CITY OF OAKLAND
COMMUNITY POLICE REVIEW AGENCY

PRE-DISCIPLINE MEMORANDUM

CPRA Case Number	Date of Sustained Finding	Subject Officer/Serial No.
20-0646		Richard Vierra (ret.), 7641

Date of Hire	Date of Promotion (if applicable)
04/04/1996	Unknown

Sustained Allegation(s)

If multiple sustained allegations, list allegations in order starting with the most severe penalty range.

Sustained MOR Violation	1st, 2nd, or 3rd Offense?	Discipline Matrix Penalty Range
MOR 398.77-1 – Refusal to Provide Name or Serial Number	1st	S3-T
MOR 370.27-1 – Use of Physical Force	1st	C-T
MOR 285.00-2 – Supervisors – Authority and Responsibilities	1st	C-S5

5-Year Disciplinary History

Confirm incident date of sustained finding(s): May 31, 2020

Date Prior Discipline Imposed	MOR Violation (Number & Section Title)	Discipline
832.7 (b)(4)		

Other Relevant Corrective Action

Based on review of Supervisory Notes File

Date	Circumstances
None	None

Overall Performance Evaluation (prior two years)

Year	Overall Appraisal	Year	Overall Appraisal
	Unknown		Unknown

Aggravating Factors	Mitigating Factors
X The misconduct was willful and deliberate.	__ The misconduct was not willful and deliberate.
__ The misconduct involved gross negligence or recklessness.	__ The misconduct involved minor negligence or recklessness.
__ The misconduct was premeditated.	**X** The misconduct was not premeditated.
X The officer had a primary and/or leadership role in the misconduct.	__ The officer had a secondary and/or minor role in the misconduct.
Based upon one or more of the following factors, the officer knew or should have known that their actions were inappropriate: **X** Length of Service __ Experience **X** Policy Directives __ Inherent nature of the act	Based upon one or more of the following factors, the officer may not have reasonably understood the consequences of their actions: __ Length of Service __ Experience __ Policy Directives __ Inherent nature of the act
__ The officer was <u>not</u> forthright and truthful during the investigation.	__ The officer was forthright and truthful during the investigation.
__ Serious consequences occurred or may have occurred from the misconduct.	__ The misconduct did not result in serious injury or harm.
__ The misconduct resulted in serious injury.	__ The officer accepts responsibility for their actions.
__ The misconduct was committed with malicious intent or for personal gain.	__ The officer is remorseful. __ The officer reported the harm caused and/or independently initiated steps to mitigate the harm caused in a timely manner.
X Multiple sustained findings from one incident.	__ Commendations received by the officer.

Additional Factors
Additional factors that may be considered include, but are not limited to: threat posed to integrity of Department; degree of culpability; severity of the misconduct including multiple violations; departmental training and standards; professional standards, training, policies, and practices; service to the citizens of Oakland; dedication to the Department; other relevant factors. ***Provide narrative of any additional factors considered:*** The factors checked above apply to the most serious sustained MOR violation: Refusal to Provide Name or Serial Number. The narrative below discusses additional application of these factors to the other sustained findings.

Discipline Matrix Review

Most serious sustained MOR Violation (meaning MOR violation with highest penalty range)	Discipline Matrix Penalty Range	Mid-Point
MOR 398.77-1 – Refusal to Provide Name or Serial Number	S3-T	S16

Proposed Discipline (Narrative Summary)

CPRA staff recommend Termination.

Lt. Vierra struck Complainant with his Asp expandable baton, knocking her to the ground. He then stood near her for several minutes while she repeatedly requested his badge number. He was required to respond, but did not.

CPRA finds by a preponderance of the evidence that Lt. Vierra's failure to provide his name or serial number was willful and deliberate. Lt. Vierra was close enough to hear the requests, there was no evidence suggesting that anything interfered with his ability to hear, he acknowledged at least one of the requests immediately, and he later acknowledged to a third party that Complainant had made the request. This was given a moderate amount of weight as an aggravating factor.

Lt. Vierra had a primary and leadership role in this particular misconduct. He was a command officer leading a company of Mobile Field Force squads. Multiple officers who reported to him were in the vicinity and could have observed and modeled his inappropriate behavior. This was given a small amount of weight as an aggravating factor.

Lt. Vierra knew or should have known based on his experience (almost 25 years, and substantial time as a supervisor) and policy directives that this particular conduct was inappropriate. OPD directives are clear on this issue. As a supervisor, Lt. Vierra was charged with knowing and implementing those directives. This was given a small amount of weight as an aggravating factor.

Lt. Vierra's decision not to provide his name or serial number was likely not premeditated. However, this was not found to be a meaningful factor in relation to this type of MOR violation because the duty to provide name and serial number is triggered by someone else's request. As a result, this was given no weight as a mitigating factor.

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During this same incident, Lt. Vierra had multiple sustained findings.

Lt. Vierra had one sustained finding related to two out-of-compliance uses of force. Both of these uses of force involved striking individuals with his Asp baton, under circumstances that did not justify such a high level of force. While these technically carry a slightly wider penalty range than the failure to provide his name and serial number, CPR found these to be the most severe and concerning violations in this case.

- Both uses of force were willful and deliberate. Lt. Vierra said that he intended to hit both individuals with his Asp, and that he made these decisions after performing a Graham v. Connor analysis of each use of force.
- Lt. Vierra had a primary and leadership role in both uses of force. He was a command officer and was leading a company of Mobile Field Force squads. He was the only OPD member to use (or even draw) his Asp or baton during the incident. But officers who reported to him were in the vicinity or learned about the use of force from Lt. Vierra shortly afterward; all of them could model his inappropriate behavior.
- One of the uses of force resulted in serious injuries to the force subject. Lt. Vierra struck Complainant in the face with his Asp. This caused a through-and-through cut to Complainant's lip that required 14 sutures, and it fractured and loosened her teeth.
- One of the uses of force involved gross negligence or recklessness. Lt. Vierra said he meant to strike Complainant but didn't mean to strike her in the face (which is also contrary to training). Even if this were true, Lt. Vierra deployed his Asp without ensuring that he had sufficient control or aim: he swung his Asp backhanded, from a position of imbalance (which is contrary to training), while reaching across an obstacle, and while stretching to reach Complainant.

As a result, this sustained finding for use of force was given a very large amount of weight as an aggravating factor.

Lt. Vierra also had one sustained finding for failure to properly supervise (Class II).

- He had a primary or leadership role in the supervisory misconduct. Even though Lt. Vierra was not the only supervisor who failed to properly supervise, Lt. Vierra was the primary Lieutenant during the incident; he was the Lieutenant assigned to lead the squads at issue; and the CPRA investigation determined that his inappropriate conduct likely influenced the other supervisor's inappropriate conduct during the incident.
- Additionally, serious consequences may have occurred as a result of this misconduct. Lt. Vierra was leading multiple squads of officers through an hours-long series of complex incidents. This required effective communication and quick deployment of resources. His failure to communicate with his subordinates and failure to direct their activities increased the risks faced by all officers working with him and by all community members they encountered during the incident.
- His failure to supervise created a situation in which he had the opportunity to engage in the other sustained conduct. Because he was running into the fray and engaging in contact with suspects instead of taking a Lieutenant-level view of the situation and managing/directing resources, he suddenly had the

opportunity to use force that would be unusual for a command officer. For the same reasons, he suddenly was in a position where the Complainant had a reason to request his badge number.

- On the other hand, during the five years before this incident Lt. Vierra received multiple positive SNF entries related to the quality of his supervision and leadership/coordination during complex incidents. (16N-03714, 16N-09881, 16N-10971, 18N-01499, and 20N-00922.)

As a result, this sustained finding for failure to supervise was given a small amount of weight as an aggravating factor.

Lt. Vierra retired before he could be interviewed by IAD or CPRA, and declined to participate in an interview after his retirement. He did provide a statement to CID before his retirement, and the CPRA investigation determined that there were serious concerns about whether Lt. Vierra was forthright and truthful during that interview. However, the CPRA investigation was not able to reach a preponderance of evidence on this issue. The CPRA investigation was also not able to determine whether Lt. Vierra was remorseful or took responsibility for his actions. As a result, none of this was given any weight as an aggravating or mitigating factor.

Considering the multiple sustained findings – and in particular the seriousness of the sustained uses of force – the appropriate discipline is Termination.