1-1. (Transcripts of the interactions between BPD officers and the neighbor and resident manager are included in Appendices B and C, respectively.)

After Mr. Grenon did not acknowledge the officers' knocks on his door, the officers used the resident manager's key to unlock and open his door. Upon opening the door, the officers saw Mr. Grenon standing near the door holding a knife. They immediately aimed their firearms at Mr. Grenon and commanded Mr. Grenon to drop the knife. They also called for additional units. As the encounter unfolded, they came to recognize that Mr. Grenon was actually holding two knives, a 6 ½-inch boning knife in his left hand and a 10-inch carving knife in his right hand. (A transcript of the initial encounter between BPD Officers Durwin Ellerman and David Bowers is included in Appendix D.)

Mr. Grenon failed to drop the knives despite repeated commands over two minutes to do so. While still holding the knives, Mr. Grenon moved his right hand forward to close the door. Officer Bowers then fired his Taser in Mr. Grenon's direction just as Mr. Grenon closed the apartment door.[6]

BPD Sergeant James Trieb arrived at the apartment building by 5:25 p.m. and was debriefed by Officer Ellerman. As captured by his body camera, Officer Ellerman reported the following:

> "So, he's been making threats to other people that he's going to kill other people. He's going to kill himself. Apartment manager. He wouldn't answer the door. We could hear him in there. So based on exigency, open the door. He's standing right there. Two knives in his hands. Draw down on him. Bowers took non-lethal."

By 6:00 p.m., BPD had roped off Mr. Grenon's door, giving it control of Mr. Grenon's door; cleared tenants from Mr. Grenon's apartment floor; shut down the apartment building's elevator; brought two crisis negotiators to the scene who were ready to place their first call to

[6] A Taser is a brand name of a conducted electrical weapon considered less-lethal force. It fires two, small barbed darts intended to puncture the skin and remain attached to its target. The darts are connected to the main weapon by wires that deliver electric current designed to temporarily incapacitate the target. Before actually shooting the Taser, the user can also create an arc display on the Taser, which emits a visible electrical current and serves as a warning to the intended target.

Mr. Grenon's residence; and positioned an officer in a building across the street that provided a view of Mr. Grenon's living room and kitchen.

Between 6:00 p.m. and 8:30 p.m., the BPD crisis negotiator telephoned Mr. Grenon's apartment 12 times and left 10 messages on his answering machine. Mr. Grenon's daughter, who had been alerted to the stand-off between her father and BPD by a Howard Center staff member, also telephoned and left messages for Mr. Grenon. Mr. Grenon did not answer the telephone or return any of the calls. The crisis negotiator also knocked on Mr. Grenon's door on four separate occasions between approximately 7:45 p.m. and 8:00 p.m. Mr. Grenon did not respond.

Former BPD Chief Brandon del Pozo, who had been in Pittsford at the Vermont Police Academy when the incident began, arrived on scene a few minutes after 8 p.m. Shortly, after he arrived, BPD attempted to place a flexible, fiber optic camera inside Mr. Grenon's apartment to better monitor Mr. Grenon. The first two attempts were unsuccessful. Around 9:05 p.m., BPD successfully inserted the camera into the apartment by drilling a hole above the front door. However, from that vantage point, the camera only provided a view of the apartment's kitchen and living room, and Mr. Grenon was not seen in either location.

After Mr. Grenon could not be seen on the camera, former Chief del Pozo made the decision to enter Mr. Grenon's apartment. Former Chief del Pozo said he made the decision because he was concerned that Mr. Grenon might kill himself. Although Mr. Grenon had never threatened to kill himself, and no witnesses reported that he had, Officer Ellerman reported to Sgt. Trieb that Mr. Grenon had threatened to kill himself.

BPD officers entered Mr. Grenon's apartment at approximately 9:17 p.m., a little less than four hours after Officers Ellerman and Bowers first knocked on Mr. Grenon's apartment door. In addition to their standard equipment, two officers were equipped with bulletproof shields and another carried a bean bag gun.

Within 10 minutes of entering Mr. Grenon's apartment, BPD determined that Mr. Grenon was hiding in the bathroom. After opening the bathroom door and pushing away the shower curtain with a broomstick, officers saw Mr. Grenon standing in the far corner of the bathtub holding the same two knives. Officers immediately retreated.

Minutes later, at Sgt. Trieb's direction, the crisis negotiator fired OC balls[7] (also known as pepper spray balls) into the bathroom on the wall over the bathtub to allow them to come down on Mr. Grenon. Within seconds, officers started coughing and leaving the apartment to

[7] OC stands for Oleoresin Capsicum, which is a highly concentrated form of the active ingredients in hot peppers. In many people, it creates a burning sensation of the eyes and mucous membranes of the mouth and may also irritate the upper airway and cause coughing.

get fresh air. Officers reported that they may have heard Mr. Grenon cough once. Other than that, he was silent and remained standing in the bathtub.

After conferring with former Chief del Pozo, Sgt. Trieb decided to approach the bathroom again. As a stack of six officers again approached the bathroom door, Sgt. Trieb said: "We have to hold off. We can't breathe in there. I can't see anything." The officers retreated back into the apartment's living room.

Around 9:36 p.m., about 12 minutes after the initial approach to the bathroom, Sgt. Trieb informed the officers that they were going to approach the bathroom again. Sgt. Trieb gave out new assignments and also substituted the two bullet-proof shields with polycarbonate riot shields. Sgt. Trieb said he felt confident that Mr. Grenon did not have a gun, and he believed the riot shields would provide more visibility and more protection because they were transparent and larger.

Rather than relying on pepper balls to subdue Mr. Grenon, Sgt. Trieb decided to switch to Tasers because the pepper balls had no effect on Mr. Grenon and the officers were "choking" on it. As former Chief del Pozo explained in a May 2019, public radio interview : "My sergeant says, 'Listen, we can definitely get up on him,' and, 'We have enough staffing here, we have enough equipment, if we could stun him with the Taser, we should be able to get in there and to take him into custody.'"[8]

Sgt. Trieb assigned Officers Ellerman and Oren Byrne to carry the riot shields. Officer Chase Vivori was assigned to Taser. Officers Bowers and Brian Wilkinson were assigned to lethal cover. Officer Jacob Seller was assigned to the arrest team. Sgt. Trieb planned to use the broomstick to push the shower curtain open and expose Mr. Grenon, who was standing in the far corner of the bathtub. Sgt. Trieb explained the plan to his officers as follows:

> "Alright, when we move in, I'm going to grab the broom, I want you [speaking to Officer Vivori] to get on his inside, Bowers on the left side. I'm going to reach up over the top of everybody, I'm going to push it, and when you can see him, I want you to light him up,[9] OK?"

Officer Ellerman then volunteered to carry both the riot shield and his Taser, which Sgt. Trieb approved.

If you entered the bedroom from the living room, the bathroom door stood in the right, rear corner of the bedroom. The bathroom itself was less than 30 square feet. The only way to enter or exit the bathroom was through the bedroom. The bathroom door was framed on the left by an exterior wall and on the right by a closet that jutted a few feet into the bedroom. The wall of the closet created a short, narrow tunnel in front of the bathroom door. The bedroom was

[8] When Tasers Fail, May 11, 2019, Reveal from the Center for Investigative Reporting and PRX. https://www.revealnews.org/episodes/when-tasers-fail/

[9] The Commission understood Sgt. Trieb's reference to "light him up," to mean discharge the Taser.

approximately 100 square feet and contained a dresser on the left and right walls, and a twin bed in the middle of the room. The head of the bed was on the wall opposite the bathroom.

The officers filed into the bedroom led by Officers Ellerman and Vivori, followed by Officers Bowers and Byrne, Sgt. Trieb, and finally Officers Wilkinson and Seller. As the seven entered the bedroom, Officer Michael Henry, who was standing near the bedroom door, said to no one in particular, "way too many in there. … way too many."

The officers arrived at the bathroom door in a tight, stack formation. Officers Ellerman and Vivori were at the front of the stack and stood just at the bathroom threshold. As it turned out, Sgt. Trieb was unable to reach the shower curtain from over the heads of officers as he originally planned. Because there was not enough room to accommodate Officers Ellerman, Vivori and Trieb at the bathroom's threshold, Sgt. Trieb asked Officer Vivori to step back and Sgt. Trieb stepped in. Now, Officers Ellerman, Vivori, Bowers and Byrne were on the left side of the stack. Officers Wilkinson, Seller, and Sgt. Trieb were on the right side of the stack, which was closest to the door leading back into the living room.

Sgt. Trieb then pushed the shower curtain open, Officer Ellerman fired his Taser, and Mr. Grenon immediately started screaming. The officers took a step back. Meanwhile, Mr. Grenon began to pull the barbs from himself. Sgt. Trieb said, "hit him again, you got him." The officers stepped forward again, still in a tight formation, towards the bathroom door. Officer Ellerman fired his Taser a second time. By this time, Mr. Grenon had started moving out of the bathtub and towards the bedroom, wielding the 6 ½-inch boning knife and the 10-inch carving knife. However, the officers in the back of the stack could not see into the bathroom and were not immediately aware that Mr. Grenon was leaving the bathroom. Their only cues came from the reactions of officers who were in front of them.

As Mr. Grenon entered the bedroom, the officers on the right side of the stack – Sgt. Trieb and Officers Seller and Wilkinson – backtracked into the living room. The officers on the left side of stack – Officers Byrne, Vivori, Ellerman and Bowers – retreated backwards, deeper into the small bedroom. Officers Byrne and Vivori took cover in the bedroom's left, rear corner. Officers Bowers and Ellerman jumped on the bed. As Mr. Grenon continued to advance, Officer Bowers fired six shots in Mr. Grenon's direction. Almost, simultaneously, Officer Vivori discharged his Taser at Mr. Grenon.

Mr. Grenon fell to the ground. A few officers moved the knives away from Mr. Grenon's body, another rolled Mr. Grenon over onto his back, and Officer Byrne began to render CPR. Sgt. Trieb checked for a pulse and found none. Paramedics, who had been staged outside the apartment building since approximately 8:30 p.m., arrived within three minutes. They took over Mr. Grenon's care, and transported him to UVM Medical Center, where he was pronounced dead at 10:01 p.m., seven minutes after arriving at the emergency department. To maintain chain of custody of Mr. Grenon's body and personal effects, Officer Henry also traveled to the emergency department. An entry in Mr. Grenon's emergency department record states: "BPD adds that they believe the patient wanted to be shot by the police."

Officer Darren Kennedy drove Officer Bowers to UVM Medical Center Emergency Department, where Officer Bowers was checked out and released.

An autopsy conducted by the Chief Medical Examiner revealed that Mr. Grenon had been shot four times with a firearm. He had also been struck at least three times by the Taser.

The medical examiner ruled the cause of death as gunshot wounds of torso and extremities. The manner of death was "homicide (shot by law enforcement)."

IX. The Aftermath

A. Taser Radio Story[10]

On May 11, 2019, the Center for Investigative Reporting and PRX published a radio story entitled "When Tasers Fail." The story was the result of a yearlong investigation that concluded that Tasers are often less effective than the manufacturer touts. The events leading to Mr. Grenon's death were featured in the story as an example of the deadly outcome that results when Tasers fail to subdue their targets.

Former Chief del Pozo agreed to be interviewed for the story. During the interview, former Chief del Pozo said of Mr. Grenon and the use of Tasers: "The Tasers hurt him enough to make him really angry and to aggravate his episode, and yet did not hurt him enough to incapacitate him."

In his testimony before the Commission, former Chief del Pozo raised questions about the reliability of tasers in these situations.

B. Trauma to the Community

Mr. Grenon lost his life, and his family lost a father and father-in-law, a grandfather, a brother, and an uncle. Although Mr. Grenon's daughter cooperated with the Commission's investigation and agreed to authorize the Commission's access to Mr. Grenon's medical records, she ultimately declined to testify before the Commission because reliving her father's death began to take an emotional toll that affected her and her family.

A few of Mr. Grenon's neighbors also declined to testify before the Commission because they were, more than two years later, still traumatized by the events that led to Mr. Grenon's death. Although the Commission has subpoena power and could have legally compelled their testimony, the Commission was sensitive to their trauma and did not compel anyone to testify who declined. The Commission also had access to the sworn statements that the witnesses gave state police investigators at the time of the incident.

The radio story on Tasers, referred to above, interviewed a friend of Mr. Grenon who also lived at South Square Apartments. She told reporters: "It was so terrible that I tried to commit suicide four days afterwards and they told me I was in the hospital for three weeks, and I'd never done that before or since, never." When asked if she remembered making the decision to

[10] When Tasers Fail, May 11, 2019, Reveal from the Center for Investigative Reporting and PRX. https://www.revealnews.org/episodes/when-tasers-fail/

kill herself, she replied: “Oh, absolutely. I wrote everything out for my cousin. For some reason, the loss of Phil and what he went through before his death was so traumatic for me. I couldn't bear up to it.”

The off-duty, BHA maintenance worker who returned to work to bring a drill to BPD told the Commission that he is still traumatized by the manner of Mr. Grenon’s death. The maintenance worker also resigned from BHA the day following Mr. Grenon’s death, angry that his employer had put him in the situation.

Most witnesses who testified before the Commission also teared up or cried at some point during their testimony. The Commission also heard that police officers and BHA staff reported that they were also traumatized by Mr. Grenon’s death.

C. Changes adopted in the wake of Mr. Grenon’s death

1. Burlington Police Department

a) De-escalation training to respond to individuals armed with knives

Former Chief del Pozo testified that after Mr. Grenon’s death, BPD contacted the Police Executive Research Forum (PERF) because PERF was specifically looking at incidents of police officers shooting people with knives. PERF traveled to Scotland and England with a group of American police chiefs to better understand how cultures that have knives but have police officers that are not typically armed with guns, safely handle those situations. PERF then began to develop a de-escalation curriculum around less or non-lethal outcomes to individuals armed with something other than a firearm. BPD piloted the curriculum with PERF and subsequently trained all of its officers in the curriculum. BPD is also now trained to train in the curriculum.

At the time of his testimony before the Commission, former Chief del Pozo said he was in the process of working with PERF to develop the next phase of curriculum.

b) Purchase of Emergency Response Vehicle

Former Chief del Pozo also testified that after Mr. Grenon’s death, BPD purchased what the department calls an emergency response vehicle and trained its officers in its use. BPD uses the vehicle to respond to crises similar to Mr. Grenon’s and other critical incidents. The $150,000 vehicle itself is an unarmored, Ford- F550 with a cargo body. The vehicle is used as mobile platform for acrylic shields, ballistic shields, helmets, higher-level body armor, pressurized water fire extinguishers, a Y-bar (a makeshift tool for de-escalation), stab- and bullet-proof blankets, bean bag gun, a pepper ball gun, a device that shoots a foam dart, two reconnaissance robots, a throw phone for crisis intervention, and a bullhorn.

The equipment is intended to allow officers to isolate, contain, and create distance from individuals in crisis for the protection of officers. A little more than half of BPD’s uniformed officers have reportedly been trained in the platform. Former Chief del Pozo said the department is also drafting a formal curriculum for the platform.

c) Additional Training

Former Chief del Pozo testified that as a result of Mr. Grenon's death, BPD sent additional officers to training to become crisis negotiators.

BPD also holds an annual scenario-based training involving barricaded armed people or armed people in the open. To successfully complete the training, officers have to either de-escalate the armed people or get them into custody and subdue them without resorting to lethal force.

d) Robot Purchase

According to former Chief del Pozo, BPD also purchased a rolling robot about the size of a thermos. The robot can be placed inside a space, such as an apartment, and drive through and transmit what is happening inside the space.

2. Burlington Housing Authority

According to BHA's Director of Property Management, in the aftermath of Mr. Grenon's death, BHA created a retention services program to help tenants maintain their housing through services. When BHA issues a Notice to Vacate to tenants, the retention services staff is notified. Staff then have 30 days to create a plan of action to help tenants maintain their housing.

BHA also adopted a "compassionate" eviction program. Anytime a termination notice is issued, BHA does not move to terminate the tenancy immediately at the end of the notice period. BHA allows time for retention services to work with the resident to correct the lease violation before it gets filed with BHA's attorney.

BHA did not provide the Commission with written documentation of these policy changes.

3. Howard Center

There was no evidence before the Commission that the Howard Center made any changes in policies, practices and procedures as a result of Mr. Grenon's death.

X. Conclusions – How and Why it Happened

1. Mr. Grenon's death was the result of a breakdown in services and communication.

2. Mr. Grenon's mental health began to deteriorate at least one year before his death. At the time of this death, he was likely experiencing psychosis. Psychosis can include hallucinations (perceiving things through the senses that are not real) or delusions (believing things that are not real). Mr. Grenon's likely psychosis took the form of delusions. He believed that people, including the police, were coming to his apartment to kill him.

3. Mr. Grenon stopped picking up his psychiatric medication after November 9, 2015. He stopped taking insulin in January 2016. After January 2016, he also stopped going to the lab for his monthly blood draws to monitor his kidney function. And, he missed two of three, scheduled appointments with his treating psychiatrist between January 4 and February 29, 2016.

   The perception of witnesses, including his treating psychiatrist, was that Mr. Grenon had lost a lot of weight between October 2015 and the time of his death. He was also weak to the point of uncharacteristically asking for help to carry his groceries to his apartment.

4. Mr. Grenon's treating psychiatrist recommended at each visit that he increase the dosage of his psychiatric medication. Although the medical records indicate he declined to do so, the records do not indicate why he declined or what additional efforts beyond a mere recommendation were made to persuade Mr. Grenon to increase the dosage. Mr. Grenon's treating psychiatrist also continued to recommend an increase in medication without ever recognizing and/or documenting in the medical records that Mr. Grenon had stopped refilling his prescription for anti-psychotic medication.

5. The deterioration in Mr. Grenon's mental health in 2015 followed the same pattern as the deterioration that culminated in his 2009 arrest and involuntary hospitalization. In 2008, feeling a sense of abandonment by this treating psychiatrist, Mr. Grenon ceased attending appointments and stopped taking psychiatric medication. His neighbors began to complain about his yelling in his apartment and his abusive and threatening behavior. The Burlington Housing Authority (BHA) issued a formal notice of lease violation. He began to mail numerous packages, described as "bizarre" to the Howard Center and did not cease mailing the packages when asked. His behavior came to the attention of police at Kinko's, while copying paperwork. He was only arrested after he failed to comply with the arresting officer's direction to accept a misdemeanor citation for trespassing. He was ultimately hospitalized. Upon admission, doctors described him as "very thin."

   In 2015, after the loss of his long-time case manager, Mr. Grenon stopped picking up his psychiatric medications, stopped taking insulin, started skipping medical and mental health appointments, and his voice mail messages to this health care providers and daughter grew

more frequent and more angry, hostile, and threatening. His neighbors began to complain about his yelling in his apartment and his abusive and threatening behavior. BHA again issued formal warnings that he was in violation of his lease. He again lost a lot of weight.

Mr. Grenon made it known that he was distressed at losing his case manager. He called the Crisis hotline at least three times to lament. He also got into a fight at his pharmacy that required the pharmacist to call Mr. Grenon's nephrologist. Mr. Grenon explained that the fight was caused by his distress at losing his case manager.

While Mr. Grenon's treating psychiatrist recognized that changes in his care team could cause Mr. Grenon to discontinue treatment, the Howard Center did not have an adequate plan to support Mr. Grenon in advance of and during the departure of his case manager.

6. BHA staff and Mr. Grenon's daughter both recognized the similarity between Mr. Grenon's 2009 deterioration and the commencement of his 2015 – 2016 deterioration and shared their concerns with the Howard Center in January and February 2016.

7. Contrary to the assumptions of Mr. Grenon's neighbors and others who came to his apartment door, Mr. Grenon was more likely not talking to himself or screaming at the apartment's walls when they heard him making noise. Rather, according to his treating psychiatrist, they were hearing Mr. Grenon leaving angry, hostile voice mail messages for his treating psychiatrist and others. The noise from Mr. Grenon's apartment likely stopped when police arrived not because he was aware of the police's presence but more likely because he had filled up the voice mailboxes of those he was calling.

   Mr. Grenon's practice of leaving angry, voice mail messages for his treating psychiatrist – messages which would not necessarily be listened to – was authorized by his treating psychiatrist and appeared to the Commission to be part of his treatment plan.

8. Under Vermont common law, "a mental health professional who knows or, based upon the standards of the mental health profession, should know that his or her patient poses a serious risk of danger to an identifiable victim has a duty to exercise reasonable care to protect him or her from that danger."[11] This obligation is known as the "Duty to Warn."

   At least three times between February 11 and March 13, 2016, the Howard Center actually warned or indicated that individuals and organizations should be warned of threats of harm made by Mr. Grenon about specific individuals (BHA property manager) or identifiable classes of individuals (Street Outreach, the police, or anyone who comes to his apartment door).

   In exercising the "Duty to Warn," on those three occasions, the Howard Center explicitly determined that Mr. Grenon posed a serious risk of danger to others.

[11] *Peck v. Counseling Service of Addison County*, 499 A.2d 422, 426 (1985).

In Vermont, individuals may not be involuntarily treated for a mental health condition unless they are found to be persons in need of treatment. The law defines a person in need of treatment as "a person who is suffering from mental illness and, as a result of that mental illness, his or her capacity to exercise self-control, judgment, or discretion in the conduct of his or her affairs and social relations is so lessened that he or she poses a danger of harm to himself, to herself, or to others."[12]

A danger of harm to others may be shown by establishing that (1) the person has inflicted or attempted to inflict bodily harm on another; or (2) by threats or actions, the person has placed others in reasonable fear of physical harm to themselves; or (3) by actions or inactions, the person has presented a danger to persons in his or her care.

Involuntary treatment can be initiated in Vermont by applying to a judge for a mental health warrant (in the case of a person who is refusing to voluntarily go to the hospital) or by applying for an emergency examination, known also as an "EE", once a person has presented at the Emergency Department and is determined to be a person in need of treatment.[13]

The Howard Center did not use either of these avenues to treat Mr. Grenon involuntarily after its February 11th warning to the BHA property manager or after its March 13th warning to Street Outreach and the BHA property manager.

To the Commission, patient behavior that triggers a mental health professional's "Duty to Warn," also meets the "danger of harm to others" criteria for involuntary treatment.

9. No attempts were made by a mental health provider to engage with Mr. Grenon after February 26, 2016, when a Howard Center staff member unsuccessfully tried to visit Mr. Grenon at his home. After Mr. Grenon missed his February 29, 2016, appointment, the plan was to wait for Mr. Grenon to make contact. After Mr. Grenon left the March 12, 2016 voice mail message threatening to defend himself with knives should anyone come to his door, no attempts were made to contact him or engage him in treatment.

10. The Howard Center did not have an adequate plan to provide treatment to Mr. Grenon during the vacation of his treating psychiatrist.

11. After the Howard Center determined on March 13, 2016, that Mr. Grenon posed a risk to others, the medical records do not indicate a treatment strategy to address the risk.

12. Mr. Grenon experienced childhood trauma and was also traumatized by his 2009 hospitalization at the Vermont State Hospital. His experiences of trauma are well documented in the Howard Center assessments throughout the medical record. It also

[12] VT. STAT. ANN. tit. 18, § 7101(17).
[13] VT. STAT. ANN. tit. 18, §7505

appeared that Mr. Grenon continued to bring up his experiences of trauma throughout the course of treatment, particularly when he appeared to have a change in mental status, which resulted in his becoming preoccupied with the trauma he experienced at the state hospital and desiring to launch a lawsuit. Despite his documented trauma history along with his preoccupation with the trauma, treatment interventions to address trauma were not included in his Howard Center treatment plans.

13. Mr. Grenon's Howard Center medical records did not include certain critical communications. For example, the records did not include the January 21, 2016 email from BHA that reported that Mr. Grenon was beginning to disturb other tenants and asked that his case manager check in with him. This omission caused Mr. Grenon's treating psychiatrist to conclude erroneously on February 1, 2016, that the Howard Center had not received any complaints from the community about Mr. Grenon's behavior.

    The records did not include the February 22, 2016 email from BHA notifying the Howard Center that Mr. Grenon was in violation of his lease and asking for assistance to help Mr. Grenon "save his housing."

    The records did not include the February 22, 2016, hand-delivered letter from Mr. Grenon's neighbor, complaining about his behavior and reporting that she and other residents are "afraid of Phil because [she] believes him dangerous when he gets agitated."

    The records did not include the March 13, 2016 email from Mr. Grenon's treating psychiatrist that notified Howard Center staff, including Street Outreach, that Mr. Grenon believed that the police were coming to his apartment to kill him and that he would protect himself with knives. This omission caused this information not to be relayed to BPD crisis negotiators when they asked for information to help them build rapport with Mr. Grenon during Mr. Grenon's last encounter with BPD.

    The records also did not include the March 15, 2016 Notice to Vacate, which BHA sent to both Mr. Grenon and the Howard Center.

14. After Mr. Grenon refused to meet with the case manager assigned to him in November 2015, Mr. Grenon's treating psychiatrist assumed the role of both case manager and treating psychiatrist. This meant that when the treating psychiatrist left for vacation, there was no one at the Howard Center familiar enough with Mr. Grenon to provide BPD crisis negotiators with information to build rapport with him during the stand-off, in particular, the information that Mr. Grenon believed that the police were at his apartment to kill him and would defend himself with knives.

15. One witness indicated she heard Mr. Grenon allude to his eviction during the yelling that precipitated the March 21, 2016 call to 9-1-1. Although BHA issued an eviction notice to a 76-year old man who they knew may have been experiencing psychosis and could not control his behavior, the Commission did not find that the eviction notice itself caused Mr.

Grenon to behave as he did in the days leading up to his death. Mr. Grenon had been leaving angry and threatening voice mails for months before the March 15, 2016 eviction notice. For example, he threatened to kill his son-in-law and the BHA property manager in February 2016.

The voice mail message he left for his treating psychiatrist in which he threatened to kill anyone who came to his door, including police and Street Outreach, was left on March 12, 2016, before he received the eviction notice. His belief that the police were coming to his apartment to stab him with knives was also formed before he received the eviction notice.

While Mr. Grenon did allude to his eviction in the March 17th letter found in his apartment after his death, he said of his eviction, only that it was illegal to evict him during the winter.

Any threats Mr. Grenon may have made inside the confines of his apartment while leaving voice mail messages that were overheard by his neighbors were likely part of the same psychotic process that triggered his earlier threats.

16. Although BHA did ask Mr. Grenon's case manager as early as January 2016 to check in with Mr. Grenon, and also copied the Howard Center on notices of lease violation and the notice to vacate, on those occasions when BHA received no reply from the Howard Center, no one followed up.

    In addition, on at least two occasions, BHA sent the notices to Mr. Grenon's former case manager even though it was aware that the case manager was no longer working with Mr. Grenon. As stated above, the emails and notices to Mr. Grenon's former case manager, who was still a Howard Center employee, never made their way into Mr. Grenon's medical records or to the attention of his treating psychiatrist.

    Furthermore, all the communications from BHA to the Howard Center were by email or letter. These communications lacked the sense of urgency that the Commission believes the circumstances required. The telephone would have been more appropriate under the circumstances.

17. BHA specifically houses tenants with disabilities, including people with mental health challenges. BHA also has a growing number of tenants with mental health challenges. It did not employ staff with expertise in the area of mental health. Although some staff professed informal knowledge of mental health issues, in some cases, the Commission found that this informal knowledge was stigmatizing and/or inconsistent with best practices or evidence-based, mental health interventions. For example, BHA believed that issuing an eviction notice to Mr. Grenon would cause Mr. Grenon to recognize the seriousness of his situation and therefore change his conduct. This is not an evidence-based treatment for likely psychosis.

Mr. Grenon's neighbors also assumed that Mr. Grenon was hallucinating when they heard him yelling in his apartment, when the more likely explanation was he was leaving angry voice mails.

18. The Commission found no evidence to support the entry in the UVM Medical Center emergency department record that was attributed to BPD that Mr. Grenon "wanted to be shot by the police." During the initial encounter with Mr. Grenon and Officers Bowers and Ellerman, Mr. Grenon did not advance on the officers. He de-escalated the situation by closing his apartment door. When officers entered his apartment, he hid in the shower. When officers pushed open the shower curtain, Mr. Grenon closed it after the officers retreated. Mr. Grenon advanced on the officers only after he was struck by the Taser, leading the Commission to conclude that Mr. Grenon wanted to live and thought he was acting in self-defense at the time he was killed.

19. The initial encounter between Officers Ellerman, Bowers and Mr. Grenon during which Officer Ellerman said twice to Mr. Grenon, "I will shoot you," set the wrong tone for an action that was intended to "help" Mr. Grenon. It may have confirmed for Mr. Grenon his delusion that officers were coming to his apartment to kill him.

    The majority of the Commission recognizes that Officers Ellerman and Bowers acted consistent with their training during their initial interaction with Mr. Grenon.[14]

    The Commission does think it is worthwhile drawing attention to the initial interaction because it underscores the impact of the incomplete information available to BPD at the time of the encounter.

    Had officers known that Mr. Grenon was under the delusion that officers were at his apartment to kill him, Officers Ellerman and Bowers would have had the opportunity to recognize that Mr. Grenon was likely more heightened after the interaction and any plan to remove him from his apartment should take his heightened state into consideration.

    The information would also have allowed the crisis negotiators to understand why Mr. Grenon wanted no contact with them and would not answer the telephone or talk behind a closed door.

20. BPD's decision to take control of Mr. Grenon's door by tying it off with rope was wise because it allowed BPD, if it chose to do so, to wait, plan, obtain information and acquire needed resources.

21. BPD had false and incomplete information, and inadequate resources during its encounter with Mr. Grenon. BPD decided to enter Mr. Grenon's apartment because of concern that he

[14] Please see Appendix D for a transcript of the body camera recording of the initial encounter between Officers Ellerman and Bowers and Mr. Grenon.

might kill himself. Officer Ellerman reported this information to Sgt. Trieb. However, Mr. Grenon never threatened to kill himself.

In addition, BPD was not informed that Mr. Grenon believed that the police were coming to his apartment to kill him and that Mr. Grenon planned to protect himself with knives.

Once inside the apartment, BPD did not have the equipment necessary to take control of Mr. Grenon's bathroom door by chocking it. With the proper equipment, BPD could have controlled Mr. Grenon's ability to leave the bathroom, which would have obviated any need to force him out of the bathroom using pepper balls and Tasers. Had BPD chocked the bathroom door, it could have also used a camera to view Mr. Grenon inside the bathroom, which would have obviated any need to enter the bathroom to determine whether he had harmed himself.

22. People in extreme states, such as psychosis and mania, often do not have typical reactions to external stimuli such as pepper balls, Tasers, or command presence. BPD did not take into account how Mr. Grenon's mental illness affected his ability to comply with their commands or how his mental state might affect his reaction to pepper balls or Tasers. They also never considered how his illness should be accommodated during the police encounter, something that is required by the Americans with Disabilities Act.

23. Although four hours elapsed before BPD entered Mr. Grenon's apartment, their incursions into Mr. Grenon's apartment began well before that. BPD drilled holes in his apartment walls in two different places and inserted a camera. While these incursions may have been necessary, each of these incursions likely heightened Mr. Grenon's sense that he was under attack. Officers need to be aware at all times the impact their actions may have on barricaded individuals in crisis and take such into account in deciding how to take such individuals into custody.

24. Although Howard Center's mobile crisis clinician was available during the encounter with Mr. Grenon, BPD did not rely on her for anything other than obtaining information that might allow the crisis negotiators to build rapport with Mr. Grenon. She remained outside in a parked car across the street from the apartment building. The mobile crisis clinician was not consulted about the use of pepper balls or Tasers on a person in Mr. Grenon's condition. Former Chief del Pozo also seemed confused about the role of the mobile crisis clinician. For example, after the pepper ball was deployed, he asked whether the crisis clinician was bringing Mr. Grenon's relative to the scene. An officer responded that the crisis clinician was parked in a nearby car. Former Chief del Pozo did not pursue the matter further.

25. Because of the number of officers in Mr. Grenon's small bedroom and the location of the bedroom's exit, four officers became trapped in the bedroom when Mr. Grenon left the bathroom and advanced into the bedroom, wielding a 6 ½ -inch boning knife and a 10-inch carving knife. Most of the officers in the bedroom could not see into the bathroom.

Therefore, they could not see Mr. Grenon leave the bathroom. Thus, their reactions were delayed. Without time and a path out of the bedroom, Officer Bowers was compelled to use lethal force to protect his fellow officers and himself against the advancing and knife-wielding Mr. Grenon.

26. The entire community has been traumatized by the manner of Mr. Grenon's death, trauma that in many cases has not been addressed and/or relieved. The trauma of Mr. Grenon's death continues to plague individuals and indeed our entire community.

XI. Recommendations – How future deaths in similar situations might be prevented

A. For community mental health agencies

1. When client/patient risk is identified, immediately develop and document treatment strategies and appropriate responses to address risk, up to and including coordination with relevant community providers and local law enforcement, as needed.

   If a client/patient will not attend appointments or respond to visits to his apartment, and emergency examination is appropriate, coordinate with law enforcement to intercept the client/patient when he is in public rather than in his home.

2. Adopt the best practice of accompanying the discharge of the common law "Duty to Warn" with a screening for an application for emergency examination.

3. Adopt internal and external communication protocols, particularly when client/patient risk is identified, to ensure that communications are received by all parties involved in the client's/patient's care.

4. Adopt a medical recordkeeping system that is able to retain and retrieve emails, snail-mail correspondence, and other written documentation pertinent to patient care in a timely manner.

5. Adopt practices to support clients/patients when assigned staff transition away from a client/patient, paying particular attention to individuals with a history of fractured relationships and develop interventions to support such individuals

6. Adopt best practices around how to engage clients/patients in treatment. Additionally, provide detailed documentation of attempts to engage clients/patients in treatment and include client's/patient's response in the documentation.

7. Create comprehensive, individualized treatment plans that address the particular challenges of clients/patients. Comprehensive treatment plans include goals, measurable and attainable objectives, and specific interventions associated with the treatment. Interventions are more than just the services to be delivered. Interventions are the specific actions that will be engaged in within the services to be delivered. Plans should include an objective way to measure whether the clients/patients are progressing toward their goals.

   When the clients' needs change, insure that the treatment plans are updated to address the new needs. Updates should be done at least annually or sooner as indicated. Document progress towards treatment plan goals and objectives and if progress is not identified, consider changing treatment intervention, objectives and/or goals to best support the individual served.

8. Refrain from assigning treating psychiatrists the dual role of case managers.

9. Refrain from giving clients/patients permission to leave voice mail messages as a treatment intervention when the voice mail messages will not be listened to.

10. In conjunction with law enforcement, implement a training program for crisis clinicians to educate them how best to work with law enforcement during a crisis. The training should include a curriculum that teaches clinicians about police practices and how clinicians can best support law enforcement during interactions with people in extreme states.

B. For providers of public housing

1. Develop and implement a best practices housing retention services program. As a component of the housing retention services plan, adopt a compassionate eviction policy that includes the creation of a housing retention plan for tenants in danger of losing their housing because of conduct related to a mental health disability or episode.

2. Recognize a landlord's duty to address or obtain assistance in addressing, situations that involve complex tenant interactions that are beyond the housing authority's knowledge and capabilities. To this end, develop and implement a systematic protocol for collaborating with community providers to meet the needs of tenants whose behaviors or extreme mental states disturb the quiet enjoyment of other tenants. The protocol should include early identification of problems, rapid deployment of interventions, and close and intentional communication with community providers.

   Community partners might include the local community mental health agency, law enforcement, mental health peer workers, advocacy organizations, the local interagency team (LIT), etc.

   The protocol should hold staff accountable for achieving results rather than simply going through the motion of checking boxes off.

3. Adopt internal practices designed to ensure that communications to community partners about tenants in crisis are received and acted upon.

4. Employ mental health social workers onsite as a resource for tenants and housing authority staff. Bringing such knowledge in-house would allow the housing authority to identify mental health issues sooner, allay resident fears, and better manage relationships with the local community mental health agency and law enforcement.

5. Offer trained, peer workers free or reduced rent in exchange for offering intentional peer support to tenants. Peer workers are individuals with lived experience of mental health conditions, extreme states and/or the mental health system who are trained to offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people. They often provide advocacy, education, mentoring, and motivation. They also work one-on-one as role models, mentors, coaches and advocates and support people in developing psychiatric advance directives and creating Wellness Recovery Action Plans (WRAP).

C. For law enforcement

1. Develop an arrest and detention protocol that accommodates an individual's known mental illness during arrests and detentions. Train officers in the protocol. Develop the protocol with input from community partners, including community mental health agencies, advocacy organizations, and people with experience of law enforcement interactions during extreme mental states. The protocol should include a system for working with mental health clinicians during an encounter.

2. If time allows, before confronting an individual in crisis, devise and role-play intervention strategies as well as an exit strategy to ensure officers do not become trapped and thus compelled to resort to lethal force for their protection. Determine if entry into an enclosed space is truly required. When confronting an individual in an extreme mental state in a small, enclosed space, use as few officers as is safe.

3. Refrain from assuming that interventions such as pepper balls or Tasers will work effectively or in a typical manner on people in crisis. Decide in advance what you will do if you do not achieve the desired effect from interventions such as pepper balls or Tasers, and where possible, maintain nonlethal options.

4. Obtain the best information available about the individual in crisis from as many sources as feasible. Assemble needed tools and equipment that will allow officers to maintain distance from and control over the individual in crisis. BPD's emergency response vehicle is an example of the types of tools and equipment that might be required in such situations.

5. When encountering individuals in a mental health crisis, make every effort to calm the atmosphere by reducing stimulation such as radio traffic, power drills, ringing telephones, ambient noise, etc.

6. Require every law enforcement officer to attend periodic, continuing education courses on best practices in mental health crisis response.

D. For communities

1. Educate families and friends about alternatives to obtain care or protection for individuals in crisis who are at risk of harming others, when a treating psychiatrist declines to apply for an emergency examination.

2. Offer community members traumatized by police shootings timely access to community resources to address their trauma.

3. Create a mechanism for all agencies involved in law enforcement interactions with people in crisis to debrief together after the legal process has concluded. The debrief should focus on lessons learned and how the agencies can work better together to obviate the need for law enforcement encounters with people in crisis.

XII. Other View (Commissioner White, joined by Commissioner Paquin)

A. Previous BPD Killing

Mr. Grenon's killing was the second killing by BPD of a person with a mental illness in fewer than three years. On November 6, 2013, two BPD officers responded to the residence of Wayne Brunette and his family following a report that Mr. Brunette was experiencing a mental health episode. Mr. Brunette had diagnoses of schizophrenia and delusional disorder. After Mr. Brunette approached one of the officers with a shovel, the other responding officer shot him four times, causing his death. The duration of the encounter, from the radio dispatch call to the radio call that shots had been fired, was just over seven minutes.

Mr. Brunette's family sued the City of Burlington. In the lawsuit, Mr. Brunette's family alleged that BPD violated the Americans with Disabilities Act (ADA).[15] A police department violates the ADA when it fails "to reasonably accommodate a person's disability in the course of investigation or arrest, causing the person to suffer greater injury or indignity in that process than other arrestees."[16]

[15] *Brunette v. City of Burlington et al.*, Case No. 2:15-cv-00061, Opinion and Order Granting in Part and Denying in Part Defendants' Motion for Summary Judgment (Doc. 95). August 30, 2018 at p. 54.
[16] *Sheehan v. City & Cty. of San Francisco*, 743 F.3d 1211, 1232 (9th Cir. 2014), *rev'd in part, cert. dismissed in part sub nom. Sheehan*, 135 S.Ct. 1765 (2015); see also *Sage v. City of Winooski*, Case No. 2:16-cv-116

Mr. Brunette's family claimed that BPD failed to follow its own policy for responding to calls involving individuals with mental illnesses and that failure amounted to a failure to provide Mr. Brunette with "reasonable accommodations to his known and qualifying disability in their interactions with Mr. Brunette on the day they shot and killed him."[17]

The policy that Mr. Brunette's family claimed BPD failed to follow was Department Directive DD13.3, entitled "Interacting with Persons with Diminished Capacities." Although the policy became effective after Mr. Brunette's death, former BPD Chief Michael Schirling testified during the Brunette litigation that DD13.3 "codif[ied] the way things were trained and operationalized for the entire 25 years" he worked at BPD.[18] Former Chief Schirling worked for BPD from 1989 to 2015.[19]

According to BPD, DD13.3 outlines the "day-to-day response methodology" for mental health calls.[20] Directive DD13.13 instructs BPD officers to follow procedures for "containment, coordination, communication and time."

Mr. Brunette's family alleged that BPD (1) did not contain the potential threat by respecting Mr. Brunette's "comfort zone"; (2) abbreviated, rather than prolonged, the encounter; (3) failed to establish a command post which would have served as a place for a reactionary distance and safe cover; and (4) did not control the situation and ensure that Mr. Brunette received the most appropriate form of professional resources.[21]

Without admitting liability, in May 2019, the City of Burlington agreed to pay Mr. Brunette's estate and family $270,00, to settle the lawsuit.

B. Failure to follow BPD Policies during encounter with Phil Grenon

BPD's alleged failures to follow BPD policies in its encounter with Mr. Brunette mirror BPD's failures to follow BPD policies in the encounter with Mr. Grenon, who like Mr. Brunette was a "qualified individual with a disability."[22]

---

[17] *Brunette v. City of Burlington et al.*, Case No. 2:15-cv-00061, Opinion and Order Granting in Part and Denying in Part Defendants' Motion for Summary Judgment (Doc. 95). August 30, 2018 at p. 54.
[18] *Brunette v City of Burlington et al.*, Case no. 2:15-cv-0061, Opinion and Order Granting in Part and Denying in Part Defendants' Motion for Summary Judgment, August 30, 2018, at p. 26.
[19] https://www.policefoundation.org/team_detail/chief-michael-schirling-ret/
[20] *Brunette v City of Burlington et al.*, Case no. 2:15-cv-0061, Opinion and Order Granting in Part and Denying in Part Defendants' Motion for Summary Judgment, August 30, 2018, at p. 25.
[21] *Brunette v. City of Burlington et al.*, Case No. 2:15-cv-00061, Opinion and Order Granting in Part and Denying in Part Defendants' Motion for Summary Judgment (Doc. 95). August 30, 2018 at pp. 33-34.
[22] Under the ADA, the term "qualified individual with a disability" means:

> An individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication or transportation barriers, or the

In Mr. Grenon's case, BPD (1) failed to respect Mr. Grenon's "comfort zone"; (2) failed to take time to obtain specialized equipment that would have prevented Mr. Grenon from getting so close to officers that they were compelled to use lethal force; (3) failed to maintain a zone of safety when dealing with a person armed with a knife; (4) failed to engage in non-threatening, calming, truthful and open-ended communication with Mr. Grenon; (5) failed to attempt other communication techniques when Mr. Grenon did not respond to the initial communication method; (6) failed to designate a command post and staging area outside of Mr. Grenon's hearing; (7) failed to consult the mobile crisis clinician who was on site about the use of the Taser on Mr. Grenon; and (8) failed to consult with the crisis negotiators before deciding to resort to a non-peaceful resolution of the standoff with Mr. Grenon.

1. Containment Policy

BPD's "containment" policy requires officers to "respect the comfort zone of the subject in order to reduce any unnecessary agitation." Officers "should continuously evaluate this comfort zone and not compress it, unless necessary."[23]

During the initial encounter between Officers Ellerman and Bowers and Mr. Grenon, Officer Bowers followed the containment policy. Realizing during the encounter with Mr. Grenon that he and Officer Ellerman were too close, Officer Bowers whispered to Officer Ellerman: "I think we're going to back up a little," [24] and both officers did so.

Sgt. Trieb also initially followed the containment policy by roping off Mr. Grenon's apartment door, which confined Mr. Grenon to his apartment and rendered him unable to leave the apartment on his own accord.

Unfortunately, later in the encounter, under the direction of former Chief del Pozo, BPD unnecessarily compressed Mr. Grenon's comfort zone and that compression led directly to Mr. Grenon's death.

Former Chief del Pozo testified that he entered Mr. Grenon's apartment because he was concerned that Mr. Grenon might harm himself. However, after entering the apartment and finding Mr. Grenon alive, unharmed and hiding in his bathtub, BPD further compressed Mr. Grenon's comfort zone by unnecessarily attempting to drive him out of the bathroom, first with pepper balls and then with Tasers, before it was safe to do so.

---

provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity. (42 U.S.C. § 12131(2)).

[23] Burlington Police Department Directive DD13.3 – Interacting with Persons with Diminished Capacities, III. A. 3 at p. 2.

[24] See Appendix A for a transcript of the initial encounter between Officers Ellerman and Bowers and Mr. Grenon.

BPD could have chocked Mr. Grenon's bathroom door to prevent his exit from the bathroom. BPD knew before it entered Mr. Grenon's apartment that Mr. Grenon's bathroom door was an outward opening door and would need to be chocked to control Mr. Grenon's egress.

BPD did not have on hand the equipment necessary to chock the door and it made no effort to acquire the necessary equipment to chock the door.

When BPD did not have a rope to secure Mr. Grenon's apartment door, Sgt. Trieb took the time to obtain a rope by borrowing it from the Burlington Fire Department. When BPD did not have the equipment necessary to insert a camera into Mr. Grenon's apartment, it took the time for former Chief del Pozo to go to his own home to secure necessary equipment. BPD also took the time to ask BHA to summon an off-duty maintenance employee back to work to supply equipment to help insert the flexible camera into Mr. Grenon's apartment. BPD did not make similar efforts to reach out to the fire department or others to secure equipment to chock Mr. Grenon's bathroom door.

2. Time Policy

DD13.3 also directs officers to use time to "elongate[e] the encounter, rather than hastening it." The policy specifically directs officers to "take time to obtain specialized equipment."[25] BPD did not do so.

3. Edged Weapon Zone of Safety Policy

BPD also failed to adhere to the provision of DD13.3 that states "when dealing with subjects armed with edged weapons officers should, where possible, maintain a zone of safety that allows for reaction should the subject decide to attack."[26]

BPD did not maintain a zone of safety even though it was possible to do so. According to former Chief del Pozo, Mr. Grenon was not under arrest and he had broken no laws. He was also not an imminent threat while hiding in his bathtub with the shower curtain closed.

Before BPD embarked on its plan to extract Mr. Grenon from the bathroom, former Chief del Pozo was aware that because of the layout of the bathroom and the adjoining bedroom, most of the officers assigned to the team that was intended to extract Mr. Grenon from the bathroom would not be able to see Mr. Grenon inside the bathroom and would not be able to see him leave the bathroom should he suddenly do so. He also knew that the bedroom was so small that should Mr. Grenon suddenly leave the bathroom, seven officers simultaneously would have to back out of the small bedroom to remove themselves from Mr. Grenon's path.

[25] Burlington Police Department Directive DD13.3 – Interacting with Persons with Diminished Capacities, Section III. D. 3 at p. 3.
[26] Burlington Police Department Directive DD13.3 – Interacting with Persons with Diminished Capacities, Section III. C. 1 at p. 3.

The decision to extract Mr. Grenon from the bathroom put officers within a few feet of Mr. Grenon in a tiny space that did not allow room to react or retreat, all of which is contrary to DD13.3.

4. Communications Policy

DD13.3 also directs that one officer should be designated as the command voice and other officers should refrain from becoming involved. Verbal communication with a subject should be non-threatening, calming, truthful, and open-ended to facilitate a subject's participation.[27]

In the initial encounter, Officers Ellerman and Bowers did not designate one command voice. They each shouted commands at Mr. Grenon. In addition, Officers Ellerman and Bowers never told Mr. Grenon what brought them to his apartment. That is, they never told him that they were responding to a 9-1-1 call. They also did not ask open-ended questions. For example, they repeatedly commanded him to drop the knife rather than ask why he was holding the knives in the first place.[28] Officer Ellerman also resorted to threatening language, telling Mr. Grenon twice that he would shoot him.

After the crisis negotiator took over, he also did not truthfully tell Mr. Grenon what brought BPD to his apartment. He also did not ask open-ended questions. His first telephone call to Mr. Grenon went as follows:

> Hey Phil. Mike from the police department. Can you pick up? Hey, Phil. I just want to talk. Can you pick up the phone please? Hey Phil. It's Mike from Burlington Police. Can you pick up the phone so we can talk?

The crisis negotiator's second call to Mr. Grenon went as follows:

> Hey Phil, this is Mike from the police department again. I need you to pick up so we can talk. OK. You know there's a bunch of officers outside and we can't go anywheres until I have a conversation with you so. I just need you to talk with me. You and I can work something out. If you — I'm going to keep calling you so. My callback number is going to be 6-5-8-2-7-0-0 and dial zero to talk to dispatch. Tell her that you're looking to talk to Mike and that I will conference in so you and I can talk. OK. Alright. Bye.

The crisis negotiator went on to leave eight, additional nearly identical messages on Mr. Grenon's answering machine. The crisis negotiator never told Mr. Grenon what brought BPD to his apartment and never asked an open-ended question.

---

[27] Burlington Police Department Directive DD13.3 – Interacting with Persons with Diminished Capacities, III. C. 2, 3 and 4 at p. 3.

[28] Officer Bowers did ask Mr. Grenon an open-ended question to which Mr. Grenon responded with an expletive, which seemed to curtail further attempts by Officer Bowers to engage Mr. Grenon with open-ended questions.

The crisis negotiator also knocked on Mr. Grenon's door on four separate occasions. A typical communication went as follows:

> "Hey, Phil. I know you're trying to open up the door, man. You can't, OK. Can you talk to me? Without you talking to me, it makes this a lot harder. OK? You need to communicate to me. I can't help you, if you don't talk to me. Come on, Phil. Talk to me. Come on Phil. Your daughter's waiting for a phone call from me. And your six grandkids are worried about you. Come on Phil. Just talk to me through the door or call me on the cell phone I left you on your answering machine, OK? We'll talk through this and then we'll get out of here. Come on Phil. Phil, I know you can hear me. And I know you know you can't get out of your door. Come on. Pick up the phone and call me or talk to me through the door. All I want to do is talk."

Again, the crisis negotiator did not ask open-ended questions. Although he said he wanted to talk, he didn't open up any lines of inquiry by asking an open-ended question.

DD13.3 also directs officers to use other communication techniques, including changing the person designated as the command voice, if the subject does not respond. Mr. Grenon did not respond and BPD did not attempt other communication techniques. BPD also did not change the designated crisis negotiator even though there was another crisis negotiator on site and available.

It is not possible to say what effect a change in crisis negotiator may have had but it was certainly worth a try before attempting to forcibly remove Mr. Grenon from his apartment. This is especially the case where the other crisis negotiator was a female and based on information received by the Commission, Mr. Grenon preferred interacting with females rather than males because of his history of childhood sexual abuse.

After BPD entered Mr. Grenon's apartment and found him hiding in the bathroom, BPD completely abandoned any attempt to negotiate with Mr. Grenon or to find out why he was hiding and holding the knives. They simply shouted the same commands.

Immediately upon entering Mr. Grenon's apartment, an officer shouted: "Burlington Police. Come out. We need to talk to you. Come out."[29]

After officers first discovered Mr. Grenon hiding in the bathtub, Officer Byrne, who was standing at the bathroom's threshold holding a ballistic shield and surrounded by officers holding lethal force, said: "Burlington Police. Sir, come out. Sir, we know you're there. Just come out. Alright, buddy, come on out."[30]

[29] Trieb 2016-03-21 2118 (A-59).mp4 at 00:01:10.
[30] Trieb 2016-03-21 2118 (A-59).mp4 at 00:05:33 and 00:06:16.

After directing the discharge of pepper balls into the shower, Sgt. Trieb shouted: "Sir. Put the knife down and show us your hands. Do it now. We're here to help you. But you need to put the knife down first."[31]

These were not the calming, truthful, open-ended, non-threatening communications that BPD's DD13.3 dictates.

5. Crisis Negotiation Policy

BPD also disregarded its departmental crisis negotiation policy. Department Directive DD15, entitled "Crisis Negotiation," provides:

> Decisions relative to non-peaceful resolution shall be made by the Incident Commander, **after** consulting with trained Crisis/Hostage Negotiators and Tactical Personnel (if on scene).[32] (emphasis supplied)

Former Chief del Pozo did not consult with the crisis negotiators before making the decision to enter the apartment and forcibly remove Mr. Grenon from his apartment, first with pepper balls and then with Tasers.

Officer Michael Henry and Corporal Krystal Wrinn were the crisis negotiators. During an interview with Vermont State Police, Officer Henry described how he found out about the decision to enter Mr. Grenon's apartment:

> Krystal and I ended up going down to my cruiser getting the negotiating equipment and so we could start setting it up because we were still talking about doing a throw phone so I'm like let's just go set up the equipment, have it ready to go. If we need to deploy it, we'll deploy it. So, we're upstairs, setting it all up and stuff, and the Chief came up and notified me, hey, we're going to make entry. I'm like OK. So, I went down with the Chief and when I got down there, they had already made entry. They were like in the kitchen to the living room. I don't know if you've been over there. It's a very small apartment. There's not a lot of room, and he wasn't the most clean person. So, I grabbed the pepper ball because the pepper ball was in the hallway on the floor, you know, and I'm certified in it to use it so I grabbed it in case we needed it. [33]

Similarly, neither Officer Henry nor Corporal Wrinn was consulted about inserting pepper balls into the bathroom. The decision to insert pepper balls into the bathroom was made following

[31] Trieb 2016-03-21 2118 (A-59).mp4 at 00:08:59.
[32] Burlington Police Department, Department Directive DD15 Crisis Negotiation, Section II. H. 2. at p. 4 (effective February 13, 2013).
[33] Officer Michael Henry, March 23, 2016, Audio Recorded Sworn Statement at 00:15:55

an exchange between Sgt. Trieb and former Chief del Pozo. Police body cameras captured the exchange as follows:

> TRIEB: He's in there with a knife.
>
> DEL POZO: Brandishing the knife?
>
> TRIEB: No, he's got it at his side. It's about that long.
>
> TRIEB: Do you want us to insert a couple of pepper balls in there?
>
> del POZO: Yeah.
>
> TRIEB: Everybody — I want everybody out of the way, except for Byrne. Henry?
>
> HENRY: Yep.
>
> TRIEB: Come on up here.
>
> HENRY: Yep.
>
> TRIEB: So, I want you —
>
> HENRY: Yep.
>
> TRIEB: You're going to go up with Byrne and myself. You're going to insert some pepper ball into the shower, OK. Hit up high. Hit up high on the wall over the shower curtain. Let it come down on him. Just so you guys know he did have a knife on him. It's about that long. He's holding it at his side.[34]

Contrary to BPD policy, the crisis negotiators were consulted neither before the decision to enter the apartment nor before the decision to insert pepper balls into the bathroom or deploy the Tasers.

6. Command Post and Staging Area Policy

DD13.3 also directs the lead person or Officer in Charge to designate a location for a command post and staging area, when warranted. The location should be out of sight of the "subject encounter." BPD did not have a designated command post and staging area and it was most certainly warranted.

[34] Henry 2016-03-21 2119 (A-56)6.mp4 from 00:05:46 – 00:06:21.

The failure to designate a command post and staging area meant that Mr. Grenon was in a position to hear BPD discuss its plans to extract him from the bathroom. BPD officers discussed their plans while huddled in Mr. Grenon's bedroom and living room. Witnesses reported that the apartment has very thin walls and sound carried. For example, police officers reported that they could hear the crisis negotiator leaving messages on Mr. Grenon's answering machine while standing in the corridor.

In addition, according to Mr. Grenon's treating psychiatrist, Mr. Grenon was likely experiencing mania and psychosis in the period before his death. Individuals experiencing mania and psychosis can have altered sensory phenomena, including sound amplification. They can hear sounds more clearly and/or can hear subthreshold sounds distinctly.

While standing fewer than 10 feet from Mr. Grenon's location, BPD discussed "light[ing] him up,"[35] "tas[ing] the shit out of him,"[36] "blind[ing] him"[37] with pepper spray and "slam[ming] him" with riot shields.[38]

In the seconds before the fatal encounter with Mr. Grenon and while standing at the bathroom threshold a mere few feet from Mr. Grenon, Officer Ellerman announced just before discharging his Taser: "As soon as I see him, I'll hit him."[39] At the time, Officer Ellerman was holding a riot shield and pointing his Taser (which resembles a firearm) in Mr. Grenon's direction.

In addition, Officer Ellerman did not adhere to his training when he fired his Taser. As a warning to the intended subject, BPD officers are trained to say "Taser, Taser, Taser" before discharging their Tasers. Officer Ellerman did not do so.[40]

Mr. Grenon, who because of likely psychosis believed that BPD officers were at his apartment to kill him, may have heard and understood references to "light him up" or "hit him" as confirmation of his belief that officers were about to kill him. Under these circumstances, it becomes understandable why Mr. Grenon left the bathroom wielding the knives after Officer Ellerman fired his Taser.

[35] Trieb 2016-03-21 2118 (A-59).mp4 at 00:18:52.
[36] Wilkinson 2016-03 21 2114 (A-61)3.mp4 at 00:08:19.
[37] Trieb 2016-03-21 2118 (A-59).mp4 at 00:13:44.
[38] Trieb 2016-03-21 2118 (A-59).mp4 at 00:17:53.
[39] Trieb 2016-03-21 2118 (A-59).mp4 at 00:19:57.
[40] During the initial encounter with Mr. Grenon, Officer Bowers did say, "Taser, Taser, Taser," as he deployed his Taser. See Appendix D for a transcript of the initial encounter between Mr. Grenon and Officers Bowers and Ellerman.

7. Taser Policy

BPD also failed to adhere to provisions of its Taser policy. Under the policy, officers having reason to believe they are dealing with a member of a special population "shall give special consideration to deploying a [Taser]."[41]

The policy defines members of "special populations" to include individuals over 65 years of age and individuals "experiencing an emotional crisis that may interfere with the ability to understand the consequences of their actions or follow directions."[42]

BPD's Taser policy defines "special consideration" as follows:

> A consideration of: (i) the potential additional risk of harm posed by deploying a CEW against a member of a special population or a subject in special circumstances; and (ii) whether other types of force are reasonably available to effectuate custody of or facilitate control over a member of a special population or a subject in special circumstances while still preserving the safety of that person, third parties, and the responding officer(s).[43]

The decision to use the Taser to subdue Mr. Grenon was made after the pepper balls failed to drive Mr. Grenon from the bathroom. The discussion leading to BPD's decision to use the Taser was captured by police body cameras and went as follows.

> del POZO: He hasn't said a word, huh?
>
> TRIEB: No. Nothing.
>
> del POZO: He was looking at ya?
>
> TRIEB: Yeah, he was standing really straight. Knife down at his side. Pushed the curtain aside. He was just standing there. I mean I think we can do that again. I mean, I guess the results could be — we could hit him with this [referring to the Taser].
>
> del POZO: Alright. Is he going to tense up or drop the knife if we hit him with that?

[41] Burlington Police Department Department Directive DD05.01 Response to Resistance / Use of Force -- Conducted Electronic Weapons (CEW) Section II. 11. at p. 4 (effective December 23, 2015).
[42] Burlington Police Department Department Directive DD05.01 Response to Resistance / Use of Force -- Conducted Electronic Weapons (CEW) Section I. 2. at p. 2 (effective December 23, 2015).
[43] Burlington Police Department Department Directive DD05.01 Response to Resistance / Use of Force -- Conducted Electronic Weapons (CEW) Section I. 4. at p. 2 (effective December 23, 2015).

TRIEB: A little bit of both, I guess. If we get a good lock up, we're going to know right away then we could just keep that constant current running until we can get in there and disarm him.

del POZO: Is there any way to reach in and tear the shower curtain off the — he's hiding behind the shower curtain?

TRIEB: Yeah.

WILKINSON: Why don't we pin him with the shield when he's under power so he doesn't fall —

TRIEB: We're still dealing with that situation. We've got a big fucking problem. I'm not trying to put officers within fucking inches of him. We can definitely rip the curtain off though. I think I can get the broom and yank it off.

del POZO: Go ahead and do that first and then come back and talk about options.[44]

TRIEB: It's really tight. It's four by four of space.[45]

Before deploying the Taser and contrary to BPD policy, BPD did not give any consideration to Mr. Grenon's advanced age or that he was experiencing a mental health crisis that interfered with his ability to understand the consequences of his actions.

BPD's Taser policy also provides that "officers having reason to believe they are dealing with an individual with a psychiatric disability shall consider consulting with the area designated mental health agency."[46]

After deploying the pepper balls but before deciding to deploy the Taser, former Chief del Pozo engaged in the following exchange with Corporal Wrinn, who was one of the crisis negotiators.

del POZO: Krystal, you said one of his family members might be coming or?

WRINN: Excuse me?

del POZO: Someone from Street Outreach is bringing them.

---

[44] Although Sgt. Trieb and former Chief del Pozo agreed to rip the shower curtain off and then come back to discuss options, the police body camera recordings captured no further discussions about options. Rather, after waiting a few minutes for the air to clear of pepper balls and swapping out the ballistic shields for riot shields, Sgt. Trieb used a broomstick to push open the shower curtain and reveal Mr. Grenon. Thereafter, at Sgt. Trieb's direction, Officer Ellerman immediately fired his Taser at Mr. Grenon.

[45] Trieb 2016-03-21 2118 (A-59).mp4 from 00:11:00 to 00:12:04.

[46] Burlington Police Department Department Directive DD05.01 Response to Resistance / Use of Force -- Conducted Electronic Weapons (CEW) Section I. 2. at p. 2 (effective December 23, 2015).

WRINN: Street Outreach is across the street right now.

del POZO: Did they bring the person who they said they were bringing?

WRINN: There is someone from Crisis here but his psychiatrist is out of the country right now.

del POZO: You pulled up the emergency --

WRINN: Yep, emergency crisis is across the street. Her name is Heather.

del POZO: OK.[47]

Although a mobile crisis clinician from the Howard Center was standing by, BPD never consulted her about using the Taser on Mr. Grenon.

C. Similarities and Differences between Two BPD Killings

The similarities between the alleged failures in Mr. Brunette's death and the failures in Mr. Grenon's death are striking: the same failure to respect the subject's comfort zone; the same failure to elongate the time of the encounter rather than arbitrarily hastening it; the same failure to create a command post and staging area; and the same failure to keep a safe distance from a person with an edged weapon.

There are also differences between the two killings that make Mr. Grenon's killing all the more perplexing and deeply troubling. For example, the encounter with Mr. Brunette involved just two BPD officers. The encounter with Mr. Grenon was led by the former Chief of Police, who had on-site, if he chose to use them, the expertise of two, trained crisis negotiators, a Howard Center mobile crisis clinician, a Deputy Chief, a sergeant, and nine other officers.

In addition, Mr. Grenon posed no direct threat to anyone while hiding in his bathtub. Not only was there time to attempt other communication methods, but also other communication methods were being prepared at the time former Chief del Pozo decided to abandon crisis negotiation and enter the apartment. There was also time to resume crisis negotiation once inside the apartment and there was time to switch to other communication methods after earlier methods were unsuccessful. There was also time to consult the mobile crisis clinician. There was time to chock Mr. Grenon's door to prevent his exit. There was time to cut a hole in the bathroom door and insert a camera to monitor his actions and communicate with him. And if all those interventions failed, there was time to gather the tools and devise a plan to rig Mr. Grenon's bathroom door to allow an officer both to deploy a Taser and also prevent Mr. Grenon from leaving the bathroom should the Taser fail to subdue him.

The Commission received no information that explains why BPD did not adhere to its own policies and take the time to protect Mr. Grenon, accommodate his mental illness as the law requires, and avoid putting BPD officers in harm's way.

[47] Wrinn 2016-03-21 2119 (A-62)16.mp4 from 00:13:32 to 00:13:57.

D. Stereotyping and Disparaging Statements

Officer Ellerman reported to Sgt. Trieb that Mr. Grenon had threatened to kill himself, and former Chief del Pozo said such concern was behind the decision to enter Mr. Grenon's apartment. However, Mr. Grenon had not threatened to kill himself and no witness reported that he had.

The Commission did not learn why Officer Ellerman incorrectly reported that Mr. Grenon had threatened to kill himself. However, this was not the only statement that Officer Ellerman made that was at odds with police body camera recordings. Officer Ellerman also reported in the sworn statement he gave to a Vermont State Police investigator that when he arrived at Mr. Grenon's apartment building, a witness reported that she had seen Mr. Grenon out in the hallway with two knives.[48]

No witness reported seeing Mr. Grenon in the hallway with two knives. Mr. Grenon's apartment building was also monitored around the clock by video surveillance and Mr. Grenon was never seen on the video recording in the hallway with two knives.

In addition, Officers Ellerman and Bowers specifically asked the resident manager if she saw anything in Mr. Grenon's hands. She replied: "No, no. He was inside his apartment." The officers then asked: "So, he was just in his room the whole time …" The resident manager replied: "He was right there in his kitchen."[49]

BPD officers also gave varying accounts of what they were told when they arrived on scene about Mr. Grenon's actions. For example, former Chief del Pozo said during his sworn interview with Vermont State Police that officers reported to him that "they heard [Mr. Grenon] screaming; they wanted to make sure there were no victims inside his apartment, so they had management give them the key."[50] Officer Byrne reported during his sworn interview with Vermont State Police that: "Bowers and Ellerman kind of like debriefed us, briefed us what was going on, how they could hear him going nuts inside when they got to the door."[51] The body camera recordings are at odds with both of these reports. There were no sounds emanating from Mr. Grenon's apartment when officers arrived.

And finally, during his interview with the Vermont State Police investigator, Officer Ellerman was asked: "Anything else that you can think of that we would or should need to note?" Officer Ellerman replied:

[48] Officer Durwin Ellerman, March 22, 2016 Sworn Statement Audio Recorded at 04:50.24.
[49] Transcripts of Officer Ellerman's witness interviews can be found at Appendices B and C.
[50] Chief Brandon del Pozo, March 22, 2016 Sworn Statement Audio Recorded at 00:07:03.
[51] Officer Oren Byrne, March 22, 2016 Sworn Statement Audio Recorded at 00:08:40.

> "I remember the property manager telling us before we made entry I think her name was Pam. She was like just so you know, he's not coming out of there alive. She was like he's not going to let you take him alive."[52]

The comment attributed to the property manager was not captured on Officer Ellerman's body camera recording and it is unknown whether she made the remark. However, whether or not she did, that Officer Ellerman would find such a statement from a lay witness worthy of inclusion in the official investigation of Mr. Grenon's death, coupled with the other discrepancies, suggest that, at best, Officer Ellerman's perceptions during the encounter with Mr. Grenon were clouded by dangerous stereotypes rather than an objective assessment of the situation with Mr. Grenon.

In addition, the comment attributed to BPD in the UVM Medical Center medical record that "they believe the patient wanted to be shot by the police" seems also to be based on stereotype rather than an objective assessment of Mr. Grenon's situation.

Although Mr. Grenon gave few verbal cues, the one oral cue he gave was "leave me alone."[53] He also gave many non-verbal cues that BPD apparently failed to register. For example, when officers initially opened his apartment door, Mr. Grenon did not attack. Rather, he de-escalated the situation by closing the door. When BPD found Mr. Grenon standing in his bathtub with the door closed and the shower curtain drawn, he did not attack. Rather, he remained standing in the bathtub with the knives at his side. When Sgt. Trieb opened the shower curtain and exposed Mr. Grenon, he did not attack. Rather, Mr. Grenon waited for the officers to retreat and then closed the shower curtain. These actions, taken singly or collectively, are inconsistent with a person who wants to be shot by the police.

While suicide-by-cop is a recognized phenomenon, BPD conducted no investigation to determine whether it was a factor in Mr. Grenon's death. In the absence of any investigation, it was stereotypical and dishonored Mr. Grenon's memory to offer for the official medical record of his death the unfounded opinion that he wanted to be shot by the police.

During his interview with a Vermont State Police investigator, another BPD officer referred to people with whom the Street Outreach team interacts as "some pretty crazy people."[54] The comment reflects a complete ignorance about Burlington residents with mental health or emotional challenges. It both minimizes their situation and also objectifies them.

[52] Officer Durwin Ellerman, March 22, 2016 Sworn Statement Audio Recorded at 00:26:37.
[53] See Appendix D for a transcript of BPD's initial encounter with Mr. Grenon.
[54] Officer Oren Byrne, March 22, 2016 Sworn Statement Audio Recorded at 00:05:22.

E. Concerns about Actions Taken in Aftermath of Phil Grenon's Death

Some of the changes BPD made in the aftermath of Mr. Grenon's death are also concerning. Among the changes that former Chief del Pozo testified he made in the wake of Mr. Grenon's death was a $150,000 investment in an emergency response vehicle equipped with tools and apparatuses to forcibly extract individuals in situations similar to Mr. Grenon's. BPD made this substantial investment without any real understanding of why Mr. Grenon behaved the way he did and without considering whether there were opportunities to engage with Mr. Grenon that BPD overlooked.

In addition, none of the specialized tools that BPD added to the emergency response vehicle (for example, the Y-bar) have been tested on people in a mental health crisis. And, it was a misplaced reliance on tools -- Tasers and pepper balls – that played a role in Mr. Grenon's death.

The Americans with Disabilities Act requires a police department in the course of investigation or arrest to refrain from subjecting a person with a disability to greater injury or indignity than other arrestees.

BPD's significant investment in tools for extraction rather than engagement has the potential to subject people in a mental health crisis to greater injury or indignity than individuals who are not experiencing a mental health crisis.

Furthermore, in the wake of Mr. Grenon's death, in August 2016, a Chittenden County man who had experienced mental illness proposed an idea to the City of Burlington to help break down barriers between police and individuals who are perceived to have a mental illness. He proposed having individuals with lived experience of a mental health diagnosis participate in the police ride-along program with the expectation that exposure and informal sharing would help to combat the stigma and stereotyping that may prevent peaceful resolutions of a mental health crisis.[55] The City of Burlington did not embrace the idea. Rather, while speaking about the idea during a meeting of the Burlington Police Commission, former Chief del Pozo said:

> "But if we set aside a group of ride-alongs for people contending with mental health issues [] it raises these liability concerns that stymie us …"[56]

Former Chief del Pozo acknowledged that people with a history of mental illness who kept that information to themselves were free to participate in ride-alongs. Only those who disclosed a history of mental illness were excluded from participating in ride-alongs. Of course, the

---

[55] Anne Donahue, "Survivor Speaks Up, Proposes Police Ride-Along Program," *Counterpoint*, vol. XXXI No. 2, Fall 2016, https://static1.squarespace.com/static/5ce5743b8e0e580001408955/t/5db869110c91f357aabd6a7a/1572366615235/Counterpoint_Fall_2016.pdf

[56] Burlington Police Commission Meeting, July 25, 2017 at 00:03:13, https://www.cctv.org/watch-tv/programs/burlington-police-commission-10#

proposed program could only achieve its objectives if prospective participants disclosed a history of mental illness.

Finally, despite two BPD killings of people with mental illness in fewer than three years and a $270,000 payout in settlement of a lawsuit arising out of one the deaths, the City of Burlington did not see fit to include people with a history of mental illness on its recently created use-of-force committee and when the omission was pointed out to the City Council, it took no action to rectify the omission.

F. Unconscious Bias and BPD's Killing of Phil Grenon

BPD's alleged failure to adhere to its own policies in Mr. Brunette's death and its failure to adhere to its own policies in Mr. Grenon's deaths; the stereotypical and disparaging statements referenced above; the absence of any explanation as to why BPD did not adhere to its own policies and take the time to protect Mr. Grenon, accommodate his mental illness as the law requires, and avoid putting BPD officers in harm's way; and the rebuffed attempts by people with a history of mental health challenges to participate in City programs to improve relations and influence use of force policies, suggest that unconscious bias against people with mental illnesses, on the part of the City of Burlington, including BPD,[57] was a root cause of Mr. Grenon's death.

An unconscious bias is, of course, a prejudice that operates below the level of belief. People or institutions are, by definition, unaware of unconscious biases. Unconscious biases are often inconsistent with one's conscious values. In addition, unconscious biases tend to be more prevalent when working under pressure.

Such biases can unconsciously influence police performance. For example, unconscious biases may result in an erroneous assessment of risk, a distortion or misrepresentation of the facts, the devaluation of a life, a reluctance to devote the time necessary to allow all peaceful resolution options to play out, and a premature use of force. Unconscious bias may also exclude marginalized people from the process of conceptualizing, identifying and ending excessive use-of-force by limiting participation to privileged members of the community.

[57] BPD Deputy Chief Jannine Wright's post on her fake Facebook page, which belittled a Burlington resident by ridiculing his mental health, is also an example of this bias at the highest ranks of BPD. *See* Aidan Quigley, "Another senior Burlington police officer in hot water for fake Facebook account," Dec 16, 2019, vtdigger.org, https://vtdigger.org/2019/12/16/another-senior-burlington-police-officer-in-hot-water-for-fake-facebook-account/?is_wppwa=true&wpappninja_cache=friendly

G. Other Recommendations

In addition to the Commission's law enforcement recommendations, the following are recommended specifically for the City of Burlington and the Burlington Police Department.

I. Revoke the City of Burlington policy that prohibits people who disclose a history of mental illness from participating in police ride-alongs.

The City of Burlington has done nothing to engage the psychiatric survivor community as a strategy to manage public safety. Community policing requires an active building of positive relationships with members of a community on an agency and personal level. Ride-alongs can play a vital role in building relationships with the psychiatric survivor community.

The issue of liability as a reason to prohibit such ride-alongs is yet more evidence of an unconscious bias. Surely, if former Chief of Police del Pozo can return to his position following a leave of absence for mental health treatment, there is no rational basis for a blanket exclusion of individuals who have disclosed a history of mental illness from participating in police ride-alongs.

Currently, most police officers' exposure to people with mental illnesses is limited to when they are in crisis. However, there is much more to the lives of people who have experienced mental health challenges. Police ride-alongs would allow officers to engage with people with a history of mental illnesses when they are not in crisis to help combat stereotypes and unconscious biases that adversely affect police performance.

II. Amend the City of Burlington resolution pertaining to "Formation of a Special Committee to Review Community Policing Practices through a Robust Community Engagement Process," to include at least two members with a history of mental illness and an interest in improving community policing practices.

III. Audit current policies pertaining to encounters with people in mental or emotional crisis to ensure that they comply with the Americans with Disabilities Act.

IV. Develop and train officers in a wider array of options to avoid use of force involving people in mental or emotional crisis, including useful and effective alternatives to repeatedly shouting "drop the knife," at people who are not complying.

V. Refrain from using tools on the $150,000 emergency response vehicle for forcible extraction before all peaceful resolution options have been exhausted.

XIII. Other Law Enforcement Involved Deaths of Individuals in Crisis

Since Mr. Grenon's death, the Commission has reason to believe that there are other law enforcement incidents that resulted in killing of people in a mental health crisis.

These deaths are not unique. Nationally, people diagnosed with untreated, so-called severe mental illnesses are at least 16 times more likely to be killed during a police encounter than other individuals.[58]

[58] Doris A. Fuller et al., Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters, Treatment Advoc. Ctr. 1, 12 (2015) https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf

XV. APPENDIX A – 9-1-1 Transfer to Burlington Police Department

The resident manager at Mr. Grenon's apartment building telephoned Vermont 9-1-1 on March 21, 2016 at 5:17 p.m.

The following is a transcript of the call's transfer to the Burlington Police Department.

BPD DISPATCHER: Burlington.

VERMONT 9-1-1 DISPATCHER: Burlington Police. Vermont 9-1-1. Williston Agent 1-6-1. We're requesting the police to respond over to 1-0-1 College Street. Sounds like you've already received a call from there regarding tenant slash resident there who is out of control. I have Pamela on the line at REDACTED requesting somebody to assist there.

BPD DISPATCHER: [Speaking to 9-1-1 Caller] What apartment are they in?

CALLER: They're in apartment 2 — 2-0-9

BPD DISPATCHER: OK. What exactly is going on ma'am?

CALLER: Yeah, he's screaming and threatening out, outside of his apartment. He's, his rent is up, he's been evicted and, for this kind of behavior and now he's in there and I just, he scared his neighbor [inaudible] he wants to stab people, he wants —

BPD DISPATCHER: OK, is he inside or outside the apartment?

CALLER: He is inside his apartment.

BPD DISPATCHER: OK, what's his name? Do you know?

CALLER: Yes, it's Phil, they're very familiar with him. Phil Gagne [sic], I think and I'm the residential manager and I was told to just call to see if —

BPD DISPATCHER: OK, is anyone hurt there that you know of, ma'am?

CALLER: Not of now.

BPD DISPATCHER: Do you know if he has any weapons?

CALLER: I don't know, no, I don't.

BPD DISPATCHER: OK, what's your last name, please?

CALLER: Delphia, D-E-L-P-H-I-A

BPD DISPATCHER: Your date of birth?

CALLER: He said this is war. He said this is war.

BPD DISPATCHER: OK, we have some officers on the way now, ma'am; your date of birth, please?

CALLER: REDACTED Thank you very much, both of you.

BPD DISPATCHER: OK.

CALLER: Alright.

BPD DISPATCHER: And do you still hear him lashing out or has it stopped?

CALLER: I didn't, I'm down — I'm up on the third floor, I couldn't talk on his floor. I didn't want him to hear me.

BPD DISPATCHER: If you wouldn't mind meeting the officers at the entrance that would be very helpful, OK?

CALLER: You got it.

BPD DISPATCHER: OK, thank you ma'am.

CALLER: Bye bye.

BPD DISPATCHER: Bye.

XVI. APPENDIX B – Police Interview of Neighbor who called Street Outreach

Officers Durwin Ellerman and David Bowers and Street Outreach worker Hannah Toof arrived at 101 College Street on March 21, 2016 at 5:18 p.m. They were met at the building's front door by one of Mr. Grenon's neighbors who earlier in the day had called Street Outreach to report that Mr. Grenon was disturbing his neighbors.

The following is the encounter between Officer Ellerman and the neighbor as captured by a police officer body camera.

NEIGHBOR: I wrote down what he said. [Reading from a notepad] "They're trying to kill me. Why don't you try it. I'm fucking tired of waiting for you." And then he goes on, "the building manager Mike Short, I want to kill you and that very rotten Dave, come into my apartment. I want to kill you." Et cetera et cetera.

OFFICER ELLERMAN: He has known mental health issues.

NEIGHBOR: Well, yeah, I know but violent known mental health --

OFFICER ELERMAN: But, I mean, if he's saying it to himself --

NEIGHBOR: It's not safe here.

XVII. APPENDIX C – Police Interview of 9-1-1 Caller

Officers Durwin Ellerman and David Bowers met with the resident manager and 9-1-1 caller before they proceeded to Mr. Grenon's apartment. As captured by the officers' body cameras, the following exchange ensued:

OFFICER BOWERS: How are you?

RESIDENT MANAGER: He's inside but he was --

OFFICER BOWERS: Did he go back in his room?

RESIDENT MANAGER: Yeah, he's in there. He's threatening everybody. He's going to stab everybody. He's going to cut tits off. And this is war because I'm evicted. Saying retard and all this stuff. I mean it's really, really scary.

OFFICER BOWERS: Did he have anything on him? Did he have anything on him, Pam?

RESIDENT MANAGER: I don't know.

OFFICER BOWERS: No? Did you see anything in his hands?

RESIDENT MANAGER: No, no. He was inside his apartment.

OFFICER BOWERS: OK.

RESIDENT MANAGER: Banging on the walls. Saying he's coming out --

OFFICER ELLERMAN: Did he say anything to you?

RESIDENT MANAGER: No, no.

OFFICER BOWERS: So, he was just in his room the whole time saying it?

RESIDENT MANAGER: He was right there in his kitchen.

OFFICER BOWERS: Gotcha.

OFFICER ELLERMAN: We'll go make contact.

XVIII. APPENDIX D – BPD Initial Encounter with Phil Grenon

Officers Durwin Ellerman and David Bowers arrived at Mr. Grenon's door at approximately 5:20 p.m.

The officers' body cameras recorded the following exchange:

ELLERMAN: [Knocking] Hey, Phil. It's Officer Ellerman. Burlington Police. Come on Phil. I can hear you in there. [Knocking] Come on Phil. You open the door or we're coming in. [Knocking] Come on Phil. Like I told you. Open the door. We're coming in. We'll come in with or without your permission. [Knocking with baton]

ELLERMAN: [Speaking to the resident manager] You got the keys?

ELLERMAN: [Speaking to Officer Bowers]: Exigency?

BOWERS: Huh?

ELLERMAN: Exigency?

BOWERS: Yep.

ELLERMAN: Phil, last chance. [Officer Ellerman tries to unlock and open Mr. Grenon's apartment door.]

BOWERS: [Speaking to Officer Ellerman] Is he against it?

ELLERMAN: [Speaking to Officer Bowers] Yeah, I think so.

[Ellerman succeeds in opening the door.]

ELLERMAN AND BOWERS: Phil.

BOWERS: Drop the knife, Phil.

ELLERMAN: Right now. Drop the knife.

BOWERS: Drop it.

ELLERMAN: [To Officer Bowers] Call for backup.

ELLERMAN: Drop the knife, Phil.

BOWERS: [Speaking into his police radio] 3-4-4 he's got a knife. Get us some other units.

BOWERS: Drop the knife. Phil, we don't need to do this. Drop the knife, man.

ELLERMAN: [To Bowers] Get your Taser out.

BOWERS: [To Ellerman] Yep.

ELLERMAN: Drop the knife, Phil. Phil, drop the knife.

BOWERS: Phil, drop the knife. Do not step towards us, Phil. Stand right there. Why can't you just talk to us. Huh? Phil, drop it and talk to us.

ELLERMAN: We just want to help you, Phil.

BOWERS: Phil. Phil, give me a response here. Give me a response here. Phil.

ELLERMAN: Don't do it, Phil.

BOWERS: Do not step towards us.

ELLERMAN: I will shoot you. I will shoot you.

BOWERS: Drop the knife. Drop it Phil.

ELLERMAN: Drop the knife, Phil.

BOWERS: Phil, I'm going to give you one more chance to drop it. [sound of Taser arc display[59]] Drop the knife. [sound of Taser arc display] Drop it.

ELLERMAN: [Speaking into police radio] 3-4-3. The entry code is REDACTED .

BOWERS: [whispering to Ellerman] I think we're going to back up a little.

BOWERS: Phil, drop the knife. There's no reason for you to have those right now. OK? All we're trying to do is talk to you, man.

GRENON: I'm a lawyer.

BOWERS: OK.

GRENON: I'm a psychiatrist.

BOWERS: Well, tell me more about it. But put down the knife.

GRENON: I just did, you stupid son of a bitch.

BOWERS: Put down the knife.

GRENON: Leave me alone.

BOWERS: Put down the knife.

GRENON: Leave me alone.

BOWERS: Put down the knife, Phil. Drop 'em.

BOWERS: Two knives. Phil, drop 'em both. [As he fired his Taser at Phil] Taser, Taser, Taser.

[59] A Taser is a brand name of a conducted electrical weapon considered less-lethal force. It fires two, small barbed darts intended to puncture the skin and remain attached to its target. The darts are connected to the main weapon by wires that deliver electric current designed to temporarily incapacitate the target. Before actually shooting the Taser, the user can also create an arc display on the Taser, which emits a visible electrical current and serves as a warning to the intended target.