

Evaluation of King County Sheriff's Office: Policy, Practice, and Review Mechanisms for Officer-Involved Shootings

Systemic Review of June 14, 2017
Officer-Involved Shooting of Tommy Le

September 2020

Presented by:
Michael Gennaco
Stephen Connolly





323-821-0586
7142 Trask Avenue | Playa del Rey, CA 90293
OIRGroup.com

Facts are stubborn things; and whatever may be our wishes, our inclinations, or the dictates of our passion, they cannot alter the state of facts and evidence...

John Adams, 1788

Introduction

On June 14, 2017, Tommy Le was shot and killed by a deputy of the King County Sheriff's Office ("KCSO") who had responded with other deputies to a 911 call regarding a man possibly armed with a knife. Following the shooting, no inquest was held into the matter, nor was there a formal opinion by the King County Prosecuting Attorney Office regarding the justification of the shooting. Fourteen months after Mr. Le's tragic death, the KCSO Use of Force Review Board reported its findings to the Sheriff. The Board determined that the shooting had been in policy, and it identified no tactics, decision-making, training, supervision or any other issues worthy of study or remediation.

This report, commissioned by the King County's Office of Law Enforcement Oversight ("OLEO") and prepared by OIR Group¹, focused on KCSO's investigative and administrative review mechanisms. The goal is to assess the objectivity and thoroughness of fact collection and the rigor of the subsequent internal review of KCSO actions.

In furtherance of that goal, we reviewed the investigative materials to determine whether KCSO's investigative policies and practices allowed for the development of a body of evidence that was adequate to the task of appropriately scrutinizing the involved deputy's actions and decision-making. We further reviewed those materials to learn whether current KCSO protocols provided for effective collection of evidence, scene maintenance, and timely post-shooting provision of medical care. We also examined KCSO incident review

¹ Since 2001, Michael Gennaco and Stephen Connolly of OIR Group have worked exclusively with government entities in a variety of contexts related to independent outside review of law enforcement, from investigation to monitoring to systems evaluation. As part of their oversight responsibilities for numerous jurisdictions, Gennaco and Connolly have reviewed scores of officer-involved shootings and devised recommendations to improve attendant investigative and review practices.

OIR Group is particularly familiar with KCSO as it has previously reviewed OLEO policies and protocols, provided technical support for the County Auditor's review of KCSO's early intervention system, and examined KCSO's complaint review process for uses of force. The early intervention and complaint review reports resulted in a number of recommendations implemented by KCSO. Most significantly, Gennaco and Connolly performed a systemic review of the deputy-involved shooting of Mi'Chance Dunlap-Gittens; they presented their findings and recommendations in a February 2020 report.

materials and protocols in order to learn whether those systems properly facilitated the ability of the Sheriff's Office to learn from critical events and adjust its practices to strengthen future performance. Finally, and based on our evaluation of the attributes and limitations in the current model, we devised recommendations to improve relevant KCSO policies, practices, and protocols – thereby promoting not only appropriate accountability but also the identification and dissemination of beneficial “lessons learned.”

Based on our review, we found that there were serious gaps in the KCSO investigation into the officer-involved shooting of Tommy Le. Not coincidentally, it was also the case where only a handful of issues for further action or remediation were identified. This marked a significant contrast to our assessment of the Dunlap-Gittens matter, where a number of substantive issues emerged during the internal review process (though they were, unfortunately, not acted upon, as our earlier report explained.) In Le, the incomplete factual record and the lack of rigor in the review process left little for the Use of Force Review Board to consider systemically. However, with regard to even the handful of suggestions that were identified, the Review Board process did not formally adopt them and no systemic changes derived directly from KCSO's review of the incident.

Moreover, the Use of Force Review Board did not fully utilize or grapple with those critical facts that it did have at its disposal. It did not plainly or clearly distill key aspects of the evidence into its summary report. Nor did it conduct an exacting assessment of the threat level presented to the on-scene deputies during various phases of the incident. Most significantly, the Review Board did not expressly consider and discuss the fact that Le was likely running away from the deputy at the time the bullets struck him – a key factor in any valid assessment of whether the level of threat to him, his fellow deputies and the on-scene civilians was sufficiently high for the discharge of the deputy's firearm.

In short, we noted problematic gaps in the areas of fact collection, identification of systemic issues, follow through on the suggestions that were identified and scrutiny of the shooter deputy's decision-making. These procedural shortcomings cast doubt on the substantive legitimacy of KCSO's internal outcomes: namely, that no accountability, learning or remediation whatsoever resulted from the agency's review of the Le shooting.

This report is intended to delineate these gaps and identify significant issues that could and should have been the focus for the Use of Force Review Board. The report also recommends remedial actions that should have sprung from KCSO's internal review process and devises recommendations to improve both the investigative and review process.

It is important to note that the current investigative and review structures have the *capability* to accomplish both a thorough and objective factual record and a robust, constructive review. However, in the two deadly force incidents we have reviewed, KCSO

fell short of reaching this potential and producing the sort of accountability, learning and remediation that an agency should demand of those entrusted with these critical functions.

This report, then, has both substantive and procedural observations about the underlying incident and KCSO's ultimate responses to it. We are hopeful that KCSO leadership considers this analysis and recommendations in the constructive, forward-looking spirit with which they are issued. An objective and thorough collection of the facts of a serious incident is indispensable for an effective review process. And an effective review process allows for accountability, learning, and course correction. When both elements are in place, the result is an effective feedback loop that better prepares that agency for similar future challenges, enhances officer safety, and potentially reduces incidences of deadly force. This report, in conjunction with our report of the Dunlap-Gittens shooting, is intent on further developing a framework within which KCSO can achieve each of these vital objectives.

OIR Group Methodology

As part of its review, OIR Group reviewed the investigative and review file provided to OLEO. We reviewed reports, photographs, testimony, and the underlying recorded interviews of witnesses and involved deputies. Unfortunately, we were not afforded the opportunity to talk with KCSO personnel responsible for the investigation and review of the incident.² We have included this step in the hundreds of prior shooting reviews we have conducted, across numerous different law enforcement agencies. The opportunity to go “beyond the documents” in this way provides important insight and perspective, thereby increasing the ultimate value of the assessment. In spite of this, and disappointingly, KCSO chose to not make its investigative and review board personnel available. On a forward going basis, we implore KCSO to create protocols so that the insight of key personnel involved with the investigative and review process can be considered during future independent systemic reviews. As a result, we reiterate the recommendation we made in Dunlap-Gittens:

² KCSO apparently misreads our request as an interest in speaking to the deputy involved in the Le shooting. We had no interest in speaking to that deputy but did have interest in speaking to KCSO detectives responsible for investigating the shooting and review board members responsible for reviewing the incident.

While we were not afforded the opportunity to speak with any KCSO member responsible for the investigation and review of this matter, to its credit and unlike our Dunlap-Gittens experience, KCSO did provide a written response to the draft report. We were grateful to receive that written feedback and the report was improved as a result. However, receiving written feedback is a poor substitute for the opportunity to have a dialogue with individuals actually involved in conducting the investigation and review of a deadly force incident.

RECOMMENDATION 1: KCSO should develop protocols to ensure that key personnel in the investigative and review process are made available to any authorized independent systemic review.

We were advised that the articulated reason that KCSO chose not to make its personnel available to this systemic review was fear of compromising its position in ongoing litigation.³ This approach is shortsighted and inconsistent with progressive risk-management practices. Those practices teach that any immediate litigative concerns should not take precedence over opportunities to create long-term systemic improvements to enhance future performance; moreover, the willingness to engage and improve can actually be advantageously presented in the context of any given lawsuit.

In fact, the law also embraces this philosophy and has developed doctrine so that any systemic improvement that an agency engages in cannot be used by litigators to the detriment of the organization. A law enforcement agency's "remedial measures," whether in the form of training, policy improvement, or systemic review, should not and need not kowtow to any existing lawsuit. Instead, any such efforts designed to improve the law enforcement agency and decrease the likelihood of a future deadly force recurrence should be embraced and implemented.

RECOMMENDATION 2: KCSO should not use concerns about pending litigation to avoid cooperating in any review mechanism designed to improve agency performance during and after critical incidents.

³ After we issued our systemic report in the Dunlap-Gittens shooting, we were advised that KCSO declined to respond in detail, citing ongoing litigation as the reason for not doing so.

Factual Summary

On June 14, 2017, deputies were dispatched to investigate a disturbance involving a man with a knife. The witness who first called 911 reported he had been assaulted by a man holding what he believed to be a knife. Later the same witness reported that he was not sure that the man who aggressed on him had used a knife but described him holding a pointed object. The witness further reported that the man may have mental health issues, as he articulated that he was the “creator.” As deputies arrived, they also learned that another individual had discharged a weapon as a warning to an individual approaching him with what he believed to be a knife and had then called 911 to report the incident.

Deputy A was the first deputy to arrive at the location. He waited for backup and Deputies B and C soon arrived. Deputy A reported that he saw a group of people in the front yard of a residence with one of them holding a firearm. Deputy A directed the man to put the gun on the ground; the man complied. The man admitted to firing the warning shot to scare away the man who had aggressed him with a knife.

Deputy A then heard Deputy C behind him yelling “drop it.” He turned and saw a man fitting the description of the assailant (later identified as Tommy Le) moving quickly toward Deputy C with his hands clenched. Deputy A then holstered his firearm, drew his Taser and moved towards Deputy C and Le to assist. Deputy A reported that Le disregarded Deputy C’s orders and that he then heard Deputy C deploy his Taser, which had no apparent effect on Le. Deputy A said that instead Le ran directly at him while making grunting sounds, with a clenched fist raised over his head.

Deputy A reported that he believed that Le had a knife in his clenched fist and deployed his Taser. Deputy A reported that at the same time, he stepped back and sideways to move out of Le’s path, trying to create distance and space. According to Deputy A, this second Taser deployment also had no apparent effect on Le, who kept running toward him and the other individuals on scene. Deputy A reported that he holstered his Taser as he continued to back away and began to draw his firearm. Deputy A reported he then heard 3-5 shots coming from Deputy C’s direction and Le fell to the ground near his feet. Deputy A reported that he kicked the object out of Le’s hand and observed that it was a pen. He immediately began to apply first aid to Le.

Deputy C indicated that he was the third deputy to arrive on scene and approached Deputy A and B as they talked to a group of people. Deputy C reported that shortly after his arrival on scene, he observed a man later identified as Tommy Le moving quickly in his direction with both fists clenched. Deputy C reported that he drew his Taser and ordered Le to stop. Deputy C reported that Le held a pointed object in one clenched fist. Deputy C reported that Le ignored his commands.

Deputy C reported that he fired his Taser, which had no apparent effect on Le as he continued to advance. Deputy C reported that he moved backward to create distance while the man began moving quickly toward Deputy A. Deputy C reported that he heard Deputy A ordering the man to stop and heard Deputy A's Taser deploy. Deputy C reported that he saw Le keep advancing, so he drew his firearm and holstered his Taser while backing up. Deputy C reported that he stepped back and to the right as Le came very near to him and to his left. Deputy C reported that he feared for his own life, that of Deputy A, and of the nearby civilians, and he fired 3-5 shots until he felt he could no longer do so because of back drop and danger to others. Deputy C reported that Le then fell to the ground, close to Deputy A.

The investigation revealed that Deputy C actually fired six rounds, with three rounds striking Le. Deputy A performed CPR on Le, medics were called and responded and Le was transported to the hospital, where he expired from the wounds he had received.

The autopsy report found the following handgun wounds:

- Wound of the left lateral back, bullet recovered from chest wall.
- Wound of the medial left back, bullet recovered from right lateral chest wall.
- Wound of the left wrist, exit wound palmar left hand.

After the incident, the Sheriff's Office released information inaccurately reporting that Le was shot because he was attacking deputies with a knife or some type of sharp object.⁴

⁴ Because the initial misinformation released by KCSO about this incident has already been addressed in a prior report, we will not delve deeply into the previously stated concerns about how such misinformation can erode public trust in the ensuing investigation and review. See, "Transparency and Media Relations in High-Profile Police Cases," Brechner Center Issue Brief, June 2018. However, we do discuss below a recurrence of the problem as it pertained to the public information that was shared about the results of the KCSO investigation and review.

Investigative Issues

No Determination of Criminality

As noted above, no inquest was conducted into the actions of the involved deputy nor did the Prosecuting Attorney make a determination regarding the criminality of the shooting. This lack of action stemmed in part from a County decision to temporarily halt inquests because of concerns that had been raised about the narrowness of the inquiry regarding the officer's intent. A proposal was then advanced to endeavor to broaden the inquiry. However, lawsuits lodged by several entities, including KCSO, have to date prevented implementation of the recommended reforms to the inquest process. Recently, and to its credit, the City of Seattle has dropped its legal challenges.

In our twenty years of experience reviewing officer-involved shootings, this is the first occasion we have encountered in which there has been no formal review of the deadly force's legality. It is ironic that efforts to make the inquest process more objective and increase perceptions of legitimacy have instead resulted in *no* criminal determination, at least for this case. Law enforcement agencies, law enforcement officers', and family members objections to the inquest process to the side, King County must have a process in place so that when a peace officer in the County shoots and injures or kills a member of the public, there is a prompt determination about the criminal legality of the use of deadly force.

RECOMMENDATION 3: The County should continue to work towards a solution so that there is a prosecutive determination in every officer-involved shooting which results in a fatality or a wounding of an individual.

Treating a Witness Officer as an Involved Officer

Under KCSO investigative protocols, involved officers and witness officers are treated significantly differently.⁵ Witness officers are interviewed the date of the incident while

⁵ We are aware that recent state law now requires criminal investigations to be conducted by agencies, completely independent of the involved agency and the creation of independent

involved officers are given up to 48 hours to prepare a written report. In this case, while there was only one deputy who used deadly force, a deputy who was a witness to the use of deadly force was treated as an involved officer, apparently because of his deployment of the Taser.

The decision to treat the witness officer in this case as an involved officer during the criminal stage of the investigation does not hold logically or analytically. While the Taser deployment is a use of force, that level of force is not what subjected the Le shooting to a criminal investigation by detectives, it was solely the actions of the shooter deputy that did so. The deputy who deployed his Taser prior to the use of deadly force should not have been treated as an involved officer during the KCSO criminal investigation.⁶

When the Le matter transitioned to an administrative review, Deputy C and Deputy A's Taser use should have been evaluated by the Use of Force Review Board since it involved decision-making and actions leading up to the use of deadly force. Deputy A's decision to use force and kick the pen out of Le's hand after he went down should also have been evaluated by the Review Board both to determine the appropriateness of the force and whether it was the optimal way to separate the pen from Le.

RECOMMENDATION 4: KCSO should modify its General Orders to make clear that only officers who use deadly force are to be treated as involved officers during the criminal aspect of the investigation.

RECOMMENDATION 5: KCSO should modify its General Orders to make clear that any lesser use of force relating to a deadly force incident should also be administratively evaluated by the Review Board.

Timing of Fact-Gathering of Involved and Witness Officers

To KCSO's credit, Deputy B, the on-scene deputy who did not use force and other deputies who were just arriving on scene as the shooting commenced were interviewed by Sheriff's Office detectives within hours of the deputy-involved shooting. However, the deputy who used deadly force instead submitted a compelled written statement about his actions and observations a day after the incident and was not interviewed until five weeks

investigative teams. However, KCSO will still be responsible for conducting an administrative investigation and review of the actions of its employees and should do so consistent with the recommendations contained herein.

⁶ The exception would be the rare occasion when the initial review of the incident indicated that the lesser use of force might amount to a criminal assault. There is no information in KCSO's investigative file that detectives had reason to believe that either unsuccessful Taser deployment amounted to such.

after the incident. Similarly, the on-scene deputy who deployed his Taser only submitted a compelled written statement a day after the incident, and no interview of him occurred until five weeks after the incident. It is unclear from the statements whether the two deputies collaborated or received assistance from their legal representatives in preparing their reports.⁷

As we stated in our Dunlap-Gittens review, a written statement, no matter how detailed, is never an adequate substitute for an interview.⁸ In a written report, the decision about what and how many details to include rests entirely with the writer. Written reports, unlike interviews, also preclude the ability to ask follow-up questions. When facts are gathered through written reports, choices about what issues to address are left to the discretion of the writer; when an interview occurs, the areas of inquiry are determined by the interviewer. Moreover, unlike an interview, a written statement can be edited, reviewed, and supplemented by the member's legal representative before being submitted. In matters of critical importance such as an officer-involved shooting, best practices always dictate conducting an interview over collecting written statements.

The five-week delay before KCSO interviewed the shooter deputy and the witness deputy who deployed his Taser is also far from consistent with best practices. It is critical for the agency to learn immediately about the officers' actions, decision-making, and observations. Obtaining a "same shift" statement is essential to any effective officer-involved shooting investigation. This is true because of the value of a "pure" statement that is relatively contemporaneous and untainted by subsequent input. Obviously, the five weeks passage of time before either deputy was interviewed prevented KCSO from obtaining a pure and contemporaneous statement. Moreover, because the five-week delay before interviewing the deputies is so contrary to normal investigative protocols, these special procedures for officers involved in shootings creates a perception among many segments of the community that police investigating police have adopted unique and favorable protocols when investigating their own.

Special rules such as these only serve to reinforce skepticism about the rigor and objectivity of such investigations. Until the investigative process provides for real-time

⁷ The Sheriff's Office suggests that the point raised here suggests an aspersion to "inappropriate collusion" by the deputies in preparing the report. We cast no such aspersions in that it is unclear under current KCSO protocols whether deputies are even prohibited from receiving assistance from counsel or other deputies prior to preparing their report. Our point here is that a timely interview provides a preferable method of collecting information about an involved deputy's observations and decision-making including eliminating the risk of influence from outside sources.

⁸ In our experience, it is the rare law enforcement agency that allows an officer who uses deadly force to write a report first instead of being interviewed.

interviews of deputies involved in a shooting, much of the public that KCSO serves will not have confidence in its approach or outcomes.⁹

We have been advised that KCSO has routinely delayed interviews of involved personnel under the supposition that recollection is improved over time. However, objective research has debunked this notion. See, for example, “What Should Happen After an Officer-Involved Shooting? Memory Concerns in Police Reporting Procedures,” *Journal of Applied Research in Memory and Cognition*, 5 (2016) 246–251, Rebecca Hofstein Grady, Brendon J. Butler, and Elizabeth F. Loftus. While KCSO maintains that proponents of delay nonetheless continue to exist, those advocates are largely limited to either police associations or those who regularly defend police in officer-involved shootings. And importantly, none of them contend that a five-week delay, as occurred here, provides the best time frame for conducting such interviews to maximum effect.¹⁰

RECOMMENDATION 6: KCSO should revise its protocols to eliminate its practice of allowing deputies involved in shootings to submit a written report in lieu of a timely interview.

RECOMMENDATION 7: KCSO should revise its protocols so that an interview is conducted of members involved in shootings prior to end of shift.

Interviews of Involved and Witness KCSO Personnel Not Videotaped

As we stated in our Dunlap-Gittens review, because officer-involved shootings are usually dynamic events in which the positioning, gesturing, hand movements of, and use of diagrams or drawings by both subjects and personnel are often critical to the analysis, the reviewing body would be advantaged by video recording the interviews of personnel. This approach has become relatively standard in civil depositions for the reasons stated here.

In this case, most of the civilian and deputy witnesses were not video-taped. For the interview of the involved deputy and one witness deputy, the interview was videotaped but

⁹ To be clear, we are writing about investigative protocols as they impact KCSO’s internal investigative processes and not about the criminal investigation and review. KCSO deputies have the right (which they universally seem to exercise) not to provide voluntary statements and interviews to criminal investigators. But for purposes of the internal investigation and review, KCSO could and should develop protocols to ensure an administrative interview from their members on the night of the incident.

¹⁰ To the degree that the recommended changes in this Report require discussion with KCSO employee associations, it is urged that such discussions begin in earnest.

only depicted the arms and hands of the witnesses as they moved items on a diagram. We reiterate our recommendation in Dunlap-Gittens that the interviews of involved members and deputy eyewitnesses to a deputy-involved shooting be video-taped.

RECOMMENDATION 8: KCSO should revise its investigative protocols so that the accounts by involved and witness members of an officer-involved shooting are videotaped.

Investigative Gaps in Fact Collection

Involved Deputy's Written Report

Deputy C wrote that shortly after arriving on scene, he saw a male who appeared to be agitated and who had his hands clenched into fists. He wrote that the male was walking at a very fast pace in his direction. Deputy C wrote that the man matched the suspect description.

Deputy C further wrote that as the man came closer, he could see that he had a “dark, pointy object in one of his hands.” Deputy C wrote that he told the suspect to stop and get on the ground. The deputy wrote that the suspect did not comply with his commands and instead, looked around, ignoring his commands. Deputy C wrote that the man then made a sudden movement towards him, with his hands clenched in a fist, holding a “pointy dark object” in his hand near his mid-chest. Deputy C wrote that he pulled out his Taser and again told the man to stop and get on the ground. Deputy C wrote that the suspect did not comply and instead advanced towards him, so he deployed his Taser.

Deputy C reported that the Taser was not effective in stopping the suspect. Deputy C wrote that he believed that he pulled the Taser trigger a second time, but it still had no effect. Deputy C reported that the suspect continued to approach him at a fast pace with the object still in his hand. Deputy C wrote that he started walking backwards to get out of the way. Deputy C reported that as he was backing up, he saw Deputy A approaching on his left, through his peripheral vision. Deputy C wrote that he then heard Deputy A tell the suspect to stop and get on the ground, but the instructions had no effect on the suspect. Deputy C reported that he saw that Deputy A had his Taser out and deployed it, but that the Taser was ineffective in stopping the suspect. Deputy C reported that he then unholstered his handgun and holstered his Taser.

Deputy C wrote that at this point, he was in fear for his life, the lives of his partners and the other individuals who had been present. Deputy C reported that he believed that earlier the suspect had tried to attack someone with a knife. Deputy C wrote that the man had also ignored the deputies' commands and was approaching in a fast and aggressive manner, quickly closing the distance between himself, Deputy A and himself, while still holding a

pointy object in his hand. Deputy C reported that it was necessary to stop the man and that his only option was using his firearm. Deputy C wrote that he fired at the suspect, who kept moving forward at a fast pace. Deputy C wrote that he fired approximately 3-5 times around the torso area. Deputy C reported that the suspect took a few more steps and collapsed.

Witness Deputy's Written Report

Deputy A reported that when he arrived on scene, he first dealt with the civilians whom he observed and instructed one of them to place down a gun he was holding. As the civilian complied and he began to talk with him, Deputy A reported that his attention was drawn to Deputy C yelling commands at a male. Deputy A wrote that the man appeared angry and agitated with clenched fists at his side. Deputy A reported that he could not see if the man was holding anything.

Deputy A reported that he holstered his firearm, drew his Taser and ran towards Deputy C to assist. Deputy A wrote that he then heard a loud "pop" consistent with a Taser being deployed. Deputy A reported that he observed the male with his right hand raised above his head while now running at a full sprint towards him.

Deputy A reported that when the male was about 5-7 feet in front of him, he was yelling, not saying words but grunting and screaming. Deputy A said he could see there was something in his right hand. Based on the information from the call and what the civilian had told him, Deputy A reported that he was fearful the man had a knife in his raised hand and was going to stab either him, another officer or the civilians behind him. Deputy A wrote that he deployed his Taser and tried to step out of the man's path. Deputy A reported that the Taser did not stop him, and that the man instead pivoted, running in a different direction toward other deputies and civilians.

Deputy A reported that he believed the suspect was a great threat to his partners and the civilians on scene based on the following factors: that he had just been told that the man had attacked civilians with a knife, that he had charged at him with something in his fist, and that he was still running in the direction of other deputies and civilians. Deputy A wrote that he thought the man's intent was to kill or seriously injure someone on scene and made the decision it was necessary to shoot him in order to stop his attack.

Deputy A wrote that he then placed his Taser in his holster and, as he was drawing his gun, he heard 3-5 gunshots. Deputy A reported that he then saw the suspect stumble towards the ground and saw Deputy C behind the suspect holding his gun.

Witness Deputy's Initial Interview

Deputy B told investigators that he arrived on scene shortly after Deputy A and the two deputies first addressed the civilians, one of whom was seen to carrying a firearm. To their credit, detectives had Deputy B draw a diagram showing the positioning of deputies, vehicles, and civilians during the incident. According to the map and Deputy B's statement, it shows Le's initial path towards Deputies B and C but that Le was not moving in the direction of either deputy when he was shot. Deputy B's diagram is not to scale, but it also depicts him a considerable distance away from Le at the time of the shooting, with two patrol cars between them. Finally, Deputy B's map shows the civilians in the front of a house even farther away from Le, with Deputy B positioned between Le and the civilians. Despite the concerns about Deputy B's safety reported by Deputies A and B in their written reports (and Deputy C's articulated partial justification for his use of deadly force), nowhere in Deputy B's interview did he express fear for his life because of Le.

Interviews with Shooter and Witness Deputy

The interviews of the shooter deputy (Deputy C) and witness deputy (Deputy A) were terse, with almost no follow up questions. The interviewers essentially asked the deputies to tell their story. The interviews of Deputy C and Deputy A were both less than 17 minutes long. During their respective interviews, the deputies were asked to use discs and car facsimiles to show the positioning of deputies and Sheriff's Office vehicles during critical times of the incident. During his interview, Deputy A placed discs in a way that indicated Le was moving away from Deputy C – and not coming directly towards Deputy A – at the time the deadly force occurred.

However, there were no follow up questions about this demonstration in the interview. Nor was the interview transcribed, summarized or documented in any follow-up investigative reports.¹¹ As a result, unless the Use of Force Review Board members actually reviewed the video recording of the interview, there would have been no realization that Deputy A had essentially demonstrated that Le was not aggressing either himself or the shooter Deputy at the time deadly force was used.

By the time the interview of Deputy C occurred, the detectives knew that the two shots that had struck Le's body mass had entered from his back. Yet the detectives asked no questions of Deputy C to account for this fact.

¹¹ The failure to either transcribe or summarize Deputy A and Deputy C's interview stands in sharp contrast to the deputy and significant civilian witness interviews that were conducted close in time to the incident which were all transcribed. It is problematic that the most important interviews conducted during the investigation were neither transcribed nor summarized.

For a thorough investigation to have occurred, the following questions should have been asked of Deputy C:

- When did you realize that Le was carrying a pen at the time of his encounter with you?
- If you had known that Le was not carrying a knife but a plastic pen would you have used deadly force?
- Was Le advancing in your direction or moving away from you when you used deadly force?
- Was Le advancing in Deputy A's direction when you used deadly force?
- What did you mean when you wrote that Le continued to keep moving forward as you used deadly force?
- Did you mean that Le was continuing to move forward away from you?
- If Le was moving away from you at the time you shot him, how did he constitute a serious threat to you at that time?
- Did you see Le ever move towards Deputy A after you deployed the Taser and before you used deadly force?
- Did you see Le ever move towards Deputy B after you deployed the Taser and before you used deadly force?
- Do you know whether Deputy B was between Le and the civilians and in a position to protect them should Le have changed course and run towards the civilians?
- Did you ever see Le move towards the civilians on scene after you deployed the Taser and before you used deadly force?
- Did the fact that at least one of the civilians was armed affect your assessment of their safety?
- What formed the basis for your determination that you needed to use deadly force in order to stop the threat that Le presented to others on scene?
- Considering the positioning of Le and the other deputies and that Le was moving away from you, was there time for you and the other deputies to further protect yourself, themselves, and the on-scene civilians without resorting to deadly force?
- Did Le's slight stature present other options besides deadly force by which to neutralize any threat?
- What were the potential back drop issues that you indicated you were concerned about that caused you to stop firing at Le?
- Can you account for why several of the rounds you fired were off target and struck the residence across the street?

In a thorough interview, Deputy A would have been asked the following questions:

- If you had known that Le was not carrying a knife but a plastic pen would you have been preparing to use deadly force as you heard gunshots as you wrote in your report?

- Was Le advancing at Deputy C when Deputy C used deadly force?
- You wrote that Le pivoted after you deployed your Taser and began running in a different direction. Does that mean that Le was not advancing directly at you when Deputy C used deadly force?
- You wrote that after Le pivoted in a different direction from you, there were deputies and civilians in the new direction he was running and when Deputy C used deadly force. Who were the deputies you were referring to?
- Was Le advancing on Deputy B when Deputy C used deadly force?
- If so, how far was Le from Deputy B when Deputy C used deadly force?
- Was Le advancing on the civilians when Deputy C used deadly force?
- If so, how far was Le from Deputy B when Deputy C used deadly force?
- Who was in the most danger from Le when Deputy C used deadly force?
- If Le was moving away from Deputy C and not moving in your direction when deadly force was used, who was in imminent peril at the time that deadly force was used?
- Would there have been other options for the on-scene deputies short of deadly force considering that Le was moving away from Deputy C, not moving towards you, not close to Deputy B and not close to the civilians?
- Did Le's slight stature present other options besides deadly force to neutralize any threat he may have presented?
- Do you know whether Deputy B was between Le and the civilians and in a position to protect them should Le have changed course and ran towards the civilians?
- Did you ever see Le move towards the civilians on scene after Deputy C deployed the Taser and before Deputy C used deadly force?
- If not, what formed the basis for your determination that you needed to use deadly force in order to stop the threat that Le presented to others on scene? Did the fact that the civilians possessed at least one firearm affect your assessment about their safety?
- Considering the positioning of Le and the other deputies and that Le was moving away from you, was there time for you and the other deputies to further protect yourself, themselves, and the on-scene civilians without resorting to deadly force?

As detailed above, because the involved deputy and witness deputy were not subjected to an interview until five weeks after the incident and because the interviews were so truncated, critical questions about their observations and decision-making were never asked. As a result, the Review Board was forced to fill in the information gaps with assumptions about those observations and decisions.¹² And most significantly, the Review

¹² Because no inquest was held, the involved and witness deputies were not subject to the examination that occurs during that process. As a result, it was even more costly that the internal

Board was not presented with a clear picture of what Le was doing and where he was moving in relation to the on-scene deputies and civilians when the shooting occurred. Because critical facts were not collected and clearly presented to the Review Board, there was not and could not have been a full reckoning of the decision to use deadly force.¹³ The superficial interviews and lack of clear reporting did not meet minimum standards expected of trained investigators.¹⁴

RECOMMENDATION 9: Before a presentation is made to the Review Board for consideration of an officer-involved shooting, a detective supervisor should review the interviews of involved and key witness personnel, evaluate whether the interview sufficiently addressed the key considerations of deputy observations and decision-making and return the matter to detectives for supplemental interviews as needed.

RECOMMENDATION 10: All interviews of involved deputies and key witnesses should be transcribed and/or summarized for inclusion in the investigative file and presentation to the Review Board.

No Remedial Action Taken Regarding Failure to Collect Taser Evidence

As noted below, the Use of Force Review Board reported that it discussed the failure of the two Taser deployments to have any effect on Le. The Board was advised that because the

interview process failed to provide the Review Board with a full account of the deputies' observations and actions.

¹³ The Sheriff's Office suggests that these questions actually may have been asked of the deputies during their appearance during the Review Board. However, because no recording or account of what the deputies told the Review Board was ever prepared, there is no way to reconstruct that process. It is critical that the fact collection of deadly force incidents be painstakingly documented, which is why interviews are universally recorded by virtually all law enforcement agencies. The evanescent appearance of deputies before a Review Board cannot and should not ever be considered a substitute for a recorded account of their actions and decision-making.

¹⁴ A KCSO sergeant reported that he arrived on scene shortly after the incident and asked Deputy A and Deputy C questions about the incident in order to complete the Supervisor Checklist for Deputy-Involved Shootings. The Checklist is intended for a sergeant to collect preliminary information from involved personnel and then provide to the detectives when they arrive on scene. In response to the question about whether the suspect was armed, the sergeant checked "Unknown". The detectives should have interviewed the sergeant about why he checked "Unknown" and what the involved and key witness deputy advised him that caused him to complete the form as he did.

Taser probes and wires remained attached to Le and traveled with him to the hospital, they had apparently already been discarded by either ambulance or hospital personnel when detectives eventually attempted to procure them. As a result, the department's Taser expert said he was limited in his ability to offer insight on why the Taser deployments proved ineffectual.

While this observation was made and documented in the Review Board summary, there was no concerted effort to change protocols to prevent future recurrences.¹⁵ Generally, after an officer-involved shooting, one or more KCSO personnel travel to the hospital to monitor the condition of the wounded individual. Making such personnel responsible for engaging with emergency and medical personnel as needed to preserve such evidence would presumably be an easy and effective solution. The Review Board did not develop such an action plan, but KCSO has the ability to ensure critical evidence retention by doing so now.¹⁶

RECOMMENDATION 11: KCSO should modify its investigative protocols to ensure that any potential evidence that travels to the hospital is promptly collected by personnel who are dispatched to accompany a wounded individual.

Over-emphasis on Investigating the “Knife” Issue

While, as described above, there were large gaps in crucial fact collecting regarding actions and decision-making of key deputy personnel, an outsized number of detective hours were devoted to whether Le possessed a knife in the time when he encountered the civilians before the deputies arrived on scene. What is clear is that Le was not, in fact, carrying a knife when he encountered KCSO deputies and was shot and killed. What is also clear is that the information transmitted to deputies while they were on their way to the call was that Le had a knife in his possession and had used it to aggress two civilians. Though the evidence suggests that the civilians may have misinterpreted the pen in Le's hand as a knife, it also establishes that the deputies were informed by dispatch that the man had a knife and therefore had reason to believe it.

It was appropriate to ask the civilians about their observations during their interviews and whether they believed Le was carrying a knife when they encountered him. It was also

¹⁵ Nor, as discussed elsewhere, did the Review Board formally consider the suggestions set out in the ART Memo to require a Taser expert to attend autopsies when a Taser is deployed or that a Standard Operating Procedure be written for the Taser Coordinator.

¹⁶ Interestingly, the on-scene sergeant was commended by the Review Board for his post-incident management.

appropriate to conduct a scene search to locate any knife that may have been discarded by Le before he encountered the deputies. And it was appropriate to learn from witnesses whether Le went back into his residence between the time he encountered the civilians and the deputies.

However, the detective reports demonstrate efforts well beyond these investigative steps. For example, detectives retrieved knives from Le's residence and showed photographs of them to a civilian witness to see if he could identify the knife as the one Le was holding when he was accosted, even though the weight of the evidence suggests that Le did not go back into his residence between his initial encounter with the civilians and his subsequent encounter with the deputies. And then detectives took a mold of a door that a civilian reported that Le struck with a sharp object and sent it to a lab to determine whether the marks were caused by a knife or a pen.

The lengths to which KCSO detectives sought to learn whether Le actually possessed a knife during his encounter with the civilians stands in sharp contrast to the short-shrift devoted to the other and more critical aspects of the encounter, namely the on-scene deputies' actions and decision-making. The fact that deputies were advised via radio that Le was possibly armed with a knife was important to consider; it increased the potential threat level that Le presented to them, even if he did not, in actuality, possess a knife. However, whether Le ever actually had a knife during his encounter with the civilians is less relevant in assessing the deputies' actions once they arrived on scene. Had investigators taken the same pains to capture the specifics of deputy conduct and decision-making, KCSO reviewers would have been better equipped to perform their evaluative function.

Moreover, this obsession with whether Le had a knife when he aggressed the civilians extended to KCSO's public statements about the incident. As noted above, initial public reports inaccurately stated that Le had a knife when he encountered deputies. And two months after the Use of Force Review Board convened, the Sheriff's Office issued a public release of the Board's findings. In that release, KCSO included photographs of knives taken from Le's room and emphasized that two civilian witnesses had identified a photograph of a butterfly knife as resembling what they believed they observed in Le's hand before deputies arrived on scene. What was not included in the public release was that the weight of the evidence suggested that Le never returned to his room between his encounter with civilians and his encounter with KCSO deputies, making the fact that knives were found in his residence essentially irrelevant.

RECOMMENDATION 12: Detectives entrusted with investigating officer-involved shootings should ensure that the actions and decision-making of the involved deputies constitutes the focal point of investigative efforts.

RECOMMENDATION 13: KCSO's public release of information should emphasize both scrupulous accuracy and an objective framing of facts in light of their relevance.

Outstanding Crime Lab Issues

A review of the investigative reports indicate that a number of requests were sent to the crime lab, including a cast taken of a door and knives retrieved from Le's residence to determine whether they may have caused the damage.¹⁷ The investigative file also includes the following additional requests for laboratory examination:

- Test casings and bullets to determine if fired by Deputy C's firearm
- Test marijuana blunt and blotter paper for illicit substances (PCP/LSD)
- Submission of Le's clothing to determine firing distance

In the investigative file that we reviewed, there was no follow up with regard to those additional three requests.¹⁸

Whenever a request is made of an outside laboratory to conduct an examination of evidence related to an officer-involved shooting, the file should reflect any results of those requests. In cases in which the request was withdrawn, the file should note that fact.

RECOMMENDATION 14: KCSO should develop written protocols instructing detectives that when they make requests of the crime lab, the results of the crime analysis should be included in the file. If the result is non-determinative or the request is withdrawn, the file should so indicate.

¹⁷ The Review Board noted that at the time it convened, this request was still outstanding but determined that it could proceed before receiving the results of this examination. The Board noted that the results of the examination could be included in the investigative file when it became available, but there was no subsequent entry in the file. We were later provided lab reports that indicated the examination of the cause of damage to the door was inconclusive.

¹⁸ When we made inquiry regarding these three outstanding requests, the only lab report produced was the results of the blotter paper test for illicit substances.

Administrative Review – Shortcomings and Concerns

Failure to Identify and Ensure Implementation of Systemic Issues: The ART Report

In our review of the Dunlap-Gittens shooting, we commented favorably on the myriad of systemic issues that the Administrative Review Team (“ART”) Report identified relating to planning, training, protocols, policies, tactics, decision-making, equipment, investigation, and supervision. We also commented favorably in that report about how the ART review recommended remedial actions designed to address each of the systemic findings through further policy development and training.

In sharp contrast, the ART reviewer who responded to the scene and was assigned to the Le shooting identified relatively few actionable issues as follows:

- Deputy C told the ART reviewer he would have preferred to have had a newer model Taser.
- Deputy A told the ART reviewer that the training from “Below 100”¹⁹ was helpful with stress management after the incident and believed it would be beneficial for all KCSO members.
- The ART reviewer wrote that he thought it would be beneficial to have a representative of the Taser Team to help the lead detective and Medical Examiner identify Taser related markings and indicated that there should be policy requiring a Taser representative attend the autopsy.
- The ART reviewer also wrote that the Sheriff’s Office Taser Coordinator suggested writing a Standard Operating Procedure regarding the functions of the on-scene Taser Coordinator.
- The ART reviewer recommended that the ART function be removed from the Internal Investigations Unit because of the “stigma” that accompanies that unit and how it makes deputies reluctant to participate in administrative reviews.

¹⁹ “Below 100” is a training initiative that aims to reduce the line of duty deaths for law enforcement officers to below 100 per year.

In every situation, performance, decision-making and the overall handling of the event should be subject to exacting review and issue identification. Such a process is needed to serve the interests of both accountability and agency improvement. Here, in a case with multiple officers, several decision points, and a fatal outcome, it seems clear that an appropriately rigorous assessment would have provided the Review Board with more than five systemic topics to discuss. The Sheriff's Office should re-frame its expectations of the systemic reviewers to ensure a baseline of thoroughness and rigor.

RECOMMENDATION 15: KCSO should devise protocols to ensure that responsibility for reviewing a deadly force incident is understood to entail careful, holistic, and objective scrutiny of all aspects of the encounter.

The Use of Force Review Board

Findings

Approximately one year after the incident, a Use of Force Review Board²⁰ was convened. Pursuant to current General Orders, the Board is to convene within 45 days after the completion of an inquest or after the decision by the King County Prosecutor's Office not to refer criminal charges against any of the involved deputies, whichever comes later. However, because neither event occurred in this case, KCSO eventually took the initiative to convene a Board. This is to the credit of the Sheriff's Office. If it had chosen to literally follow its General Orders and wait for the criminal review to conclude, KCSO's administrative review would still be pending.²¹

In this case, per KCSO protocols and according to the Review Board summary, the involved deputy and the deputy who deployed his taser appeared at the Review Board hearing and answered questions about their actions and decision-making. However, there

²⁰ Under current KCSO protocols, the Use of Force Review Board is now called the Critical Incident Review Board.

²¹ To its credit, the King County Police Officers Guild similarly did not object to this appropriate deviation from KCSO General Orders.

is no information in the summary, or any other document, about what questions were asked of the deputies and what information was provided.²²

As we stated in our systemic review of the Dunlap-Gittens case, it is unusual in our experience for involved officers to appear and provide such evidence before a reviewing board.²³ By the time the deputies appeared, they had also provided a written statement and had been interviewed by KCSO detectives.

The Review Board summary noted that the Taser model used by Deputy C could not provide information of whether contact was made. The summary further noted that the different Taser model used by Deputy A could record such contact information, but there was no indication of contact in the downloaded data. KCSO's Taser expert opined that it was likely that at least some of the Taser probes made contact due to the condition of some of the wires, but the evidence was not conclusive. The summary noted that attempts to recover the Taser wires for evaluation from medics and from the hospital were not successful.

The Review Board summary indicated that evidence was presented regarding the likely position of Deputy C when he shot and where the shots struck, although it does not detail the particularities of that evidence.²⁴ The summary further noted that the Board heard evidence from the lead detective on the results of the autopsy, wounds, and cause of death, but does not include any specific information about the entry of the bullet wounds.²⁵

The Review Board summary reported that in answer to the question "was the use of force justified or unjustified, regardless of the tactics or choices leading to the use of force," the Board voted unanimously that the use of deadly force was justified in that Le caused

²² As we discussed above, the Review Board questioning of the deputies is not recorded, nor is a document produced reflecting the questions asked and information provided.

²³ We discuss our impressions of this practice below.

²⁴ KCSO's Administrative Review Team Memorandum indicated that Le was struck by at least two rounds to his "torso".

²⁵ The Sheriff's Office suggests that this passage presumes that discussion was not had at the Review Board about the location of gunshot wounds. That is not the presumption of this report; the point here is that the Review Board summary did not expressly note that the fatal wounds to Le entered in the back.

The Sheriff's Office further notes that the General Orders have changed regarding what information is to be included in the summary report but provided no explanation how those changes would now ensure express inclusion of these important facts on a forward going basis.

Deputy C to believe that “if not stopped, [Le] posed a serious threat of harm to Deputy C, Deputy A, and the residents standing nearby.”

The Review Board summary also noted that the Review Board unanimously found that there were no reasonable alternatives to the use of force. The Board opined that:

Control holds and other defensive take-downs create a risk of harm from the weapon, in this case a pen, as well as the risk that the deputy’s firearm will be grabbed by a suspect and used against the deputy or others.

In reviewing the delivery of medical aid to Le, the Board found that Deputy A provided first aid to Le immediately after the shooting and that first aid was rendered and provided appropriately. The Board noted that the aid kit Deputy A possessed did not have the optimal material to place over and seal bullet wounds. The Board summary noted that this issue was currently being addressed by the Advanced Training Unit and extra material was to be provided to current Care Under Fire kits.

The Review Board summary noted that it was “unclear” whether there were any issues identified with equipment with regard to the ineffective deployments of the Tasers. The summary noted that the Sheriff’s Office had entered into an agreement to upgrade all its Tasers.

We have been advised by the Sheriff’s Office that the ART representative made a presentation at the Review Board. However, the Review Board summary expressly noted that the Administrative Review Team investigation had no significant additional information to provide to the Board. With the exception of the Taser upgrade discussion, there is no reference in the Review Board summary to any deliberation whatsoever about the remaining four topics that were raised in the ART memorandum.

In addition to the above and according to the Review Board summary, the Board unanimously voted “yes” in affirmation of the following claims:

- The shooting was intentional.
- The deputy’s choices leading up the event were sound.
- Inadequate or improper training was not a contributing factor to the event.
- Policies and procedures were followed after the event.
- There were no violations of policy related to the use of force.
- There were no identified issues with supervision or command.
- There were no issues identified with communications.
- There were no issues identified with policies or procedures.
- There were no policy violations identified not associated with the use of force.

Two months after the Use of Force Review Board convened, the Sheriff's Office issued a public release of the Board's findings. In that release, KCSO included photographs of knives taken from Le's room and that two civilian witnesses had identified a butterfly knife as resembling what they believed they observed in Le's hand before deputies arrived on scene.

Moreover, the public release contained the following language:

Although deputies and witnesses were convinced Le had a knife, it is not clear that events would have evolved differently if deputies realized that Le held a pen. A pen can be used as an improvised weapon. Aimed at vulnerable parts of the body, like the face or throat, it can cause serious bodily injury if used to stab someone.²⁶

Composition of Critical Incident Review Board

The current KCSO General Orders designates members of the former Use of Force Review Board, newly termed the Critical Incident Review Board.²⁷ Voting members of the Board include a Union representative appointed by the bargaining unit of the member under review and the Department's Legal Advisor. For either to have a vote on the propriety of the reviewed member's conduct and performance is inconsistent with their customary role.

Union representatives are obligated to advocate for their members for all employment matters, including accountability and discipline. Asking such individuals to fairly and objectively evaluate the performance of their members, as participation in this process should entail, requires them to step out of their roles as advocates and into a quasi-judicial role. The expectation that a Union representative could effectively navigate those inconsistent roles is unfair. Moreover, the participation of a Union advocate in a vote about the propriety of deadly force undermines public perceptions of objectivity, regardless of the substantive merits of the advocate's views.

Legal Advisors' usual role is captured in their title: they provide legal advice to the organization. Traditionally, a bright line is created between those providing such advice and the actual decision-makers, so as to preserve the ability of each to contribute in focused and clearly delineated ways. Incorporating the Legal Advisor into the voting body

²⁶ We discuss the problematic nature of these public statements below.

²⁷ In its written response, the Sheriff's Office suggests that we are unaware of changes to KCSO General Orders since the Le incident. This section and others that follow expressly discuss many of the changes implemented in KCSO's review of critical incident policy and how -- while improvements over the former General Orders -- they inadequately address review of force issues identified in our Dunlap-Gittens report and restated herein. The Sheriff's Office response fails to note how other any other changes in use of force policy impact the conclusions or findings of this report.

blurs those lines and threatens to dilute the unique value that counsel should be bringing to the process.

RECOMMENDATION 16: The Sheriff’s Office should modify its General Orders so that participation by Union representatives and Legal Advisors in the Critical Incident Review Board is limited to a non-voting role.

Artificial Limitation on Circumstances to be Considered in Determining Whether the Use of Deadly Force is Justified

The question asked by the Review Board in the Le shooting eliminated important factors that should be considered in determining whether the force was justified. To be specific, the question set out in the General Order: “Was the use of force justified or unjustified, regardless of the tactics or choices leading up to the use of force?” expressly instructs the Board to disregard members’ tactics or choices in determining whether the force was justified. However, instead of being disregarded, those facts are expressly *included* in the “totality of circumstances” analysis that shapes contemporary best practice in force review. The question as currently written not only discourages but overtly restricts the Board’s ability to frame its justification analysis with the proper inclusive scope.

RECOMMENDATION 17: KCSO should amend its General Order so that the Critical Incident Review Board is instructed to opine on the following question: Was the use of force justified or unjustified in light of the totality of the circumstances, including the tactics and decision-making that preceded the force?

Lack of a Mechanism for Implementation and Follow Through

As we wrote in our systemic review of the Dunlap-Gittens matter, it is also apparent that KCSO’s shooting review structure had no ability to ensure implementation and follow through of any recommendations advanced by its own critical incident review process. Whether it be training, policy development, or equipment review, there was no structure for developing an “action plan” and assigning it out for implementation. There was also no mechanism for ensuring that any assignments – and their subsequent fulfillment – are reported back to the leadership of the organization. Simply put, there was no formal mechanism under current protocols to ensure implementation for even the most worthwhile of ideas.

Without action, even insightful identification of issues and potential solutions is of no lasting benefit to a law enforcement organization. Someone must chart a path forward and ensure that the talk results in improvement. Unless there is a mechanism for ensuring that

worthwhile suggestions are turned into action items, as we stated in our Dunlap-Gittens review, those ideas are destined to die on the vine. While disappointingly the Le review did not produce the same breadth of suggestions that emerged from the Dunlap-Gittens process, the ones that did certainly merited follow up. For example, the Board noted that the first aid kit used in the Le matter lacked important supplies that could have been helpful in attending to Le's injuries, and that future first aid kits were destined to include such supplies. It would have been helpful for the Board to help ensure that a specific plan was promptly implemented by assigning to someone the responsibility for execution and reporting back.

The Review Board further noted that because there was no timely retrieval of the Taser wires from medical responders and/or hospital staff, and that evidence was therefore not available for forensic examination. But it took no systemic measures to prevent such similar losses in the future. The Review Board could have and should have assigned a member responsibility for modifying investigative protocols to address this circumstance in future critical incidents. (See Recommendation 11, above.)

Other issues identified by the ART Review also did not apparently end up being discussed by the Review Board and/or no action plan was devised for implementation. There was no apparent discussion about the suggestion by Deputy C to provide the "Below 100" training to all KCSO members. There was similarly no apparent discussion regarding the suggestion to have a KCSO Taser expert attend autopsies in which Tasers are deployed nor any discussion about creating a Standard Operating Procedure for the on-scene Taser coordinator. While we were advised that the recommendation to move the ART team out of the Internal Investigations Unit was accepted and implemented, there is no discussion of the recommendation in the Review Board memorandum and no indication that the Le review caused that change to occur.²⁸

Accordingly, much like in the Dunlap-Gittens review process, the Le review process did not involve a systemic review, discussion, and documentation of the ART recommendations nor did the Review Board formally consider, vote, or accept those recommendations. To the degree that any of the systemic recommendations resulted in improvement, it appears that those improvements were already in process and/or not directly a result of the Review Board meeting. And the suggestions to have a Taser coordinator attend autopsies where a Taser is used, creating a Standard Operating Procedure for Taser coordinators, and a suggestion to export certain training to the whole Sheriff's Office were not considered or endorsed and allowed to again "die on the vine".

²⁸ As noted elsewhere and according to the Review Board summary, the Taser upgrades were already in process by the time of the Review Board and apparently did not come about as a result of the Le Review Board process. And according to the ART Memo, the suggestion to move the ART program out of the Internal Investigations Unit had already been made repeatedly.

To reiterate: the infrastructure that can turn ideas about systemic reform into actual improvements is a necessary component of any functional review process. In its public response to our Dunlap-Gittens systemic review, the Sheriff's Office indicated that KCSO had already addressed these articulated concerns by the recent change in the General Orders that created a Review Board Coordinator. However, a close look at the revised General Order shows that while the Review Board Coordinator is a positive development, as currently written the Coordinator position cannot achieve the reforms sought by the Dunlap-Gittens systemic review and re-emphasized here.

The responsive General Order, 6.02.045 now states:

REVIEW BOARD COORDINATOR RESPONSIBILITIES:

The Review Board Coordinator will be responsible for:

1. Taking comprehensive notes of the Board hearing.
2. Documenting the votes per voting member, and reasons for dissenting votes.
3. Assisting the Chair with drafting the final Findings and Recommendations memo to the Sheriff.
4. Ensuring the records relied upon in the Board hearing are preserved in IAPro.
5. Monitoring and documenting completion of recommended actions, and ensuring such documentation is preserved in IAPro.

While the creation of a Coordinator position is helpful to ensure that the above tasks are accomplished, a review of the functions of the Review Board Coordinator show that they are more ministerial than managerial in nature. The General Order 6.02.045 imparts to the Coordinator neither the responsibility nor the authority to go beyond the delineated (and useful) functions and actually ensure that intended projects for reform are staffed, pursued, and completed.

Accordingly, we recommend that the General Orders be modified as follows:

Upon the conclusion of the Review Board meeting, the Chair will designate a specified attendee the responsibility of implementing any agreed to recommended actions, along with a time certain for completion of the task.

The Chair will be personally responsible or designate personal responsibility to an individual with command authority to ensure that personnel assigned implementation of the recommendations are both successful and timely.

RECOMMENDATION 18: KCSO should devise protocols to ensure that any recommendations accepted by the Use of Force Review Board (and endorsed by the Sheriff) are implemented by:

- Assigning the responsibility of implementation to specific KCSO personnel.
- Delegating a KCSO command staff member the responsibility of ensuring effective and timely implementation.

Involved Officers' Direct Involvement in the Review Board Process

As detailed above, bringing in the involved personnel and asking them directly about various aspects of their decision-making is a curious aspect of KCSO's Review Board. The appearance of the deputies is not tape-recorded and a detailed record of the "Q & A" is not systemically captured. Similar to the Dunlap-Gittens review, in the Le case, both the involved deputy and a deputy who did not use deadly force but deployed his Taser provided their recollection of events and answered questions from the Board.

The participation of involved personnel seems to be an attempt to provide the Review Board the opportunity to inquire about decision-making in ways that go beyond the initial interviews. It also theoretically presents an opportunity for the involved deputies to use their own experiences in providing feedback on ways to improve the organization's response to similar challenges.

As well-meaning as this concept may have been, we do not see it as an effective vehicle for improving the process or its outcomes. As stated throughout this report, we agree that the initial interviews, conducted for purposes of the criminal investigation, leave significant areas un- or underexplored. However, the practice of inviting involved personnel into the Review Board meeting at the very end of the process, and under circumstances that would seemingly inhibit candor on all sides, does not provide a reliable means of filling these information gaps and producing a more comprehensive assessment.

Instead, as in our review of the Dunlap-Gittens matter, we renew our recommended approach of formal administrative interviews for each involved personnel and critical witnesses. This method, adopted by many agencies, ensures an effective and efficient fact-gathering process that provides needed information to reviewers and avoids the stilted dynamics of "in the moment" questioning in front of a Review Board. And, though there is much potential value in having involved personnel share ideas about organizational response to critical incidents, a more effective method would be to include that component as an after-review debriefing.

In December 2019, the General Orders were modified in an apparent effort to limit routine appearances by involved members before the Critical Incident Review Board:

Statements and interviews will normally serve as sufficient evidence so that members under review will not be called to testify at the Review Board, however if it is determined that a member's presence is required, those members who are ordered to appear before a Critical Incident Review Board shall do so.

The General Orders further indicate that members are able to call any witnesses on their behalf and have an attorney present during the proceeding.²⁹

While the subsequent modifications to the Review Board are a move in the correct direction, the option that the Board retains to call members before the body is still problematic for the reasons stated above. And the ability of members to call witnesses to the Board could result in turning the Board from its design and intent as a "review" body to a "factfinding" one.

If the Review Board believes additional information about the incident from KCSO members is needed for full review, it could and should order a follow up formal interview to uncover those facts rather than relying on the informal appearance still contemplated by the revised General Order.³⁰

RECOMMENDATION 19: KCSO should revise its protocols to completely eliminate the participation of involved personnel in the Use of Force Review Board process.

Providing Feedback to Involved Personnel

As noted above, KCSO's changed process appropriately reduces occasions for the Review Board to directly engage with involved personnel as part of the decision-making process and response. That being said, as we stated in the Dunlap-Gittens review, there is significant value to a process of providing information *to* involved personnel regarding

²⁹ Prior to the December 2019 General Order modifications, legal counsel would ordinarily not be present during Review Board meetings.

³⁰ The Sheriff's Office maintains that this process has changed so that deputies no longer testify at boards, and instead are interviewed thoroughly in advance to prepare a complete record of their statements ahead of the actual hearing. While that may be so for the majority of cases, the language of the *current* General Order plainly states that "those members who are ordered to appear before a Critical Incident Review Board shall do so."

specific issues considered and addressed by KCSO internal reviewers.³¹ We suggest that one knowledgeable participant be assigned to provide an objective, unvarnished debriefing to involved personnel at the end of the process. In that same forum, the involved individuals could share their own perspective on the investigative and review process, as well as suggestions for improved future performance and readiness.

The current General Orders fail to adequately address the recommendation in the Dunlap-Gittens systemic review and reiterated here relating to a full debrief of involved members. The GOM 6.01.055 (1)(c) currently states that the commander shall, “Upon notification of a justified shooting from the Critical Incident Review Board, ensure that the involved member receives appropriate acknowledgement.”

A mere “acknowledgement” of the findings of the Review Board falls far short of the potential advantages of the more robust interaction we envisioned: one where the involved personnel are given constructive insight about identified issues and findings, and have the chance to offer their own observations in return.³²

In order to remedy these deficiencies in the current General Order, we recommend consideration of the following additional language:

The Chair will also designate a specified attendee the responsibility of meeting with involved members and providing both a complete debriefing of issues raised during the Review Board process and an opportunity for members to provide their insights and perspectives.

The Chair will be personally responsible or designate personal responsibility to an individual with command authority to ensure that personnel assigned do timely conduct the debrief to involved members.

RECOMMENDATION 20: KCSO should routinely assign a Review Board member the responsibility to provide detailed feedback to involved personnel regarding decision-making or tactical issues raised during the Review Board meeting, as well as to offer a forum for deputies to share their experience of the review process.

³¹ As we stated in our Dunlap-Gittens review, in situations involving policy violations and potential discipline, any debriefing should be tailored to ensure that the formal accountability process is not compromised.

³² In 2018, OLEO made a similar recommendation for a “tactical debrief” to involved and supervisory KCSO personnel but the recommendation was not implemented.

Methods to Export Learning to KCSO Personnel

As noted above, the administrative review process should examine any deadly force incident through the prisms of accountability, policy, tactics, equipment, and supervision. In addition to any finite changes in policy, protocols, practices, equipment, and training regimens, the agency should also provide a “debrief” to all personnel on lessons learned. Such a protocol would be beneficial for its own sake, but also as a remedy for the “locker room talk” – always incomplete and often inaccurate – that we have found fills the void when agencies do not affirmatively debrief their key issues.

Through the issuance of training bulletins and other debriefing mechanisms, progressive law enforcement agencies ensure that all members can benefit from the lessons gleaned from critical incidents. Law enforcement’s traditional leeriness about closely analyzing key events – in part a function of intended deference to involved personnel and in part a cultural aversion to perceived “Monday morning quarterbacking” – is commonplace. But it causes agencies to miss out on important opportunities for improved future performance.

RECOMMENDATION 21: KCSO should develop mechanisms designed to openly discuss “lessons learned” from any deadly force incident as a means of enhancing the ability of all members to meet future challenges.

Review Board Process: Unanswered Questions

Questions re Deputy C’s Application of Deadly Force

As discussed above, there were significant gaps in the information collected during KCSO’s investigation of the on-scene deputies’ decision-making that preceded the use of deadly force, especially with regard to the observations and actions of the shooter deputy and most critical witness deputy.³³ These gaps would have presented challenges to any

³³ The Sheriff’s Office notes that an OLEO representative was present for the Review Board and had the opportunity to participate in questioning the involved deputies. KCSO further asserts that in the Review Board, deputies answered extensive questions posed by Board members, including the OLEO representative, and that the deputies filled in any potential information gaps at that time. However, with the only record of the Review Board proceeding being the summary which contains no information whatsoever of any specific additional information the deputies may have related,

review body in carrying out its responsibilities. Here, the Review Board could have and should have returned the investigation for a more extensive interview of the shooter deputy and the key witness deputy. However, as detailed below, even within the constraints of an incomplete factual record, the Review Board fell far short of a robust analysis of the events and the deputies' performance.³⁴

Lack of Articulated Plan

The Review Board failed to evaluate whether the on-scene deputies sufficiently articulated a plan on how to handle the call. While the Board complimented the deputies for how they handled the initial response and singled out for praise Deputy C's decision to position himself where he could observe if the subject returned to the scene, there was no evidence that the three on-scene deputies ever devised or communicated a plan to each other. For example, when Deputy C arrived at the location, he could have initially approached the two deputies who had arrived before him and advised them that he would position himself strategically as a lookout for the subject. Without such overt communication, deputies are left to assume what each other is doing – sometimes inaccurately and in ways that deleteriously impact coordinated response. However, even though the formulation of a tactical plan is now universally taught as a superior technique when multiple deputies respond to an incident, the Review Board did not consider the apparent lack of such a plan in this case when reviewing the efficacy of the deputies' coordination or performance.

Review Board's Failure to Analyze that Le Was Likely Running Away from the Shooter Deputy at Time of Shooting

While the KCSO investigative reports do not plainly indicate such, the non-transcribed interviews of the involved and key witness deputy indicate that Le was likely shot while running away from the deputy who used deadly force. This evidence is buttressed by the statements of another witness deputy and the autopsy evidence, which established that the two fatal shots entered Le from the back.³⁵

there is no way for any attendee to begin to reconstruct what questions were asked of the involved deputies and how well the "information gaps" were filled.

³⁴ Given that no inquest was held and no civilian jury considered the actions of the involved deputy, it was even more incumbent on the Review Board in this case to assess in exacting fashion the decision to use deadly force.

³⁵ The Sheriff's Office response suggests that our conclusions that Le was likely running away from Deputy C was based entirely on the autopsy evidence showing the two fatal bullet strikes to the back. However, as explained herein, our conclusions are more significantly derived from the

The written account of the shooter deputy could lead a cursory examination of the statements to reach a different conclusion. He describes Le as first aggressing him and moving in his direction and then depicts Le as continuing to “move forward” when he shot him in the “torso.” While Le was indeed “moving forward” in the sense of moving in a forward direction, he was in actuality likely moving away from the involved deputy when he was shot.

And while Deputy A describes Le as falling near his feet after he was shot, he does not indicate in his statement and interview that Le was running at him as if to aggress him. On the contrary, Deputy A’s positioning of the individuals and their path during his interview suggest that Le was traveling more in a parallel direction rather than directly toward him at the time that Deputy C shot Le.³⁶

While the positioning and movement of the deputies and Le are critical to understand the threat level faced by Deputy C when he used deadly force, his description of Le as continuing to “move forward” and the lack of any meaningful follow up questions make it unnecessarily difficult to piece together the event. One could infer that the investigators did not believe it particularly important to create a factual record that precisely articulated the positioning and movement of the deputies and Le. But, as set out below, such information is critical to a comprehensive analysis of the respective deputies’ threat calculations and attendant actions.

The fact that Le was likely moving away from the shooter deputy at the time the two fatal rounds struck him in the back means that the threat level to the shooter deputy himself was diminishing at the time he fired – even if the deputy believed Le possessed a knife. Moreover, the fact that Le was not moving toward Deputy A at the time the shooter deputy fired also lessens the actual threat that the partner officer was experiencing.

Considering that at the time that deadly force was deployed, Le was not aggressing either deputy and actually likely moving away from the shooter deputy means that what may have been a higher threat level warranting the two deployments of the Taser when Le *was* aggressing the deputies was diminished and diminishing when deadly force was used. Deputies are trained to continue to evaluate (and re-evaluate) the threat level presented to them in determining whether and how to deploy force. The Review Board did not consider whether the deputies conducted this evolving evaluation in keeping with expectations; nor

on- scene deputies’ statements to KCSO investigators and the diagrams they drew during the investigative process.

³⁶ If Le had been running straight at Deputy A and away from Deputy C when he was shot, the positioning would have likely presented serious danger of Deputy A being struck by Deputy C’s discharged rounds.

did it seemingly explore whether a diminished threat level warranted other tactical or force options than the deadly force that was utilized.

The event was unquestionably rapidly moving; initially Le was running toward Deputy C and then Deputy A with what the deputies believed may have been a knife in his hand. Moreover, the repositioning of all three main actors was dynamic as two unsuccessful Taser deployments were attempted by the deputies. As stated above, the Review Board's fact set was compromised as a result of deficient interviews of Deputies C and A; the Board should have required more robust interviews. And regardless of how the Review Board ultimately evaluated the decision-making of Deputy C, it was requisite that it expressly considered the likelihood that Le was moving away from the deputy at the time the fatal shots were delivered and how that fact impacted the threat level analysis. Glossing over complicating facts do not cause them to go away.

The shooter deputy indicated that in addition to his fear for himself and for Deputy A, he also feared for the lives of other deputies on scene and the civilians. However, at the time the deputy used deadly force, there is no indication that Le was intent on aggressing Deputy B, the only other deputy who was on scene. Nor was there any indication that Le was intent on aggressing the civilians, one of whom was known by the deputies to be armed. Deputy B, the only other deputy on scene at the time of the incident, was positioned between Le and the civilians and likely could have interceded had Le moved in his direction or the direction of the civilians.

Neither Deputy B nor the civilians were specifically questioned about whether they feared for their own lives when Le was shot, but their interview responses do not state or even suggest this.³⁷ The Review Board's lack of engagement with these facts, and their potential relevance to the reasonableness of the deadly force application, was a deficiency in the analysis that seriously undermined the Board's ultimate conclusions.

Failure of the Review Board to Articulate the Disparity in Size and Stature of Le and the Three On-Scene Deputies

While any analysis of the use of deadly force is expected to consider the "totality of circumstances," the Review Board did not expressly document whether it considered the fact that there were multiple deputies on scene and the significant disparity in stature

³⁷ Some of the civilian witnesses indicated they believed that Le was still advancing towards the deputies when he was shot contradicting the witness accounts from the deputies and the physical evidence. Their divergent account can be reconciled by the fact that they were viewing the incident considerably further than the on-scene deputies, the rapid sequence of events, and that initially Le was advancing on Deputy C and then Deputy A and only moved away after the unsuccessful Taser deployments by Deputies C and A.

between the on-scene deputies and Le provided a potential opportunity for less lethal force options. The autopsy report describes Le as 5 feet 4 inches and 123 pounds; each of the three on-scene deputies was considerably larger in height and weight. Moreover, their strength in numbers meant that one could provide lethal cover while still allowing two to engage in some sort of physical takedown. The presence of multiple deputies should at least have been expressly considered in the analysis of alternative (and perhaps preferable) options.

Ambiguous Language in the Review Board's Summary of the Incident

Instead of engaging in a rigorous and holistic assessment, the Review Board adopted ambiguous (and potentially misleading) language to summarize the event, and the analysis that was provided was superficial and incomplete. For example, as detailed above, the Review Board summary noted the following:

Deputy [C] then resorted to his firearm, shooting six times, striking Mr. Le three times, to stop Mr. Le's forward movement and perceived attack. Mr. Le continued to advance as Deputy [C] fired his weapon finally falling within inches of Deputy [A].

The summary's reporting of Le's "forward movement" and the fact that he "continued to advance" could be interpreted that Le was aggressing and attacking both Deputy C and Deputy A at the time he was shot in ways similar to Deputy C's report of the incident. However, this is a more accurate summary of the event:

Deputy C then resorted to his firearm, shooting six times, striking Mr. Le three times with the two fatal rounds striking him in the back. At the time Mr. Le was struck by the bullets fired by Deputy C, he was no longer advancing on him and was moving away from the shooter deputy. After being shot, Mr. Le ended up falling near Deputy A, though Le was not advancing on Deputy A at the time he was shot but instead was moving parallel with him.

As noted above, the Review Board concluded without further analysis that "if not stopped, [Le] posed a serious threat of harm to Deputy C, Deputy A, and the residents standing nearby". Conclusory statements about the threat of harm to others are not helpful in evaluating the actual level of threat presented. An exacting and robust Review Board would engage in such a threat analysis as demanded by the Sheriff's Office own instructions to perform a "totality of circumstances" assessment and carefully evaluate the threat of harm by citing the evidence available.

KCSO's Suggestion that Even if Deputies Knew Le Was Armed with Only a Pen, Deadly Force Would Have Been Justified

As noted above, the Review Board summary also noted that the Review Board unanimously found that there were no reasonable alternatives to the use of force. In that analysis, the Board opined that:

Control holds and other defensive take-downs create a risk of harm from the weapon, in this case a pen, as well as the risk that the deputy's firearm will be grabbed by a suspect and used against the deputy or others.

This part of the Review Board's summary is perhaps the most troubling, in that it suggests that deputies should not ever use control holds and other defensive take-downs when they observe a subject armed with a pen. Whenever control holds and other defensive take-downs are effectuated, there is a risk that the deputy's firearm will be grabbed by a suspect, whether the suspect is armed with a pen or not armed at all. And to suggest that a higher level of force than control holds or takedowns is necessary whenever a deputy encounters a person aggressively holding a pen in his or her hand is an extraordinary statement that would not be endorsed by many defensive tactics instructors.

KCSO's public release reporting the Review Board's findings contained the following language:

Although deputies and witnesses were convinced Le had a knife, it is not clear that events would have evolved differently if deputies realized that Le held a pen. A pen can be used as an improvised weapon. Aimed at vulnerable parts of the body, like the face or throat, it can cause serious bodily injury if used to stab someone.

KCSO's messaging to its public (and as concernedly to its own members) that its deputies might well use deadly force when again confronted with a subject armed only with a pen is also a remarkable statement. While virtually any object (including a plastic pen) can cause harm under extraordinary circumstances, the weaponry and other tools that KCSO deputies carry combined with the training they are provided should virtually always enable three on-scene deputies to neutralize any threat a person holding a pen might present without resorting to deadly force. Deputies do accept some degree of risk simply as a result of being a law enforcement officer. The public should expect that deputies would accept that slight risk of injury and deploy communication and de-escalation skills or go hands-on to effectuate custody instead of shooting that person multiple times. And KCSO's public would be correct to challenge the statement in the Sheriff's Office public release.

RECOMMENDATION 22: In cases involving multiple deputies on-scene, KCSO's Review Board should always consider whether the deputies articulated any plan prior to engagement and consider that fact in its "totality of circumstances" deadly force analysis.

RECOMMENDATION 23: KCSO's Review Board summary should accurately depict the situation faced by its deputies when the decision to use deadly force is made, and refrain from characterizations or omissions that could be misleading.

RECOMMENDATION 24: KCSO's Review Board should articulate any disparity in size and stature between its members and the subject and consider that factor as well as how many deputies are on scene in its "totality of circumstances" evaluation.

RECOMMENDATION 25: KCSO'S Review Board should not justify the use of deadly force with conclusory statements in lieu of performing an exacting threat level analysis.

RECOMMENDATION 26: KCSO should re-evaluate and consider retracting its public statement that, if multiple deputies are confronted with an individual known only to be holding a plastic pen, then the deployment of deadly force could well be the result.

Evidence of Off-Target Rounds Not Sufficiently Explored

The investigative reports noted that several rounds struck a nearby residence, with one of the bullets traveling through a window and lodging into the rear interior of the house, another striking a drain pipe in the front of the house, a third striking house siding in the garage area, and a fourth striking a fence. While the bullet that went through the window was addressed the night of the incident, the other strikes were not discovered until the residents called the investigators the day after the incident.

Even though the presence of stray bullet strikes was well-documented, their existence was not apparently considered during KCSO's administrative review.³⁸ Stray bullet strikes merit attention as evidence of deadly force rounds that have missed their intended target and created potential danger to uninvolved third parties. However, the shooter deputy was not asked about the rounds that were off-target, nor was there meaningful investigation

³⁸ In our Dunlap-Gittens review, we also commented about the failure of the KCSO review process to consider the stray rounds that were fired by involved deputies.

into the risk presented by the occupied residence as backdrop for the rounds. Finally, there was no evidence of follow up by KCSO to facilitate compensation for affected parties.

A robust review process would have included an assessment of the off-target rounds as a component of deputy performance. Deputies are trained to consider their backdrop when deciding when and whether to use deadly force. In this case, the shooter deputy was not asked about his backdrop and whether he considered the risk of gunfire to residents versus his concern for the deputies and civilians on-scene. Nor did the review process consider whether the off-target rounds raised questions about the deputies' marksmanship.

In addition to evaluating the involved deputies' performance, the internal review should have also considered whether KCSO sufficiently responded to the fact that several bullets entered or struck the residence, and whether those residents were made whole in the aftermath of KCSO's application of deadly force.

RECOMMENDATION 27: Whenever an investigation involves multiple rounds and inadvertent collateral damage, KCSO should consider their existence in evaluating deputy performance, including the asking of relevant questions about backdrop and target acquisition.

RECOMMENDATION 28: Whenever an investigation finds that stray rounds have entered into an occupied structure, KCSO's review process should consider whether its response to that event appropriately considered the welfare of those occupants and whether any damage suffered by the residents was appropriately resolved.

Post-Incident Rescue Efforts

The investigation revealed that immediately after the shooting, Deputy A immediately provided CPR to Le. As we noted in our Dunlap-Gittens systemic review, the transition from tactical to rescue mode is often difficult to accomplish but Deputy A made a smooth and laudatory transition. When performance by personnel is particularly creditable, the review should reinforce such behavior. In the same way that suboptimal performance should be identified and critiqued, when performance is exemplary there should be feedback and recognition to personnel responsible for it.

RECOMMENDATION 29: KCSO should devise protocols that require its Review Board to identify and formally recognize exemplary conduct by its personnel.

Recommendations

- 1: KCSO should develop protocols to ensure that key personnel in the investigative and review process are made available to any authorized independent systemic review.
- 2: KCSO should not use concerns about pending litigation to avoid cooperating in any review mechanism designed to improve agency performance during and after critical incidents.
- 3: The County should continue to work towards a solution so that there is a prosecutive determination in every officer-involved shooting which results in a fatality or a wounding of an individual.
- 4: KCSO should modify its General Orders to make clear that only officers who use deadly force are to be treated as involved officers during the criminal aspect of the investigation.
- 5: KCSO should modify its General Orders to make clear that any lesser use of force relating to a deadly force incident should also be administratively evaluated.
- 6: KCSO should revise its protocols to eliminate its practice of allowing deputies involved in shootings to submit a written report in lieu of a timely interview.
- 7: KCSO should revise its protocols so that an interview is conducted of members involved in shootings prior to end of shift.
- 8: KCSO should revise its investigative protocols so that the accounts by involved and witness members of an officer-involved shooting are videotaped.
- 9: Before a presentation is made to the Review Board for consideration of an officer-involved shooting, a detective supervisor should review the interviews of involved and key witness personnel, evaluate whether the interview sufficiently addressed the key considerations of deputy observations and decision-making and return the matter to detectives for supplemental interviews as needed.

- 10: All interviews of involved deputies and key witnesses should be transcribed and/or summarized for inclusion in the investigative file and presentation to the Review Board.
- 11: KCSO should modify its investigative protocols to ensure that any potential evidence that travels to the hospital is promptly collected by personnel who are dispatched to accompany a wounded individual.
- 12: Detectives entrusted with investigating officer-involved shootings should ensure that the actions and decision-making of the involved deputies constitutes the focal point of investigative efforts.
- 13: KCSO's public release of information should emphasize both scrupulous accuracy and an objective framing of facts in light of their relevance.
- 14: KCSO should develop written protocols instructing detectives that when they make requests of the crime lab, the results of the crime analysis should be included in the file. If the result is non-determinative or the request is withdrawn, the file should so indicate.
- 15: KCSO should devise protocols to ensure that responsibility for reviewing a deadly force incident is understood to entail careful, holistic, and objective scrutiny of all aspects of the encounter.
- 16: The Sheriff's Office should modify its General Orders so that participation by Union representatives and Legal Advisors in the Critical Incident Review Board is limited to a non-voting role.
- 17: KCSO should amend its General Order so that the Critical Incident Review Board is instructed to opine on the following question: Was the use of force justified or unjustified in light of the totality of the circumstances, including the tactics and decision-making that preceded the force?
- 18: KCSO should devise protocols to ensure that any recommendations accepted by the Use of Force Review Board (and endorsed by the Sheriff) are implemented by:
 - Assigning the responsibility of implementation to specific KCSO personnel.
 - Delegating a KCSO command staff member the responsibility of ensuring effective and timely implementation.

- 19: KCSO should revise its protocols to eliminate the participation of involved personnel in the Use of Force Review Board process.
- 20: KCSO should routinely assign a Review Board member the responsibility to provide detailed feedback to involved personnel regarding decision-making or tactical issues raised during the Review Board meeting, as well as to offer a forum for deputies to share their experience of the review process.
- 21: KCSO should develop mechanisms designed to openly discuss “lessons learned” from any deadly force incident as a means of enhancing the ability of all members to meet future challenges.
- 22: In cases involving multiple deputies on-scene, KCSO’s Review Board should always consider whether the deputies articulated any plan prior to engagement and consider that fact in its “totality of circumstances” deadly force analysis.
- 23: KCSO’s Review Board summary should accurately depict the situation faced by its deputies when the decision to use deadly force is made, and refrain from characterizations or omissions that could be misleading.
- 24: KCSO’s Review Board should articulate any disparity in size and stature between its members and the subject and consider that factor in its “totality of circumstances” evaluation.
- 25: KCSO’S Review Board should not justify the use of deadly force with conclusory statements in lieu of performing an exacting threat level analysis.
- 26: KCSO should re-evaluate and consider retracting its public statement that, if multiple deputies are confronted with an individual known only to be holding a plastic pen, then the deployment of deadly force could well be the result.
- 27: Whenever an investigation involves multiple rounds and inadvertent collateral damage, KCSO should consider their existence in evaluating deputy performance, including the asking of relevant questions about backdrop and target acquisition.
- 28: Whenever an investigation finds that stray rounds have entered into an occupied structure, KCSO’s review process should consider whether its response to that event appropriately considered the welfare of those occupants and whether any damage suffered by the residents was appropriately resolved.

29: KCSO should devise protocols that require its Review Board to identify and formally recognize exemplary conduct by its personnel.