

Senate Committee On Judiciary and Ballot Measure 110 Implementation  
Chairman, Senator Floyd Prozanski  
Vice Chair, Senator Kim Thatcher  
Member, Senator Michael Dembrow  
Member, Senator Sara Gelser  
Member, Senator Dallas Heard  
Member, Senator Dennis Linthicum  
Member, Senator James Manning, Jr.

HB2513 is scheduled for 11 May 2021. I offer the following for your consideration and response.

Fourteen police reform bills are before the 2021 legislature. All have merit. Two address training specifically. HB2513 addresses the recognition and intervention for those suffering from severe mental illness using crisis intervention modules and for those in cardiorespiratory distress. HB2162 authorizes research into and changes in training, with a focus on equity.

I am unable to identify provisions in these bills that address escalation, fatalities, near misses, prevention, quality, and sentinel events. These form the foundation for assessing errors and failures that can result in death and harm and ultimately interventions to prevent disasters. The National Police Foundation safety initiative references them and historically the airline (1931) and health care industries have relied on these methodologies for decades.

Why does it matter? We know some officers, when faced with a point of contact crisis, struggle to distinguish between a mobile device and a gun their firearms and tasers, or whether or not to employ force, even perhaps deadly.

I recommend our legislators query police executives about the content and processes of their crisis intervention modules. Do they emphasize mitigation and de-escalation? Do they include in-depth and repetitive real

time simulations of encounters where split second decisions are matters of life and death? How are officers certified and re-certified and how often?

We must provide our police with the necessary training to enforce law and order in ways that protect crime suspects, citizens in harm's way, and the police. If we fail, our communities and our police force are protected and served as need be. It makes us challenge the assertion, "I have never seen a police reform bill that I could not support," (Oregon legislator 2021).

Sincerely,

david.a.nardone  
Hillsboro, OR 97124-5094  
House District #30 - Representative Sollman  
Senate District #15 - Senator Riley

<https://www.theatlantic.com/technology/archive/2016/12/aviations-opaque-definition-of-the-near-miss/509027/>  
*How Airlines Decide What Counts as a Near Miss*

*Safety experts have known the value of near-miss tracking and root-cause analysis in preventing tragedy since at least 1931, when engineer Herbert William Heinrich theorized in *Industrial Accident Prevention: A Scientific Approach* that there were 300 near-misses for every 29 accidents and every one serious accident or fatality. In Heinrich's model, the near-miss incidents are the bottom of a pyramid, the accidents are the next level up, and the fatal accidents are at the top.*

<https://www.policefoundation.org/leo-near-miss/>  
*Law Enforcement Officer (LEO) Near Miss Officer Safety Initiative*  
*The National Police Foundation developed a voluntary and anonymous reporting system that enables law enforcement personnel to read about and anonymously share stories of close calls or "near misses." A near miss is defined as a situation where a law enforcement officer could have been seriously injured or killed, but*

*harm or death was averted. Each near miss incident provides lessons learned to protect other officers who encounter similar situations, but only if the incident was reported and shared. Our mission is to enable and encourage law enforcement personnel to share their near miss experiences so the lessons learned from them can be used by other officers and incorporated systematically into agencies' training, policy, and equipment decisions to prevent injuries and fatalities.*

<https://pubmed.ncbi.nlm.nih.gov/29763131/>

*Medical Error Reduction and Prevention*

*Medical errors are a serious public health problem and a leading cause of death in the United States. It is challenging to uncover a consistent cause of errors and, even if found, to provide a consistent viable solution that minimizes the chances of a recurrent event. By recognizing untoward events occur, learning from them, and working toward preventing them, patient safety can be improved.*

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4475608/>

*Near Misses and Their Importance for Improving Patient Safety*