



USE OF FORCE INVESTIGATIVE REPORT

DATE OF INCIDENT: 11/10/24
INVOLVED PERSON: Guadalupe Reyes
INVOLVED OFFICER: Ofc. Brady Strodbeck
INVOLVED OFFICER: Ofc. Eric Floyd
INVOLVED OFFICER: Ofc. Jakob Goold
WITNESS OFFICER: Lt. Russell Mengel
WITNESS OFFICER: Lt. Travis Poore
WITNESS OFFICER: Sgt. Larry Miles
OIA: 24-0071
DATE OF REPORT: 12/16/25

CASE SYNOPSIS

On November 10, 2024, Boise Police Department (BPD) officers responded to a suspicious circumstances call at an apartment complex in Boise. Officers determined that a resident, Guadalupe Reyes, was armed with a knife and holding a male neighbor hostage inside his (Mr. Reyes') apartment.

Mr. Reyes refused officers' attempts to negotiate. After approximately two hours, a man whom officers believed was Mr. Reyes exited the apartment and was taken into custody on an exterior landing just outside the apartment door. As other officers handcuffed the man, Ofc. Strodbeck opened the apartment door to check on the hostage inside. Ofc. Strodbeck announced himself and called for anyone inside to identify themselves. A man suddenly appeared and charged Ofc. Strodbeck while armed with a large knife. The man ignored the Ofc. Strodbeck's commands to stop. Ofc. Strodbeck fired several rounds from his department-issued rifle, striking the suspect, who fell at Ofc. Strodbeck's feet.

Officers later determined that the man who initially exited the apartment was the hostage. The man who was shot while charging Ofc. Strodbeck with the knife was identified as Mr. Reyes. Mr. Reyes died because of his gunshot wounds.

DETAILED DESCRIPTION OF INCIDENT

On November 10, 2024, at approximately 2:39 pm, BPD officers were dispatched to a suspicious circumstances call at an apartment complex in Boise. The reporting person called dispatch on a non-emergency line from a California phone number. The caller reported that her father was armed with a knife and had a hostage inside his apartment. The caller did not know the exact address of her father's apartment.

BPD Sgt. Miles was one of the responding officers. Based on the circumstances of the call, Sgt. Miles was initially concerned that it might be a hoax "swatting" call, as BPD had responded to several of these in the recent past.

As officers arrived in the area, Sgt. Miles directed their efforts to determine which apartment was the subject of the call. Sgt. Miles engaged with dispatch and requested a police officer in California locate and contact the reporting person to learn more information. Officers learned that the reporting person was on a Facetime video call with her father, who she identified as Guadalupe Mr. Reyes. She reported that because of the video call, she could see that Mr. Reyes was armed with a knife and was threatening to kill an unidentified male hostage who was laying on a bed in the apartment. She reported that Mr. Reyes had possibly stabbed the hostage in the hand and that Mr. Reyes was likely high on methamphetamine. Officers learned that a few days prior, Mr. Reyes had been hospitalized after dousing himself with gasoline and threatening to set himself on fire.

While coordinating with dispatch and California law enforcement, Sgt. Miles simultaneously organized a react team comprised of arriving patrol officers. React team members were assigned specific roles and various contingency plans were made. After identifying the correct apartment, a containment perimeter was established. Surrounding apartments were evacuated. Emergency medical personnel were staged nearby. Officers were provided with a driver's license photograph of Mr. Reyes.

Sgt. Miles coordinated with Lt. Mengel, who had assumed incident command. Lt. Poore assisted Lt. Mengel at the command post. Crisis negotiators began trying to contact Mr. Reyes by phone and by calling out to him on a loudspeaker. Mr. Reyes never responded to any attempts to contact him.

Mr. Reyes' apartment was one of two apartments on the second floor of a four-plex building situated in a courtyard. The two upstairs apartments shared a small exterior landing (approximately 8 feet wide and 4 feet deep) and were accessed from the courtyard by a shared exterior stairwell.

Officers determined that the adjoining upstairs apartment was vacant. They were able to obtain keys and permission to access the vacant apartment, which shared a common wall with Mr. Reyes' apartment. Once inside the vacant apartment, officers had close access to Mr. Reyes' apartment. The vacant apartment provided a mirror image floorplan of Mr. Reyes' apartment. The common wall permitted officers to

potentially hear any sounds emanating from Mr. Reyes' apartment. An additional arrest team including a K9 was placed at ground level in the courtyard.

Lt. Mengel, the incident commander, consulted with the BPD Special Operations Unit (SOU) which deployed 8 SOU team members to assist BPD patrol officers.

The first SOU member to arrive was Ofc. Strodbeck, who joined Sgt. Miles and the react team in the vacant apartment adjacent to Mr. Reyes' apartment.

Shortly after Ofc. Strodbeck reached the adjacent apartment, officers began to hear bumping sounds from inside Mr. Reyes' apartment, possibly furniture being moved. Officers were concerned Mr. Reyes might be barricading the door with furniture. During this time, crisis negotiators were still unsuccessfully trying to contact Mr. Reyes.

After approximately 2 hours on scene with numerous unsuccessful attempts to communicate by phone and loudspeaker, Mr. Reyes's apartment door opened, and a man walked out on the landing. Because the adjacent apartment door was open, the react team officers saw the man and gave him commands to lay down. He obeyed the commands and lay down on the landing. Officers saw that he was shirtless and had blood on his chest. Because the man looked like the driver's license photo the officers had previously seen, they believed he was the suspect, Mr. Reyes.

The react team officers included an officer designated to search and handcuff the suspect, one to provide lethal cover, and Ofc. Floyd to provide less lethal (non-deadly) coverage. Ofc. Floyd was equipped with a Taser and a 40 mm less lethal launcher. The 40mm launcher was hanging on a sling in front of his body.

The three react team officers moved to the small landing and began to cover, handcuff, and search the suspect for weapons. Because of their proximity to the suspect, Ofc. Floyd covered the suspect with his Taser rather than the 40mm launcher, which was still suspended on the sling. Realizing their back was to the closed door of Mr. Reyes' apartment, an officer asked that someone cover the door. Ofc. Strodbeck then stepped onto the crowded landing and positioned himself in front of the door.

Believing that the person being handcuffed was Mr. Reyes, Ofc. Strodbeck opened the door to Mr. Reyes' apartment to check on the welfare of the hostage he believed was inside. Ofc. Strodbeck did not enter the apartment but verbally identified himself as Boise Police. He told anyone inside to call out and make themselves known. The apartment front door opened into a short hallway approximately 10-12 feet long. At that moment, a man brandishing a large knife rounded the corner and entered the

hallway charging toward Ofc. Strodbeck. Ofc. Strodbeck gave a verbal command to stop and then fired approximately 8 rounds at the man who was rapidly closing on him with the knife. Despite being struck by 7 rounds, the man continued forward, still holding the knife until he collapsed on the landing at Ofc. Strodbeck's feet.

Seconds prior to the shooting, the officers' movements on the crowded landing caused Ofc. Floyd's right side to be pushed into the wrought iron railing. His pistol (in the holster) somehow wedged between two vertical railing slats causing him to be stuck in that position. Ofc. Floyd was forced to reach over the railing, unholster his pistol, and maneuver his now empty holster out from between the vertical railing slats to free himself. Because of this Ofc. Floyd's Taser was in one hand and his pistol in the other when Ofc. Strodbeck fired. Ofc. Floyd unintentionally fired the Taser when Ofc. Strodbeck fired his rifle, likely due to a stress response. The Taser probes did not strike anyone.

Officers moved the handcuffed suspect, later identified as the hostage, off the landing and down the stairs. Officers quickly moved Mr. Reyes into the adjacent apartment and began lifesaving measures. Emergency medical personnel, who were previously staged near the scene, took over lifesaving measures and transported Mr. Reyes to the hospital. Mr. Reyes died because of his gunshot wounds.

During the ensuing Critical Incident Task Force (CITF) investigation, it was determined that Ofc. Floyd's 40mm less lethal launcher had also inadvertently fired (but did not strike anyone) during the incident.

The hostage told CITF investigators that he resided in the same apartment complex as Mr. Reyes. He said he saw Mr. Reyes outside and asked him for alcohol. Mr. Reyes invited the man to his apartment for alcohol and then became paranoid and aggressive. He said Mr. Reyes threatened him with a knife and held him there against his will. He said he was afraid that Mr. Reyes would kill him. Investigators noted that he was bleeding from two small cuts on his fingers.

An autopsy determined that Mr. Reyes tested positive for alcohol (446 mg/dL) and diphenhydramine (830 ng/mL) at levels considered toxic and potentially lethal at the time of the incident.

SCOPE OF REVIEW

Boise City Code Title 2 Chapter 10 defines the authority and duties of the Office of Police Accountability (OPA). As the City's police oversight entity, the OPA is authorized to investigate and evaluate the conduct of Boise City police officers involved in critical

incidents. Critical incidents include the use of force or any other police or law enforcement action that results in the death of one or more persons, or serious bodily injury requiring hospital admission. OPA is also authorized to make BPD policy, procedure, practice, and training recommendations to the Mayor, the City Council, and the Chief of Police.

BOISE POLICE DEPARTMENT POLICY

- A. 300 Use of Force
- B. 424 Portable Audio/Video Recorders
- C. 319 Standards of Conduct

INVESTIGATIVE FINDINGS

A. CRITICAL INCIDENT TASK FORCE FINDINGS:

After the officer-involved shooting incident, the Ada County Critical Incident Task Force (CITF) was activated, led by the Ada County Sheriff's Department. The CITF conducted a forensic investigation of the scene, interviewed witnesses, interviewed the involved officer, collected dispatch records and audio/video evidence, and produced numerous reports. The investigation was detailed and thorough.

The Gem County Prosecuting Attorney reviewed the CITF investigation and determined that Ofc. Strodbeck's use of deadly force against Mr. Reyes was reasonable and justified under Idaho law.

B. BOISE POLICE DEPARTMENT FINDINGS:

BPD conducted a thorough administrative review of this critical incident, which included reviewing the CITF investigation in its entirety and administrative interviews with the involved officers.

Overall, BPD's administrative review found that while the use of deadly force by Ofc. Strodbeck was within policy, the decisions made in the moments preceding that event led to an avoidable tactical breakdown.

Use of Deadly Force by Ofc. Strodbeck

Ofc. Strodbeck's use of deadly force against Mr. Reyes in these circumstances was objectively reasonable and within policy. Mr. Reyes presented an immediate threat of death or serious injury to Ofc. Strodbeck and others on the landing by charging them while armed with a knife. However, the decision to open the apartment door tactically challenged the team.

At the time the door was opened, Officer Strodbeck believed the victim remained inside the apartment and an immediate welfare concern existed. The team had not yet confirmed the victim's identity or location and was already in a compromised position on the landing. Opening the door based on that mistaken belief eliminated the remaining barrier between officers and the suspect, removed their limited time and distance advantage, and led them into an immediate threat scenario.

The interplay between Ofc. Strodbeck and Sgt. Miles in those seconds reflects a breakdown in command communication. Sgt. Miles had not issued a definitive "hold" or "do not enter" order, and Officer Strodbeck did not verbalize intent prior to acting. This mutual hesitation and lack of clear command authority led to a split-second decision in which tactical initiative was lost.

Ofc. Strodbeck Not Equipped with an On-Body Video Camera

Ofc. Strodbeck was off-duty when he responded to the incident as an SOU call-out. Another officer was detailed to obtain the on-body video (OBV) cameras assigned to each responding off-duty SOU officer from the BPD office. The shooting incident occurred before the OBVs assigned to those officers arrived at the scene.

While responding to a critical event without an OBV is a technical violation of department policy, the finding in this case is exonerated. This was a known limitation within the SOU deployments at the time and has since been corrected with the issuance of additional body-worn cameras to ensure personnel are properly equipped regardless of their response location.

Supervisory Considerations

Lt. Mengel

Lt. Mengel clearly operated as the incident commander but did not announce over the radio that he had assumed incident command. BPD noted that the officer assuming incident command should always make a clear announcement over the radio to that effect. Upon arrival on scene, Lt. Mengel was actively engaged in coordinating with Sgt. Miles and other officers. He provided appropriate guidance, delegated roles, and actively worked to obtain additional resources. He effectively deployed available resources. During this incident, Lt. Mengel complied with BPD policy concerning supervisor responsibilities.

Lt. Poore

Lt. Poore was ending his shift as watch commander when this incident occurred. He deployed to the scene anyway and effectively assisted Lt. Mengel, the incoming watch

commander. Lt. Poore complied with policy and carried out his supervisory responsibilities appropriately.

Sgt. Miles

Sgt. Miles acted in accordance with his training and his role as the react team leader. He recognized that the call could be a “swatting” hoax and actively gathered intelligence to determine the precise location and legitimacy of the call. Sgt. Miles coordinated with the incident commander, formed a react team, designated roles, established a perimeter, requested additional resources, developed contingency plans, utilized the adjacent apartment, and formed an arrest team downstairs. Sgt. Miles also recognized potential crossfire issues and adjusted officers' positions accordingly.

Prior to contact, Sgt. Miles had designated an appropriate arrest and containment location—which was not the second-floor landing. This demonstrated sound planning consistent with react practices.

The unexpected self-evacuation of the male—later confirmed to be the victim—created a rapidly evolving scenario. Although officers reasonably treated him as a potential suspect until confirming otherwise, it is noted that no discussion occurred beforehand regarding the possibility of the victim self-evacuating. This represents a planning consideration for future operations rather than a supervisory deficiency.

When officers took the male into custody on the narrow landing, this constituted a tactical error and created an officer-safety concern. The landing placed personnel in tight quarters directly in front of an uncleared suspect apartment on the second story, limiting movement, reducing reaction time, and placing officers unnecessarily close to a threat location.

However, while tactically unsound, this decision occurred in a time-compressed, dynamic situation and does not rise to the level of a policy violation. Overall, Sgt. Miles maintained communication, exercised supervisory oversight, and acted within department expectations. The issues identified will be addressed in department-wide training.

Unsafe Handling of Less Lethal Weapons by Ofc. Floyd

Taser

BPD's examination of OBV and Taser records reflects that Ofc. Floyd practiced safe handling of his Taser by keeping his finger off the trigger in the moments before the

shooting. However, when the shooting occurred, Ofc. Floyd unintentionally deployed the Taser, likely due to a stress response, depressing the trigger for 4 seconds.

This action violated BPD policy concerning safe weapons handling set forth in Policy 319.5.10 (c). BPD recommended that Ofc. Floyd receive additional training regarding safe handling of the Taser.

40mm Launcher

Ofc. Floyd's 40 mm less lethal launcher discharged inadvertently during the incident. This occurred when Ofc. Floyd was transitioning from his 40 mm to his Taser. The Taser was hanging on a sling around Ofc. Floyd's shoulder and was likely triggered by his own gear due to congestion on the landing. Because Ofc. Floyd had been trained to leave the 40mm in the ready mode during this type of transition, BPD found that his handling of the launcher was not a policy violation. BPD noted that the procedure has since been revised.

BPD recommended that the training division ensure that all officers who are trained to use the 40mm launcher receive the updated training.

Departmental Improvement Areas

Pre-Planning and Scenario Development: Supervisors must plan for multiple outcomes, including unexpected victim/suspect movement and designate safe custody locations prior to contact (when available).

Incident Command Declaration: Ensure verbal incident command identification and clear delegation of tactical control in every critical event.

Command Communication: Establish clear verbal orders before critical actions such as door breaches, searches, or suspect contact. Officers should confirm supervisory intent aloud before acting independently when possible.

Training Emphasis: Expand scenario-based training for react and field supervisors to include victim evacuation, stairwell contacts, and multi-level apartment environments. Sergeants and commanders will serve as supervisors in these role-play scenarios as appropriate to ensure personnel train for the positions they will fill operationally. These updated training elements will be implemented no later than summer 2026.

C. OFFICE OF POLICE ACCOUNTABILITY FINDINGS:

BPD's findings regarding this incident were detailed and thorough. OPA concurs that the use of deadly force itself was justified and with the findings regarding deficiencies in supervisory and tactical operations. In addition, OPA finds two additional policy violations occurred unrelated to the use of deadly force and offers further analysis.

Failure to Activate On-Body Video (OBV)

Officer Strodtbeck did not record the incident on an OBV during a critical incident in which activation is mandatory per BPD Policy 424.6. While it is understandable that a SOU member be deployed quickly from off-duty before the SOU equipment arrives on scene, BPD's OBV policy does not allow an exception for this situation. Policy 424.6 provides that an officer's portable recorder shall be activated in all enforcement and investigative contacts. The policy only qualifies that mandate with a provision stating, "at no time is a member expected to jeopardize his/her safety in order to activate a portable recorder." The policy also provides that the recorder should be activated in all situations as soon as reasonably practicable. This was not a situation in which camera activation would jeopardize an officer's safety. What's left is a mandate to record the incident and a qualifier to do so as soon as practicable. Neither were done in this incident. This failure impeded full documentation of a high-risk and ultimately critical incident. OPA finds this a policy violation.

This finding is consistent with the OPA Use of Deadly Force Report dated April 2024. In that incident, an SOU member deployed from off-duty without an OBV to a high-risk critical incident. OPA noted that BPD Policy and SOU directives required officers to be equipped with and record on their OBV when uniformed and taking enforcement action. Neither the policies nor directives contained an exemption for officers responding while off-duty and without immediate or timely access to their OBV equipment. OPA notes that BPD has remedied this situation and all SOU members are now equipped with duplicate OBVs to ensure all future incidents are appropriately recorded.

Unintentional Discharge of Taser and 40mm Less Lethal Launcher and Unsafe Weapon Handling

BPD found the unintentional discharge of the Taser by Ofc. Floyd violated BPD policy regarding safe weapons handling set forth in Policy 319.5.10 (c) and exonerated Ofc. Floyd on the unintentional discharge of the 40 mm launcher. OPA concurs and offers additional analysis. In addition, OPA finds the weapon handling of Ofc. Goold was unsafe and a violation of Policy 319.5.10.

Taser and 40 mm Discharge:

When the man believed to be the suspect exited the apartment, Ofc. Floyd intended to cover him with the 40mm less lethal launcher. He had previously made the launcher ready to fire by placing it in "single action" mode. Single action mode enables discharge with a lighter trigger pull than when it is in "double action" mode. When it is in double action mode, the launcher can be fired but the trigger pull is heavier requiring more deliberate force by the user to pull the trigger and fire the weapon. Due to the close proximity of the subject, Ofc. Floyd transitioned to his Taser to cover him. Ofc. Floyd had been trained that if an officer needs to rapidly transition from the 40mm launcher to different weapon without firing the launcher, it is acceptable to leave the launcher in single action mode rather than unloading the launcher to return it to double action mode.

After transitioning to the Taser, the 40mm launcher remained in single action mode hanging on a sling around Ofc. Floyd's shoulders. It is likely that an item on the officer's gear belt or tactical vest contacted the trigger, causing it to fire because of the lighter single action trigger setting.

Unsafe Weapon Handling:

Ofc. Gould was assigned lethal cover on the react team and inadvertently pointed his handgun at other officers taking the victim into custody on the landing. BPD found the firearms handling unsafe and inconsistent with department training and protocols. While this was likely a result of taking the victim into custody on the small, crowded landing with inadequate space to effectively manage all roles, this exposed officers to lethal fire and did not comply with BPD training. OPA finds this a violation of Policy 319.5.10.

Supervision and Tactical Operations

This incident evolved over more than 2 hours. During much of that time, crisis negotiators were attempting to contact the suspect, but the event was otherwise static. Supervisors used the time to appropriately plan and assemble resources, as detailed in BPD's findings. During planning however, they failed to plan for the most basic scenario: a compliant subject coming out of the apartment. BPD's upstairs team was in position to react to a crisis event, such as an immediate threat to the hostage's life. The downstairs team was positioned in the courtyard near the base of the stairs. Sgt. Miles correctly assessed that if the suspect suddenly fled from the apartment, it was best to let him run down the stairs and be contained by the downstairs team. He recognized the additional risk and difficulty of the upstairs team trying to subdue a non-compliant or combative suspect on the small landing or the stairs.

When the man believed to be the suspect walked out of the apartment, there was no plan for that situation. The upstairs team reacted with multiple officers giving commands simultaneously, causing confusion and a momentary lack of understanding between the man and the officers. Designating a single officer to communicate would have been more effective and better aligned with BPD training and protocols.

Contrary to the preplanning to send the subject down the stairs to the arrest team, the react team moved on to the small landing and began taking the man into custody. Supervisors' better course of action would have been to intervene and keep to the planned course. Because they were exposed to the uncleared suspect apartment, Ofc. Strodbeck moved onto the landing to cover the door. When Ofc. Strodbeck opened the apartment door he acted based on a reasonable belief that a hostage was inside, potentially stabbed and in need of medical attention. While Ofc. Strodbeck's concern for the hostage's safety was valid, the action was premature. Opening the door at that moment unnecessarily escalated the confrontation, removed the element of control, and exposed officers to immediate lethal danger. Waiting until the handcuffed subject was moved off the landing and officers were coordinated on a plan would have better aligned with BPD training and protocols.

This decision also significantly constrained officers' tactical options and limited their ability to manage the encounter in a coordinated and controlled manner. Ofc. Floyd became entangled in the railing and experienced two unintentional discharges of less lethal weapons. Ofc. Goold inadvertently pointed his handgun at other officers. The resulting loss of coordination was reasonably foreseeable and could have been mitigated had supervisors taken the basic step of planning for the possibility that a compliant person, suspect or hostage, might exit the apartment. Likewise, they did not plan for a negotiated surrender, despite having crisis negotiators on scene and actively working to communicate with the suspect.

When Ofc. Strodbeck opened the apartment door, he called out and identified himself as a Boise police officer. He asked for anyone inside to answer him. Almost instantly he was met by a man 10-12 feet away charging towards him with a large knife. Because of the crowded situation on the small landing, he was unable to retreat or move out of the doorway. Given these facts, Ofc. Strodbeck and the others near him were in imminent danger of death or serious injury when he fired. His use of deadly force was reasonable and compliant with law and policy. Deploying a Taser was not a viable option given his proximity to a rapidly closing deadly threat and the fact that Tasers are not always effective.

Overall, OPA notes that while supervisors appropriately planned for contingencies, assembled and staged resources, delegated roles, and otherwise complied with de-escalation policy by actively managing the situation, there were notable supervisory and tactical shortcomings. OPA finds that while none of these issues alone constitutes a policy violation, their cumulative effect significantly reduced operational effectiveness and contributed to a chaotic environment in the moments leading up to the shooting.

To address the supervisory and tactical concerns, OPA recommends BPD continue to emphasize scenario-based training to ensure all supervisors perform in supervisory roles with repetitions in timely and appropriate decision making in dynamic situations. In addition, scenarios should include situations in which separate react and arrest teams are needed (when adequate resources are present). OPA also recommends trainers continue to emphasize in every training session that when delegating roles, a specific officer is designated to give verbal commands and the other officers must exercise discipline in holding their own roles and not contribute to the communications.

POTENTIAL CONTRIBUTING FACTORS AND MITIGATION EFFORTS

During the CITF investigation, individuals known to Mr. Reyes reported a history of depression, illegal drug use, severe alcohol abuse, and suicidal ideations. On October 25, 2024, just over two weeks prior to this incident, Mr. Reyes poured gasoline over himself and his vehicle, while threatening to light himself on fire. Co-workers assisted in resolving the incident and seeking care. Law enforcement was not involved.

On the day of the shooting incident, Mr. Reyes had telephone contact with family members wherein he appeared extremely intoxicated, paranoid, and agitated. Mr. Reyes left a voice message for a friend indicating his desire to die that day. Undoubtedly, substance abuse and mental health challenges were escalating and heightened at the time of the incident and were contributing factors in this case.

In responding to the call, officers quickly determined it was a hostage situation and not a "swatting" hoax. They used a variety of resources to determine the location of the call, which was initially vague. Officers implemented appropriate de-escalation protocols, including attempting to contact and negotiate with Mr. Reyes for over two hours.

While BPD and OPA noted operational deficiencies and opportunities for focused training, these factors did not create the outcome. Mr. Reyes engaged in threats of violence, was significantly impaired by alcohol, failed to cooperate, and aggressively advanced on officers while armed with a large knife. The use of deadly force was necessary.

CONCLUSION AND RECOMMENDATIONS

The incident underscores the need to reinforce tactical discipline, communication standards, adherence to arrest and contact-cover principles, safe weapon handling, and consistent use of on-body video. These improvements can enhance officer safety and operational effectiveness in future high-risk incidents.

OPA commends BPD for its thorough review, critical analysis, and ongoing efforts to enhance supervisory development and engagement at all levels.

LINK TO DOCUMENTS

The Critical Incident Task Force report, the officer body-worn camera video, and BPD news releases of this critical incident may be viewed at:
<https://www.cityofboise.org/departments/police/critical-incidents/> under “2024Critical Incidents” and “November 10, 2024.”

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