King County

Office of Law Enforcement Oversight
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MEMORANDUM

DATE: May 3, 2013

TO: Larry Gossett
Chair, Metropolitan King County Council

FROM: Charles Gaither
Director, Office of Law Enforcement Oversight

SUBJECT: Quarterly Update on Audit Recommendations

I. Introduction

Pursuant to Motion 2012-0366 ("Motion"), I submit the quarterly update on the audit recommendations put forward by the King County Auditor's Office ("Auditor") and the King County Office of Law Enforcement Oversight ("OLEO"). The underlying intent of the Motion is to assure individual accountability my members of the Sheriff's Office, to increase the effectiveness of the OLEO, and to build and maintain the public trust. To that end, this memorandum will address the following recommendations:

- Relate the collaborative efforts between the OLEO and the Sheriff's Office in planning and developing guidelines and measureable objectives to assure the maximization of the effectiveness and benefits of oversight;

- Relate the collaborative efforts of the OLEO and the Sheriff's Office in developing and promoting a voluntary mediation program; and

- Report on the status of the OLEO's annual report, which will detail the progress of the Sheriff's Office's implementation of audit recommendations and include detailed statistics on the number, type, and unit location of allegations of misconduct and complaints received.

II. Discussion of Audit Recommendations

A. Collaborative efforts between the OLEO and the Sheriff's Office in planning and developing guidelines and measurable objectives to assure the maximization of the effectiveness and benefits of oversight[1]

Status: Ongoing

At the outset, the OLEO set out to establish a strong collaborative working relationship with the Sheriff's Office and the King County Police Officer's Guild ("Guild"). By creating a collaborative environment with these organizations, the policies and objectives underlying police operations were enhanced to assure compliance with best practices and to maintain the public trust, which affirmed the benefit of effective oversight of police operations throughout King County and its contract cities.

Over the last quarter, the OLEO partnered with the Sheriff's Office and the Guild to achieve the following:

- Partnered with the Sheriff's Office to purchase an interactive firearms simulator. This system replicates scenarios in which a deputy may be required to use lethal and non-lethal force. This interactive system requires the deputy to consider alternative force options and, when lethal force cannot be averted, to articulate his rationale for drawing, exhibiting, and firing his weapon. This interactive system has been incorporated into the Sheriff's Office's use of force training curriculum and has been well received its deputies.

- Partnered with the Sheriff's Office to revise the manner in which officer involved shootings and other critical incidents are investigated. Going forward, all officer involved shootings will be subject to concurrent criminal and administrative investigations. This was not the case when the OLEO began operations in October 2011. Concurrent investigations will ensure that allegations of misconduct and/or violations of Department policy are fully investigated and that the subject deputy is held to account for his actions.

- Partnered with the Sheriff's Office's Internal Investigations Unit ("IIU") to revise its internal controls and standard operating procedures. This was necessary to assure consistency in the manner in which personnel complaints were reviewed and ultimately adjudicated by the Sheriff. Prior to our input, the quality of IIU investigations turned on the expertise of the investigating officer. While expertise is an important variable, experience has shown that strong internal polices and controls assure quality investigations and bridges the gap when expertise and skill sets vary among investigators.

[1] *Motion 2012-0366* @ page 9.

- Partnered with the Sheriff to standardize its roll call training. Prior to our input, the Sheriff's Office did not require its deputies to meet regularly for roll call or to participate in related training. While the Sheriff's Office did require its deputies to submit to training by acknowledging receipt of special orders or other directives by email, it did not direct roll call training or assure that the training materials provided to its deputies were understood. Going forward, the Sheriff's office will require its deputies to meet once per week for roll call and submit to roll call training. This will assure deputies are provided with legal updates, directives, training, and special orders necessary to perform their jobs at a high level.

B. Collaborative efforts between the OLEO and the Sheriff's Office in developing and promoting a voluntary mediation program[2]

Status: Ongoing

I recently met with personnel from the Sheriff's Office to discuss the OLEO's mediation program and to identify personnel complaints ripe for mediation. Based on those conversations and mediation materials provided by the United States Department of Justice, the following evaluation criterion was created.

Evaluation Criteria

King County Ordinance 16511 provides, in relevant part:

> [OLEO], in collaboration with the Sheriff's Office, shall establish and administer a voluntary officer-citizen mediation program. The program shall provide an alternative method to resolve citizen complaints by allowing willing citizens and officers to meet under the guidance of a professional mediator to discuss and resolve their differences. The office and the sheriff's office shall establish standards and guidelines for determining when a particular complaint may be referred to mediation. *Serious complaints are excluded from the use of mediation to resolve allegations*. Prior to the complainant agreeing to utilize the mediation process to resolve the complaint, the office shall explain the mediation process to the complainant, including that if the officer participates in good faith, the officer will not be subject to discipline and the complaint will be administratively dismissed. (Emphasis added)

In consideration of Ordinance 16511, a complaint may be considered for mediation if it resulted from a failure to communicate or a lack of communication such that the allegation would be resolved better through mediation than through the formal disciplinary process. These cases include allegations of conduct that has more than a minimal negative impact on the operations or professional image of the department; or that negatively impacts relationships with other officers, agencies, or the public. However, mediation will not be offered as an alternative

[2] *Id.*

remedy to discipline if a deputy has participated in two mediated complaints within a 12 month period.

Examples of such cases include:

- Courtesy
- Use of Profanity
- Procedural Issues related to vehicle stops
- Other procedural issues: (Why was I handcuffed? Why was a report not taken? Why was I detained so long?)
- Vehicle Operations (Speeding /Sirens/ Code Responses)

Cases to be evaluated on a case-by-case basis:

- Racial, gender, LGTB, or other bias
- Profiling
- Cases involving employees with a history of citizen complaints

Cases that should not be mediated:

- Use of force
- Sexual harassment
- Allegations of criminal misconduct
- Cases where there are criminal charges pending from the underlying contact with the law enforcement officer

On May 2, 2013, I met with Guild President Steve Eggert. He expressed enthusiasm for the program and a willingness to participate in training designed to give mediators a better understanding of police operations. This training will be facilitated by the Honorable Terry Carroll, Julia Gold, Andrew McCurdy, Ann McBroom, and Steve Eggert and will be held in June 2013.

C. Status of OLEO's annual report, which will detail the progress of the Sheriff's Office's implementation of audit recommendations and include detailed statistics on the number, type, and unit location of allegations of misconduct and personnel complaints received[3]

Status: Ongoing

On April 29, 2013, the Sheriff's Office provided the OLEO with statistics related to the number, type, and frequency of personnel complaints received by IIU. This information will be included in the OLEO's annual report. The annual report will also detail the Sheriff's Office's implementation of the audit recommendations put forward by the King County Auditor and

[3] *Id.*

OLEO. As OLEO's annual report will not be released until May 2013, a spreadsheet detailing the current status of all audit recommendations is included for your review.

PERFORMANCE AUDIT ACTION PLAN			Target Completion Dates	
Audit	Motion			
Effective Management and Supervision				
1A	A3a	The Sheriff is requested to notify staff of the sheriff's office about county policy regarding reporting of potential breaches of conduct and transmit to the council a copy of a sheriff's office department-wide memorandum outlining expectations and procedures for capturing and reporting all complaints, misconduct and policy violations into the sheriff's office's Blue Team application.	September 30, 2012	COMPLETED 10/1/12
1B	A3b	The Sheriff is requested to transmit monthly reports to the Council describing efforts to include a new "Failure to Supervise" GOM section, with the reporting requirement terminating upon transmission of a report upon completion that includes the text of the adopted policy.	September 30, 2012	COMPLETED 10/1/12 NO MONTHLY UPDATE REQUIRED
2	A3c	The Sheriff is requested to transmit to the Council an action plan for continuing to remind sheriff's office staff that compliance with personnel conduct and reporting requirements is mandatory.	December 31, 2012	
3A	A3d	The Sheriff is requested to transmit monthly reports to the Council describing efforts to amend the GOM to allow either the Sheriff or IIU, or both, to file a complaint or an allegation of a policy violation without restriction, with the reporting requirement terminating upon transmission of a report upon completion that includes the text of the adopted policy.	September 30, 2012	COMPLETED 10/1/12 - NO MONTHLY UPDATE REQUIRED
3B	A3e	The Sheriff is requested to transmit monthly reports to the Council describing efforts to amend the GOM to compel direct supervisors and commanders to fully cooperate with IIU in the handling of sheriff or IIU-initiated complaints, with the reporting requirement terminating upon transmission of a report upon completion that includes the text of the adopted policy.	September 30, 2012	COMPLETED 10/1/12 - NO MONTHLY UPDATE REQUIRED
Complaint Policies and Procedures				
4	B3a	The Sheriff is requested to establish, publish and inform sheriff's office staff regarding the use of a standardized complain process, to transmit to the Council a report detailing the SOPs for reporting and investigating complaints, including the text of all relevant GOM sections, SOPs, and supporting internal documents (e.g., checklists, forms), and to notify Council and OLEO when the SOPs are materially changed in the future.	September 30, 2012	COMPLETED 10/1/12
5	B3b	The Sheriff is requested to transmit to the Council an action plan for identifying and addressing any policy gaps to ensure full CALEA compliance and ongoing accreditation in advance of the scheduled 2013 CALEA reaccreditation process.	December 31, 2012	COMPLETED 1/7/13
6	B3c	The Sheriff is requested to transmit to the Council a report outlining the SOPs for how department staff will document all complaints, including the text of all relevant GOM sections, SOPs and supporting internal documents (e.g. templates, forms), and to notify Council and OLEO whenever the SOPs are materially changed in the future.	September 30, 2012	COMPLETED 10/1/12
7	B3d	The Sheriff is requested to transmit to the Council a copy of a revised organizational chart for KCSO, and to notify Council and OLEO whenever an organizational change is made that modifies the reporting or chain of command related to the IIU commander.	September 30, 2012	COMPLETED 10/1/12

Use of Accountability Tools				
8	C3a	The Sheriff (or designee) is requested to report quarterly to the Council during contract negotiations, in executive session as necessary, regarding the status of bargaining related to extending the 90-day rolling period for maintaining complaint and incident data and extending the 180-day limit on the completion of complaint investigations.	Ongoing, beginning in September 2012	**Briefings have been ongoing in executive session**
9	C3b	The Sheriff is requested to transmit a report to the Council detailing the SOPs that supervisors will be expected to follow to increase the variety of data that must be entered into the Blue Team system and forwarded to IIU, including a discussion for how the SOPs are expected to enhance the effectiveness of the Early Intervention System and Blue Team application.	September 30, 2012	**COMPLETED 10/1/12**
10	C3c	The Sheriff is requested to transmit quarterly reports to the Council detailing the use and implementation of the SOPs regarding how department staff is documenting all complaints, including data on the number and type of complaints received, the geographic breakdown of complaint intake, the number of complaints entered into the Blue Team system, and a description of any ongoing obstacles and efforts to achieve comprehensive countywide implementation.	Ongoing, beginning in January 2013	**Will be delivered during first quarter 2013.**
11	C3d	The Sheriff is requested to transmit to the Council an action plan for implementing an ongoing training schedule for supervisors on the effective use of the Blue Team system, as well as how to investigate and document misconduct complaints and inquiries, which includes the number of training hours and how often trainings occur.	December 31, 2012	**COMPLETED 2/7/13**
12	C3e	The Sheriff is requested to report annually to the Council on its training resources and programs, the number of training hours completed and the number of employees that received training, and the department's efforts to explore opportunities to expand training resources or identify training programs in other jurisdictions.	Ongoing, beginning in September 2012	**First year report submitted 10/1/12**
Implementation of Law Enforcement Oversight				
13	D3a	The OLEO Director is requested to report quarterly to the Council regarding collaborative efforts with KCSO to plan and develop guidelines and measureable objectives to assure the maximization of the effectiveness and benefits of oversight.	Ongoing	
14	D3b	The OLEO Director is requested to report quarterly to the Council regarding efforts to develop and promote the formal mediation program, including information on the use of the mediation program once established.	Ongoing	
15	D3c	The OLEO Director is requested to transmit an annual report to the Council detailing progress in successfully implementing audit recommendations, including detailed annual statistics and the number, type, and unit location of allegations and complaints received.	April 2013	
16	D2b	Pending the outcome of labor negotiations, the Council will reassess sections of King County Code relating to oversight of the sheriff's office and amend the code as necessary.	TBD	

King County

Memorandum

Metropolitan King County Council

TO: Councilmember Bob Ferguson, Chair Government Accountability, Oversight and Financial Performance Committee

CC: Councilmember Joe McDermott, Councilmember Larry Gossett, Councilmember Kathy Lambert, Councilmember Larry Phillips, Councilmember Julia Patterson, Councilmember Jane Hague, Councilmember Pete vonReichbauer, Councilmember Reagan Dunn

From: John Resha, Principal Legislative Analyst

RE: Integration of the Office of Law Enforcement Oversight Risk Assessment Report with the King County Auditor's Report 2012-01 and Proposed Motion 2012-0366

On July 24, 2012, the King County Auditor delivered Auditor Report 2012-01, a Performance Audit of the King County Sheriff's Office and Office of Law Enforcement Oversight. This report was developed in response to the requirements of K.C.C. 2.20.037. This Audit report was organized in four main sections with six findings as follows:

Findings from the 2012 Performance Audit of King County Sheriff's Office and Office of Law Enforcement Oversight (Report 2012-01):

Effective Management and Supervision

Finding 1: KCSO Supervisors, Chain of Command, and the IIU Have Not Consistently Demonstrated Leadership in Sustaining Accountability Practices.

Finding 2: Egregious Misconduct or Policy Violations Require Immediate Response from Sheriff and Top Management.

KCSO Complaint Policies and Procedures

Finding 3: KCSO's GOM and the IIU's SOPs Were Not Effective in Providing Direction to Commissioned Personnel, or in Compelling KCSO Management to Consistently Enforce the Complaint Policies Necessary to Achieve Organizational and Officer Accountability.

Finding 4: Several of KCSO's Policies and Practices Were Not Consistent with the Commission on Accreditation for Law Enforcement Agencies' (CALEA) Standards for Accredited Law Enforcement Agencies.

KCSO Accountability Tools

Finding 5: KCSO Implemented An Accountability System, but Underutilization of System Tools Impacts Their Effectiveness in Improving Accountability Department-Wide.

Implementing Law Enforcement Oversight

Finding 6: Organizational, Legal, and Labor Issues Have Hampered Effective Oversight in King County.

On September 11, 2012, Charles Gaither, Director of King County's Office of Law Enforcement Oversight (OLEO) delivered to the Council a Risk Assessment Report prepared by a contractor, Police Assessment Resource Center (PARC). Per Mr. Gaither's report delivery cover letter this report is intended to:

- identify areas where improvements in policies, procedures, and practices are needed to mitigate risks arising from categorical use of force incidents,
- assure the adequacy of KCSO's early intervention program, and
- assure the internal investigative processes are thorough and consistent with best practices.

The OLEO report is divided into four main areas/chapters including:

- Chapter 1: Use of Force
- Chapter 2: Deputy-Involved Shootings
- Chapter 3: Investigations of Personal Misconduct
- Chapter 4: Office of Law Enforcement Oversight

Staff has reviewed the report and while it contains 25 recommendations, staff focused on identifying findings that were the basis of the recommendations. Because Chapter 4 is focused on OLEO and the assessment was commissioned and funded by OLEO, staff followed Council's guidance in Ordinance 16511, which establishes a permanent ongoing law enforcement audit process that includes a review of the effectiveness of OLEO. So, in order to avoid any questions of impropriety or conflicts of interest, staff set this chapter aside. This means that while findings are noted for Chapters 1 through 3, no findings are being reflected in this memorandum for Chapter 4.

Managing the Risk of Misconduct for the King County Sheriff's Office – produced by the Police Assessment Resource Center (PARC) – Staff Identified Findings from the Report:

Chapter 1: Use of Force

- The KCSO use of force policy does not comport with best practice: It is too general and rather vague. (pg. 15)
- The KCSO should adopt a policy carefully describing the circumstances under which deadly force is permissible. (pg. 19)
- The KCSO has specific policies governing Tasers, pepper spray, shooting to and from motor vehicles, and less than lethal shotguns. Each of these policies could be more detailed and give greater guidance to deputies using these force instrumentalities. (pg. 20)
- A deputy involved in a shooting should be treated as any other traumatized civilian in an investigation. As a general rule, homicide investigators interview civilians involved in, or witnessing, a shooting or in-custody death incident as soon as possible regardless of their emotional state. (pg. 31)

- After a thorough examination of the Shooting Review Board, we (PARC) noted the absence of serious deliberation and explicit reasoning for the decisions made by the board. (pg. 32)
- While packets were "pretty good" in terms of classifying and documenting the incidents, most of the packets lacked clear justifications of why the conduct was "within policy" and many of the packets lacked key documents. (pg. 38)
- KCSO's internal review was patently inadequate, thereby bringing into question the Department's capacity to fairly judge its own deputies. (pg. 42)

Chapter 2: Deputy-Involved Shootings

- The demographic data from reviewed incidents suggests that bias against minorities is most likely not an issue. (pg. 44)
- In the shooting reports we reviewed, there were very few instances where deputies used non-lethal methods to engage the suspect.
- We (PARC) believe that the frequency of these situations (a deputy firing at a vehicle) warrants a more rigorous analysis as well as a review of tactical training regarding move vehicles and use of force options.
- The investigative process for shooting incidents should be substantially modified and should include administrative, policy and criminal liability analyses. (pg. 47)
- Despite several positive qualities (demonstrated in the Shooting Review Board Packets), details regarding the incidents are missing and the completeness of each shooting review packet greatly varies. (pg. 48)
- The following aspects of Shooting Review Boards need immediate improvement:
    - There is no record of what is said or the evidence presented during hearings. (pg. 53)
    - Shooting review packets for deputy-involved shooting incidents from 2005 to 2011 were not maintained. (pg. 53)
    - Every Shooting Review Board was recorded to have voted unanimously. (pg. 54)
    - Voting members of a Shooting Review Board include members who could be viewed to have bias or conflicts of interest, including peer deputies and representatives of the King County Police Officers' Guild (the labor union representing KCSO deputies and sergeants). (pg. 54)
    - There is clear evidence that KCSO does not hand these incidents in a timely fashion. (Shooting Review Boards hear cases on average 7.7 months after the incident) (pg.56)

Chapter 3: Investigations of Personal Misconduct

- KCSO worksites do not have the same bureaucratic separation from investigations of employees and thus may be subject to some amount of bias in the processing of complaints (as opposed to a separate Internal Investigations Unit). (pg. 62)
- There needs to be additional language added to reporting responsibilities of the KCSO members (relative to reporting misconduct). (pg. 63)
- The (180 day tolling provision) deadline places a time constraint on important investigations that may take longer than 180 days to complete. (pg. 64)
- We (PARC) found a few instances of missing documentation, and IIU should ensure this happens as little as possible, but the complaint packets were of a high standard. (pg. 66)

- In order to improve investigations of misconduct against a KCSO employee, the investigations must have explicit standards that explore all aspects of the case. (pg. 66)

Comparison of the Reports
A review of both reports suggests a significant fundamental difference between the two reports:

The Auditor's report looks at the environment in which internal investigations and oversight take place.
OLEO's report looks at how investigations are conducted and managed, and what they contain.

The reports appear to look at similar data sets and arrive at complimentary findings but largely at different operational levels.

Relationship to Proposed Motion 2012-0366
In general, the policy proposed as part of Proposed Motion 2012-0366, while formed from the findings of the Auditor's report, apply to areas of concern identified in both reports. For example, the Auditor found "Egregious Misconduct or Policy Violations Require Immediate Response from Sheriff and Top Management"; and the OLEO report found "There needs to be additional language added to reporting responsibilities of the KCSO members (relative to reporting misconduct)". Both of these findings are addressed by the policy found in Section A of proposed Motion 2012-0366:

> "It is the policy of King County that individuals within the sheriff's office who witness or have knowledge of a potential breach of conduct by any employee of the sheriff's office shall report the concern to the sheriff or his designee;"

In other cases the OLEO findings do not have as clear a relationship to the Auditor's findings in that the OLEO findings are largely about "how" you might achieve policy and best practices. For example the Auditor found that "Several of KCSO's Policies and Practices Were Not Consistent with the Commission on Accreditation for Law Enforcement Agencies' (CALEA) Standards for Accredited Law Enforcement Agencies" and the OLEO report found that "While packets were "pretty good" in terms of classifying and documenting the incidents, most of the packets lacked clear justifications of why the conduct was "within policy" and many of the packets lacked key documents" While these are both about best practices of policies, the OLEO finding is about how the file that achieves and supports the policy issues and the Auditor's report is about the policies and policy environment.

With such significant variability staff was not in a position to complete a full crosswalk of the two reports in the short time available.

Furthermore, staff recognizes that a majority of the recommendations in the OLEO report have outstanding legal risk and labor questions that as yet have not been reviewed or answered by legal counsel.

Approach to Integrating the OLEO Report into Proposed Motion 2012-0366
After consulting with legal counsel, Council offices and the Sheriff's Office, and reviewing similar legislative approaches to complex policy and operational challenges staff returned to the approach used for the historical challenges facing the Elections Department. In that case, a

phased approach was used to address the various findings of the Blue Ribbon Commission. When translated to the current situation, a phased approach would establish policy, continue on an implementation path with the Auditor report recommendations, and call on the Sherriff to develop and propose a formal work plan to incorporate the applicable recommendations of the OLEO report. Additionally, this would give Council the opportunity to conduct appropriate due diligence with legal counsel to understand the findings and recommendations.

Additional CC:

King County Sheriff Steven Strachan
Cheryl Broom, King County Auditor
Mark Melroy, Lead Staff Government Accountability, Oversight and Financial Performance Committee
Kelli Carroll, Lead Staff Law, Justice, Health and Human Services Committee
Michael Woywod, Chief of Staff, King County Council

Managing the Risk of Misconduct for the King County Sheriff's Office

Report Prepared for the Office of Law Enforcement Oversight

PARC POLICE ASSESSMENT RESOURCE CENTER

Merrick J. Bobb and Staff
Police Assessment Resource Center (PARC)
September 6, 2012

Police Assessment Resource Center (PARC)

President

Merrick J. Bobb

Research Associates

Nick Armstrong, MPA

Chris Moulton, MPP

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PARC POLICE ASSESSMENT RESOURCE CENTER

Executive Summary

This report, *Managing the Risk of Misconduct for the King County Sheriff's Office*, focuses on that agency's ("KCSO" or "Department") internal oversight of investigations of use of force and employee misconduct. We found that the investigations into misconduct of KCSO employees were of a high quality. It was clear what happened in the investigations and key interviews were conducted of suspects and witnesses. While the investigations of KCSO employees were of high quality, we nonetheless concluded that they could be improved. Thus, we found that KCSO's Internal Investigations Unit (IIU) functions well in its investigations. We could not, however, say the same about internal reviews and critiques of shootings and other uses of force. We reviewed all shootings occurring during 2005-2011. In none of those instances was a shooting held to be out of policy.

After analyzing KCSO records, we recommend that the KCSO should create a Use of Force Review Board for all lethal and all non-lethal uses of force involving a KCSO employee, and that a parallel team of specially trained investigators should "roll out" to the on-scene investigations of significant uses of force. The recommended Use of Force Review Board should include three members: the head of training at KCSO, a citizen representative, and a rotating Chief. Additionally, we recommend that the Director of the Office of Law Enforcement Oversight (OLEO) have one nonvoting place on the Use of Force Review Board. The Use of Force Review Board should:

- Replace the Shooting Review Board
- Document all votes by members
- Meet reasonable yet speedy deadlines
- Release a statement after each review explaining how the Board arrived at its decision.

The Director or another member from the OLEO team should roll out to deputy-involved shootings and other serious uses of force to question KCSO employees and conduct interviews,

and take such further steps as may be necessary to fulfill OLEO's duties set forth in the ordinance.

This report also includes recommendations for policy changes and other procedural reforms. We recommend changing the general use of force policy, Taser policy, and OC or pepper spray deployment policies, as well as policies for handling of high-risk individuals, firing to and from motor vehicles, and bean-bag deployment. We also recommend ending the 72 hour time period for KCSO employees to make a statement regarding their role in a use of force incident, and to instead take the statement immediately after an opportunity is given for the individual to consult with an attorney or union representative but before the individual is relieved of duty. The statement should be face-to-face and recorded and transcribed as part of an interview. If possible, the suspect should give an interview regarding the incident. Following use of force incidents, particularly in deputy-involved shooting cases, we recommend that the Department clearly record the date when the criminal investigation has begun and concluded, and that all internal deadlines following use of force incidents be adhered to. We found that the analysis of shooting incidents was incomplete and did not look at the incident in question from the perspective of administrative policy, tactical and strategic issues, discipline, and training. Moreover, interviews of the shooter and witness deputies, if taken at all, were missing from the files provided us. Thus, we recommend that uses of force incidents be better documented and that these records be retained indefinitely.

Other aspects of the report cover investigations of alleged misconduct of KCSO employees, improvements to the early warning tracking system, and a discussion of the Office of Law Enforcement Oversight's role for KCSO. We also criticize the 180-day provision in which to complete an administrative investigation. For particularly complex cases, or for a large docket of cases, the shortness of the deadline could mean that investigations do not conclude in time and discipline for misconduct cannot be meted out. The report concludes in a discussion of the

functions of OLEO and recommends that this office be bolstered in its staffing, structure, and authority.

Here is a list of the recommendations we propose in our report:

1. We propose that the Austin (TX) Police Department's general use of force policy be used as a model for KCSO's general use of force policy. (p. 16)

2. We recommend Taser International's new guidelines for targeting to be added to KCSO's Taser policy. (p. 20)

3. We recommend compelling a deputy to make a statement immediately after a use of force incident has occurred while the events are still fresh in the deputy's mind. Furthermore, we recommend the statement not be a written statement, but instead a recorded interview by a commanding officer. (p.31)

4. We recommend the creation of a Use of Force Review Board. (p. 32)

5. In terms of organization, we recommend that the entire use of force case file, including all reports and documents describing the Use of Force Review Board's findings and recommendations and the Supervisor's Use of Force Review should be combined into one file by IIU. (p. 34)

6. We recommend that a KCSO member interview suspects involved in use of force incidents and then include these interviews in the Use of Force Review packets. (p. 39)

7. We recommend adding the following question and space for comments to the Supervisor Use of Force Incident Review form (after number three on the form, before the Supervisor investigative steps question):

Were there any reasonable alternatives for the use of force? If yes, then what are they? (p. 41)

8. We recommend that supervisors answer this new question (#7) by listing potential alternatives to the reported force and then why those alternatives would have been reasonable or unreasonable in the incident. (p. 41)

9. We recommend that KCSO make greater use of less lethal options and that consideration of them be included in any shooting analysis. (p. 45)

10. We recommend that KCSO develop a crisis intervention team to communicate with and manage individuals who are under the influence for intoxicants, experiencing mental health issues, or suffering from an extreme emotional state. (p. 46)

11. We recommend that a deputy involved in a shooting give a formal, recorded interview prior to being relieved of duty, whether or not a statement has been provided. If the interview is entirely voluntary on the deputy's part, it may be conducted by a representative of Major Crimes. If, however, the interview is compelled, it should be conducted by IIU or a specialized team in order not to jeopardize a prosecution because of Fifth Amendment violations. (p. 46)

12. We recommend that IIU "rollout" with Major Crimes to scenes where one or more deputies have used their firearm and conduct a parallel investigation. (p. 47)

13. We recommend that the King's County Sheriff's Office focus more of their investigation of shooting incidents on the deputy who used their firearm, witnesses, and the incident as opposed to circumstances surrounding the suspect. (p. 50)

14. We recommend that incident reports regarding deputy involved shootings include more balance in details of the incident and the investigation thereafter. (p. 51)

15. We recommend that the Shooting Review Board release a detailed, written statement that explains how the Board came to its decision and include it in the shooting review packet. (p.52)

16. We recommend that KCSO retain a permanent file of each Shooting Review Board hearing with notes of the proceedings. (p. 53)

17. We recommend that the King County Sheriff's Office adopt a practice of allowing and encouraging, when appropriate, dissenting opinions in the Shooting Review Boards. Additionally, we recommend that all votes should be recorded and kept on record with other Shooting Review Board packet materials. (p. 54)

18. We recommend that KCSO no longer include deputies on the Shooting Review Board or on our recommended Use of Force Review Board. (p. 54)

19. We recommend that KCSO remove all representatives of the Guild from all future Shooting Review Boards or our recommended Use of Force Review Board. (p. 55)

20. We recommend that KCSO add a citizen member to the Shooting Review Board or our recommended Use of Force Review Board for all future reviews. (p. 55)

21. We recommend that KCSO clearly indicate when the criminal investigation is completed to check whether the department is meeting its own deadlines and to adhere to the 30 day rule of holding a Shooting Review Board hearing after an incident. (p. 56)

22. We recommend that IIU handle all complaints of KCSO employees. (p. 62)

23. We recommend that KCSO repeat the policy of immediately reporting criminal misconduct so that all observations of general misconduct are immediately reported as well. (p. 63)

24. We recommend that KCSO immediately end this 180 day tolling provision for administrative investigations. (p. 64)

25. We recommend that KCSO create a clear written standard for all IIU investigations. (p. 66)

Introduction

At the instance of King County's Office of Law Enforcement Oversight (OLEO), Merrick Bobb was retained to analyze whether the King County Sheriff's Office's ("KCSO" or "Department") policies and practices comport with the best learning nationally on the evaluation and management of deadly and less than deadly force. The Police Assessment Resource Center (PARC) provided staff to assist Mr. Bobb. Mr. Bobb and PARC ("we") did not investigate cases or form conclusions whether individual shootings or instances of force were justified or if particular officers' conduct was in policy. Rather, the review was calculated to examine the thoroughness, completeness, and fairness of the Department's practices and procedures. Although KCSO conducts better-than-average investigations, including a number of excellent ones, their scope is narrower than what best practice currently requires. KCSO's policies do not always reflect the thinking and advances in policy development in other law enforcement agencies over the last few years. In order for KCSO more vigorously and effectively to manage the risk of police misconduct, we make recommendations to KCSO to devise better tactical and strategic training options for its officers, improve the quality of supervision and management, avoid unnecessary force and shootings, and more widely and objectively investigate and review force incidents. Also, the OLEO Director urgently requires the necessary resources, staff, and access to make meaningful the authority granted him by ordinance.

Principally, we recommend a unified shooting and use of force review board to consider the criminal and administrative policy ramifications of all serious force incidents. The scope of the investigations should include a more robust examination and a point by point analysis of a given incident to determine whether the KCSO personnel violated the criminal law, the policies of the KCSO, made good strategic and tactical decisions from the moment of deployment to the conclusion of the incident, and acted in a manner consistent with KCSO training. The investigation should also consider whether the Department should change its policies or training in light of the incident and whether there were realistic alternatives to the force employed that would have led to the safe capture the suspect without compromising the safety

of the deputy. The investigation should consider the possibility of civil litigation and respond responsibly and speedily.

We reviewed all claims made against King County from 2006-2012 arising out of the activities of sworn personnel, including all judgments, settlements, or closed cases which alleged excessive force, abuse of power, wrongful shooting, or false imprisonment. It is striking that King County has, with one or two exceptions, an excellent track record with respect to the disposition of claims without payouts.

One of those exceptions was a recent case with an exceptionally high settlement. We reviewed as much of the file as KCSO was willing or able to provide us. We were particularly interested in the depth and quality of the internal investigation of the incident given that the use of force in question was held "not unreasonable" during internal KCSO review but was evidently evaluated by King County lawyers as running a high risk of an astronomical judgment. What we found was that the case had not been rigorously analyzed by KCSO and that its conclusions were not supported by the record. Although the witness statements (both civilian and officer) and incident reports were thorough and well-documented, overall, the investigation was incomplete and lacked critical explanations and justifications for the findings and recommendations. The discussion of the incident provided no facts upon which a conclusion could be based that the Deputy's actions were reasonable and that there was no alternative way in which to handle the incident. The paucity of reasoning and critical analysis in the case was troubling, particularly in light widespread public awareness of the incident. It suggests that KCSO's use of force analysis needs to be more rigorous.

Moreover, the packet lacked any discussion of the Deputy's conduct in light of previous uses of force or misconduct. The King County Labor Negotiators agreed to a union proposal that early warning and tracking records may only be maintained for a rolling 90 day period. The 90 day rule should be addressed immediately—it hamstrings any meaningful effort to manage the risk

of police misconduct and identify problem or potentially problem officers. That short span of time is inadequate for risk management purposes, and we recommend that the data be retained for the entirety of the deputy's career in the Department plus a minimum of five years thereafter.

We found further that the Department would benefit from having simultaneous investigations of the criminal and administrative policy analysis with care taken not to contaminate the criminal side. The KCSO should critically examine its use of Garrity. Any force or shooting investigation should trigger an examination of how the given deputy or detective performed in this incident and over the course of his or her career.

The early warning and tracking system should reflect:

- All complaints received from whatever source about the officer's conduct;
- All instances in which the officer used force;
- All instances in which the officer was involved in a shooting, hit or non-hit, fatal or nonfatal;
- All instances in which the officer was investigated criminally or for administrative violations or received discipline in any form.

There should be proactive efforts to identify at-risk officers and a program to reduce the risk of repeated or future misconduct. Although the KCSO purports to use IAPro's Blue Team system, we did not find that it was used or consulted in connection with any shooting or use of force we came across. Nor did we find that the KCSO reviewed Blue Team records in connection with any effort to identify problem officers and deal with them. There appeared to be no systematic risk management to analyze a given deputy's use of force history in connection with possible corrective action. We recommend that a thorough system for risk management be instituted.

Scope of the Investigation

We considered the thoroughness and integrity of internal KCSO investigations of shooting incidents, studying in detail 15 shootings that took place in the years 2005-2011. We had reasonable access to the Department's files and personnel and interviewed and met personally with a wide group of individuals in the KCSO. We had the cooperation of the KCSO and the OLEO. We found that important documents and files have been lost, misplaced, or destroyed, thereby hampering our analysis and demonstrating that the KCSO was seriously deficient in its records keeping and failed to recognize the importance and necessity of fully investigating and retaining investigatory evidence.

Chapter 1 considers KCSO policies related to the use of deadly and seriously injurious force. In particular, we considered whether the current General Orders Manual offers appropriate support and guidance to street officers in making decisions about use of deadly and highly injurious force. We conclude that it does not. We examined the KCSO use of force policy and related policies. We found in the main that KCSO policies do not comport with the best policies of leading law enforcement agencies, the Department of Justice, and the model policies promulgated by leading scholars and practitioners. We offer examples of recommended policies throughout Chapter 1.

Chapter 2 deals with the quality of internal shooting investigations by Major Crimes and the actions taken by the Shooting Review Board. On the whole, the investigations were handled competently but were far from complete. Analysis of the shootings by the review board was pro forma and not calculated to achieve meaningful internal review. To our knowledge, there has never been a shooting that has been held to be unjustified or out of policy. We do not claim that any particular shooting was unjustified because we did not independently review the underlying case. We nonetheless strongly recommend that the Shooting Review Board provide thorough written analysis of the shooting along the lines of a decision point analysis. An example of such an analysis is appended.

Chapter 3 examines the investigations of complaints and allegations made against KCSO personnel. We found the investigations to be of a high quality, however, we critique the 180 day tolling provision for administrative investigations, an over usage of Garrity protection, and lack of written standards for IIU investigations. Overall, the complaint investigations are satisfactory, especially when compared to the use of force and shooting reviews, but still need improvement.

Chapter 4 describes the Office of Law Enforcement Oversight (OLEO) and offers our recommendations on how the KCSO should better utilize OLEO's services. We first describe OLEO's powers and then compare OLEO to two oversight groups in Los Angeles that were models for OLEO's creation. We then recommend several changes that will bolster OLEO and ultimately the KCSO in terms of structure, powers, and process.

Also in the applicable time period, KCSO policies and procedures did not appropriately provide for the essential additional inquiries concerning administrative and tactical issues that occur in officer-involved shootings or serious use force. Nor in practice did the Department generally examine those issues. We recommend a use of force review board be created for that purpose.

Law enforcement agencies should review officer-involved shootings with two primary goals in mind. First, they must hold their officers accountable: After mastering all of the pertinent facts, they must carefully assess whether the involved officers and their supervisors and commanders have violated any agency policy or procedure or have acted in a manner inconsistent with their training. Second, they must use the incident as a learning tool: Those charged with reviewing the case must determine what lessons can be learned from the Department's experience with critical incidents and should use those lessons to inform and improve the Department's policies, procedures, training, and management. As a basic requirement for effective and accountable policing, a transparent, responsible, and fair review

process engenders trust and cooperation from the community served by the agency, thereby enhancing officers' safety and raising the clearance rate for crimes, and leads to less frequent and more judicious uses of deadly force.

Commencing in September 2011, KCSO began the practice of convening a group of executives to consider and memorialize observations about lessons learned from officer involved shootings and other critical incidents. The Post Action Review memoranda generally consist of two or three pages of observations and recommendations for changes in policy and procedure, if necessary. In the main, these memoranda are excellent at spotting many instances where improvement is needed. There were excellent discussions, for example, of needs to sharpen training and practice by KCSO in multijurisdictional critical incidents; in the use of unmarked cars and officers not clearly identifiable as belonging to the KCSO in a shooting at motor vehicles case; and in an instance where an officer had forgotten or neglected to bring along his Taser.

There were also discussions that properly identified issues but stopped short of considering whether discipline of an officer was appropriate. In one instance, an officer failed to give warning, as required by KCSO policy, that a Taser was about to be fired. This violation of administrative policy should have led to a recommendation for an internal affairs investigation but apparently did not.

In another Post Action Review, an examination of the shooting of an unarmed suspect, there was no discussion of the possible strategic, tactical, and procedural errors that gave rise to the confrontation that ended with an unarmed person dead. Indeed, the memorandum displays a less than inquisitive response to the shooting in question and in essence exonerated the officers without investigation: "Nothing in this review is intended to judge the involved personnel who had to make a split-second decision upon which they may have felt their lives depended." To ignore the elephant in the room—whether it really was a split-second decision

and whether it was an objectively reasonable tactical choice and whether there were equally effective alternatives—is to ignore the principal purpose of a lessons learned review. A post action review should put the actions of all personnel under scrutiny to determine whether the officer could or should have responded differently and whether there were reasonable alternatives to shooting the suspect. The exercise should point out strategic, tactical, policy, disciplinary, and training issues which need to be addressed.

Another post action review considered an instance where an officer shot at a moving vehicle. While noting that the officer's actions may have violated policy, there was no analysis of the officer's conduct or a recommendation for an administrative investigation of it.

In sum, we applaud the Department for commencing post action, lessons learned reviews. The reviews nonetheless need to be wider in scope and consider in detail the strategic, tactical, policy, disciplinary, and training issues raised by the conduct of each deputy who participated in the event in question. In each instance, a determination should be made whether the deputy's actions could or should have been different and whether the incident could have been concluded and the suspect arrested with less force and without compromising officer safety. Additionally, these review documents should have a uniform template with "action" items and deadlines for follow-up reports on the status of implementing the stated action items.

Principles of Analysis

Our recommendations for KCSO accordingly rest upon specific, fundamental principles. The scope of Internal Affairs investigations, particularly those of officer-involved shootings and seriously injurious force, should not be limited to whether an officer acted criminally or violated administrative policy. It should include an analysis of the wisdom of policy and examine practice, training, disciplinary, and risk management questions. Internal Affairs investigations do not begin and end with the disciplinary decision. Rather, they are importantly a search for ways to achieve an arrest, or other legitimate law enforcement end, without compromising

officer safety but in a manner that lessens risks of unnecessary or avoidable death or serious bodily injury to the officer, the suspect, and any other person.

1. Use of Force

In this chapter, we review KCSO policies related to the use of deadly and physical force. We compiled and analyzed various datasets, reports, and manuals to better understand and evaluate KCSO's justification, investigation, and management of use of force incidents. We examined a key case study to observe and assess a major KCSO use of force investigation. In our review, we compare KCSO's force policies and procedures to prevailing industry standards and best practices.

I. Use of Force Policy

Chapter 6 of the KCSO General Orders Manual defines the organization's general use of force policy, how to report use of force incidents, and the various weapons and actions that constitute force. KCSO's "Use of Force Policy Statement" states as follows:

> Deputies shall not use either physical or deadly force on any person except that which is reasonably necessary to effect an arrest, to defend themselves or others from violence, or to otherwise accomplish police duties according to law. To the extent that Sheriff's Office Policy may contain provisions more restrictive than the state law, such provisions are not intended, nor may they be construed or applied, to create a higher standard of care or duty toward any person or to provide a basis for criminal or civil liability against the County, the Sheriff's Office, or any of it's [sic] officials or individual deputies. Secondly, whenever force is used, criminal charges should be filed against the suspect, when appropriate.[1]

We appreciate the effort of the KCSO to include the notion of reasonableness in the use of force policy. Overall, however, the use of force policy does not comport with best practice: It is too general and rather vague. It lacks many of the elements which considered best practice by the Department of Justice since 2001.[2] More importantly, it misstates the law.

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[1] "6.00.000 Use of Force," *King County Sheriff's Office General Orders Manual* (2012).

[2] These elements are listed in the Department of Justice's *Principles for Promoting Police Integrity* (January 2001).

First, the policy should include the values of the Sheriff's Office and citizens' Constitutional right to be free from excessive force. **Therefore, we propose as a model the statement set forth below, based upon one recently adopted by the Austin (TX) Police Department:**

> The protection of life is the primary core value and guiding principle of the King County Sheriff's Office. As such, all employees will strive to preserve human life while recognizing that duty may require the use of deadly force, as a last resort, after other reasonable alternatives have failed or been determined impractical. The department's basic goal is to protect life, property, and to preserve the peace in a manner consistent with the freedom secured by the United States Constitution. It is our duty to guarantee these inalienable rights in strict accordance with the highest principles of our society. Operating with the statutory and judicial limitations of police authority, our role is to enforce the law in a fair and impartial manner. It is not our role to legislate, render legal judgment, or punish.
>
> Employees should, by professional attitude and exemplary conduct, ensure all persons are treated with respect and courtesy. Employees should be cognizant of the fact that they are a part of the community they serve and are accountable to the community for their decisions and the consequences of those decisions. Employees should make every effort to involve the community in problem solving, crime suppression, and crime prevention. Employees should strive to know the residents they serve. Positive contact between employees and residents will enhance the public understanding of the employee's role in society and help build partnerships from which crime and fear of crime can be reduced.
>
> Knowledge of the law itself and the ability to understand those ideals upon which the law is built are the cornerstones of law enforcement. Compassion and discretion will play an important role within the philosophy of any employee.
>
> Employees of the Sheriff's Office are professionals. We must realize our main responsibility is the protection of the community, and the preservation of human life and dignity. We are guided by the philosophy set forth here and the policies and procedures incorporated into this and other Sheriff's Office manuals.

Secondly, the use of force policy should correctly state the legal standard and articulate the circumstances under which members of the KCSO are permitted to use deadly force. An example, set forth below, is taken from *Manual of Policies and Procedures* of the Los Angeles County Sheriff's Department (LASD) and from PARC's Best Policies Manual:

GENERAL USE OF FORCE POLICY

Department members are authorized to use only that amount of force that is objectively reasonable to perform their duties. Department members maintain the right to self-defense and Department personnel have a duty to protect the lives of others.

The community expects and the KCSO requires that Deputies use only the force necessary to perform their duties and proportional to the provocation presented. The level of force applied must reflect the totality of circumstances surrounding the immediate situation, including the presence of an imminent danger to Deputies or others and the absence of more effective or safer alternatives. Deputies shall exhaust every reasonable means of apprehension before resorting to the use of deadly force.

The Deputy need only select a level of force that is necessary, proportional to the threat, and within the range of "objectively reasonable" options. "Objectively reasonable" means that Department members shall evaluate each situation requiring the use of force in light of the totality of circumstances, including, but not limited to, the seriousness of the crime, the level of threat or resistance presented by the subject, or the danger to the community, in determining the necessity for force and the appropriate level of force. Deputies must rely on training, experience and assessment of the situation to decide an appropriate level of force to be applied. Reasonable and sound judgment will dictate the force option to be employed. The more immediate the threat and the more likely that the threat will result in death or serious physical injury, the greater the level of force that may be proportional, objectively reasonable, and necessary to counter it.

When time, circumstances, and safety permit, there may be alternatives to using force. When safe under the totality of circumstances, Deputies should use advisements, warnings, verbal persuasion, and other tactics. Additionally, under the totality of the circumstances, a Deputy should de-escalate force, including, when reasonable and safe, disengaging to a position that is tactically more secure or allows a Deputy greater distance, if to do so will reduce the immediacy of the threat or allow more time for the Deputy to call for backup or to consider or deploy a greater variety of strategic and tactical options. Area containment, surveillance, waiting out a suspect, summoning reinforcements, or calling in specialized units may be an appropriate and safe response to a situation and should be considered.

Deputies shall use restraint techniques at all times that do not impair respiration and do not involve placing restrained individuals on their stomachs other than momentarily. Deputies shall avoid sitting, standing, or kneeling on an individual's chest or back.

A use of force must be objectively reasonable to pass constitutional muster. The objective standard is from the perspective of a reasonable police officer, not the subjective intent of the actual officer involved. The most recent Ninth Circuit case discussing reasonableness is *Nelson v. City of Davis* (9th Cir. July 11, 2012) where the court stated:

> "A seizure results in a constitutional violation only if it is unreasonable. Graham v. Connor, 490 U.S. 386 (1989). Defendants contend that any seizure here did not meet that standard. The determination of unreasonableness requires us to decide "whether the totality of the circumstances justified a particular sort of . . . seizure," *Tennessee v. Garner,* 471 U.S. 1, 8-9 (1985). To resolve this question we must balance "the nature and quality of the intrusion on the individual's Fourth Amendment interests against the countervailing governmental interests at stake." *Graham*, 490 U.S. at 396 (internal citations and quotation marks omitted). When the governmental interests at stake are substantial, a greater intrusion upon the Fourth Amendment rights of the person may be justified. Conversely, when the governmental interest is insubstantial, the application of even minimal force may be unreasonable. When balancing the degree of force used against the governmental interests, "it is the need for force which is at the heart of the [analysis]." *Headwaters Forest Def. v. Cnty. of Humboldt* ("Headwaters II"), 276 F.3d 1125, 1130 (9th Cir. 2002) (quoting *Liston v. Cnty. of Riverside*, 120 F.3d 965, 976 (9th Cir. 1997)) (emphasis in original).
>
> ...
>
> To evaluate the need for the government's use of force against Nelson we consider a number of factors, including "the severity of the crime at issue, whether . . . [the suspect] pose[d] an immediate threat to the safety of the officers or others, and whether he . . . actively resist[ed] arrest or attempt[ed] to evade arrest by flight." Graham, 490 U.S. at 396."

Furthermore, a recent *Police Chief* article written by a Pennsylvania police chief outlines several strategies for determining reasonableness for use of force.[3] For example, Chief Spotts' recommends that officers consider the following factors when using force may be appropriate:[4]

- The seriousness of the offense

[3] Spotts, David J. "Reviewing Use-of-Force Practices." *Police Chief*, August 2012. Accessed August 16, 2012. http://www.nxtbook.com/nxtbooks/naylor/CPIM0812/index.php#/12.
[4] *Ibid.*

- The immediacy of the threat
- The level of resistance

The KCSO should adopt a policy carefully describing the circumstances under which deadly force is permissible. Set forth below is a model policy on the subject derived from the LASD, the LAPD, and PARC.

DEADLY FORCE POLICY

The KCSO's policy on use of firearms and deadly force is:

- Discharging a firearm at another human being is an application of deadly force and must, therefore, be objectively reasonable.
- Each Department member discharging a firearm must establish independent reasoning for using deadly force. The fact that other law enforcement personnel discharge firearms is not by itself sufficient to justify the decision by a Department member to shoot. Lethal instrumentalities include firearms and edged weapons. A head strike with an impact weapon is a lethal use of force. Other instrumentalities, including batons and other impact weapons, Tasers, rubber bullets, and beanbag rounds can be lethal if misapplied.
- Department members may use deadly force in self-defense or in the defense of others, only when they reasonably believe that death or serious physical injury is about to be inflicted upon themselves or others.
- Department members may use deadly force to cause the arrest or prevent the escape of a fleeing felon only when they have probable cause to believe that the suspect represents a significant threat of death or serious physical injury to the member or other person(s). If feasible, members shall identify themselves and state their intention to shoot before firing at a fleeing felon.

"Serious physical injury" includes physical injury which creates a reasonable risk of death, or which causes serious and permanent disfigurement, significant physical pain, serious impairment of health or loss or protracted impairment of the function of any bodily organ, limb or mental or sensory faculty.

- The firing of warning shots is inherently dangerous. They should not be fired except under the most compelling circumstances. Warning shots may be fired in an effort to stop a person only when the Department member is authorized to use deadly force, and if the member reasonably believes a warning shot can be fired safely in light of all the circumstances of the encounter.

- Cover fire is defined as target specific controlled fire which is directed at an adversary who poses an immediate and ongoing lethal threat. This tactic shall only be utilized when the use of deadly force is legally justified. Target acquisition and communication are key elements in the successful use of this tactic. Department members employing cover fire must establish their reason(s) for utilizing this tactic.
- Head strikes with impact weapons are prohibited unless deadly force is justified.
- Likewise, strikes or jabs to the throat, neck, sternum, spine, lower abdomen, groin, or kidneys are prohibited unless deadly force is justified. The use of the baton as a club is prohibited.
- Also prohibited unless deadly force is justified are head strike(s) with a personal weapon, including knee or foot strikes, which may result in death or serious physical injury, a concussion, loss of consciousness, or broken bones; or pushes, shoves, take downs, throws or other tactics which may result in a person hitting his or her head against a hard object (e.g. roadway, driveway, floor, wall, door jamb, jail bars, etc.).
- Unnecessarily or prematurely drawing or exhibiting a firearm limits a deputy's alternatives in controlling a situation, creates unnecessary anxiety on the part of members of the public, and may result in an unwarranted or accidental discharge of the firearm. The deputy's decision to draw or exhibit a firearm should be based on the totality of the circumstances and the deputy's reasonable belief there is a substantial risk that the situation will escalate to the point where deadly force may be justified. When a deputy has determined that the use of lethal force is not necessary, a deputy shall, as soon as practicable, secure or holster the firearm.

The KCSO, to its credit, has specific policies governing Tasers, pepper spray, shooting to and from motor vehicles, and less than lethal shotguns. Each of these policies could be more detailed and give greater guidance to deputies using these force instrumentalities. Set forth below are examples of model policies in this area based upon the melding of elements from policies in major police departments around the country.

To its credit, the KCSO has a written Taser policy that incorporates many elements of best practice in the area. It is particularly important that the KCSO Taser policy and training reflect Taser International's new guidelines for targeting the probes. Training Bulletin number 15 lowered the recommended point of aim from center of mass to lower-center of mass for front shots. Taser notes that the preferred area is the center mass of the back. **We recommend the following additions to the Taser policy:**

TASER POLICY

Drive or Touch Stun Mode

- Use of the Taser in drive stun or touch stun mode is discouraged except in situations where cartridge mode deployment is impossible and active aggression or aggravated aggression by the subject cannot be reasonably dealt with in any other safer fashion.
- When a Taser is used against an individual in drive stun or touch stun mode, it shall be used only in one standard discharge cycle and the member using the Taser must then reassess the situation. In no situation will more than two standard discharge cycles in drive stun or touch stun mode be used against any individual — if the second application is ineffective, other tools shall be considered.
- Deputies are prohibited from using the Taser in drive stun mode against all sensitive areas, including the head, face, neck, chest, genitals, or a woman's breasts.

Cartridge Mode

A Taser in probe or cartridge mode should only be employed against persons who are engaged in active aggression or aggravated aggression, violent behavior, or are threatening or committing suicide or threatening physical injury to themselves or other persons actually present.

- When a Taser is used against a subject it shall be for one standard discharge cycle and the member using the Taser must then reassess the situation. Only the minimum number of cycles necessary to place the subject in custody shall be used. In no situation will more than three standard discharge cycles be used against any subject— if the third cycle does not make contact or is ineffective, the Taser deployment shall end.
- Deputies are prohibited from using the Taser against all sensitive areas, including the head, face, neck, chest, genitals, or a woman's breasts.

Verbal and Visual Warnings

Unless it would put a Deputy or any other person at risk of death or serious physical injury, a verbal announcement of the intended use of the Taser shall precede the application of a Taser device in order to:

- Provide the individual with a reasonable opportunity to voluntarily comply.
- Provide other Deputies and individuals with a warning that a Taser device may be deployed.
- If, after a verbal warning, an individual continues to refuse to comply with a Deputy's lawful orders and it appears both reasonable and practical under the circumstances, a Deputy may, but is not required to, display the electrical arc (provided there is not a cartridge loaded into the Taser) in a further attempt to gain compliance prior to the application of the Taser.

Prohibitions

It is prohibited to use the Taser on persons as a form of coercion or punishment. The Taser shall not be used:

- When the suspect is visibly pregnant, elderly, very young, visibly frail, or disabled unless deadly force is the only other option.
- In any environment where a Deputy knows that a potentially flammable, volatile, or explosive material is present (including but not limited to OC spray with alcohol or other volatile propellant, gasoline, natural gas, or propane).
- When the suspect is in an elevated position where a fall is likely to cause substantial injury or death.
- When the suspect is in a location where the suspect could drown.
- When the suspect is operating a motor vehicle or motorcycle and the engine is running or is on a bicycle or scooter in motion, absent overtly assaultive behavior that cannot be reasonably dealt with in any other safer fashion.
- When an individual is handcuffed or otherwise restrained, absent overtly assaultive behavior that cannot be reasonably dealt with in any other safer fashion.
- To escort, prod, or jab individuals.
- To awaken unconscious or intoxicated individuals.
- Special caution shall be exercised in cases where the individual is demonstrating difficulty breathing, or exhibiting signs of severe stress, excited delirium, hyperventilation, high temperature, or is under the influence of controlled substances or alcohol.

Handling Suspects after Deployment

- Deputies should take advantage of the window of opportunity while the subject is under the effects of the Taser to handcuff and take the subject into custody.
- Deputies shall notify a supervisor that the Taser has been deployed.
- Deputies shall have medical personnel examine any suspect that has been stunned by a Taser as soon as it can be done safely.
- Only qualified medical personnel shall remove the Taser probes or darts from a person's body.
- Used Taser darts shall be considered a sharp biohazard, similar to a used hypodermic needle, and disposed of accordingly.
- Deputies shall transport or arrange transport immediately to the emergency room of the nearest hospital if an individual who has been tased is unconscious, demonstrating difficulty breathing, or exhibiting signs of severe stress, excited delirium, hyperventilation, high temperature, or is under the influence of controlled substances or alcohol.
- All subjects who have been exposed to Taser activation must be regularly monitored while in police custody even if they receive medical care.

The KCSO has specific policies concerning the use of pepper spray. The policies are good ones and appear to recognize that Oleoresin Capsicum spray (OC spray) is an inflammatory agent that causes an intense burning sensation of the skin, eyes, and mucous membranes. When inhaled, the respiratory tract will become inflamed and temporarily restrict breathing to short, shallow breaths. The individual may experience choking, gagging, gasping for breath, or, on rare occasion, unconsciousness. The individual may experience nausea, lung pain, or temporarily impaired thought processes. The individual may become disoriented or lose his or her balance. The KCSO should, however, consider the following additions and revisions:

OC or Pepper Spray
Prohibitions and Cautions

- It is prohibited to use OC spray on persons as a form of coercion or punishment or for retaliation.
- OC spray should not be used against individuals displaying passive or low-level resistance. OC spray should only be used against persons who are engaged in threatened resistance or assault, defensive or active resistance, active aggression, aggravated active aggression, violent behavior, or to prevent individuals from threatening or committing suicide or to physically injure themselves or other persons actually present.
- If possible, avoid using pepper spray on persons who appear to be in frail health, young children, women believed to be pregnant, the disabled, the elderly, or persons with known respiratory conditions.
- Closely monitor suspects who are obese, displaying signs of over-stimulation by drugs or alcohol, over-exertion, involvement in a protracted or violent struggle, or experiencing hyperventilation or having a highly accelerated heart rate. Such individuals must be kept in an upright position and must not be maintained or transported in a face down position or in any other way that impedes free breathing.
- Deputies shall avoid sitting, standing, or kneeling on an individual's chest or back. Deputies may not kneel or otherwise put pressure on an individual's chest or back if to do so compromises the individual's capacity to breathe.
- OC spray shall not be used in any environment where an Deputy knows that a potentially flammable, volatile, or explosive material is present (including but not limited to OC spray with alcohol or other volatile propellant, gasoline, natural gas, or propane).
- OC spray shall not be used when the suspect is in an elevated position where a fall is likely to cause substantial injury or death.
- OC spray shall not be used when the suspect is in a location where the suspect could drown.

- OC spray shall not be used when the suspect is operating a motor vehicle and the engine is running or is on a bicycle, motorcycle, or scooter in motion, absent overtly assaultive behavior that cannot be reasonably dealt with in any other safer fashion.
- When an individual is handcuffed or otherwise restrained, absent overtly assaultive behavior that cannot be reasonably dealt with in any other safer fashion.
- When the suspect is detained in the police vehicle, absent active aggression or aggravated aggression that cannot be reasonably dealt with in any other safer fashion.
- Unless it would put a Deputy or any other person at risk of death or serious physical injury, a verbal announcement of the intended use of OC spray shall precede the application of OC spray.

Post-Deployment Procedures

- Handcuff the individual as quickly and safely as possible.
- Remove the individual as soon as possible from the contaminated area and expose the individual to fresh air.
- Determine whether the person sprayed is wearing contact lenses and remove them as soon as possible after exposure to OC spray.
- Immediately after spraying a suspect, Deputies shall be alert to any indications that the individual needs medical care. This includes, but is not necessarily limited to, breathing difficulties, gagging, profuse sweating, or loss of consciousness. Upon observing these or other medical problems, or if the suspect requests medical assistance, the Deputy shall immediately summon emergency medical aid or transport the individual immediately to the emergency room at the nearest hospital.
- Suspects that have been sprayed shall be monitored continuously for indications of medical problems and shall not be left alone while in police custody.
- Flush the eyes, face, and other contaminated skin area of the individual with profuse amounts of water.
- Repeat flushing at short intervals, if necessary, until symptoms of distress subside.
- Continue flushing the contaminated skin of the individual in custody, at the stationhouse as needed.
- Do not rub or touch skin of contaminated person. Also, do not use salves, creams, ointments, commercial eye washes, or bandages.
- Reassure the individual that the effects of pepper spray will dissipate shortly and encourage the individual not to panic and stay calm.

The KCSO should have a policy and training to address the arrest of high-risk individuals.

The policy and training should consider the following elements:

POLICY ON ARRESTING HIGH-RISK INDIVIDUALS

A high-risk individual is a person who appears to be mentally ill, in a temporary mentally disturbed state, or in a highly agitated state due to drugs, alcohol, or other causes and is conducting himself or herself in a manner which a Deputy reasonably believes is likely to result in serious injury to the high-risk individual, or a Deputy, or others. A specially trained crisis intervention team (CIT) shall be summoned to the scene to take charge of and manage communication with the high-risk individual. If a high-risk individual person is a danger to himself or herself or others, force may be used to prevent imminent serious physical injury or death.

- Physical force will be used only to the extent necessary to restrain the subject until delivered to a hospital or detention facility.
- Deadly physical force will be used only as a last resort to protect the life of the Deputy or any other person present.
- If the high-risk individual is armed or violent, no attempt will be made to take the individual into custody without the specific direction of a supervisor unless all the requirements for the use of deadly force are present and there is an imminent threat of physical harm to the individual or others present.
- If a high-risk individual is not immediately dangerous, the person should be contained until assistance arrives.
- If the high-risk individual is unarmed, not violent, and willing to cooperate, a Deputy may take such person into custody without the specific direction of a supervisor.
- When there is time to negotiate, all the time necessary to ensure the safety of all individuals will be used.

Duties of first responding patrol Deputies

- Upon arrival at scene, the first responder or responders should assess the situation.
- The first responders should request additional personnel, if necessary.
- If a high-risk individual is unarmed, not violent, and is willing to cooperate, the individual may be taken into custody without the specific direction of a supervisor.
- As long as the high-risk individual does not pose an imminent threat of death or serious physical injury to himself or herself or others but is armed, violent, or unwilling to cooperate, Deputies should attempt to isolate and contain the individual while maintaining a zone of safety between the Deputies in the individual. The appropriate zone of safety will vary from incident to incident but a safe distance should be maintained. Such minimum safe distance should be maintained even if the individual does not remain stationary.
- Deputies should ascertain if a patrol supervisor is responding, and, if not, request a response.
- Deputies should not attempt to take the individual into custody without the specific direction of a supervisor.
- Deputies should request an ambulance, if one has not already been dispatched.

Duties of Patrol Supervisor

- Upon arrival at the scene or sooner if the situation warrants, request that a supervisor respond to actively direct and supervise Deputies. Determine whether a request for SWAT and hostage negotiators is necessary and, if so, request them.
- If the high-risk individual is isolated and contained but will not cooperate, direct members concerned not to use their firearms or use any other deadly physical force unless their lives or the life of others is in imminent danger.
- If necessary, request assistance of an interpreter if a language barrier exists.
- If the individual is contained and is believed to be armed or violent but due to containment poses no immediate threat of danger to any person, no additional action will be taken without the authorization of the Incident Commander.

When it becomes necessary to take a violent or resisting high-risk individual into custody:

- Deputies should utilize appropriate less than lethal tactics in a coordinated effort to overcome resistance. The patrol supervisor should direct and control all activity.
- Whenever at all possible, members shall avoid tactics that may result in serious back injury or chest compression, thereby reducing the subject's ability to breathe, including sitting, standing, or otherwise putting bodyweight on an individual's neck, chest, or lower back.
- High-risk individuals taken into custody shall be rear handcuffed at the earliest opportunity. If necessary, alternate restraining devices such as Velcro ankle or leg straps may be used to further restrain a subject whose actions continue to pose an immediate risk of injury to the individual, the Deputies, or other persons.
- Note, however, that the use of restraints to "hog-tie" an individual (restraining a person by connecting or tying rear handcuffed hands to cuffed or shackled ankles or legs) is prohibited.
- Immediately after an individual has been controlled and placed under custodial restraint using handcuffs and other authorized methods, the person shall be positioned so as to promote free breathing. The subject shall not be maintained or transported in a face down position.
- The member assuming custody of the individual shall closely observe him or her for any apparent injuries. If the area is dark, a flashlight or other source of illumination should be used to maintain a clear view of the individual at all times.
- If the individual appears to be having difficulty breathing or is otherwise demonstrating life-threatening symptoms, medical assistance must be requested immediately.
- Have a high-risk individual taken to a hospital in ambulance. A Deputy shall accompany the individual in the patient area of the ambulance.
- If an ambulance is not available and the situation warrants, transport the individual to the hospital by a two- person car if able to do so with reasonable restraint, at the

direction of a supervisor. Under no circumstances will a high-risk individual be transported to a police or detention facility prior to medical clearance at the hospital.

- Inform examining physician, upon arrival at hospital, of the circumstances which brought the patient into police custody and the use of any force.
- Ensure that the patient remains at the hospital until the conclusion of examinations by medical personnel and transport as appropriate upon conclusion of the examination.

Persons under the influence of PHENCYCLIDINE (PCP) or methamphetamines (meth)

- All persons who exhibit objective symptoms of being under the influence of phencyclidine (PCP) or meth shall be given medical treatment prior to booking. Those arrestees not exhibiting symptoms of being in need of immediate medical treatment will be transported by police vehicle. When in doubt, deputies will request an ambulance to transport the suspect.
- Deputies shall request an ambulance to transport arrestees who exhibit objective symptoms of being under the influence of PCP or meth and who appear to be in need of immediate medical treatment. PCP or meth arrestees are considered to be in need of emergency medical treatment when they display any of the following objective symptoms:
    - Unconsciousness.
    - Muscle rigidity.
    - High temperature.
    - Are exceptionally combative, argumentative, or may become violent.
- Deputies shall restrain the arrestee by utilizing handcuffs to secure the arrestee's hands behind his or her back. Handcuffs shall be double-locked. Once the arrestee has been handcuffed behind his back, deputies shall, if necessary, secure the arrestee's legs with a department-approved restraint device. In doing so, the deputies shall place the arrestee on their left side and not allow the arrestee to roll into a "face/chest" downward position (prone).
- Deputies shall continuously monitor the arrestee while in their custody. At least one deputy shall ride with the emergency medical personnel in the ambulance and maintain custody of the arrestee during transportation. The deputy's partner or a backup deputy shall follow the ambulance to the hospital.

KCSO's policy on shooting to and from motor vehicles is generally acceptable. We recommend some additional language set forth below to emphasize the reasons why these shootings are dangerous and ineffective:

- **Shooting at or from motor vehicles.** Bullets fired at moving vehicles are

extremely unlikely to stop or disable the moving vehicles.
    - Bullets fired may miss the intended target or ricochet and cause injury to Deputies or other innocent persons.
    - The vehicle might crash and cause injury to Deputies or other innocent persons if the bullets disable the operator.
    - Moving to cover, repositioning, or waiting for additional responding units to gain and maintain a superior tactical advantage maximizes Deputy and public safety and minimizes the necessity for using deadly force.
    - Shooting accurately from a moving vehicle is extremely difficult and therefore unlikely to successfully stop or prevent a threat to the Deputy or other innocent persons.
- **Shooting from a Moving Vehicle.** Firearms shall not be discharged from a moving vehicle except in the immediate defense of life.
- **Shooting at a motor vehicle.** A Department member shall not discharge a firearm at a motor vehicle or its occupants in response to a threat posed solely by the vehicle unless the member has an objectively reasonable belief that:
    - The vehicle or suspect poses an immediate threat of death or serious physical injury to the Department member or another person, and
    - The Department member has no reasonable alternative course of action to prevent the death or serious physical injury.
    - A Deputy threatened by an oncoming vehicle shall move out of its path, if at all possible, instead of discharging a firearm at it or any of its occupants.

The KCSO utilizes less than lethal shotguns to fire beanbag or round rubber ball rounds. KCSO's current policy does not contain adequate detail to put a deputy clearly on notice as to the circumstances when these options may be used. Set forth below is a model policy on beanbag rounds. A parallel policy should be developed on rubber ball rounds.

Beanbag rounds: Authorized Use, Prohibitions, and Cautions

- Beanbag rounds may only be used to subdue or incapacitate an individual engaged in active aggression or aggravated active aggression, or to prevent imminent physical harm to the Deputy or another person, or to prevent individuals from committing suicide. Beanbag rounds are authorized for use against inanimate objects, such as windows, if such use presents no reasonable likelihood of harm to individuals.
- All less lethal shotguns must be stored in the trunk or rear storage area of patrol vehicles.

- It is prohibited to use beanbag rounds on persons as a form of coercion or punishment or for retaliation.
- Beanbag rounds should not be used when the suspect is visibly pregnant, elderly, very young, visibly frail, or disabled unless deadly force is the only other option.
- Beanbag rounds should not be used when the suspect is in an elevated position where a fall is likely to cause substantial injury or death.
- Beanbag rounds should not be used when the suspect is in a location where the suspect could drown.
- Beanbag rounds should not be used when the suspect is operating a motor vehicle or motorcycle and the engine is running or is on a bicycle or scooter in motion, absent active or aggravated active aggression by the suspect that cannot be reasonably dealt with in any other safer fashion.
- Beanbag rounds should not be used when an individual is handcuffed or otherwise restrained.
- It is prohibited to use beanbag rounds against a crowd unless the Deputy has the approval of a supervisor and can:
    - Target a specific individual who poses an immediate threat to cause imminent physical harm; and
    - Reasonably assure that other individuals in the crowd who pose no threat of violence will not be struck by the weapon.
- Deputies are cautioned that the target area for a beanbag round substantially differs from a deadly force target area. Instead of aiming for the center mass of the body, beanbag shotguns are aimed at the abdomen, thighs or forearms. The head, neck, and groin must not be targeted.
- Deputies should be aware that targeting the chest has on occasion proven lethal when beanbag round is fired at a close range of less than 21-30 feet.
- Deputies are further cautioned that the accuracy of the rounds decreases significantly after approximately 50 feet and their flight becomes erratic, striking objects to the right, left, or below the target, increasing the risk to innocent bystanders.

Tactical Considerations

- The optimal distance for a beanbag is between 21-50 feet. Accuracy drops off rapidly after 50 feet, and 80 feet appears to be a maximum functional range. The beanbag rounds present a risk of death or serious physical injury at less than 10 feet when fired at the chest, head, neck, and groin.
- Deputies should also be prepared to employ other means to control the individual — including, if necessary, other force options consistent with agency policy—if the individual does not respond sufficiently to the beanbag and cannot otherwise be subdued.

Verbal Warnings

- In cases in which the distance between the deputy and the target makes it practical, and unless it would put a deputy or any other person at risk of death or serious physical injury, a verbal announcement of the intended use of a beanbag round shall precede the firing of the round in order to:
- Provide the individual with a reasonable opportunity to voluntarily comply.
- Provide other deputies and individuals with a warning that a beanbag round may be deployed.

Beanbag rounds may only be used in a manner consistent with training provided by this Department.

- Deputies must successfully complete a department approved training course. Additional practice and training on firing beanbag rounds is held to be annually.

Operations

- All shotguns firing beanbag rounds must be painted in a bright color or otherwise marked clearly so as to make them instantly distinguishable from a shotgun firing live rounds.
- All shotguns firing beanbag rounds will be carried in the trunk of the patrol car and separate from lethal weapons.

Handling Suspects after Deployment

- Deputies should take advantage of the window of opportunity while the subject is under the effects of the beanbag to handcuff and take the subject into custody.
- Deputies shall notify a supervisor that the beanbag has been deployed.
- Deputies shall have medical personnel examine any suspect that has been stunned by a beanbag as soon as it can be done safely.
- Deputies shall transport or arrange transport immediately to the emergency room of the nearest hospital if an individual who has been hit with a beanbag round is unconscious, complaining of pain, demonstrating difficulty breathing, or exhibiting signs of severe chest injury, severe stress, excited delirium, hyperventilation, high temperature, or is under the influence of controlled substances or alcohol.

Duties of Deputies after Deployment to Report

- A Deputy has "deployed" a beanbag for reporting purposes if the Deputy has displayed or fired a beanbag shotgun.
- Deployment of a beanbag shotgun does not constitute discharging a firearm, for department policy purposes.
- Anytime a beanbag shotgun is deployed, whether a suspect is struck or not, Deputies shall notify a supervisor and document the incident in the use of force report which, among other things, shall state as accurately as possible the distance from which the beanbag round was fired.

Supervisor Responsibilities after deployment

- Respond to incident scene where beanbag shotgun was activated.
- Ensure that all medical concerns and responsibilities have been met.

II. Documenting Use of Force Incidents

Use of force incidents must be reported and documented in a Deputy's Report and the deputy must notify an on-duty supervisor immediately after the incident has occurred. [5] However, the involved deputy's statement for the Deputy's Report must be "submitted to the commanding officer who compelled it no later than seventy two [sic] (72) hours after being ordered to do so."[6] Also, before providing a statement for the Report, the deputy may confer with an attorney or Guild representative. **We strongly oppose the 72 hour time period for the deputy to provide a statement.** The 72 hour period given to deputies after a statement is compelled increases the likelihood of the deputy reconstructing the incident as time passes rather than purely recollecting the events. **We recommend compelling a deputy to make a statement immediately after the incident has occurred while the events are still fresh in the deputy's mind.** We believe that a deputy involved in a shooting should be treated as any other traumatized civilian in an investigation. As a general rule, homicide investigators interview civilians involved in, or witnessing, a shooting or in-custody death incident as soon as possible, regardless of their emotional state. There is no proven scientific evidence that giving deputies several days to distance themselves from the incident will help their recollection. Indeed, the more time that passes the greater the opportunity for internal or external factors to impinge upon and distort memory.

Furthermore, we recommend the statement not be a written statement, but instead a recorded interview by a commanding officer. A skilled investigator will ask insightful questions to cover the important details concerning the shooting. Additionally, every statement and recorded interview should have a clear date and time showing when the deputy went on

[5] "6.01.000 Force, Reporting Use of," *King County Sheriff's Office General Orders Manual* (2012).
[6] *Ibid.*

record. Many, not all, of the statements recorded by KCSO do not have a date and time. A recorded interview immediately after the incident occurred allows a third party (the commanding officer) to inquire about aspects of the incident that the deputy may not have thought to include or may have consciously excluded in a written statement. In addition, a written statement by the deputy could marginalize any wrongdoing and therefore lessens the likelihood of discipline.

Once notified of the use of force incident, the on duty supervisor investigates and reviews what happened during the incident and interviews the persons involved in the use of force and any witnesses. The supervisor then reviews the deputy's written statement. After gathering the available information, the supervisor prepares a Supervisor's Use of Force Review, forwards "the original incident report and associated documents to the appropriate Detective unit if necessary,"[7] and then forwards the Supervisor's Use of Force Review with copies of the entire case packet to the Precinct/Section Commander via the chain of command. The Precinct/Section Commander reviews the packet for completeness then forwards it to the Division Commander who reviews it for completeness and makes comments and/or recommendations. Finally, the Division Commander forwards the case packet to the Internal Investigations Unit (IIU) for review and further investigation of whether or not a policy violation is alleged. In Chapter 1, Section V. below, we critique the quality of those case packets.

III. Use of Force Review Board

Currently, the only evaluation processes for use of force incidents are the Use of Force Review packets and, for deputy-involved shootings, the Shooting Review Board. After a thorough examination of the Shooting Review Board and its proceedings, we noted the absence of serious deliberation and explicit reasoning for the decisions made by that board. **We thus recommend the creation of a Use of Force Review Board.** This Use of Force Review Board would replace the existing Shooting Review Board and have jurisdiction over serious use of

[7] *Ibid.*

force incidents and all deputy-involved shootings, hit or non-hit, fatal or nonfatal. The Board might be comprised of three voting members including the head of training at KCSO, a citizen representative, and a rotating Chief. In addition, the head of the Office of Law Enforcement Oversight (OLEO) would serve on the Board as a non-voting advisor.

We recommend a formal review by a Use of Force Review Board for:[8]

- Force resulting in admittance to a hospital
- Any death following a use of force by a KCSO deputy
- All head strikes with impact weapons
- Strikes with a personal weapon, including knee or foot strikes, which may result in death or serious physical injury, a concussion, loss of consciousness, or broken bones; or
- Pushes, shoves, take downs, throws or other tactics which may result in a person hitting his or her head against a hard object (e.g. roadway, driveway, floor, wall, door jamb, bars, etc.)

The Use of Force Review Board should meet and review serious use of force incidents soon after they occur yet after the investigation leading to the Supervisor's Use of Force Review. Our assumption is that the Use of Force Review Board would meet no later than 10 business days after the incident in question. Accordingly, the Supervisor's Use of Force Review would need to be completed within five business days of the incident. A parallel investigation could provide more oversight and act as an assurance of accuracy. In this deliberation, the Board would determine if the KCSO employee's conduct was consistent with established policies and procedures and if the employee's tactics were consistent with training. Also, when reviewing the KCSO employee's conduct, the Board should evaluate and consider the employee's personnel complaints file, history of use of force, and the number and type of complaints filed against the employee. Reviewing the employee's personnel file can reveal patterns in the employee's conduct and potentially inform the Board why they used force in this instance.

[8] "Activation of Force/Shooting Response Teams," LASD Manual of Policies and Procedures, 5-09/434.05.

Members of the Board would have to come to a consensus that the KCSO employee's use of force falls under one of the following disposition choices:[9]

- Unjustified or a violation of department policy
- Due to either inadequate or improper training
- Accidental
- Justified
- Unable to make a determination[10]

The Use of Force Review Board should then order a formal IIU investigation of all unjustified findings to determine the criminal and administrative policy implications of the incident in question.

In terms of organization, we recommend that the entire use of force case file, including all reports and documents describing the Use of Force Review Board's findings and recommendations and the Supervisor's Use of Force Review should be combined into one file by IIU. Correspondingly, all appropriate databases should be updated based upon the information contained within the use of force case file.

IV. Use of Force Data

We analyzed use of force data from 2009 to 2011 provided by the professional standards division by division, year, quarter, and types of force used.

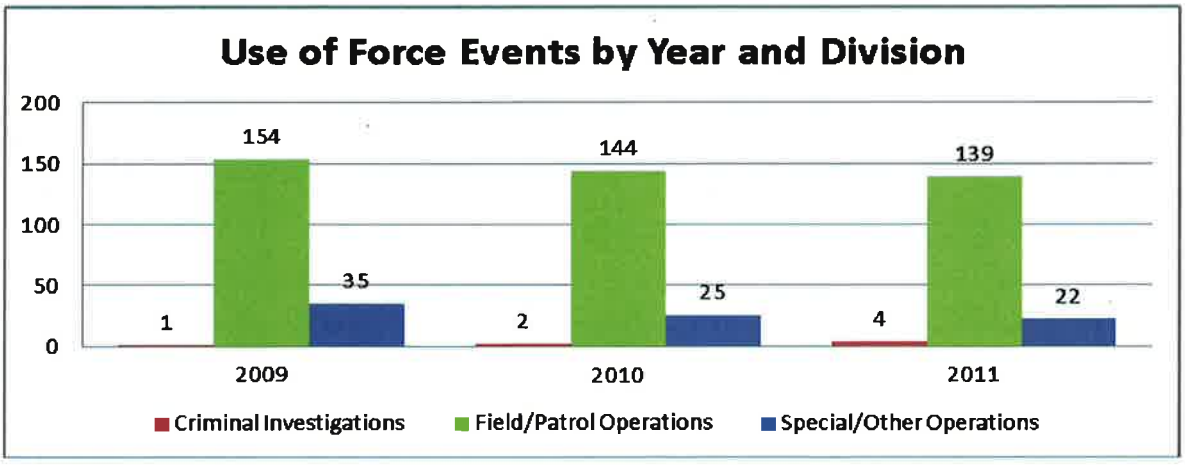
From 2009 to 2011, the annual number of reported use of force events has been falling considerably. In 1999, there were 192 force events, 171 events in 2010, and 165 events in 2011. Therefore, the total annual use of force events dropped at a rate of 11 percent from

[9] The listed disposition choices are derived from the KCSO Shooting Review Board recommendation options.
[10] This disposition indicates that there is not enough information to make a determination regarding the use of force.

2009 to 2010 and then dropped at a rate of 20 percent from 2010 to 2011. Overall, use of force events dropped almost 30 percent from 2009 to 2011. Reducing use of force events by almost 30 percent over two years is a praiseworthy feat. Our hope is that the commendable reduction in force events is due to an actual decrease in the occurrence of force events and not a failure by the KCSO to report its use of force.[11]

The dataset we reviewed divided up the use of force events by division (Criminal Investigations, Field/Patrol Operations, or Special/Other Operations) and quarter (Q1 through Q4). Table 1 shows the breakdown of use of force events each year for each division. The vast majority of force events from 2009 to 2011 (over 83 percent of the events) occurred within the Field/Patrol Operations Division that includes precincts throughout King County. Although the number of annual force events for the Criminal Investigations Division is very small, the events increased from 2009 to 2011. This upward trend in force events for Criminal Investigations should be closely monitored to ensure exemplary personnel conduct.

Table 1



[11] According to the 2012 report *The King County Sheriff's Office: Policies and Procedures for Internal Affairs Investigations* by Hillard Heintze, KCSO only reported 2 use of force complaint cases for the entire year of 2011. This small number of force-related complaint cases could mean either of the following: KCSO generates very few complaints, KCSO does not adequately report all of its complaints, or as Hillard Heintze indicated on page 72 of their report, "...some complaints which should be formalized are not." As an example of the latter, KCSO does not count pepper spray incidents as force incidents and therefore these complaints would not be included in the statistics.

KCSO breaks down the types of force used into 14 different categories (shown in Table 2). In a single force event, more than one type of force could be used, so the frequency of the various types of force used (shown in Table 2) does not match the total number of force events (shown in Table 1). As Table 2 shows, a little over 30 percent of force used from 2009 to 2011 was with a Taser. However, as seen in Table 3, Taser usage dropped each year from 2009 to 2011 while the other types of force used combined increased each year overall.

Physical force from the deputies without a weapon constituted over 59 percent of force used from 2009 to 2011 while force from outside weaponry or a canine represented over 40 percent of force used.[12]

Table 2

Type of Force Used	Number of Times Used from 2009 to 2011
Taser	276 (30.4%)
Control Hold	174 (19.2%)
Take down	153 (16.9%)
Handcuffing	107 (11.8%)
Hand/Elbow Strike	47 (5.2%)
Canine	39 (4.3%)
Push/Shove	31 (3.4%)
Foot/Knee Strike	26 (2.9%)
OC (Pepper Spray)	26 (2.9%)
Impact Weapon	12 (1.3%)
Firearm	9 (1.0%)
Vehicle	4 (0.4%)
Other Chemical	3 (0.1%)
LVNR (Lateral Vascular Neck Restraint)	1 (0.0%)
TOTAL	908 (100.0%)

[12] Physical force without a weapon includes control holds, take downs, handcuffing, hand/elbow strikes, push/shoves, foot/knee strikes, and LVNR (lateral vascular neck restraint). Physical force from outside weaponry includes Tasers, canines, OC (pepper spray), impact weapons, firearms, vehicles, and other chemicals.

Table 3

Type of Force Used	Number of Times Force Used by Year			
	2009	2010	2011	2009-2011
Taser	106	88	82	276
Control Hold	39	67	68	174
Take down	49	42	62	153
Handcuffing	25	40	42	107
Push/Shove	9	8	14	31
Hand/Elbow Strike	20	15	12	47
Foot/Knee Strike	6	10	10	26
Canine	14	17	8	39
Firearm	1	1	7	9
OC (Pepper Spray)	14	6	6	26
Impact Weapon	2	6	4	12
Vehicle	1	2	1	4
LVNR	0	0	1	1
Other Chemical	2	1	0	3
TOTAL	288	303	317	908

V. Use of Force Review Packets

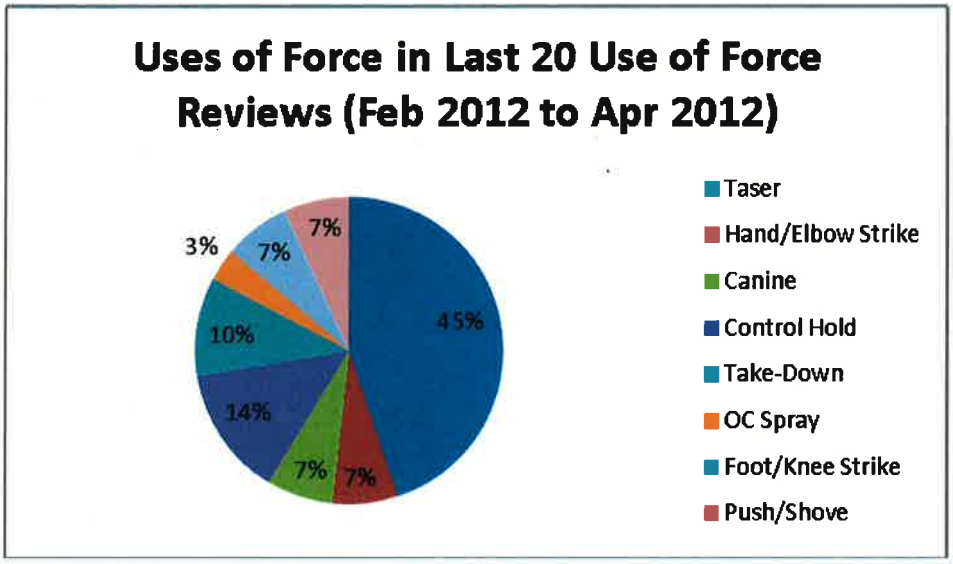
We evaluated the last 20 Use of Force Reviews for KCSO that span from February 2012 to April 2012 as well as a 2009 Use of Force Review to see a statistically valid sample of how KCSO examines its use of force incidents. Each incident is described in a Use of Force Review packet which includes documents pertaining to each case and the Supervisor's Use of Force Review. The documents in the packets were put together based on files listed in Blue Team.

A. Data from Packets

We analyzed the 20 packets in terms of data and found that all uses of force within the packets were found to be "within policy." 75 percent of the packets showed that the KCSO deputies were attempting to arrest the involved suspects before the incidents escalated to those

deputies using force on the suspects. In terms of the types of force that were employed in the 20 incidents, Table 4 below shows that Tasers constituted an overwhelming percentage (45%) of the 29 total uses of force.[13] This high percentage of force events using a Taser calls into question whether KCSO is overly reliant on Tasers in managing cases or are there many more uses of force going unreported? While KCSO may encourage Taser usage over other force options, it is possible that a lack of reporting of other force events could elevate the Taser numbers as a percentage of total force used.

Table 4



B. Findings and Recommendations

Overall, the Use of Force Review packets were pretty good in terms of classifying and documenting the incidents. Nevertheless, most of the packets lacked clear justifications of why the conduct was within policy and many of the packets lacked key documents. Each packet included the following:

- Summaries of the incident

[13] Several of the use of force incidents included more than one use of force employed, so the total uses of force is 29, not 20.

- Listings of the involved parties and deputies
- Details about where and when the incident occurred
- Documentation of the Blue Team routings through the chain of command
- Incident reports and supplements
- Witness and deputy statements
- Incident reviews conducted by the Supervisor
- Photos of the crime scene
- Audio or video recordings if taken
- Taser recorded firing data sheet if used

While the packets summarized the incidents considerably well, most did not include statements or interviews from the suspects themselves. Maintaining impartiality is difficult without hearing both sides of the incidents. Furthermore, deputies, in their statements, may portray their own conduct more favorably to avoid discipline. We recognize that suspect statements for various reasons may not always be reliable sources, but any allegations of misconduct should be fully investigated. **We recommend that a KCSO member interview suspects involved in use of force incidents and then include these interviews in the Use of Force Review packets.** Currently, these interviews are being completed by Department supervisors. It is KCSO's intention to provide all Department supervisors with digital recording devices to assist them in conducting interviews. Having supervisors complete the use of force interviews is a practice that we commend, but we must remind the KCSO to have all recorded interviews included in the Use of Force Review packet. In instances where suspects do not wish to be interviewed, involved deputies should clearly indicate in the packet that the suspect declined an interview.

Several packets did not clearly indicate key aspects of the force incidents. Information may have been omitted or documents may have been left out. Two of the 20 packets did not list the charges against the suspect at the time of the incident and one packet did not list the type of

force employed. In the case of the packet without the type of force listed, we had to infer from the incident summary what kind of force was used. This is unacceptable. The type of force should be carefully classified for a proper investigation of the incident and so that the incident can be easily transformed to data for overall use of force analysis by IIU.

After a use of force incident, deputies' on-duty supervisors are required to review the use of force incidents and fill out a "Supervisor Use of Force Incident Review" form that consists of the following eight questions in this order:

1. Was Probable Cause for the arrest or Reasonable Suspicion for the detention clearly articulated in the incident report?
2. Was the reason and necessity to use force clearly articulated in the Deputy's Report?
3. Was the amount of force and methods used reasonable to effect the lawful purpose intended?
4. Supervisor investigative steps (briefly describe):
5. Were Department policies followed (GOM 6.00.000 Use of Force and 6.01.000 Use of Force Reporting)?
6. Were training issues identified?
7. Other comments:
8. If Taser was used, list location(s) where prong(s) struck subject (examples: "upper left arm", "left chest", "lower back"):

Supervisors have the opportunity to add supplemental comments to their answers to the questions. Many of the Supervisor Reviews we reviewed included extensive comments expanding upon and justifying their answers to the questions. These exemplary reviews clearly indicated why the supervisors came to various conclusions and went beyond merely describing the supervisors' investigative steps. The vast majority of the supervisors, however, simply answered the questions with "yes" and no explanation. Supervisors that add justifications to

their answers (in the comments spaces) provide those who subsequently review or investigate the use of force with more insight about the reasonableness of or motive behind the conduct.

We recommend adding the following question and space for comments to the Supervisor Use of Force Incident Review form (after number three on the form, before the Supervisor investigative steps question):

- **Were there any reasonable alternatives for the use of force? If yes, then what are they?**

Stating whether or not reasonable alternatives to the use of force could have been employed bolsters KCSO's respect for human rights in regards to excessive force and shows that the Department is willing to question certain tactics even if those tactics may be "within policy." For example, since 45 percent of the force used in the last 20 use of force incidents was by a Taser, were there less harmful alternatives like OC spray that could have been used? **We recommend that supervisors answer this new question (above) by listing potential alternatives to the reported force and then why those alternatives would have been reasonable or unreasonable in the incident.**

In regards to number five (above) on the Supervisor Use of Force Incident Review form regarding Department policies, almost all of the force reviews lacked an explanation of why Department policies (GOM 6.00.000 Use of Force and 6.01.000 Use of Force Reporting) were followed. Instead, listing why the department policies were followed, preferably with citations from the KCSO General Orders Manual, transparently demonstrates whether or not the use of force or the use of force reporting procedures were actually within policy.

VI. Use of Force Review: Key Incident

We closely reviewed for completeness, fairness, and transparency a use of force incident which resulted in a traumatic head injury to the victim. Although the witness statements (both civilian

and deputy) and incident reports were thorough and well-documented, overall, the investigation was incomplete and lacked critical explanations and justifications for the findings and recommendations. The packet lacked any consideration of the Deputy's previous uses of force, any misconduct, or issues that could further explain his actions. The conclusion that the use of force was justified lacked a substantial basis in fact. There was a dearth of analysis of the necessity for the level of force employed or consideration of reasonable alternatives. Litigation was brought on behalf of the victim, and the case ultimately settled for a very substantial figure. The disparity is troubling between the KCSO's internal analysis of the incident and whatever analysis resulted in the settlement.

Furthermore, there was no IIU investigation of the incident since IIU cannot self-initiate personnel misconduct investigations in use of force incidents unless a complaint against the deputy is made or the incident is a shooting where the subsequent Shooting Review Board rules that the discharge of the firearm was unjustified or a violation of department policy. As previously mentioned, a Use of Force Review Board ruling that an employee's use of force was unjustified would trigger an IIU investigation.

KCSO's internal review was patently inadequate, thereby bringing into question the Department's capacity to fairly judge its own deputies. As discussed in the final chapter of this report, the Office of Law Enforcement Oversight (OLEO) must possess the authority to reject inadequate use of force reviews.

2. Deputy-Involved Shootings

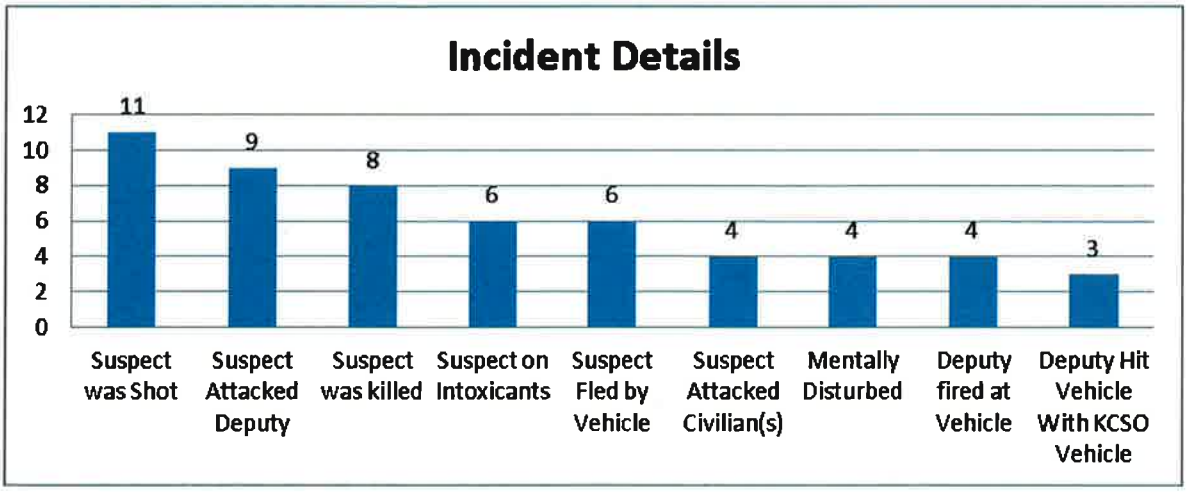
We reviewed deputy-involved shooting incidents for the King County Sheriff's Office (KCSO) to analyze the quality of deputy actions when using a firearm and of the internal investigation process thereafter. Each incident is described in a shooting review packet which includes documents pertaining to each case, and material released by the Shooting Review Board ("Board"). The Board holds a hearing on each shooting incident, and renders a decision on the deputy's actions during the event.

There were 15 KCSO shooting incidents that we examined—ten had been reviewed by the Shooting Review Board, and all occurred between 2005 and 2011. The other five incidents had not yet reached the Board. We did not second-guess whether the deputy involved was correct or justified in using their firearm. Rather, we observed the nature of the shootings, the ensuing investigation, and the Board Review that followed. We found many examples of excellent law enforcement and commend the King County Sheriff's Office for its efforts to conduct their job under high-pressure circumstances at a high level with aplomb. Even with KCSO's high quality of law enforcement, we believe that actions taken during shooting incidents and the following investigation should be improved.

I. Deputy-Involved Shooting Data

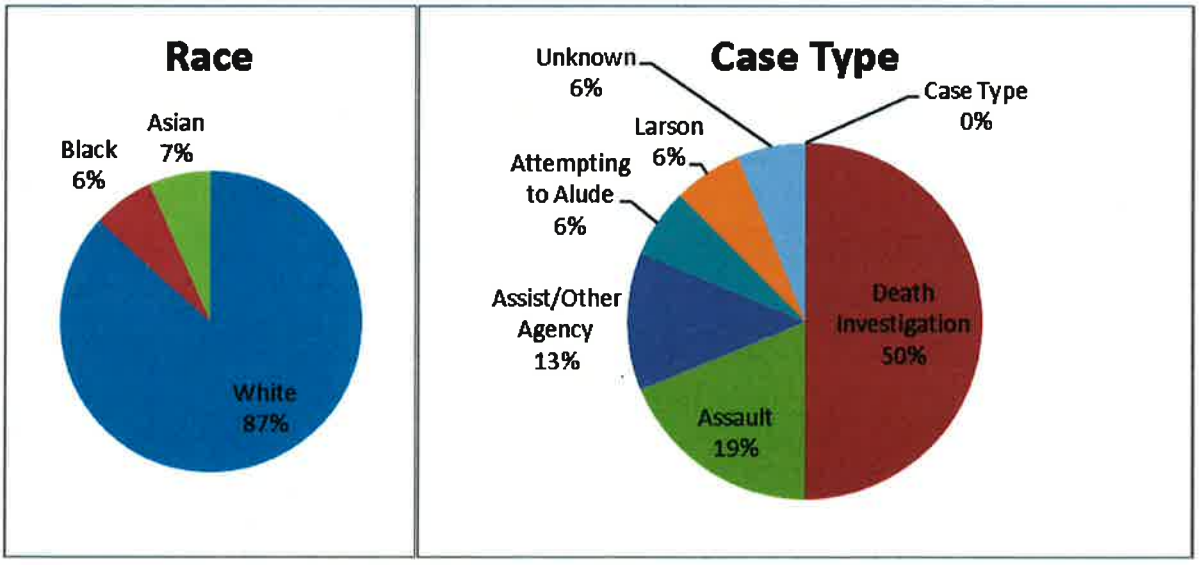
In the cases we reviewed, many of the involved suspects threatened or attacked a deputy, threatened or attacked a civilian, had suicidal ideation, or were intoxicated. In 15 shooting incidents, 11 suspects were hit, and of the suspects shot, 8 died. Table 5 shows the breakdown of case data details:

Table 5



Another trend we found was the high number of incidents that involved a deputy firing at a vehicle. More about these incidents will be discussed below.

Table 6



With 8 out of the 15 cases resulting in death by gunfire, "Death Investigation" is the most common case type, with "Assault and Assist/Other Agency" following in frequency. The demographic information shown in Table 6 from these incidents suggests that bias against

minorities is most likely not an issue. Nearly all of the suspects, 14 out of 15, were male and most were Caucasian—13 out of 15. The average and median age for the involved suspect was 37. There was no information on gang activity or terrorist suspicion.

II. Field Tactics

There are areas where KCSO should improve their field tactics. The KCSO General Orders Manual states that deputies may use their firearm only when every other means to apprehend the suspect has been exhausted[14] and when the deputy believes that the suspect poses a threat of serious physical harm to the deputy or others.[15] In the shooting reports we reviewed, there were very few instances where deputies used non-lethal methods to engage the suspect. Verbal commands with proper deputy identification were used in every shooting report. After communication with the suspect, the deputies would then proceed to deploying their firearm as the next step in nearly every case. There is only one case where a Taser-gun was used before the deputies used their firearm to immobilize the suspect. None of the incident reports mention the use of tear gas, bean-bag guns, flash-bang devices, pepper-spray, K-9 deployment, or other less lethal options before firing at the suspect. **We recommend that KCSO make greater use of less lethal options and that consideration of them be included in any shooting analysis.** Inasmuch as KCSO's policy requires that deadly force cannot be used until every reasonable means of apprehension is exhausted, each review of the shooting should explicitly remark whether alternative means were employed prior to using deadly force and, if not, why they were not used.

Many of the shooting incidents involved individuals who were under the influence of intoxicants, experiencing mental health problems, or enduring an extreme emotional state. The Police Bureau in Portland, Oregon, and at other law enforcement agencies across the country, employs a crisis intervention team (CIT) to handle situations where the suspect is

[14]"6.00.025 Use of Force, Deadly Force, Use of," *King County Sheriff's Office General Orders Manual* (2012).
[15]"6.00.025, Part 3 section b, Deadly Force, Use of," *King County Sheriff's Office General Orders Manual* (2012).

recklessly endangering their own life, or the life of another in the immediate area.[16] These CIT teams are trained to handle suspects who are not fully lucid or fully aware of the consequences of their actions due to intoxication or extreme emotional state. Many of these CIT teams include mental health experts and deputies who specialize in suicidal or out of control behavior. At KCSO, mental health experts can become involved only after the situation has been stabilized. A unit similar to the Portland's CIT team could help prevent deputy involved shooting incidents. As demonstrated in our recommended policies for dealing with high-risk individuals, **we recommend that KCSO develop a crisis intervention team to communicate with and manage individuals who are under the influence for intoxicants, experiencing mental health issues, or suffering from an extreme emotional state.**

The four investigations where a deputy fired at a vehicle had inadequate investigations and lacked support for a finding that those shootings were within policy. We believe that the frequency of these situations warrants much more rigorous analysis as well as a review of tactical training regarding moving vehicles and use of force options, as set forth in the additions we recommended in the prior chapter to the policy on shooting to and from motor vehicles.

III. Investigation

For deputy-involved shootings, Major Crimes considers whether the shooting violates the criminal law. The deputy involved provides basic information regarding the incident to Major Crimes, is relieved of his or her weapon, and will either give a statement or be questioned about the incident in a transcribed interview within 72 hours. In none of the 15 cases we reviewed was there an interview of the deputy who used their firearm. Rather, the deputy provided a written statement. The statements given by KCSO deputies were often truncated and self-serving. The deputy is not challenged as he or she might be in a formal recorded interview. The facts are not fully developed. Accordingly, **we recommend that a deputy**

[16] Police Assessment Resource Center, "The Portland Police Bureau: Officer-Involved Shootings and In-Custody Deaths," Accessed May 14 2012, http://www.parc.info/client_files/Portland/First%20Report/1%20-%20Officer-Involved%20Shootings%20and%20In-Custody%20Deaths.pdf.

involved in the shooting give a formal, recorded interview prior to being relieved of duty, whether or not a written statement has been provided. If the interview is entirely voluntary on the deputy's part, it may be conducted by a representative of Major Crimes. If, however, the interview is compelled, it should be conducted by IIU or a specialized team in order not to jeopardize a prosecution because of Fifth Amendment violations.

We believe that the investigative process for shooting incidents should be substantially modified. As noted earlier, the Shooting Review Board should be reconstituted as a Use of Force Review Board to consider both shootings and all other serious uses of force. Very few deputy-involved shootings present issues of criminal liability of the deputy in question. Prosecution of law enforcement officers is even rarer. It is nonetheless important that each shooting be analyzed criminally and presented to a prosecutor for a speedy acceptance for prosecution or rejection.

At the same time, it is also important to analyze whether a given shooting violated KCSO policy and, if so, whether the deputy should be subject to discipline. It is also critical that every shooting be considered from the viewpoint of tactics and strategy to determine whether policy or training needs to be changed. These various investigations may be carried out by different groups within the Department. Major Crimes currently handles the criminal aspects of the deputy-involved incidents. There should be a parallel investigation therefore by IIU of the administrative and policy implications of the shooting and by the training unit on the tactical and strategic issues. **We thus recommend that IIU "rollout" with Major Crimes to scenes where one or more deputies have used their firearm and conduct a parallel investigation.**

A. Specialized Team

Police and Sheriff's Departments in some jurisdictions in the United States have created teams of investigators who specialize in analyzing law enforcement conduct in lethal and nonlethal force situations. The team has advanced training in investigatory techniques, witness

interviewing, forensics, and of the skills necessary to analyze a given force incident for its criminal, administrative, training, tactical and strategic implications. The Metropolitan Police Department in Washington D.C. has one of the nation's best specialized teams in this regard.[17] The Metropolitan PD uses a Force Investigation Team (FIT) to examine shooting incidents involving police. The FIT unit creates specialized reports with the aforementioned elements of policy, training, tactics, and conduct. The KCSO may have too few shootings on an annual basis to justify a standing team. Nonetheless, it would be useful if KCSO trained a group of individuals who would specialize in analyzing officer involved shootings and serious uses of force.

IV. Shooting Review Packets

The Shooting Review Board packets demonstrate several strong qualities as a reporting device. The language used in the opening memo and the reporting deputy entries in the follow-up supplemental reports are clear and easy to understand. The layout of the follow-up supplemental reports and the evidence lists make important information explicit to the reader. All pieces of evidence are clearly listed along with first-person accounts of how it was collected by the reporting deputy. Reporting deputies also include adequate documentation of evidence collection and contacting witnesses.

A. Focus of Packet

Despite these positive qualities, details regarding the incidents are missing and the completeness of each shooting review packet greatly varies. Along with missing first-hand accounts from the deputy who fired their weapon and poor organization, many reports do not have nearly enough details to clearly illustrate the events that lead to the deputy using their firearm. The purpose of these incident reports is to identify what happened and why the deputy used their weapon. In some of the shorter reports, such little detail regarding the

[17] Police Assessment Resource Center, "The Portland Police Bureau: Officer Shootings and In-Custody Deaths," Accessed May 14 2012, http://www.parc.info/client_files/Portland/First%20Report/1%20-%20Deputy-Invovled%20Shootings%20and%20In-Custody%20Deaths.pdf

incident is given that even the moment when the deputy fired their weapon is completely omitted. To accurately judge whether the deputy was adhering to policy and training when using their firearm, it is crucial that all accounts from the involved Deputy are included in these packets. We are not recommending that all packets be of a certain length, but we are stating that all shooting reports be given due diligence in investigation and documentation.

The focus of the information in the packet can also deter the reader from accurately judging whether the deputy had correctly used their weapon. Documents from the investigations focus more on the suspect who was shot rather than the shooting incident itself. Many of the suspects involved in these incidents were mentally disturbed, depressed, suicidal, or a combination of these traits. Several of the investigations make a considerable effort to demonstrate that the suspect was unstable during the incident rather than showing that the deputy had used proper tactics. Providing a clear picture of the suspect and their behavior during the incident is an important aspect of any packet, and should be included in every one where it is applicable. Every shooting review packet should also clearly describe the details of the deputy's tactics so that a professional opinion can be formulated regarding the deputy's actions. Again, missing accounts by the involved deputies are crucial here; information about what steps the deputy made to diffuse the situation, and use non-lethal force before utilizing their firearm are missing from the packets. The actions of the deputies are of equal importance to the actions of the suspects and their respective dispositions during the incident. All packets should include a thorough report regarding the deputy or deputies involved and their ability to follow department procedures during the incident.

Some examples of when too much focus is put on the suspect rather than the deputy and the incident:

- In the investigation following a shooting and killing of a suspect, much of the information included in the report focused on the suspect's criminal past and desire not

to be caught for an outstanding warrant. The suspect's history is given much more attention than the shooting incident itself.

- One report gave the account of a woman's stay in a hospital after she was shot by a deputy. This report does give a thorough account of the incident, but even more detail is provided on the suspect's travel to the hospital, her subsequent stay, and her background leading up to the incident.

We recommend that the King's County Sheriff's Office focus more of their investigation on the deputy, witnesses, and the incident as opposed to circumstances surrounding the suspect.

Some of the incident reports gave a disproportionate amount of attention to minor pieces of information. Much of this unnecessary detail is provided in the evidence collection portion of the reports. For instance,

- There is a written statement from a deputy whose duty was to put up the "do not cross" tape, stand over a gun so that it is not touched, and transport the gun to the station.
- A member of the bomb squad gave a two-page statement about the retrieval and use of the bomb robot at a crime scene. It goes through the process of how the robot broke a lock and went inside the house. This is the first narrative found in the report.
- A suspect was shot on the balcony of his apartment. The suspect was claiming to have a large explosive in house and was ready to detonate it. The investigation thereafter dedicated several pages of reporting from deputies describing the suspect's gun collection.

It should be noted that we do not believe that these details should be omitted from the report packets; we are highlighting the imbalance of attention in them. In nearly all of the reports, there is twice the information on how the evidence was collected than the shooting incident itself. Overemphasis on evidence collection and lack of organization can obfuscate the findings

in the investigation. There would be greater clarity to these reports if evidence collection details were placed in the back of these packets. With such little information coming from the deputies involved in the shooting, and an abundance of information coming from tertiary figures in the incident report, this imbalance of focus in the reports can lead to errors in the judgments of those who make important decisions regarding these cases—particularly the members of the Use of Force Review Board. **We recommend that the incident reports include more balance in details of the incident and the investigation thereafter.**

B. Packet Organization

The shooting review packets provided were not well organized. For the purposes of this report, documents were pieced together for each shooting incident under review. After reading the material in each packet, we requested key interviews and statements that were absent among the materials provided. We received a majority of the statements and interviews that were requested, but at the time of this report, some are still missing. More regarding document retention will be addressed later.

We suggest the following standard for all future review packets:

1. A written Memorandum from the Review Board with a decision and a full explanation of the reasoning behind it, and other important details;
2. A detailed description of the incident, the events leading up to it, the options available to the deputy, the availability of less than lethal alternatives, and a discussion whether the incident could have been handled differently and in a safer manner.
3. A transcription of the formal interview of the deputy or deputies involved in the shooting;
4. A first person account of the witness deputies;
5. Interviews or statements of civilian witnesses;

6. First person account by investigative deputies who came onto the scene after the incident to describe what was seen, who they talked to, and what evidence was collected;
7. First person account by the deputies who come to the scene solely to collect evidence [supplemental material];
8. Evidence list (one list would be optimal) [supplemental materials];

V. Shooting Review Board

Each deputy-involved shooting is investigated and analyzed by a Shooting Review Board. These review Boards provide a crucial function to KCSO, however, there are some aspects to the Review Board that need immediate improvement.

For each shooting incident under review, the Board makes a judgment regarding the incident and releases a memo to relevant parties—including the involved deputy. These memos present an explanation of how the Board ruled and a very brief explanation of why it did. All ten shooting incident packets that had gone under review had nearly identical explanatory memos from the Shooting Review Board. They state that the firearm was used intentionally, the deputy was justified in using it, the deputy caused no violation when using the firearm, and that their training was adequate. Following this ruling there is an explanation that the department recognized that the deputy used their gun to defend themselves and that no further action is needed. There is little to no explanation of the situation, why the deputy was correct in using their firearm, what particular pieces of evidence did they find compelling, or why their training was adequate. Essentially, there is no explanation of what lead the Board to the particular conclusion that was reached. A detailed written statement from the Board should fully explain all of these questions. **We recommend that the Shooting Review Board release a detailed, written statement that explains how the Board came to its decision and include it in the shooting review packet.**

A. Documenting Shooting Reviews

Documentation and record-keeping are critical elements to the Shooting Review Board's credibility. These two elements of the Board need improvement. Court cases involving civilians are recorded by a court reporter and are kept on record. We believe that deputy-involved shootings also warrant a kept record of proceedings. Currently, there is no record of what is said or the evidence presented during Shooting Review Board hearings. Notes taken during the Shooting Review Board proceeding will help the Sheriff's Office to evaluate these hearings and to support their decisions if they are challenged in the future. A retained record of the Shooting Review Board will assist in risk management; this record would provide supporting evidence in a civil suit or a similar legal action regarding the incident. Notes taken of the Shooting Review Board proceedings should be kept in a file with all relevant documents of each Shooting Review Board hearing. The KCSO General Orders Manual states that the Chief Deputy will send case findings to the Internal Investigations Unit for record retention.[18] Shooting review packets for deputy-involved shooting incidents from 2005 to 2011 were not maintained. In our investigation of KCSO, all documents relevant to each deputy-involved shooting had to be located from other locations of the department (i.e. Major Crimes, Patrol Operations, etc.) to recreate the Shooting Review Board packets for our purposes. After the initial analysis of each packet, crucial documents were missing. Interviews or first person statements by the firing deputies or key witnesses were not initially included in the packets. Many of these transcribed interviews and statements were eventually located and forwarded to our organization, but a few remain absent. **We recommend that KCSO retain a permanent file of each Shooting Review Board hearing with notes of the proceedings.**

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[18] 6.03.030 of the General Order Manual (2012) states that IIU shall, "retain the **entire** case packet in compliance with the Record Retention Schedule." The Washington State's record retention schedule for cases held by Law Enforcement agencies is a minimum of "5 years after conclusion of investigation and until exhaustion of appeals process."
http://www.sos.wa.gov/archives/recordsretentionschedules.aspx.

B. Voting

Also absent is any indication of dissention among the members of the Board on the final opinion. Every Board was recorded to have voted unanimously. After speaking with former KCSO Captain Tony Burtt, it appears that unanimous votes to exonerate the involved deputy are standard for Shooting Review Board hearings. Burtt expressed that he has never heard of a dissenting opinion on the Shooting Review Board. He stated that after some discussion of the facts of the case, the Board would vote to exonerate the deputy and no one held to a dissenting opinion through the voting process. **We recommend that the King County Sheriff's Office adopt a practice of allowing and encouraging, when appropriate, dissenting opinions in the Shooting Review Boards. Additionally, we recommend that all votes should be recorded and kept on record with other Shooting Review Board packet materials.**

C. Board Members

The members of the Board must serve in this capacity without personal or professional bias. The Board's voting members currently include a Chief, a Captain, and at least one Sergeant. Ranking KCSO members in the chain of command of the deputy being reviewed are not allowed to vote on the Board. We commend KCSO for this practice, and advise that this policy be added to the General Orders Manual. Other voting members include deputies, a legal advisor, and KCSO Guild representatives. Peer deputies sitting on the Board will not likely vote to condemn the deputy of acting unjustifiably or outside of department policy. Personal connections may lead to bias—favorably or in some cases unfavorably. **We recommend that KCSO no longer include deputies on the Shooting Review Board or on our recommended Use of Force Review Board.**

Deputies representing the KCSO Guild are required to act in the interest of Guild members and to provide protection. When a Guild member sits on the Shooting Review Board, particularly in cases where they have a vote, there is a conflict of interest. The Guild representative cannot judge the actions of a deputy who used a firearm without bias because their role in the Guild.

We recommend that KCSO remove all representatives of the Guild from all future Shooting Review Boards or our recommended Use of Force Review Board.

It is common for Sheriff and Police departments to have citizens sit and vote on shooting reviews or use of force reviews. The citizen member of the Board will not likely have biases that members within the department might have and bring an outside perspective to the reviews to make the final judgment and proceeding fair and balanced. **We recommend that KCSO add a citizen member to the Shooting Review Board or our recommended Use of Force Review Board for all future reviews.**[19]

D. Timing of Board Hearing

In addition to these adjustments to the Shooting Review Board and possibly the Use of Force Review Board, we would like to make a recommendation about the timing of a hearing after the incident. There is a sequence of events that must take place after a KCSO member has discharged their firearm, but it is difficult to understand if the department is adhering to these rules due to poor record keeping. In the shooting review packets, we could not locate the date of when the criminal investigation was completed. This is important because there are deadlines that occur after the criminal investigation is completed. If there is an administrative investigation, such as a use of force review, then it must be within 180 days of the matter coming to the attention of the Sheriff's department, but in "cases of a deputy involved fatal incident, the one hundred and eighty (180) day period will commence when the completed criminal file is provided to the Prosecuting Attorney," as stated in 3.03.150, part 1, section a of the GOM. Also in the General Order Manual, under 6.03.010, part 1, it states that the "Shooting Review Board shall meet within thirty (30) calendar days after the completion of the criminal investigation or completion of any inquest." What we have observed from the shooting review packets is that the average case was heard by the Shooting Review Board 7.7 months after the incident. All dates in each shooting review packet were checked and no

[19] Please refer to part one section three of this report to see how the Board should be comprised.

follow-up report or any other recorded action by a deputy occurred within two months of the respective Board's hearing. Recent evidence of KCSO's lag in reviewing use of force cases can be seen in Table 7. The table shows that all cases are more than 180 days old, and thus cannot have a use of force review, and the Shooting Review Board hearing was, on average, 11 months after the shooting incident occurred. This is clear evidence that KCSO does not handle these incidents in a timely fashion. **We recommend that KCSO clearly indicate when the criminal investigation is completed to check whether the department is meeting its own deadlines and to adhere to the 30 day rule of holding a Shooting Review Board hearing after an incident.**

Table 7

2011 Officer Involved Shooting Incidents				
All cases are more than 180 days old†				
		Criminal Review		
Date of Shooting	Suspect	CID Investigation	Inquest Completed	PAO Review Completed
3/19/2011	Deceased	Yes	Yes, 214 days after incident (Oct. 19, 2011)	Yes, 233 days after incident (Nov 7, 2011)
4/17/2011	Deceased	Yes	Yes, 288 days after incident (Feb. 6, 2012)	Ongoing
7/24/2011	Survived	Yes	N/A	Yes, Suspect Charged
8/10/2011	Deceased	Yes	Scheduled, 404 days after incident 9/17/2012	Ongoing
9/2/2011	Survived	Yes	N/A	Yes, Suspect Charged

		Administrative/Misconduct/Policy Review			
Date of Shooting	Suspect	Use of Force Review	IIU Investigation	Shooting Review Board$^{\Delta}$	Lessons Learned Review
3/19/2011	Deceased	No*	No‡	4/23/2012	5/1/2012
4/17/2011	Deceased	No*	No‡	5/15/2012	4/19/2012
7/24/2011	Survived	No*	No‡	5/22/2012	9/12/11 & 5/22/12
8/10/2011	Deceased	No*	No‡	No	9/17/2011
9/2/2011	Survived	No*	No‡	5/10/2012	5/10/2012

† GOM 3.03.150 and KCPOG CBA, Article 19-Section 9 both state: "Administrative Investigations must be completed within 180 days of the matter coming to the attention of the Sheriff's Office Command Staff/Captains." For non-fatal incidents, the 180 days is tolled *only* while the file is being reviewed or prosecuted by the PAO (it is not tolled during the criminal investigation). For fatal incidents, the 180 days starts when the PAO receives the file and is not tolled at all unless criminal charges are filed.

* GOM 6.01.000 mandates that Use of Force Review is required whenever a deputy uses either deadly force or physical force, or for any incident that results in injury or complaint of injury.

‡ KCPOG CBA, Article 19-Section 9, (A)2 prohibits discipline for misconduct after the 180 day administrative investigation period.

Δ Per GOM 6.03.010, Shooting Review Boards evaluate whether the discharge of the firearm was accidental or intentional, justified or unjustified, a department policy violation, or due to either inadequate or improper training.

^ GOM 6.03.010 mandates that a Shooting Review Board should have been held in this case no later than Nov. 18, 2011.

[&]GOM 6.03.010 mandates that a Shooting Review Board should have been held in this case no later than March 7, 2012

GOM 6.03.010 mandates that a Shooting Review Board should have been held in this case. The deadline for holding a Shooting Review Board has likely passed; however, the exact date on which the Board should have been held is still being researched.

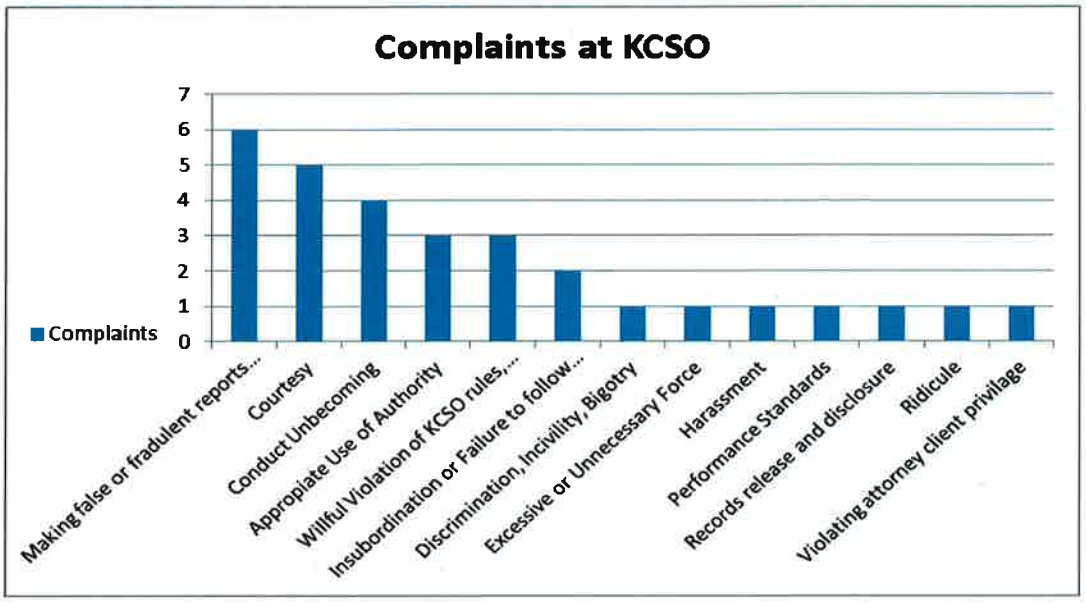
ϕ GOM 1.05.050 mandates a post major incident "lessons learned" review meeting be conducted within four weeks following the incident. A written overview of the review is required to be completed within two weeks of the meeting. OLEO is continuing to research the issue, but can find no record at this time that indicates compliance.

3. Investigations of Personnel Misconduct

Investigations of personnel misconduct are important to maintaining a high standard for the KCSO. These investigations at KCSO are carried out by IIU, and IIU sends the file to a commander for a recommendation of whether the allegation(s) should be sustained. These investigations of KCSO members demonstrate the department takes them very seriously. Many of the allegations investigated by IIU were sustained, and the reports that cover the allegation cases are of a high quality. We were provided 17 packets with allegations against 19 KCSO workers. For the 19 employees there were 30 allegations assessed, and all were levied against the KCSO members during 2011 and 2012. There were 16 allegations that were sustained, 5 allegations were unavailable, 4 allegations were unfounded, 3 allegations were non-sustained, 1 was undetermined, and 1 was dropped before a final decision by IIU was passed. None of the rulings were exonerated.[20] Most of the packets had clear materials and explanations about why the decision by IIU was made, but some cases needed improvement. Table 8 shows the complaints at KCSO during this time period:

[20] These are the options for allegations assessed against KCSO members.

Table 8



The most common KCSO complaints that PARC observed were "Making false or fraudulent reports," "Courtesy," and "Conduct Unbecoming."

I. Complaint and Allegations Process

Complaints can come to any KCSO worksite and will be screened at whichever worksite they are received. If a complaint is submitted to IIU, it is screened in that department to determine the next step in the complaint process. The initial screen determines whether the complaint is a Non-Investigatory Matter (NIM), Supervisory Action Log (SAL), or an Inquiry. A NIM is a complaint levied against law-enforcement machinery (i.e. red-light cameras, helicopter noise), against a policy or law, or alleging conduct that, if true, is not a policy violation. The SAL category is for complaints of minor violations such as appearance infractions or infrequent tardiness, and an Inquiry is an allegation of misconduct that is more serious than the SAL, such as Obstructing Justice or Conduct Unbecoming. Once a complaint is determined as a NIM, no further action is required, while the SALs are entered in both the Blue Team database and EIS (Early Intervention System), and handled by the commanding officer. An Inquiry is either

entered by IIU, or a supervisor, then determined by an IIU commander whether to handle the decision within the worksite of the deputy involved or by IIU.

A preliminary investigation is launched to obtain a statement from one or more complainants and gather information. The IIU works with the Commander of the workstation where the complaint has taken place, and determines the sequence of the criminal and administrative investigations, and if the deputy involved should be put on administrative leave or reassigned. The investigating personnel then conduct their investigation, and send their results to a review group that consists of an IIU investigator, a KCSO labor negotiator, a representative from the PAO, and KCSO's Professional Standards Division Manager.

Note: the OLEO Director was a participant in these meetings, but his participation was blocked by the Guild by way of grievance. OLEO believes his participation is crucial to accessing the quality of IIU investigations.

The Shooting Board Review convenes after receiving this information and can only provide comments about the case to the unit commander who will be making a recommendation. This group does not have any decision-making authority on the process. The unit commander has the option to sustain the complaint or request further action on the case. If the complaint is sustained, the unit commander then may make a recommendation for discipline. The case is then given to the Chief Deputy who reviews the file and either imposes the written reprimand of discipline, or if the disciplinary action is greater than a written reprimand, informs the deputy that a Loudermill Hearing will be scheduled. After the Loudermill hearing, if the decision to enact the disciplinary action is upheld, it is meted to the deputy soon after.

Here is the complaint process if it is received by IIU:

- The complaint is received and screened by an IIU commander to determine if the complaint is a policy violation. If the commander decides that an investigation should be

launched, it is then assigned via Blue Team to either a Section Commander or an IIU Sergeant. A schedule is then set to allow for the investigation and subsequent disciplinary actions to be carried out.

- After completion of the investigation, Section commanders will route their findings to the IIU Commander. The Commander then updates IAPro, makes a recommendation on next steps, and creates a memo notifying the employee of these actions.

- If necessary, a Loudermill hearing is scheduled, and a final disposition letter is sent to the complainant via IIU. The IIU Commander will close out the case in IAPro with an update of the records.

The complaint process is of a high quality with logical steps in the investigation and decision-making process. The steps from receiving the complaint, to the investigation, and to the disciplinary action are clearly described in the KCSO General Orders Manual. When the investigation is handled by IIU, it is important to prevent outside parties from influencing the outcome of the case. We commend KCSO for only allowing outside parties, such as the PAO labor negotiators and HR managers, to have a commentary role only in the matter until the disciplinary action has taken place.

The investigations conducted by IIU are also of a high quality—something that will be elaborated further in the next section. KCSO worksites do not have the same bureaucratic separation from investigations of employees and thus may be subject to some amount of bias in the processing of complaints. For either personal or professional reasons, investigations that are kept internal to workstation might find different results than if it were conducted by a division that is unaffected by cases outcome. **We recommend that IIU handle all complaints of KCSO employees.**

While the process of the internal investigations are of a high quality, there needs to be additional language added to reporting responsibilities of the KCSO members. Reporting general misconduct of KCSO members should be done immediately by peer employees of the department. Any observation of criminal misconduct or what could potentially be criminal misconduct by a peer member of KCSO is to be reported immediately to an on-duty supervisor by all KCSO employees as stated in the General Orders Manual, section 3.03.020. General misconduct observed by member KCSO employees should also be reported immediately to their on-duty supervisor. Informing KCSO department executives of possible actions of misconduct will help to make the subsequent investigation more accurate and timely. Currently, there is no language in the GOM that states when a KCSO member should report the observation of general misconduct by a fellow employee. A significant gap in the reporting of possible misconduct raises the chances that an error in the investigation or concealing the facts regarding the misconduct can occur. **We recommend that KCSO repeat the policy of immediately reporting criminal misconduct so that all observations of general misconduct are immediately reported as well.**

I. Investigation Quality

All complaint investigations that we received were handled by IIU, thus we cannot comment on the quality of the investigation completed by KCSO worksites.

IIU's handling of complaints is commendable. The case against the KCSO employee is clear, supporting documents are always included, and the final decisions are consistent to the materials in the complaint packets. Almost all packets have a final memo at the beginning of the packet, a sequence of events that lead to the final decision of IIU, letters to relevant parties, and interviews with key witnesses and suspects. Other materials found in the packets are a copy of the KCSO employee's Garrity Rights, incident reports, court documents, emails discussing the case, and pictures used to support claims made in the case. Not only are basic facts regarding the case easily accessible, but so is the basic narrative of the case and the contentious elements that ultimately decide the outcome of the case.

In the General Orders Manual, rule 3.03.150 states that, "Administrative Investigations must be completed within one hundred and eighty (180) days of the matter coming to the attention of the Sheriff's Office Command Staff/Captains." From the date of the incident to the creation of the final memo, all of the cases were open and closed within 6 months except for one. **We recommend that KCSO immediately end this 180 day tolling provision for administrative investigations**. The deadline places a time constraint on important investigations that may take longer than 180 days to complete. The General Orders Manual states that the Sheriff has the ability to extend an administrative investigation beyond the 180 days due to various factors, including extended illness or the unavailability of a critical witness, however, the Sheriff must request extension from the Bargaining Unit. We do not believe that administrative investigations should have a time constraint. The investigations should proceed in a timely manner, but not obstructed by a looming deadline.

With one serious exception, the packets had all of the necessary materials and were well organized. These complaint packets came with memos that explain the basic facts of the case and the finding of the matter. Also included are summaries of who was involved in the case, and a brief summary of the incidents leading up to the complaint. Transcribed Interviews by key individuals associated with the case and the deputy facing allegations were also included. The memo, summaries and interviews come in that order, and there is a copy the Garrity Admonishment and the Deputy Bill of Rights included in most packets.

Correspondingly, Garrity protection was afforded to witnesses in a very high frequency of the packets we examined. The KCSO should carefully study the critique by the Department of Justice regarding the overuse of Garrity by the Seattle Police Department (SPD).[21] Garrity provides important and fundamental protections for police officers, but its protections are

[21] The title of the study is *United States' Investigation of the Seattle Police Department-Garrity Protections*. The report can be found on the Department of Justice's website here: http://www.justice.gov/crt/about/spl/documents/seattlepd_TA_11-23-11.pdf.

limited. DOJ's investigation has shown that SPD attempts to apply Garrity to all uses of force and deputy involved shooting incidents. SPD's inappropriate blanket invocation of Garrity may result in the exclusion of important evidence from an investigation. Moreover, SPD's failure to shield criminal investigators from Garrity materials could taint and render unusable other critical evidence. These practices compromise both SPD's ability to supervise officers' use of force and its ability to fully and efficiently conduct criminal and administrative investigations. Put simply: This practice makes it too difficult to quickly exonerate officers who have followed policy and to properly discipline officers who have not. Further, these practices compromise the ability of prosecutors or other outside agencies to adequately assess incidents and to hold officers accountable for their actions. We have not formally investigated KCSO's use of Garrity in uses of force and deputy involved shooting incidents, however, we recommend that KCSO review the Department of Justice's study on SPD's usage of Garrity.

A. Allegation Packet Materials

The memos and summaries in the packets include analysis and discussion of the case, and there is explanation of what led to the finding. The interviews are thorough and have penetrating questions that reveal important details about the case. The allegation reports gave clear picture of why the deputy was facing the complaint, and why IIU made their determination.

The conclusions reached by Commanders were typically a logical result of the materials in the packets. Cases that were unfounded were due to contradictory testimony by the complainant. When the complainant did not follow through on completing the IIU complaint form, or when the complainant was unavailable to the IIU investigator for questioning, the case was dropped. Sustained allegations resulted in fair discipline. There were two terminations, and both cases involved employees that were charged with multiple allegations with strong supporting evidence. Four employees were given written reprimands, two faced additional training for their sustained allegations, and one was given an oral reprimand plus additional training.

With the exception of one case, the KCSO complaint process is well-functioning and effective. The allegations of misconduct are thoroughly investigated and the documentation of the proceedings makes the complaint process transparent. We found a few instances of missing documentation, and IIU should ensure this happens as little as possible, but the complaint packets were of a high standard. When compared to the use of force or deputy involved shooting investigations, the complaint investigations are of much higher quality. These complaint packets demonstrate that KCSO has the ability to carry out strong self-regulatory work. We hope that they apply this ability to all incidents when misconduct is a possibility.

B. Possible Improvement for Investigations

The current standard of investigations of KCSO members is of a high quality but they are not yet exemplary. In order to improve investigations of misconduct against a KCSO employee, the investigations must have explicit standards that explore all aspects of the case. Many of the cases do not suffer from lack of thoroughness, but many cases do lack consistency. Each case should explicitly demonstrate a standard of investigation to show that all aspects of situation have been exhaustively explored.

There are key elements that each investigation should possess and should be easily identifiable to those who read a KCSO IIU allegation report. **We recommend that KCSO create a clear written standard for all IIU investigations.** There are standards available that KCSO can emulate in codifying their own standard for investigations. In Table 9, there is a Complaint Review Matrix that is used by OLEO to review complaint cases against members of law enforcement. KCSO can use this review matrix, or another one of their choosing, to implement this suggestion of creating a standard. Some standards from the attached matrix may not apply to KCSO's practice of investigations, so here are the rules that we believe are imperative to a complete investigation:

1. All pieces of critical evidence are collected and recorded.

2. There is a chronological log or description of the incident and of the investigation timeline.
3. Interview all witnesses relevant to the case within KCSO and in the Public (non-Department). Tape- or video-record all interviews and have them transcribed.
4. Thoroughly canvass the scene of the incident for witnesses.
5. Ensure that each allegation facing a KCSO member is germane to the circumstances and actions of the individual being accused.
6. The Executive KCSO member in charge of overseeing the case should check all aspects of the case for inconsistencies and to ensure that all cases have been thoroughly investigated.

The above rules will help keep all internal investigations consistent and able to withstand scrutiny. There are some instances where the complaint investigations do not adhere to the above guidelines:

- One investigation involved a Marshal who was threatened with a complaint by an ex-husband who wanted the Marshal to agree to a divorce settlement. If the Marshal did not agree to the divorce settlement, then the ex-husband would file the allegation. The case was dropped as Undetermined after a background check was completed and the complainant did not follow through with the allegations. There should have been more evidence collection and interviews to make the investigation consistent with others.
- Four KCSO members were accused of obstructing justice by an attorney who lost a case that involved the deputies. The attorney was representing defendants whom the deputies had arrested. The attorney did not complete the filing for the allegation and the case was dropped. The attorney should have been interviewed regarding his/her suspicion of the deputies obstructing justice.
- A Marshal in charge of checking people who were entering a King County courthouse allowed a man to leave the court building after being identified with what

may have been a controlled substance. There is only a written report from the Marshal regarding the incident, but an interview should have been conducted with the Marshal and transcribed thereafter.

Many of the investigations were concluded after IIU had reached an apparent conclusion, but more could have been done to ensure that the conclusion was correct. We believe that the current fashion that investigations are executed are satisfactory, particularly when compared to investigations of use of deadly force, but more can be done to make them laudable. We are not admonishing KCSO's Internal Investigation Unit for how they have investigated employees in the past, but are providing a guide on how they can be improved.

Table 9[22]

Q#	QUESTION DESCRIPTION FOR REVIEW OF COMPLAINT INVESTIGATION FILES
1	Are all pages of the investigation present?
2	Is the investigation missing any critical evidence that is known to have been collected?
3	Is the investigator's chrono log included in the file?
4	Were all interviews conducted by the investigating officer tape-recorded or video-taped?
5	Were all identified Public (non-Department) witnesses (including complainants) interviewed?
6	Were all Department employees who witnessed or were involved in the incident interviewed?
7	Was the scene of the incident canvassed for witnesses?
8	Did the IO address all significant inconsistencies between interview statements gathered during the investigation?
9	Was all significant physical evidence pertinent to the investigation collected and preserved?
10	Were reasonable efforts used to corroborate complaints that were withdrawn, filed anonymously or by a person other than the victim of the misconduct, or did not have a statement from the complainant due to their unavailability?
11	Were all allegations properly framed?
12	Was there any indication that misconduct, other than that "framed" as an allegation also occurred?
13	Did the involved officers indicate there was a reportable UOF during this incident?
14	Was the matter referred to the District Attorney for criminal filing considerations.
15	Overall, does the auditor have any significant concerns or questions that potentially impact the adequacy and thoroughness of the investigation that have not already been addressed in previous questions?
16	If this incident resulted following a stop or detention by the officer, was reasonable suspicion for the stop articulated?
17	If this incident resulted in a field search (e.g., person, vehicle or home) was the legal basis of the search articulated.?
18	Did the adjudicating officer use the following to assess witness credibility, as applicable: CA Jury Instructions standard, consider the accused officer's complaint/discipline history (TEAMS) and/or consider the civilian's criminal history?
19	Was there any indication that the adjudicating officer gave automatic preference to an officer's statement over those of other witnesses, including that of the CP?
20	Was there any indication that the adjudicating officer automatically concluded insufficient information was available to determine credibility because the only available information were the conflicting statements of the complainant and involved officer(s)?
21	Did the adjudicating officer dismiss a witness statement based solely on familial or social relationship?
22	Was the complaint adjudicated using the preponderance of evidence standard to adjudicate all framed allegations?
23	Did all allegations receive a final adjudication before the complaint was closed?
24	Does the auditor agree with the Final Adjudication rendered for each allegation?
25	Did the adjudicating officer evaluate the complaint to identify underlying problems and/or training issues, and was this noted in the AO's Report?
26	Did the Department notify the complainant in writing of the complaint's resolution?

[22] Ignore rule 18 in this list. Rule 18 does not apply to complaint investigations. To retrieve a copy of this document, please contact the Office of Law Enforcement Oversight.

4. Office of Law Enforcement Oversight (OLEO)

The powers of the OLEO are set forth in King County Ordinance Chapter 2.75. The ordinance establishes the Office of Law Enforcement Oversight (OLEO) as an investigatory agency. OLEO is established under the legislative branch of King County government. The head of that office, the "Director," serves a term of four years and can only be removed for cause. The Director is empowered to review and certify whether citizen's complaints and other investigations conducted by the KCSO are thorough and objective. Among the other powers of the Director is the ability to:

> Make recommendations for action by the sheriff on needed improvements in policies, procedures and practices stemming from analyses that look beyond the individual cases of misconduct to identify systemic problems within the sheriff's office. In addition to investigational materials available to the office, the director shall make use of all other available materials, including internal and external audits and reviews of the sheriff's office and critical incident reviews, in developing and making recommendations for improvements. Chapter 2.75.050 (C) (2).

The Director has broad authority to oversee, participate in, and render judgments with respect to misconduct investigations. With the exception of ongoing criminal investigations, OLEO has unimpeded and real-time access to unredacted case information and all information related to ongoing investigation files. OLEO must be given notice the opportunity to participate in questioning witnesses in all serious misconduct matters. OLEO must certify whether a given investigation was thorough and objective. The Director has the power to compel further investigation unless overruled by the County Executive.

The models for OLEO include two oversight groups at the Los Angeles County Sheriff's Department (LASD)—the Office of Special Counsel (Special Counsel) and the Office of Independent Review (OIR). The duties of OIR closely resemble that of the Director:

> This group of six lawyers with significant civil rights experience has been empowered to direct and shape internal affairs investigations in the LASD. No investigation can be closed unless the OIR certifies that it was full, fair,

> and thorough. The OIR has the power to participate as necessary and appropriate in ongoing investigations by internal affairs, including interviewing witnesses, responding to crime scenes, and reviewing tangible evidence and relevant documentation. The OIR monitors all ongoing, internal investigations, and reviews all completed investigations to ensure that the content, disposition, and recommended discipline are appropriate. Additionally, the OIR is empowered to make recommendations of disposition and discipline on all investigations within its purview.[23]

Special Counsel has the responsibility, as does the Director, to investigate and report upon systemic problems within the law enforcement agency and make recommendations on needed improvements. In this capacity, both Special Counsel and the Director look beyond individual misconduct cases to identify systemic issues. The Director's public reports should resemble the following:

> The public monitoring reports, which address the fundamental excessive force and integrity issues in policing, are calculated to foster a constructive, task-oriented, and problem-solving dialog, stripped of ideology and rhetoric. A primary goal is to assist the department in devising ways to eliminate excessive or unnecessary, lethal or non-lethal force. Another goal is for law enforcement to learn to handle situations that legitimately call for the use of force in a way that produces an acceptable result from the law enforcement perspective while providing a reduced risk of injury to both the officer and the suspect. Approaching the reports with these goals in mind sharpens the strategic and tactical analysis, and makes room for a wider and more free-ranging inquiry into alternative solutions to the control of excessive force. By stripping the discussion of blame, rhetoric, and ideology, everyone involved is freer to focus on the problem rather than worrying about mistrustful suspicions, personal motivations, and political agendas.
>
> In addition to the hope of providing both better and safer policing, it is hoped that the risk of legal liability for the law enforcement agency will be significantly reduced. Monitors are accountable to different constituencies. First, each is accountable to the law enforcement agency to provide assistance or reports calculated to focus police management on internal decision-making, policy formulation, and efforts to responsibly anticipate and manage liability risk. More importantly, a monitor is accountable to the public at large to provide a thorough and fair appraisal of law enforcement, and to make

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[23] Merrick Bobb, "*Civilian Oversight of the Police in the United States*," *Saint Louis* University Public Law Review, Volume 22, Number 1, 2003, p.18.

> the heretofore mystery-shrouded, internal processes of the police more transparent and comprehensible.
>
> To fulfill these dual responsibilities to agency and the general public, a monitor must speak candidly about weaknesses in internal police mechanisms for accountability and responsibility. The monitor must scour and test the law enforcement agency's policies, procedures, and practices to determine whether they are, in fact, up to the job of preventing misconduct. The monitor should propose new policies and practices where the old ones have failed. Additionally, OLEO ought to consider how the agency he or she is monitoring compares to other police departments with respect to the use of lethal and non-lethal force. After such comparison, the monitor should suggest the implementation of best practices from other law enforcement agencies.[24]

OLEO, as presently constituted, cannot accomplish the foregoing. OLEO is understaffed to an astonishing degree. There has been only one employee in addition to the Director, and as talented as that individual and his successor are, it is impossible to fulfill the duties of the office given the number of matters pending at any one time. The office requires an additional lawyer, an investigator or two, an individual skilled in data and statistical analysis, and an office manager. Those resources should be provided to OLEO rapidly.

OLEO requires the active support of the County and the County Executive fiscally and politically. OLEO is a County agency it is not part of the King County Sheriff's Office. In a sense, the Director is the eyes and ears of the County with regard to the Sheriff's Office. Among the goals of the County in setting up OLEO is to reduce misconduct and the liability of County taxpayers for it. KCSO's risk management strategies need to be formalized and expanded. The linchpin is to track officer performance through an early warning and tracking system and to deal at an early stage with problem or possibly problematic officers. To do that effectively, one cannot impose features like the rolling 90 days currently in place. Similarly, OLEO should have the authority to reject inadequate use of force reviews to ensure thorough, independent investigations. The Director requires the resources and freedom to report upon systemic failures to manage risk.

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[24] *Ibid.*

OLEO is not responsible to the Sheriff and is not part of the KCSO. The Director reports only to the County. Only the County has the power to fire the Director, and can do so only for cause. As such, the Director is outside the KCSO's disciplinary system. Any complaints about the Director should be in the form of a complaint directly to the County Executive and not by way of a grievance process or other forms of redress by KCSO employees.

Likewise, neither the KCSO nor its employees' representatives should fashion rules governing how the Director goes about his job. The Director should roll out go to the scene of officer involved shootings and other serious uses of force, question KCSO employees, review documents, files, and databases, conduct interviews, and take such other steps as may be necessary to fulfill the duties set forth in the ordinance.