

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

*Insight Gained from Systemic Review of January 27, 2017,
Officer-Involved Shooting of Mi'Chance Dunlap-Gittens*

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Introduction

On January 27, 2017, Mi'Chance Dunlap-Gittens was shot and killed by deputies of the King County Sheriff's Office ("KCSO") after KCSO devised an undercover scheme to detain Dunlap-Gittens' friend D.R.¹, in conjunction with a murder investigation. Following the shooting, the Prosecuting Attorney's Office convened an inquest into the matter and the jury found no basis to recommend charges be filed against any of the involved deputies. This report, commissioned by the King County's Office of Law Enforcement Oversight ("OLEO") and prepared by OIR Group,² is not intended to relitigate those findings. Instead, our review focused on KCSO's *internal* investigative and review mechanisms. The goal is to assess the objectivity and thoroughness of fact collection and the rigor of the subsequent administrative review of KCSO actions.

In furtherance of that goal, we reviewed the investigative materials to determine the degree to which KCSO's investigative policies and practices provided an ability for KCSO to develop a body of evidence that was adequate to the task of appropriately scrutinizing the involved deputies' actions and decision-making. We further reviewed the investigative materials to learn whether current KCSO protocols allowed for effective collection of evidence, scene maintenance, and timely post-shooting provision of medical care. We also examined KCSO incident review materials and protocols in order to learn whether those systems properly facilitated the ability of KCSO to learn from critical events and adjust its practices to strengthen future performance. Finally, and based on our evaluation of the attributes and limitations in the current model, we devised recommendations designed to improve relevant KCSO policies,

¹ Because D.R. was a juvenile at the time of the incident, his initials have been used instead of his full name.

² Since 2001, Michael Gennaco and Stephen Connolly of OIR Group have worked exclusively with government entities in a variety of contexts related to independent outside review of law enforcement, from investigation to monitoring to systems evaluation. As part of their oversight responsibilities for numerous jurisdictions, Gennaco and Connolly have reviewed scores of officer-involved shootings and devised recommendations to improve attendant investigative and review practices.

OIR Group is particularly familiar with KCSO as it has previously reviewed OLEO policies and protocols, provided technical support for the County Auditor's review of KCSO's early intervention system, and examined KCSO's complaint review process for uses of force. The early intervention and complaint review reports resulted in a number of recommendations implemented by KCSO.

practices, and protocols – thereby promoting not only appropriate accountability but also the identification and dissemination of beneficial “lessons learned.”

Based on our review, we found that there are some features worthy of praise in KCSO’s current investigative and review mechanisms. In particular, we were struck by the detail with which the Administrative Review Team (ART) process identified issues worthy of reflection and reform. However, once issues were identified through that process, they were largely countermanded or ignored by an apparently disapproving Use of Force Review Board. Additionally, even if some or all of the internally generated recommendations had been accepted, there was no apparent structure for their implementation. In essence, while a unit of KCSO was given leave to identify and advance ideas for improvement, those reforms were allowed to die on the vine.³

Along with the useful insights that were produced internally but never acted upon, there are other issues we cite here that were apparently not identified or pursued at any stage of the KCSO review. These elements, which relate to the planning, execution, and aftermath of the operation, would be featured in the kind of comprehensive, holistic assessment of critical incidents that we advocate for all law enforcement agencies.

This report, then, has both substantive and procedural observations about the underlying incident and KCSO’s ultimate responses to it. We are hopeful that KCSO leadership considers this analysis and recommendations in the constructive, forward-looking spirit with which they are issued. An objective and thorough collection of the facts of a serious incident is indispensable for an effective review process. And an effective review process allows for accountability, learning, and course correction. When they occur, the result is an effective feedback loop that better prepares that agency for similar future challenges, enhances officer safety, and potentially reduces incidences of deadly force. This report is intent on further developing a framework within which KCSO can achieve each of these vital objectives.⁴

OIR Methodology

As part of our review, OIR Group reviewed the investigative and review file provided to OLEO. We reviewed reports, photographs, testimony, and the underlying recorded interviews of witnesses and involved deputies. Unfortunately, we were not afforded the opportunity to talk

³ In response to a media inquiry, KCSO indicated that because the review of this incident occurred under a previous administration, it was difficult for the current one to learn what became of any recommended systemic reforms. However, as detailed below, there is considerable documentation regarding the underlying bases and the recommendations that the current administration could certainly revisit. On a going forward basis, we understand that KCSO has been working on policy improvements that speak to the need for documentation and implementation of accepted reforms that emerge from the deadly force review process.

with KCSO personnel responsible for the investigation and review of the incident. We have included this step in the hundreds of prior shooting reviews we have conducted, across numerous different law enforcement agencies. The opportunity to go “beyond the documents” in this way provides important insight and perspective, thereby increasing the ultimate value of the assessment. In spite of this, and disappointingly, KCSO chose to not make its personnel available. On a forward going basis, we implore KCSO to create protocols so that the insight of key personnel involved with the review process can be considered during future independent systemic reviews.

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

Factual Summary

On January 27, 2017, detectives from KCSO’s Major Crimes Unit were investigating a homicide that occurred two days prior. D.R. was identified by detectives investigating the homicide as a “person of interest.” Detectives then began corresponding with D.R. on social media, posing as an underage female in an effort to lure him to a location for purposes of arresting him. Through that messaging, arrangements were made to meet up with D.R. for the supposed purpose of purchasing alcohol. Detectives used an unmarked van and drove to a location in Des Moines that D.R. advised.

Two plain-clothes detectives were in the passenger compartment of the van, while three detectives (Sergeant A, Detective B, and Detective C) were located in the back. D.R. and a juvenile later identified as Mi’Chance Dunlap-Gittens approached the van. When the three detectives then opened the back of the van, Sergeant A immediately observed the two individuals holding firearms. Sergeant A discharged his firearm, and then Detectives B and C fired at the fleeing Dunlap-Gittens, who fell to the ground. It was later determined that Sergeant A fired one round, Detective B fired three rounds, and Detective C fired eight rounds.

Medical attention was provided to Dunlap-Gittens by the on-scene detectives, and he was transported to the hospital, where he eventually died from the gunshot wounds he had suffered. D.R. ran from the location and was located inside a nearby residence; he eventually agreed to voluntarily come out of the location, was detained and questioned.

The subsequent investigation revealed that D.R. had not been involved in the initial homicide that had prompted the operation. D.R. did plead guilty to possessing a firearm in conjunction with the encounter with the detectives.

Investigative Issues

Timing of Fact-Gathering of Involved and Witness Officers

To KCSO's credit, the involved detectives who did not use deadly force were interviewed by KCSO detectives within hours of the officer-involved shooting. However, the sergeant and two detectives who used deadly force declined to provide statements to KCSO investigators. Instead, the involved officers provided compelled written statements about their actions and observations. While the statements are detailed, they were apparently completed days after the incident. The report of Sergeant A is dated three days after the incident, Detective B's written statement is dated four days after the incident, and Detective C's statement is undated.⁵ It is unclear from the statements whether the involved officers collaborated in preparing the statements or received assistance from their legal representative.

A written statement, no matter how detailed, is never an adequate substitute for an interview. In a written report, the decision about what and how many details to include rests entirely with the writer. Written reports, unlike interviews, also preclude the ability to ask follow-up questions. When facts are gathered through written reports, choices about what issues to address are left to the discretion of the writer; when an interview occurs, the areas of inquiry are determined by the interviewer. In matters of critical importance such as an officer-involved shooting, best practices always dictate an interview over collecting written statements.

It was approximately two weeks before KCSO interviewed involved personnel. This delay (of days before a written statement, and even longer for an interview) is not consistent with best practices. It is critical for the agency to learn immediately about the officers' actions, decision-making, and observations. Obtaining a "same shift" statement is essential to any effective officer-involved shooting investigation. This is true not only in terms of public confidence in the legitimacy of the process, but also because of the value of a "pure" statement that is relatively contemporaneous and untainted by subsequent input.⁶ Obviously, both of these attributes are diminished with the passage of time that occurred in this case.

⁵ The KCSO supervisor who received Detective C's statement should have reviewed it upon submission and ensured that it was dated.

⁶ We have been advised that KCSO has routinely delayed interviews of involved personnel under the premise that recollection is improved after two sleep cycles. In this case, the two-week delay was far greater than two sleep cycles. Moreover, research has debunked the notion that officer recall is better after two days. See, for example, "What Should Happen After an Officer-Involved Shooting? Memory Concerns in Police Reporting Procedures," *Journal of Applied Research in*

RECOMMENDATION TWO: KCSO should revise its investigative protocols so that an interview is conducted of personnel involved in shootings before the end of shift.⁷

Lack of Identification of Interviewing Detectives

On at least one occasion, the interviewing detectives did not identify themselves in the tape-recorded interviews. Best investigative practices teach that basic information, such as the identification of the interviewer, the individual being interviewed, any other persons in the room, the date and time of day, the description of the incident being investigated, and the location of the interview, be captured on tape at the beginning of the interview. Some investigators routinely carry a script or checklist to ensure that such basic information is obtained.

RECOMMENDATION THREE: KCSO should develop protocols for officer-involved shooting investigations to ensure that basic investigative information is obtained at the inception of the interview.

Telephonic Interview of Civilian Witness

A review of the file reveals that at least one civilian witness was interviewed telephonically. In officer-involved shooting investigations, where the placement, positioning, and movement of individuals can prove critical, telephone interviews limit the effective collection of information. Investigative protocols should presume that witness interviews in officer-involved shooting investigations will be conducted in-person. In cases in which an in-person interview proves impracticable, the investigative file should set out the extenuating circumstances.

RECOMMENDATION FOUR: KCSO should revise its investigative protocols to require in-person witness interviews and if such proves impracticable a reference in the file as to the extenuating circumstances.

Interviews of Involved and Witness KCSO Personnel Not Videotaped

At one point during the audio-taped interview of one KCSO detective, the investigator asked the witness to describe what he was doing for purposes of the record. The request by the investigator is consistent with best investigative practices. However, an even more effective way to capture the account of witness and involved deputies would be to videotape the interviews. Because officer-involved shootings are usually dynamic events in which the positioning, gesturing, and

Memory and Cognition, 5 (2016) 246–251, Rebecca Hofstein Grady, Brendon J. Butler, and Elizabeth F. Loftus.

⁷ To the degree that the recommended changes in this report require discussion with KCSO employee associations, it is urged that such discussions begin in earnest.

hand movements of both subjects and personnel are often critical to the analysis, the reviewing body would be advantaged by video recording the interviews of personnel. This approach has become relatively standard in civil depositions for the reasons stated here.

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

Investigative Gaps in Fact-Collection

A. Failure to Interview the Supervisor Who “Approved” the Undercover Plan

As noted below, the Administrative Review Memorandum found that the undercover operation did not include a written operations plan or a risk analysis. When inquiry was made by the KCSO administrative reviewer about this, he was informed via email from a supervisor of the detectives involved in the operation that neither document had been created. The email response indicated that the supervisor had talked with two of the sergeants about planning, safety, and contingency regarding *another* operation that had been discussed that was to occur in Renton but never happened. The supervisor indicated that he “assumed” that similar discussions had been communicated to the team about the operation that eventually did occur in Des Moines and resulted in the deadly force. The supervisor indicated in the email his belief that the involved units did assess, plan, and respond as planned.

The administrative review notes indicated that the reviewer also had an informal conversation with the supervisor who confirmed that the conversation with the team was, in fact, about the Renton operation – not the one in Des Moines that actually happened. In fact, the information that was obtained suggests that there was little or no vetting by supervisors of the plan that was actually devised.

This supervisor should have been interviewed as part of the administrative review. In order for KCSO to effectively assess the degree and efficacy of the vetting of this plan, it was important to obtain a more robust statement from the off-scene supervisor. The email response provided by the supervisor and the follow up informal discussion was an inadequate substitute for a comprehensive interview about what he was told about the plan, if anything, and what consideration he used to approve the field work of the detectives. The failure of KCSO to conduct that interview left the agency with a significant information deficit from which to adjudge the performance of its personnel and its supervisory controls.

RECOMMENDATION SIX: KCSO should ensure that its review protocols require that supervisors reportedly involved in the approval of operations plans that result in the use of deadly force be interviewed as part of the shooting review.

B. Failure to Interview K-9 Officer

Sergeant A, the KCSO on-scene supervising detective, noted that a K-9 officer was staged close by to provide a uniformed presence once unmarked units had contained the area. Sergeant A reported that the dog was staged so that it could immediately track any fleeing suspect. However, it is unclear from the investigative report how quickly the K-9 unit was able to respond and begin tracking the at-large subject after the shooting.⁸ After D.R. ran from the van, the K-9 deployment did not result in his apprehension, and he was able to successfully double back to the apartment from where he had come. As noted below, the patrol debrief report indicated that the K-9 deployment ran into challenges because of the number of law enforcement personnel on the track,⁹ yet the K-9 officer was not asked directly about these issues as part of the internal review.

The K-9 officer prepared a report about his activity related to this incident. However, as the KCSO administrative review indicated, the statement had “little information regarding the briefing” and the K-9 officer stated that he was assigned to “stage nearby” while the operation occurred. The KCSO reviewer reported that “after getting the signal to move in [the K-9 officer] drove toward the location when he heard shots fired over the air. He arrived on scene and deployed his dog as one of the suspects ran away on foot. *Little more information was provided that would be necessary for this review.* [emphasis added]”

Even though a full interview of the K-9 officer’s actions and observations would have likely recovered significant material on what he was told at briefing, where he actually staged, and how and why his deployment did not effectively contribute to the mission’s intended objectives, KCSO failed to conduct one. As a result, any review of that part of the operation was extremely limited and largely reliant on information from secondary sources.

RECOMMENDATION SEVEN: KCSO should develop protocols to ensure that all team members of an operation that results in the use of deadly force are interviewed.

No Remedial Action Taken Regarding Poor Quality of Crime Scene Photographs

A KCSO crime scene detective testified at the inquest that there was an equipment failure regarding the scene lighting. As a result, the videos and photographs taken of the crime scene were of very poor quality.

When the photographic results were obtained, it was apparent that important evidence was not captured during the processing of the crime scene. However, this investigative gap was not raised

⁸ Sergeant A reported that the K-9 officer was to be staged at a nearby Safeway store.

⁹ The “track” is the search route followed by a K-9 and accompanied by officers.

nor discussed during any of KCSO's internal review processes. In addition to KCSO decision-making and performance, a robust internal review includes identifying any shortcomings during the processing of the crime scene in order to ensure that future crime scenes are not subject to the same issues. The failure of KCSO to formally consider and address issues of this sort inhibits learning and remediation that could improve future performance.

RECOMMENDATION EIGHT: KCSO should formally identify any issues regarding processing of the crime scene in officer-involved shootings and consider remedial measures to reduce the likelihood of future occurrences.

Administrative Review: Summary of KCSO Findings

Patrol Debrief Memorandum

Within 48 hours of the incident, a patrol deputy prepared a memorandum that memorialized a debrief of the incident by several SeaTac deputies. The memorandum stated that its purpose was to provide the patrol deputies' perspective of the incident and to aid in both the official debrief of the incident and future tactical deployments. The memorandum identified issues in the operation that, in the opinion of the author, went well. But it also raised the following issues as concerns:

- While detectives had advised, prior to deployment, deputies to stay out of the area, almost all deputies were caught unaware and only apprised of the situation after the deputy-involved shooting.
- Several perimeter units, members of the K-9 track, and other agency members had no idea what was transpiring even as the tactical team was preparing to deploy to the apartment where the suspect was located.
- Dispatch was similarly "in the dark" about command operations.
- Several deputies were unaware of who was in charge and who was orchestrating and coordinating aspects of the investigation.
- The use of the K-9 track was hampered by the "gaggle of" deputy bodies.
- Essential details of the post-incident operation and decision-making were not entered into the computer aided database.

KCSO's protocols do not provide for this type of memorandum authored by patrol deputies. Well-meaning as it was, one concern about the preparation of such a memo is the accuracy of the data upon which the conclusions relied. Patrol deputies would necessarily base their assessments on limited facts. A preferable method to gain the insight of responding patrol deputies would be to ask each deputy to document any observations in a supplemental report, refrain from any analysis, and provide those reports to the Administrative Review Team for further consideration.

While the patrol deputies' observations are certainly relevant to a full evaluation of the planning phase and post-incident response, their role should be limited to providing factual accounts of their own involvement and leaving the analysis to those assigned that responsibility.¹⁰

RECOMMENDATION NINE: KCSO protocols should be revised to clarify that only one team is responsible for an administrative review of critical incidents and should encourage personnel with potentially helpful observations and insight to contact that administrative reviewer.

The Administrative Review Team Report

The Administrative Review Team (ART) identified the following issues and presented them to the Use of Force Review Board:

- There was no written operations plan or risk analysis.
 - Roles were not clearly established nor documented.
 - No documentation of considerations made during the planning.
 - No formal documentation of approval.
- Inconsistent uniforms were worn by arrest teams.
 - Was arrest team clearly marked and immediately identifiable as police especially considering the low lighting?
- The roles for perimeter teams were unclear: Were they perimeter teams or arrest teams or both?
- There was no clear delineation between the arrest team and the undercover operatives.
- No marked vehicles were used in takedown of suspects.
- The operation was not conducted on a recorded line.
- Information not adequately provided to patrol deputies in the area by dispatch or operations supervisors.
- Deputies were unfamiliar with re-banded radios.
- No body armor was used by the undercover assets.
- The command post was next to the scene.
- The command post was not moved once suspect was believed to be in nearby residence.
- After advisement that the command post was to be moved, nobody went to new location.
- Detectives continued to process scene once there was information that the suspect was inside a nearby apartment.
- Several KCSO captains were on scene without clear definition as to their roles.
- Limited number of KCSO personnel who have formal undercover operations training

¹⁰ Having well-established, thorough, and credible review processes will support this request to personnel.

- A crime scene log not completed.¹¹
- Inner and outer perimeter personnel were unclear about roles.
- Removal of the van from secondary scene was inconsistent with principles of crime scene management.
- Deconfliction was not completed.

In addition to this impressive identification of issues involving deputy decision-making prior to the incident and post-incident handling of the scene, the ART review recommended remedial actions designed to address each of them through further policy development and training.

The ART review concluded that there was a special need to update policies regarding undercover operations and training.

The Use of Force Review Board

Approximately ten months after the incident, pursuant to KCSO protocols, a Use of Force Review Board (“Review Board”) was convened. To KCSO’s credit, a detailed written summary of the event and documentation of the deliberations and analysis conducted by the Review Board was prepared. In our experience with other jurisdictions, force review boards generally do not provide detailed documentation of the proceedings; accordingly, we were especially impressed with the KCSO’s level of detail.¹²

In this case, per KCSO protocols, the involved deputies and the two deputies in the passenger compartment of the van appeared at the Review Board hearing and answered questions about their actions and decision-making. In our experience, it is unusual for involved officers to appear and provide such evidence before a reviewing board.¹³ By the time the deputies appeared, they had provided a written statement, had been interviewed by the KCSO detectives that had conducted the criminal inquiry, and had testified at the inquest. While a summary of the information provided by involved officers to the Review Board was included, their statements were not recorded or transcribed.

¹¹ According to the ART review notes, a crime log was initiated but the log did not include the times when each individual left the scene.

¹² Unfortunately, and in contrast to the detailed report available for review, as noted above, KCSO did not provide us access to the attendees as we conducted our review. As a result, we were not able to benefit from any further insight of those individuals.

¹³ We discuss our impressions of this practice below.

The Review Board summary noted that there was substantial discussion of tactical decisions leading to the shooting including:

- The decision of the undercover detectives not to wear vests;
- The decision to place the arrest team in the undercover van rather than a separate vehicle;
- The pre-planning meetings;
- Any discussion regarding whether the juvenile of interest would try to conduct an armed rip off rather than sell the liquor; and
- Undercover training.

There was also discussion about whether Sergeant A should have been part of the arrest team, since he had responded to the initial homicide (the victim of which was the son of a Seattle police officer) and may have been emotionally impacted.

According to the Review Board summary, the Review Board unanimously voted “yes” to the following issue statements:

- The shootings were intentional.
- All shots fired by all deputies were justified.
- There were no reasonable alternatives to the use of force.
- Inadequate training was not a contributing factor to the event.
- Policies and procedures were followed post-event.
- There were no violations of policy related to the use of force.

The Review Board voted 4-1 affirmatively with regard to the following issue statement:

- The deputies’ choices leading up to the application of deadly force were sound.

The dissenting member pointed to the ART memorandum expressing concern about the tactical plan as the basis for the “no” vote.

According to the writeup, there was “general discussion” about the:

- Variability of the uniforms worn.
- The undercover detectives’ decision not to wear a ballistic vest.

The summary indicated that OLEO expressed concerns about:

- Whether there was sufficient supervision and upper management involvement.
- Whether the sergeant should have been involved in the tactical operation since he had responded to the initial homicide.

The summary notes that the Review Board Chair asked the involved deputies if they had any comments. According to the report, the deputies indicated:

- The administrative review took too long to occur.
- They would like more training, better equipment, and more uniform equipment.
- They would like soft body armor.
- They appreciated the work of the Personal Assistance Team and personnel who attended the inquest and provided support.

Regarding the ART review and memorandum, the summary indicated that the involved deputies believed:

- There were internal differences of opinion about the tactics leading up to the shooting.
- The ART should have talked to the involved deputies as part of the review process.
- They thought that the risk of guns being involved was low considering the ruse was only a young woman trying to buy alcohol.
- They were willing to assume more risk when attempting to apprehend a homicide suspect.
- The individuals who developed the plan were very experienced and highly trained.
- If they had known that there would be an attempted robbery and both subjects would be armed, they may have done things differently, but hindsight is 20/20.

The Review Board memo concluded that:

All the deputies feared for their own lives, the lives of their partners, and the lives of citizens the suspect might encounter as he ran toward the apartment building and up the slope of the driveway. The suspect ran from the deputies, continued to hold the firearm, looked back over his shoulder and appeared to be prepared to fire toward the deputies. The incident evolved very rapidly, in a matter of seconds. The firearm was recovered from Mr. Dunlap-Gittens when he was apprehended. The Board believed the deputies were justified in using lethal force to try to protect themselves, their partners and possible innocent civilians.

Administrative Review: Issues and Concerns

Issues with KCSO's Force Review Process

A. The “disconnect” between the Administrative Review Team and Use of Force Review Board findings

As detailed above, and to its credit, KCSO's ART review identified a number of issues involving decision-making, tactics, training, and the agency's post-incident response and advanced a number of recommendations designed to better its personnel for future similar challenges. However, while some of the findings were discussed at the Review Board meeting, all were seemingly rejected and discarded by the Review Board. As a result, not one of the numerous findings made during the ART was embraced by the Review Board and not one of the recommendations was implemented.

It is difficult to fathom that not one recommendation put forward by the ART was found to be worthy of implementation by the Review Board. As a result, all of the considerable work and insight that went into the fact collection, analysis, review, and synthesis by the ART process ended up being all for naught.

It is not enough for the Review Board to simply discuss any findings and recommendations put forward by the ART process without being accountable for their own influence over the KCSO's ultimate handling of these matters. Rather, the Review Board should be tasked with making specific findings as to each of the issues and recommendations advanced by the ART process. For those that are rejected, the Review Board should put forward its rationale for deviating from the agency's own reviewing expert. For those that are accepted, it should formally ensure that the recommendations to address the findings and observations are advanced internally.

RECOMMENDATION TEN: KCSO should revise its protocols to ensure that the Use of Force Review Board expressly adopt or reject each finding and recommendation advanced by the Administrative Review Team.

RECOMMENDATION ELEVEN: For those Administrative Review Team findings and recommendations that are rejected, the Use of Force Review Board should set out in writing the rationale for rejection.

KCSO's Lack of a Mechanism for Implementation and Follow Through

It is also apparent that KCSO's review structure has no ability to ensure implementation and follow through of any recommendations advanced by the ART, its own review process, and input from other sources such as the involved deputies.¹⁴ Whether it be training, policy development, or equipment review, there is no structure for developing an "action plan" and assigning it out for implementation. There is also no mechanism for ensuring that any assignments are reported back to the leadership of the organization. Simply put, there is no formal mechanism under current protocols to ensure implementation for even the most worthwhile of ideas.

Simply identifying potential issues and discussing them is ephemeral and of no lasting benefit to a law enforcement organization. Someone must chart a path forward and ensure that the talk results in improvement. Unless there is a mechanism for ensuring that helpful suggestions are turned into action items, those ideas are destined to die on the vine. And that is apparently what happened with each and every proposal that was devised by KCSO and set out above. It is imperative that protocols be devised so that improvements suggested from within are transformed into meaningful reform.

RECOMMENDATION TWELVE: KCSO should devise protocols to ensure that any recommendations accepted by the Use of Force Review Board are implemented by:

- Assigning the responsibility of implementation to specific KCSO personnel.
- Delegating a KCSO command staff member the responsibility of ensuring effective and timely implementation.¹⁵

Involved Officers' Direct Involvement in the Use of Force Review Board Process

As detailed above, a curious aspect of KCSO's Review Board involves bringing in the involved personnel and asking them directly about various aspects of their decision-making. While the narrative report about the Review Board proceedings discusses some areas of inquiry and the involved detectives' responses, the fact gathering is not tape-recorded and a detailed record of the "Q & A" is not systemically captured.

¹⁴ A review of the ART materials indicate that the reviewer met with a supervisor after the Review Board presentation who took "notes" regarding potential action items, but any further efforts toward implementation apparently ended there.

¹⁵ It is our understanding that recent changes to the General Orders Manual may address the spirit of this Recommendation.

The participation of involved personnel seems to be a noble attempt to provide the Review Board the opportunity to inquire about decision-making that may not have been answered during the initial interviews. It also provides an opportunity for the involved deputies to provide the Review Board feedback on ways to improve the organization's response to similar challenges.

As well-meaning as the protocol may have been intended, the process does not provide an effective mechanism to gain insight from the involved personnel about their decision-making. As stated throughout this report, we agree that the Review Board (and the ART) needs to have additional information from involved personnel about decision-making and performance that goes beyond the initial interviews conducted for purposes of the criminal investigation. However, the practice of inviting involved personnel into the Review Board meeting at the very end of the process, and under circumstances that would seemingly inhibit candor on all sides, does not provide a reliable means of acquiring this perspective.

Instead, we recommend an approach that many agencies adopt: namely, formal administrative interviews for each involved personnel and critical witnesses.¹⁶ This method ensures an effective and efficient fact-gathering process that provides needed information to reviewers without the disjointed and seemingly awkward process of one or more personnel being asked questions about their performance by individuals on the Review Board.¹⁷ To elicit worthwhile feedback on ways to improve the organization from involved personnel, as we discuss below, a more effective method would be to include that component as an after-review debriefing.

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

RECOMMENDATION FOURTEEN: In order to obtain full information regarding involved personnel decision-making, KCSO should include an administrative interview as part of the fact gathering process.

¹⁶ In fact, in this case, the involved personnel indicated that they would have preferred that the ART talk to them during the review process.

¹⁷ The process may partially explain the seeming disconnect between the involved detectives' initial characterization of the incident (as high risk, with a likely potential that D.R. would be armed and inclined to attempt a robbery) versus their apparent assertions during the Review Board (that they had not anticipated a robbery attempt or armed subjects, given that the ruse was only a young woman trying to buy alcohol). The Review Board has no mechanism to address these seeming inconsistencies or challenge personnel with earlier conflicting statements.

Feedback to Involved Personnel

As noted above, KCSO's current process provides an opportunity for the Use of Force Review Board to ask questions of involved personnel about their decision-making as well as their recommendations and other feedback. We also note our concerns about the disadvantages of that approach, and the need to get information *from* the officers in a different forum and prior to the Review Board gathering itself. That being said, there is significant value to a process of providing information *to* involved personnel regarding specific issues considered and addressed by KCSO internal reviewers.¹⁸ We suggest that one knowledgeable participant be assigned to provide an objective, unvarnished debriefing to involved personnel at the end of the process. In that same forum, the involved individuals could share their own perspective on the investigative and review process, as well as suggestions for improved performance and readiness in the future.

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

Development of Methods to Export Learning to KCSO Personnel

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

Progressive law enforcement agencies ensure through the issuance of training bulletins and other debriefing mechanisms the export of helpful and insightful information so all members can benefit. Law enforcement's traditional aversion to revisiting its major incidents in detailed, critical ways is not consistent with confident and rigorous self-scrutiny.

RECOMMENDATION SIXTEEN: KCSO should develop mechanisms designed to openly discuss "lessons learned" from any deadly force incident to better prepare each member for similar future challenges.

¹⁸ In situations involving policy violations and potential discipline, any debriefing should be tailored to ensure that the formal accountability process is not compromised.

Involved Detectives' Statements

A. Sergeant A: Summary of Statement

Sergeant A reported to KCSO detectives that when the subjects were approximately 4–6 feet away, he pulled open the passenger sliding door and loudly announced, “Sheriff’s Office.” Sergeant A wrote that the area was not well-illuminated, but he saw the subjects start to move, startle and look at him. Sergeant A stated that the subject he believed was D.R. pulled his hands out of his sweatshirt and reached down toward his pants. The sergeant reported that the other subject raised his sweatshirt and he could see a firearm with the barrel pointed down in the subject’s right hand.¹⁹

Sergeant A stated that while he moved to get out of the van, he started to draw his gun, and could see the second subject’s gun barrel start moving up toward the detectives. The sergeant wrote that his fellow detectives were now “contained inside a non-armored box” and that if the subjects started shooting, it would be like “shooting fish in a barrel.” Sergeant A indicated that he then fired his pistol at the unknown subject just after pulling it out of the holster and rotating the barrel forward. Sergeant A reported that he did not have a sight picture when he fired, nor was his arm extended.

Sergeant A reported that he saw the unknown subject turn away from him and then focused on D.R., who the sergeant indicated was running away. The sergeant reported he returned his attention to the first subject and heard shots being fired as that subject was running up the driveway. Sergeant A reported that that subject was looking back at the detectives with the gun still in his hand. The sergeant reported that he ordered the subject to drop the gun and began to bring his gun up to fire. Sergeant A reported that the subject was moving to an elevated, advantageous position. Sergeant A indicated he still feared for his life and the life of his partners as well as the safety of the community. Sergeant A reported that as his gun sights settled on the individual, the subject fell to the ground.

B. Detective B: Summary of Statement

Detective B told KCSO detectives that when the van door swung open, the two individuals looked at them in surprise. Detective B said he saw one of the individuals with a gun coming up in his right hand. Detective B said he yelled “Police!” while another deputy yelled “Police” and

¹⁹ As detailed below, Detective B also reported seeing a gun in Dunlap-Gittens’ right hand. However, Dunlap-Gittens’ mother reported to the media that her son was left-handed.

“Get on the ground.” Detective B said he focused on the individual with the gun but was able to see the second individual run away.

Detective B said that at the same time the first individual was raising his gun, Sergeant A was exiting the van. Detective B said he saw Sergeant A coming up with his gun and heard two pops, he believed Sergeant A had fired one round and that the subject had “probably” shot.²⁰ Sergeant A got out of the van, and Detective B lost sight of Sergeant A for a second. Detective B said that he and Detective C were getting out of the van while the individual with the gun was “peeling away.”²¹

Detective B said the individual still had the gun and was looking at the detectives. Detective B said he thought that the subject may have shot Sergeant A or shot at the detectives, and Detective B then fired one shot.²² The detective reported that the individual turned slightly and started to move away toward the back of the van. Detective B wrote that he could see the subject was still holding the firearm and not showing any signs of giving up, so the detective fired another shot. Detective B said it appeared that his shot did not have any effect on the subject as the subject continued to run up the hill of the driveway, looking back at the detectives while still holding the weapon.

Detective B wrote that he feared that if the subject reached high ground, he could use that position to shoot at the detectives and gain a tactical advantage. Detective B reported that he fired another shot at the subject as Detective C was firing, and the subject fell to the ground.²³

²⁰ As noted above, the investigation determined that Sergeant A only fired one round, and neither Dunlap-Gittens nor D.R. fired their weapons.

²¹ Detective B reported that because he got out of the van so quickly, he injured his shoulder. There is no evidence of Detective B being treated for this injury in the file. Moreover, Detective B was not asked whether his shoulder injury compromised his ability to tactically respond to this incident.

²² Interestingly, one of the staged plain-clothes detectives, Sergeant E, told investigators that when he arrived, he saw a male laying on the ground. According to Sergeant E, Detective B had his gun out and said: “He had a gun, he had a gun.” If Detective B had believed at that time that the subject had actually shot at the detectives, one would have expected him to have so informed Sergeant E. This question was not explored during KCSO’s investigative or review process.

²³ The investigation revealed that the fatal shot to Dunlap-Gittens’ head was fired by Detective B. Two other bullets that caused injuries to Dunlap-Gittens were fired by Detective C.

C. Detective C: Summary of Statement

Detective C reported that on the date of the incident, he was in the back of the van when Sergeant A opened the sliding door of the van. Detective C said that he and Sergeant A identified themselves simultaneously and instructed the subjects to get on the ground. Detective C indicated that he saw both subjects pull up their sweatshirts with one individual holding a black object which he believed to be a gun. Detective C stated that neither individual immediately ran and looked more surprised than afraid.

Detective C reported that Sergeant A then blocked his view of the subject as Sergeant A stepped from the van. Detective C stated that he heard a loud “pop” which he recognized as a gunshot. While Detective C exited the van, he stated that he heard Sergeant A yell “drop the gun” twice.

Detective C indicated that he unholstered his pistol and fired as he was in fear for his life and the lives of his partners. Detective C reported that when he fired, the subject had his back turned and was beginning to run up a hill while looking over his shoulder at the detectives. Detective C reported that he feared that the subject would shoot at the detectives as he ran away or find a position of cover and shoot at them from that position. Detective C noted that the detectives had no cover. Detective C further reported that he feared that if the subject were to get away, he posed a serious danger to the public and indicated that he stopped firing when the subject began to fall.

Review Process: Issues and Unanswered Questions

A. Questions re Sergeant A’s Application of Deadly Force

As noted above, Sergeant A described his one shot as immediate and undertaken without using his sights. However, despite the subject continuing to possess a gun as he ran away and his fellow detectives firing multiple rounds as the subject did so, Sergeant A did not fire any further rounds. And it is apparent from the forensic bullet comparisons that the one round fired by Sergeant A likely did not strike Dunlap-Gittens. Considering this evidence, an alternative plausible scenario neither addressed during the interview of Sergeant A nor during the review process is whether the one shot he fired was not intentional but an accidental discharge of his weapon.

Law enforcement officers are generally trained that if they encounter a deadly force situation, they are to continue firing until the threat has ended. In this situation, Sergeant A did not apparently follow this training as he fired one round without having acquired a target and then fired no more.

During the interview of Sergeant A, there was no effort to question Sergeant A about why he fired only one round and whether that discharge might have been accidental. Nor was there any analysis during the review process about the possibility of an accidental discharge or whether the firing of one round by Sergeant A was consistent with training expectations. The lack of analysis or specificity in considering Sergeant A's firing pattern fell short of the comprehensive and detailed assessment warranted by every deadly force incident.

RECOMMENDATION SEVENTEEN: In application of deadly force cases where involved personnel fire only one round, KCSO's investigative and review protocols should expressly consider whether the firing of the weapon was an accidental discharge.

B. Lack of Analysis as to Whether Detective B and Detective C's Use of Deadly Force Was Consistent with KCSO Training and Expectations²⁴

As indicated by their statements, when Detectives B and C used deadly force on Dunlap-Gittens, he was running away from them.²⁵ While these two involved deputies indicated that Dunlap-Gittens looked back at the detectives and was still carrying a gun, there was no apparent detailed assessment during KCSO's review process whether the level of threat posed by Dunlap-Gittens at that point was sufficient for deadly force to be deployed.

The significant time gap between the initial shot fired by Sergeant A and the subsequent rounds fired by Detectives B and C was reported by a number of witnesses. The involved detectives,

²⁴ Because, as explained above, this report is intended as a systemic review and because KCSO's use of force policies have been modified since the date of the incident, the report will not relitigate whether the deadly force used in this matter should have been deemed out of policy. But it does seek to illustrate the need for KCSO to elevate its level of scrutiny with regard to determining how each round fired comports with the agency's training and expectations.

²⁵ This was also corroborated by an examination of the trajectory of the bullets after they struck Dunlap-Gittens. The medical examiner testified at the inquest that Dunlap-Gittens suffered the following injuries:

- Bullet wound to back of head to front of head (immediately incapacitating);
- Bullet wound to back of left thigh to front of left thigh (not life threatening);
- Bullet wound to back of right buttock to front of body;
- Bullet wound to back of right thigh to front of right thigh (not life threatening); and
- Bullet wound to front of scrotum to back.

witness detectives, and several civilian witnesses²⁶ described a gunshot sequence where there is an initial volley, a pause and then additional shots. In fact, the two undercover detectives in the front compartment described a sufficient break in the sequence of shots that gave them time to exit the van before the second volley occurred. Detective B described Sergeant A firing and then himself and Detective C firing their weapons. In contrast to the shot fired by Sergeant A, the evidence indicates that Detectives B and C had more time to reflect upon the need to fire additional rounds.

As noted above, the Review Board offered a conclusory statement that relied on the detectives' descriptions, adding that the subject "appeared to be prepared to fire toward the deputies." It is unclear what specific observations by the detectives, or other factual support, provided the basis for this vague conclusion. If a fleeing subject stops, turns, or raises his gun toward the deputies, those motions – if still subject to different interpretations – comprise objective evidence that the individual has modified his behavior from flight to aggression. However, in this case, no such observations existed. The subject's looking back as he continued to run in this case (a fact cited by the officers) is more consistent with a reflexive effort to see what the deputies were doing – and not an attempt to engage and aggress them.

Nor does the speculation articulated by the detectives about the subject reaching "higher ground" and gaining a tactical advantage provide an additional basis for using deadly force in this case.²⁷ The advantage of time and distance that is created when the subject flees (even if he is moving up a slope) needs to be used by deputies in order to deploy more safely, seek cover, and gain tactical superiority – and not turned into a further basis for perceived threat without specific supporting detail. To the Review Board's credit, it did not apparently rely on this rationale to justify the application of deadly force in this case.

Finally, the articulated concern about the subject successfully fleeing and then harming unidentified civilians cannot provide a substantive basis for using deadly force. In this case, there were no identified civilians in potential harm's way during the encounter. And in any urban environment, it will almost always be the case that an armed subject intent on doing violence to another has the possibility of doing so. Here, and by all objective accounts, the two subjects were only intent on escaping the threat of arrest or physical harm posed by three armed men who jumped out of the back of a van. In fact, in this case and as detailed below, the stray rounds by the detectives that entered an occupied apartment created a greater threat to innocent civilians

²⁶ Detective D told KCSO investigators on the night of the incident that two civilian witnesses reported hearing one shot, a pause, and a volley of shots.

²⁷ Moreover, the detectives allowed the subjects to meet the van at this particular location where their natural flight path would result in them achieving an elevated position over the deputies.

than any actions taken by the subjects. To the Review Board's credit, it also did not apparently rely on this rationale to justify the application of deadly force in this case.

Still, in its willingness to accept the generalized threat perception articulated by the involved officers, and its refraining from an overt dismissal of the "higher ground" or "threat to public" justifications, the Review Board fell short of clear and effective messaging in its findings. We recognize that the three detectives were startled and uncertain in the seconds that the event unfolded, and that two of the officers later reported they believed that the subject had already fired. However, the essential question from this fact set is what justification is needed to use deadly force upon armed subjects who attempt to flee.

In this case, the message communicated by the Review Board's findings is unclear at best, and perhaps even problematic. From a systemic perspective, we urge KCSO to engage with all interested parties and stakeholders to reconsider under what situations deadly force should be authorized for fleeing subjects in a manner that is clear, specific, and responsive to community expectations and principles of progressive law enforcement.

RECOMMENDATION EIGHTEEN: KCSO should engage with stakeholders and its community to determine whether the use of deadly force should be endorsed when an armed subject is running away from law enforcement.

RECOMMENDATION NINETEEN: KCSO should advise its members that concerns about fleeing subjects gaining a "tactical advantage" will be scrutinized rigorously, given the ways that increased time and distance generally improve officer options.

RECOMMENDATION TWENTY: KCSO should advise its members that speculative, generalized concerns about a subject escaping and harming innocent third parties is an insufficient basis for the application of deadly force.

C. Evidence of Off-Target Rounds Not Sufficiently Explored

Inquest testimony from a crime scene detective revealed that they identified four bullet strikes to the front of a nearby apartment building, three of which passed through the front wall. Detective D told investigators on the night of the incident that he and Sergeant E started checking the apartments on either side of the crime scene and discovered that an apartment occupied by two women had two rounds that had come through their house, eventually landing in the bathroom

and hallway wall. The KCSO investigative report noted that one of the occupants of that residence called 911 just after the bullets traveled into her apartment.²⁸

Even though the presence of stray bullet strikes was well-documented, their existence was not considered during KCSO's administrative review. Stray bullet strikes merit attention as evidence of deadly force rounds that have missed their intended target and the inherent dangers of uninvolved individuals being inadvertently struck. However, the involved deputies were not asked about the rounds that were off-target, nor was there meaningful investigation into the risk presented by the occupied apartments as backdrop for the rounds. The investigation also did not assess KCSO's response to the appropriate concerns of the impacted apartment residents on the night of the incident. Finally, there was no evidence of follow up by KCSO to facilitate compensation for affected parties.

A robust review process would have included an assessment of the off-target rounds as a component of deputy performance. Deputies are trained to consider their backdrop when deciding when and whether to use deadly force. In this case, the deputies were not asked about their backdrop and whether they considered the risk of gunfire to apartment residents versus their articulated risk that if the subject was able to escape, he might be violent with those same individuals. Nor did the review process consider whether the off-target rounds raised questions about the deputies' marksmanship.

In addition to evaluating the involved deputies' performance, the internal review should have also considered whether KCSO sufficiently responded to the fact that several bullets entered the apartment of uninvolved apartment residents and whether those residents were made whole as a result of KCSO's application of deadly force.

RECOMMENDATION TWENTY-ONE: Whenever an investigation finds that stray rounds have been fired, KCSO should ask the involved deputies about those rounds and consider their existence in evaluating the performance of the deputies.

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

²⁸ A dispatch report indicated that shortly after the incident, a female reported that a bullet had gone through her daughter's room and landed within three feet of her daughter's head. A review of the recording showed that, commendably, the dispatcher displayed appropriate empathy and sensitivity to the caller.

D. Failure of KCSO to Review Involved Detectives' Tactical Positioning

As noted above, the detectives reported that after they encountered the armed subjects, they found themselves at a tactical disadvantage. For example, Detective C reported that after they got out of the van, they had no cover, and the detectives all talked about the tactical superiority the subject had as a result of his run to higher ground. However, despite this recognition, there was no articulated consideration by involved personnel of ways to address these tactical deficiencies, such as moving to cover or repositioning to eliminate the tactical superiority of the subject. Nor was the possibility of tactical redeployment to safer positions raised with the detectives during their interviews or considered during the review process.

Officers are routinely taught that tactical principles such as moving to cover and tactical redeployment can reduce threats presented by armed subjects. In this case, while the detectives apparently recognized the threat, there was no evidence or consideration that they took any actions to reduce the threat but instead decided to use deadly force. Had the investigation made inquiry of the detectives and the Review Board considered whether tactical options existed once the subjects began running away, a more holistic review could have resulted, and additional learning and remedial action could have been devised.

RECOMMENDATION TWENTY-THREE: KCSO's investigative and review protocols should be revised so that inquiry is made as to whether alternative tactical options existed to reduce any threats presented to the involved personnel.

E. Failure to Maintain Training Records

Undercover operations are a unique law enforcement function that demand specialized training. The ART review endeavored to determine which of the KCSO detectives tactically involved in the incident or its planning had attended undercover training. The training records maintained by KCSO did not indicate consistently whether any of those personnel had attended such instruction. As a result, the ART review was required to ask training personnel from the providing agency, who confirmed from memory that at least two of the individuals had attended the training. But for a number of personnel involved in the operation, there were no records of their having received formal undercover training.

The failure of KCSO to maintain full training records of its personnel is particularly concerning. All law enforcement agencies should be able to readily access a database containing full and complete training records of its personnel. This serious shortcoming in maintaining records was identified as part of the ART review, yet there is no evidence that any action was undertaken to correct this serious flaw in recordkeeping. KCSO should immediately develop policies and

protocols to ensure that all training provided to its personnel is documented and easily accessible by supervisors.

RECOMMENDATION TWENTY-FOUR: KCSO should heed its own internal recommendations and develop policy requiring any participant in an undercover operation to have undergone formal undercover training.

RECOMMENDATION TWENTY-FIVE: KCSO should review the way it maintains training records so that each member's training history is complete and readily accessible.

F. Failure to Inquire or Analyze Whether the Undercover Operation Was Consistent with Training

Despite an inability to discern with any precision the amount of undercover training each of the tactical team members had received, the Review Board noted that Detective F, who planned the undercover operation, taught undercover classes for KCSO. However, Detective F was never asked by KCSO whether his operational planning was consistent with the undercover training he received or taught. Nor did KCSO ever objectively analyze whether the planning of the operation was consistent with generally accepted practices. And despite concerning issues being identified by KCSO about whether the planning was consistent with accepted practices, no remedial action ever emanated from the agency's review process. In short, the failure to identify any shortcomings communicated an acceptance of future operations being done the same way.

RECOMMENDATION TWENTY-SIX: KCSO personnel involved in the development of operational planning should be asked whether the plan was consistent with training they had received.

RECOMMENDATION TWENTY-SEVEN: KCSO personnel should objectively and independently determine whether operational planning and decision-making was consistent with law enforcement practices, no matter how much training the involved personnel may have had.

G. Inadequate Assessment of Risk Factors Associated with the Undercover Operation

A review of the involved detectives' statements indicates the following regarding the lead up activities with the identified subject:

- The area the subject wanted to meet was a high crime area.²⁹
- The subject had a recent firearm arrest.
- The subject was suspected of being involved in gang activity.
- The subject would not identify where he was going to be.
- The subject declined to meet at the initial locations suggested by the detectives.³⁰
- The area chosen by the subject to meet was poorly lit.
- The area chosen by the subject was believed by detectives to be a gang area with multiple escape routes.
- The area chosen by the subject was difficult to observe because of the extensive housing units.
- When the subject began to approach the van, he was accompanied by another individual which was not part of the original plan.³¹
- The subjects were dressed in dark baggy clothing that would make it easy to conceal a weapon.
- According to Sergeant A, both subjects appeared “stiff” with their shoulders raised, which indicated to him that they were nervous.
- Both subjects appeared to have their hands in the front pockets of their sweatshirts and out of view, which to Sergeant A was “concerning.”

²⁹ As stated by the on-scene supervising detective: “The area has lots of crime to include violent crime, gangs, drugs and prostitution. When working this area, you will often find people working against law enforcement efforts. This includes signaling to others that police are in the area.”

³⁰ As reported by Sergeant A, Detective F told him at the field briefing that the subject was not willing to meet at two locations suggested by the detectives. Sergeant A explained that the initial two locations were easy to observe, well-lit, and open. As detailed above, the location the subject demanded for a meet was neither well-lit nor easy to observe. Sergeant A was not asked whether the refusal of the subjects caused him to reconsider the advisability of proceeding with the operation.

Sergeant A additionally stated that Detective F advised that the subject may “jerk us around a bit once we get in the area,” meaning changing the deal location. However, there was no apparent discussion about whether the team should accede to the subject’s dictating yet another change in the meeting location. And, in fact, the subject did not come out immediately, even as the van took several turns down the street.

³¹ However, Sergeant A reported that he felt that D.R. would not be alone and did not know who or how many would come with him. Yet the sergeant reported that he “felt comfortable moving forward with the operation.”

- Neither subject was talking or gave a non-verbal greeting to the undercover detectives in the front of the van.³²

Detective F, who had developed the contact with D.R. and planned the undercover operation, reported that he had warned the entire group of the possibility of a “rip”³³ by the subject because it was consistent with his prior criminal activity. Detective F said he also warned the arrest team of a “rip” from others in the area because of the violent nature of the neighborhood.

Despite these factors unfolding as the operation proceeded, and the misgivings expressed by the involved detectives in their interview statements, no one determined that the risk had become too great and aborted the operation. Supervisors are taught that undercover operations need to be continually evaluated as events change, as they did here. However, Sergeant A, the on-scene supervisor, was not asked about his decision-making and why he chose to continue the operation despite the escalating risks presented to the team.³⁴

As noted above, during the Use of Force Review Board proceedings, the involved personnel indicated that they were willing to take additional risk in order to apprehend a homicide suspect. While law enforcement officers are expected to take some risk whenever they go on duty, all are trained to perform their responsibilities in a manner that minimizes that risk whenever possible.³⁵

³²According to Sergeant A, the lack of greeting concerned him because in his past experience, almost every undercover deal has had an element of greeting between parties.

³³ “Rip” is a colloquial term for robbery.

³⁴ Sergeant A was not alone in expressing concern about the operation as events unfolded. Detective B, who was in the back of the van, said that as the scenario progressed the whole incident was beginning to concern him: “Making us drive several times back and forth in front of their apartments, their hesitation to come meet us in the street and now two males walking toward us when we were expecting one made me feel like they may be setting us up for a robbery.” Detective C, who was also in the back of the van, reported that he started to become concerned that the subjects’ intent may not be to sell a juvenile alcohol but rather to possibly “rob her and her pimp.”

³⁵ Appendix A-13 of the KCSO Special Enforcement Team’s Standard Operating Procedures, “Undercover Operations” states: “The primary concern of any investigation or operation is public and officer safety, not the arrest of the suspect.” The Appendix also instructs that “all detectives will be aware of the danger signs that might indicate a possible robbery, assault, or “Rip Off” including “last minute changes in the transaction by the suspect” and “unknown or unseen associate of the suspect suddenly becoming part of the operation.” King County did not consider during its administrative review whether the involved personnel followed these dictates as set out in policy.

In this case, and as detailed above, the high risk of the operation continued to escalate as matters unfolded, yet it did not result in any curtailment or reconsideration. Moreover, there were other factors evident to the operation's decision-makers and better options to accomplish the desired result that were apparently not considered in making this risk/reward calculus:

- The detectives recognized that the homicide being investigated did not involve perpetrators who had planned to kill the decedent; by all accounts the death resulted in the subject's attempt to escape apprehension.
- The detectives lacked probable cause to arrest the subject for the homicide.³⁶
- The person of interest had a social media presence and was not likely to flee the jurisdiction.
- Detectives could have surveilled the known whereabouts of the person of interest and effectuated a detention that was safer to the detectives.

In short, several aspects of this operation, from conception to deployment to final execution, raised legitimate questions about the inherent and evolving risks (including a dangerous environment, a recalcitrant subject, and several unanticipated complications) in balance with the known law enforcement objectives. A more robust "cost-benefit analysis" was clearly warranted before and during the incident and should have been addressed in its aftermath.

RECOMMENDATION TWENTY-EIGHT: KCSO should revise its protocols to expressly promote a careful review of foreseeable risk factors in the design and authorization of undercover operations.

H. Disregard for Potential Deleterious Impact of the Lack of a Written Operations Plan

Written operations plans and risk analyses are standard fare for undercover operations and routinely expected of high-functioning police agencies. The advantages of setting out a plan in writing include:

- An opportunity to reflect and identify the challenges of the operation;
- A written risk assessment of the operation provides an opportunity to consider whether a less risky alternative existed to achieve the objective sought;
- An opportunity for an uninvolved supervisor to review the plan from a more distant and objective perspective;
- An ability for all involved personnel to better understand the plan and eliminate confusion about the mechanics, roles, and objectives; and

³⁶ According to the on-scene detective supervisor, Detective F reminded everyone on the team that the "probable cause" that formed the basis for D.R.'s detention was for forgery and possession of stolen property and that he was only a person of interest in the homicide.

- An opportunity to review the operation after the fact and match the results to the initial envisioned plan for purposes of improvement.

The failure to devise an operations plan and prepare a written risk assessment in this case had a consequential impact when the plan was placed into action. As noted elsewhere and recognized by the KCSO internal reviewer, team members were uncertain about their roles. There was also confusion about whether the van was going to stop and how close the subjects were to come to the van. And there was confusion about whether the detectives inside the van were a security team, an arrest team, or both. An operations plan and risk assessment could have brought clarity to the team members and eliminated the confusion that occurred once the team implemented the operation.

As noted above, when the KCSO reviewing sergeant inquired about the operations plan he was informed that KCSO policy did not require one, and that the supervisor had talked about safety issues when an earlier arrest plan had been considered. However, the fact that an operations plan was not *required* does not mean that one was not advisable. And the fact that risk and safety factors were discussed about another operation is a poor substitute for a discussion about a new plan with clearly different variables. While the failure to write an operations plan was identified by KCSO's own personnel, with a suggestion for a requirement that operations plans and risk assessments be done for all undercover operations,³⁷ there was no action taken with regard to the internal recommendation.

RECOMMENDATION TWENTY-NINE: KCSO should endorse the internal recommendation offered after this incident to require written operations plans and risk assessments for all undercover operations.

I. Advisability of Placement of the Arrest Team in the Van

Detective F, who decided to place the team in the van, indicated that it was done to protect the undercover detectives, and so that the team would be close should the identified subject run as expected.³⁸ However, those who determined to place plain-clothes detectives in the back of the van apparently failed to consider how the subject might react when he was presented with three such detectives rapidly opening the back door of the van. The fact that the two subjects were

³⁷ Guidance should likewise be provided on the basic requirements of an operations plan with a checklist of minimal requisite considerations.

³⁸ The planning and involved detectives made much of the fact that they practiced getting out of the van quickly prior to initiating the operation. However, that scenario was based on the subjects running away and not being armed. There was no apparent thought or practicing about what to do if the subjects produced weapons.

carrying weapons was, in all likelihood, more because they were intent on protecting themselves from a “rip” than in anticipation of confronting plain-clothes officers.

In the split second that the detectives burst from the back of the van, it was reasonable to expect that the subjects would bring their guns up to protect themselves and then run – which is exactly what occurred. Even though the detectives verbally identified themselves as law enforcement officers and gave the subjects instructions as they exited the van and began shooting, it is not surprising that the subjects reacted as they did.

Involved KCSO personnel recognized the tactical disadvantage they faced when the two subjects produced firearms. Sergeant A reported that had the subjects decided to shoot at the deputies in the back of a van, it would have been like “shooting fish in a barrel.” Detective B wrote that “three of us were crammed in the back of a van and at an extreme position of disadvantage.” And as noted above, KCSO’s administrative reviewer recognized the unclear delineation between the arrest team in the back of the van and the undercover team in the passenger compartment. The KCSO ART reviewer noted that the lack of clear delineation could confuse people involved in the incident and raised the question whether the suspects “knew the people coming out of the van were police or bad guys.”

And, as with the prior decision not to terminate the operation as risk factors escalated, the involved personnel were not asked about whether they considered the risk of placing the arrest team in the same vehicle as the undercover team. Despite these concerns being raised internally, KCSO determined that the decision-making was consistent with expectations and refrained from suggesting remediation or reconsideration of the tactics – even for purposes of future operations.³⁹

RECOMMENDATION THIRTY: KCSO should confer with internal and outside experts in undercover operations and reconsider whether the deployment of personnel in this case was consistent with principles of officer safety and best undercover practices.

RECOMMENDATION THIRTY-ONE: If the review with outside experts identifies significant shortcomings in the deployment strategy that was

³⁹ KCSO’s own internal administrative reviewer indicated in his notes that he spoke to the individual who ran the undercover class that was attended by several personnel involved in the planning of this operation. That supervising instructor advised the KCSO reviewer that the tactics used in terms of an arrest team coming out of an undercover vehicle was not something that they taught and was contrary to best practices.

used, KCSO should expressly incorporate this recognition into its undercover operations protocols.

J. The Wearing of Inconsistent Uniforms by the Arrest Team

As noted above, KCSO's administrative review noted that the deputies in the back of the van wore mismatching equipment. The review noted that the failure of the deputies to have uniform and markings that identified them as law enforcement was compounded by the unique circumstances of this operation: the team suddenly and unexpectedly coming out of the back of a van in a poorly lit location. The review concluded that the failure of the arrest team to wear uniform markings contributed to the likelihood that the subjects would not recognize them as law enforcement and take actions such as displaying their weapons intended to protect them from what may have been perceived as a robbery.⁴⁰ While this issue was identified by KCSO⁴¹ and apparently discussed at the Review Board meeting, no apparent remedial action was ordered or implemented.

RECOMMENDATION THIRTY-TWO: KCSO should consider whether policies or protocols need to be adopted to ensure that when plain-clothes personnel anticipate a tactical operation, that they are clearly and consistently identifiable as law enforcement personnel.

K. Confusion Among Team Regarding Role of Detectives in Back of Van

Sergeant A, who was the supervising detective in the back of the van, told investigators that the plain-clothes detectives in unmarked cars were to stage on both ends of the street and contain the area once the subject came out to the street. But he also said that he decided to deploy himself and two detectives in the back of the van to serve as security for the undercover team *and to act as an arrest team*. The supervisor explained that the arrest team would then be close to the subject if he ran.

However, once D.R. and Dunlap-Gittens started to approach the van, there was no call to the staged detectives to move in, contain the scene, and apprehend the individuals. Instead, the supervisor urged the undercover detectives to encourage the subjects to come closer so that they

⁴⁰ Of particular concern to the ART were the markings of involved Detective C. The review noted that, based on the photographs taken of him at the time of the incident, he did not have an identifying shirt, his gun was on his chest and either blocked his Sheriff marking or he was not wearing one. It concluded that the clothes he was wearing did not clearly show his status as a KCSO detective.

⁴¹It was also a matter of concern by the jurors at the inquest; four of the six jurors found that the arrest team was not adequately identified as law enforcement officers.

would be close by when they opened the back doors and moved to apprehend them. It was apparent from the actions that at some point during the field operation, the idea of using the staged detectives as the arrest team had been abandoned.⁴² What was not apparent was whether this change in directions was effectively communicated to all members of the operation.⁴³

This confusion about the team members' roles was similarly identified by the ART process, and a suggestion was raised to incorporate best practices of undercover instruction so that undercover operatives and arrest teams were completely separated. However, this recommendation did not result in any apparent remedial action within the organization.

L. The Danger to Undercover Detectives Due to the Evolving, Uncertain Plan

Detective G testified at the inquest that her role in the undercover operation was to play a juvenile prostitute. She chose not to wear a vest so that it would not be obvious to D.R. that she was law enforcement. Detective G stated that the plan was to avoid D.R. having direct contact with the van due to safety concerns. She said that when they got to the area, they were to try to identify D.R. by passing up and down the street, and once the identification was made to have other teams move in or the team from the back of the van make contact with him.

Detective G testified that at some point D.R. informed her that he saw the van and that she wanted to continue forward in order to prevent direct contact with him. She also testified that one of the circumstances that the team had planned for was a robbery. Detective G testified that when she saw two males approaching the van, she became very nervous and concerned that a robbery was about to happen.⁴⁴

⁴² And this decision was inconsistent with what Detective F told KCSO investigators, namely that after team assignments were made he briefly spoke with the undercover detectives and told them they needed to control the meet by keeping the van moving and not to come to a stop to allow themselves to be robbed. However, this directive was apparently not received by Sergeant A, the field team supervisor, who allowed the van to come to a stop and actually urged the undercover operatives to allow the subjects to come closer. The failure of Detective F to advise all team members of the role of the undercover detectives was not specifically addressed as a performance issue during the administrative review of this incident.

⁴³ In addition to the confusion expressed by detectives inside the van about what their role was, KCSO's own reviewer found similar confusion from the staged detectives' statements about whether their roles were to be the arrest team, the perimeter team, or both.

⁴⁴ This differed from Sergeant A's statement above that *he* expected that they would encounter two subjects. That possibility was increased by the undercover detectives "ordering" five bottles of alcohol, making it unwieldy for one person to carry and deliver to the van. This potential glitch in the plan—and the lack of cohesion in team members' understanding – was not identified or discussed during KCSO's internal review.

Detective G testified that there was “confusion” about whether they were going to move the van forward or not. She said that she heard a voice from the back of the van to “call them closer.” She testified that she then heard the van doors pop open, and a command of “Sheriff’s Office. Drop the gun,” followed by immediate gun fire.

Detective G testified that she was fearful of her life, recognized that she was not wearing a vest, and knew that the van doors were wide open behind her. Her first reaction was to sink into the passenger seat, using the pillar between the doors as cover. Detective G said she heard a break in the gunfire, jumped across to the driver’s seat, and exited the van through the driver’s door. Detective G said that Detective H, the driver of the van, was the only team member that had any form of radio communication.

Detective G testified that there was still active gunfire going on and Detective H told her that they needed to get out of there. She went back into the van through the driver’s door, and then they drove away with the rear doors and possibly the passenger door still open. Detective G said that the team had not talked in the planning phase of the operation about where the van should go, but eventually they stopped at a vacant gas station and donned soft vests and Sheriff’s jackets.

Detective H testified at the inquest that he was in the driver’s seat in the van when he heard Sergeant A say, “Sheriff’s Office” and another voice say, “Sheriff’s Office.” Detective H stated that he heard gunshots and exited out the driver’s door. He said after he got out, he squatted down by the window and heard more shots going off. Detective H said that he started thinking that he was in an undercover capacity, with only his badge on under his shirt and a commission card in his wallet identifying himself as a deputy sheriff. He proceeded to get down behind the left driver’s tire and broadcast that shots were being fired.

Detective H testified that he heard the gunfire stop and then observed Detective G come outside of the van. Detective H said he pushed Detective G back in the van and drove the van away with the front passenger door open.

The above narration from the undercover detectives exemplifies the complete confusion within the evolving plan and the intense fear and vulnerability they felt when the van’s back doors opened and gunfire commenced. As detailed throughout, it was not unexpected that the subject would be armed. Yet no contingency was provided for what the undercover detectives should do if shots occurred. It was clear as events unfolded that once the gunfire began, the undercover detectives did not have time to drive away; instead, they were forced to improvise by exiting the driver’s side of the van and using it as cover as additional rounds were fired. They found

themselves in considerable danger and lacked even rudimentary safety equipment in their designated undercover roles.

Despite this alarming narrative, and suggestions raised by the Administrative Review Team of ways to reduce the likelihood of placing future deputies unnecessarily in harm's way, the Use of Force Review Board found no basis to recommend changes in undercover operations, protocols, training, or deployment. Ensuring that protocols are modified to provide safety to deputies should be of paramount importance to KCSO's review process.

RECOMMENDATION THIRTY-THREE: KCSO should implement the well-founded recommendation from the administrative review to develop protocols to ensure that undercover operatives and arrest teams are separated.

M. The Decision to Not Have the Undercover Detectives Wear a Tactical Vest

It is a tantamount principle of officer safety that all law enforcement officers, including plain-clothed officers, who expect to have contact with subjects wear body armor to protect themselves. In this case, the undercover officers chose not to do so even though they ended up stopping the van and allowing the potentially armed subjects to get close to them. When the arrest team emerged from the back of the van and began using deadly force, the undercover detectives recognized how disadvantaged they were and were forced to hide behind the van. Had the subjects been intent on returning fire, the undercover detectives would have been in serious potential jeopardy. In addition, because the arrest team had no idea where the undercover detectives had retreated to, the undercover pair were subject to the possibility of being struck by friendly fire.

In short, as the operation unfolded, it left the undercover detectives in a position of extreme peril. Seriously contributing to that danger was the initial decision by them not to wear a safety vest. While this issue was identified by KCSO, the Review Board team apparently determined that the team's decision not to deploy safety vests was consistent with the agency's expectations. With "no action" devised to address this situation on a forward going basis, the implication is a message that KCSO detectives should continue to feel free to deploy the same way in future operations.

RECOMMENDATION THIRTY-FOUR: KCSO should revise its protocols to ensure that when an operation unnecessarily endangers its personnel, direction and guidance is devised to prevent future similar scenarios from occurring.

RECOMMENDATION THIRTY-FIVE: KCSO should change its policy to ensure that all personnel be required to don ballistic vests whenever there is a probability of a tactical encounter.

N. Lack of Uniformed Presence At or Near the Scene

Many undercover operations assign the arrest function to uniformed officers. The reason for doing so is that the presence of uniformed personnel and marked vehicles reduces any likelihood of confusion to the subjects about whether subsequent commands and other actions designed to take them into custody are being carried out as a law enforcement operation. Another significant advantage is that uniformed deputies carry all of the force options (pepper spray, Tasers, batons), radios, handcuffs, and protective gear needed to effectuate a safe arrest.

With the exception of a K-9 officer somewhat nearby, the “plan” in this case did not involve the use of a uniformed arrest team. The KCSO investigation or review did not ask those responsible for the operation’s planning why there was no uniformed involvement or consider whether a uniformed presence would have been preferable to the plain-clothes detectives standing by in unmarked cars. As a result, this strategic decision, and its consequences, were not explored during the after-action review of this incident.

RECOMMENDATION THIRTY-SIX: KCSO should revise its undercover operations protocols to recognize the advantage of assigning the arrest function to uniformed personnel.

O. Evaluation of the Probable Cause Determination

The detectives involved in planning the undercover operations indicated that while they did not have sufficient evidence to arrest D.R. for the homicide, they did believe that they had probable cause to arrest him for possession of stolen property and forgery. The evidentiary basis for this determination appears to largely rest on an equivocal and poorly documented identification of D.R. As it turned out, D.R. was neither involved in these crimes, nor in the homicide being investigated.

While the establishment of probable cause requires a lesser standard of proof, the fact that the central premise turned out to be mistaken warranted further consideration – particularly given its importance to the undercover operation and the eventual use of deadly force. However, KCSO’s ART process did not include an evaluation of the probable cause determination and its sufficiency. Any holistic review of the incident should have considered whether there was sufficient evidence to focus on D.R. as involved in the homicide or any ancillary crimes.

Such an assessment would have provided helpful information that could have served as a remedial instrument for the involved detectives and all sworn members of KCSO. The fact that this area of exploration was not pursued resulted in the forfeiture of any learning and improvement for the agency.

RECOMMENDATION THIRTY-SEVEN: KCSO should revise its officer-involved shooting protocols to ensure that the review include an objective assessment of any asserted Constitutional basis for detention or arrest.

P. Potential Impact of Fatigue on Planning and Tactical Performance

In many jurisdictions, it is standard for investigators to ask personnel who used deadly force to inquire about how much sleep the law enforcement official had prior to starting the shift. In situations in which the involved personnel are detectives and do not always work a regular shift, the question becomes even more relevant. Certainly, fatigue can impact decision-making and tactical abilities for even the most seasoned law enforcement officer. In this case, the involved deputies were not formally asked about how long it had been since they had a regular sleep cycle. Accordingly, the issue was not evaluated one way or the other as a potential factor in performance.

RECOMMENDATION THIRTY-EIGHT: In officer-involved investigations, KCSO should develop protocols to regularly ask involved personnel the last time they had a full sleep cycle and other questions related to potential physical factors on performance and assess relevant responses as part of the review process.

Q. Sergeant A's Self-Assignment to the Arrest Team

Sergeant A was one of the first KCSO personnel that responded to the earlier homicide, in which the son of a police officer was killed. According to reports, Sergeant A also unsuccessfully attempted life-saving measures on the victim. These are emotionally impactful events; however, when it came time to conduct an undercover operation involving an apprehension of a person believed to be responsible for the killing, Sergeant A self-assigned himself to the arrest team. And, as it turned out, Sergeant A fired the first shot as the arrest team came out of the van.

Questions were raised by the ART and OLEO about whether it was advisable for Sergeant A to have self-assigned to a tactical role in the undercover operation in light of his intimate involvement in the attempted rescue of the homicide victim. As noted above, during the Review Board colloquy, Sergeant A asserted that his earlier involvement in responding to the homicide had no impact on any subsequent decision in the undercover operation.

Though Sergeant A's perspective is obviously relevant, KCSO should not have relied on it alone in concluding that his dual role as rescue deputy in the homicide and tactical member in the undercover operation did not merit further assessment. Even if an individual consciously attempts to place his prior experience aside in making subsequent planning and tactical decisions, the unconscious connection may still exist in a way that compromises objectivity and regard for safety. And it was clear from the investigation that there were at least four other KCSO personnel on site that could have replaced Sergeant A as a member of the tactical team. This issue was certainly worthy of additional reflection and analysis by KCSO.

RECOMMENDATION THIRTY-NINE: KCSO's protocols should require consideration and a finding by the Use of Force Review Board whenever there is evidence that an involved deputy's prior experiences could objectively have warranted recusal from the operation in question.

RECOMMENDATION FORTY: KCSO should devise a training bulletin regarding this issue, and the advisability of assigning non-involved personnel to avoid the reality or appearance of conflict when practicable.

R. Post-Incident Rescue Efforts

The investigation revealed that immediately after the shooting, involved personnel and the staged detectives provided CPR to Dunlap-Gittens. The transition from tactical to rescue mode is often difficult to accomplish but by all accounts, the detectives made a smooth and laudatory transition. When performance by personnel is particularly creditable, the review should reinforce such behavior. In this case, the KCSO review process did not comment on the post-incident medical attention that was provided by its personnel. In the same way that suboptimal performance should be identified and critiqued, when performance is exemplary there should be feedback and recognition to personnel responsible for it.

RECOMMENDATION FORTY-ONE: KCSO should devise protocols requiring its Use of Force Review Board to identify and formally recognize exemplary conduct by its personnel.

S. Post-Incident Response by Rescue Personnel

As noted above, paramedics were timely called, took over treatment of Dunlap-Gittens at the scene and transported him to the hospital. According to Sergeant E, however, rescue was staged, but it took a "few times before they came in." However, this potential issue raised by Sergeant E was not addressed during KCSO's investigation and review. Getting life-saving personnel on

scene quickly is vital after an officer-involved shooting. Many agencies obtain reports or interview rescue personnel to determine whether the handling of the scene presented any challenges or obstacles to timely delivery of medical services. KCSO investigative protocols should be modified so that the insight and observations of rescue personnel are collected.

RECOMMENDATION FORTY-TWO: KCSO's investigative protocols should include an evaluation of its role in the timeliness and effectiveness of outside medical delivery at the scene, including interviews with rescue personnel.

T. Designation of County Personnel to Address Concerns of Family Members

In this case, after Dunlap-Gittens was transported to the hospital, family members learned that he had been shot and traveled to the hospital. However, according to media reports, it was hours before the family members were advised that Dunlap-Gittens had been shot by law enforcement personnel. Moreover, the information they were initially provided later proved to be faulty.

Officer-involved shootings are obviously tragically impactful on family members. However, even the best-intentioned law enforcement agencies often struggle to navigate their interactions with affected parties. The adversarial events that gave rise to the deadly force are obviously one part of this. But some of it is a simple function of the myriad responsibilities that agencies have – investigative and otherwise – in the aftermath of these incidents. The obvious interest that family members have in those events often can end up being not a priority. As a result, communication gaps can magnify the tensions for family members in a situation that is already emotionally fraught. And criminal detectives, for all their skills, are understandably focused on their own roles and not necessarily adept at the unique outreach required by this dynamic.

For these reasons, some police agencies have assigned the “family liaison function” to special personnel who are trained in community engagement and specifically designated to address concerns and questions of family members. Whether that individual is a KCSO or King County employee is subject to discussion, but the basic concept has been found to be beneficial in a situation that is inherently strained and merits special attention.

In the same way that involved officers have important support as they work through any trauma arising from having taken a life, the County should recognize a similar responsibility to family members who have had a life taken. Providing such a resource for the family will ensure that a family's loss is not inadvertently compounded by misinformation or insensitivity in the hours after the tragic event.

RECOMMENDATION FORTY-THREE: KCSO and the County should consider devising protocols so that an individual is assigned to serve as a family liaison in the aftermath of an officer-involved shooting.