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

Systemic Review relating to November 25, 2019 Officer-Involved Shooting of Anthony Chilcott

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Introduction

On November 25, 2019, Anthony Chilcott was shot and killed by two plainclothes detectives of the King County Sheriff’s Office (KCSO) after they attempted to stop him in their unmarked vehicle and apprehend him for stealing a vehicle three days prior. This report focuses on systemic issues associated with KCSO’s investigative and administrative review of this officer-involved shooting. KCSO conducted a misconduct investigation\(^1\) of this incident after internal allegations were made that the subject detectives used excessive or unnecessary force; acted in violation of Sheriff’s Office directives, rules, policies or procedures; and performed at a level significantly below the standard achieved by others in the work unit. The misconduct investigation resulted in some sustained allegations and led to a written reprimand for one detective and employment termination for the other detective.

This report is intended to further discussion on aspects of the incident that could be improved upon: (1) for future decisions leading up to and on using force, and (2) with KCSO’s internal post-critical incident processing and review mechanisms. To this end, this report examines what occurred during the incident, including the training and policies in place that informed law enforcement actions. And, this report also examines the administrative processes that KCSO utilized to internally process, investigate, and review the incident. Our independent review of training, policies, and processes and knowledge of leading industry practices allows us to make recommendations to change systems within KCSO to improve law enforcement performance. This report discusses the incident from a systemic context to shed light on what can be improved to prevent or mitigate against incidents like these from happening again and is separate from any KCSO determination regarding individual accountability.

KCSO’s review of the incident lacked analysis that would lead to better internal recommendations for continuous improvement at an individual deputy level and at the department level.

Regardless of the outcome of the internal misconduct investigation, KCSO has an obligation to analyze the incident for lessons learned. This analysis often lends itself to potential internal changes and implementation strategies. We uncovered multiple areas that can be improved upon to prevent similar incidents in the future. Through establishing stronger review mechanisms, KCSO has the opportunity to work towards greater accountability and safer law enforcement service delivery for both community members and officers.

The tactical decisions and actions made throughout the Chilcott incident unnecessarily escalated the situation and endangered the suspect, the detectives themselves, and proximate third parties.

\(^1\) Case number IIU2020-015.
Reportable force by the two detectives included:

- Using their vehicle to push the suspect’s vehicle in a different direction;
- Attempting to extract the suspect from the window of the suspect’s vehicle;
- Striking the suspect with the muzzle of a firearm two separate times; and
- Fatally shooting the suspect with their firearms.

We found that the detectives employed tactics that fell outside of what KCSO trains and failed to prioritize use of time, distance, and shielding for apprehension.

Among the troublesome tactical decisions and actions was the detectives taking law enforcement action while in a plainclothes\(^2\) capacity rather than staying covert and allowing for marked units to initiate apprehension. The lack of planning around the apprehension created a dire safety situation, as the detectives had no markings to make them clearly identifiable as police; lacked any safety equipment, such as ballistic vests; and did not have basic tools, such as less lethal weapons, to take law enforcement action. Immediate contact appeared unnecessary given the lack of apparent threat that the suspect posed. Approaching a vehicle with tinted glass that obscured the suspect’s appearance and actions exacerbated the situation.

Attempts to extract the suspect from a vehicle higher off the ground and use of muzzle strikes to the head to gain compliance escalated the situation further and provided the opportunity for the suspect to gain leverage, increasing the need for deadly force.

While some KCSO precincts or contract jurisdictions have taken steps to prevent similar incidents in the future, OLEO has identified additional strategies, policies, and processes to improve KCSO’s service to the community in such circumstances.

Authority, Purpose, and Methodology

The Office of Law Enforcement Oversight (OLEO) represents the interests of the public in efforts to hold KCSO accountable for providing fair and just police services. Through its independent reviews, OLEO seeks to instill public trust in law enforcement, promote transparency and integrity of KCSO operations, and help ensure the professionalism of KCSO. One of the ways that OLEO provides oversight is by conducting systemic reviews that evaluate circumstances associated with critical incidents, such as officer-involved shootings, and that make related recommendations to KCSO on policies and practices.

\(^2\) The detectives involved in this incident were in plain (civilian) clothes driving a leased vehicle. A leased vehicle does not have Sheriff’s Office markings, nor does it have the equipment available in a marked Sheriff’s Office vehicle. KCSO also has unmarked vehicles that are equipped with lights, sirens, and radio, not to be confused with the Yukon that the detectives drove during this incident. Similarly, the detectives did not set out in an undercover (fabricated appearance) capacity during this incident.
OLEO was established in King County Charter Section 265. OLEO’s authorizing ordinance, set forth in King County Code Chapter 2.75, affords OLEO the authority to provide recommendations for improvement related to the office’s oversight of KCSO. Specifically, OLEO is authorized to conduct systemic reviews and recommend changes to improve the quality of police investigations and policies, practices, and operations of KCSO. OLEO is also authorized access to all investigative files for auditing and reporting purposes that are relevant to its work. These provisions prohibit OLEO from disclosing any names or other identifying information of officers involved in incidents.

OLEO first monitored and reviewed the internal misconduct investigation for this incident that was referred to the Internal Investigations Unit (IIU) by the Administrative Review Team (ART) after potential policy violations were identified. OLEO attended administrative interviews, spoke with the assigned detective about investigative strategy, and reviewed the completed investigation for thoroughness and objectivity.

OLEO then attended KCSO’s Critical Incident Review Board (CIRB) that took place on October 15, 2020. In addition to the information gathered at the CIRB, OLEO reviewed the investigative file that included reports, photographs, WSP in-car camera video footage, and the recorded interviews of witnesses and involved detectives. OLEO also reviewed both the Seattle Police Department’s independent criminal investigation of the incident and the lessons learned from KCSO’s ART administrative investigation.

Additionally, OLEO spoke with KCSO personnel responsible for investigating the incident, reviewing the investigation, and implementing changes in response to lessons learned from the incident. The opportunity to engage in discussion with KCSO personnel and extend our review beyond documents and recordings allowed OLEO to gain additional insight and perspective, increasing the value of our assessment. OLEO appreciates KCSO’s willingness to provide input in this manner, giving our office the ability to obtain answers to questions and make more nuanced recommendations.

**Summary of the Incident**

This incident summary is based on information obtained from OLEO’s review described above. Other facts may come to light during subsequent investigations or proceedings.

On November 22, 2019, a Ford F-150 Raptor truck was stolen from a gas station in Black Diamond, Washington and, inside the vehicle, was the owner’s dog. Anthony Chilcott was identified as the person who stole the Raptor.

On November 25, 2019, Detectives 1 and 2 set out to assist the search by Washington State Patrol (WSP) for the stolen Raptor. The detectives involved in this incident were both part of the Special Emphasis Team (SET), which, according to their standard operating procedures,
exists to address and resolve community problems and crimes by employing unconventional and non-traditional investigative methods. That day, Detectives 1 and 2 were working undercover in plainclothes and driving an unmarked GMC Yukon with no emergency lights or sirens. Detective 1 was the driver and Detective 2 was in the front passenger seat. The detectives had seen a Black Diamond Police Department bulletin, which stated there was probable cause to arrest Chilcott for Theft of a motor vehicle, Theft in the first degree, Theft in the second degree, Taking Pet Animal, Driving While License Suspended in the third degree, and Stalking. The bulletin stated, “Subject Chilcott has reacted violently toward law enforcement in the past and has a caution notice in WACIC.”

Around 11:00 a.m., a WSP sergeant and a KCSO deputy separately spotted the Raptor. The WSP pursued the vehicle but then lost sight of it. The KCSO deputy broadcasted on the radio that he was blocking the road when the Raptor hit his patrol vehicle’s push bar. Upon clarification by a KCSO sergeant who was monitoring the situation, the sergeant concluded the Raptor did not ram the deputy, but that the contact was incidental. This information about an incidental contact was conveyed to Detective 2. Additionally, the KCSO sergeant instructed over the radio that KCSO units could assist in trying to box in the suspect vehicle, but were not allowed to pursue the vehicle.

During area checks for the Raptor, Detectives 1 and 2 spoke with a mailman who stated he had seen the Raptor drive by at about 120 miles per hour with no police chasing it.

The next set of events occurred over the span of less than five minutes. At about 11:51 a.m., Detectives 1 and 2 were driving northbound on Cumberland-Kanaskat Road when they saw the Raptor traveling toward them, southbound, at a high speed. Detective 2 advised radio that they had spotted the stolen vehicle, and that they would be turning around to follow it. Detective 2 also requested that WSP be notified because there had been a trooper traveling southbound on Cumberland-Kanaskat Road.

After turning the Yukon around, Detective 1 initially lost sight of the Raptor. He regained sight of the Raptor and then saw it pull over to the right side (west side) shoulder of 352nd Street and Cumberland-Kanaskat Road near a power plant. In his compelled written statement, Detective 1 stated that the Raptor had its left turn signal on, and it appeared to be set up to make a U-turn back north/east of Cumberland-Kanaskat Road. Detective 1 stated that the Raptor was angled toward the left. Detective 1 noted that there were two children and an adult across the street. Based on a map of the Raptor’s location points and diagram later drawn by one of the children, the two children and adult could have been approximately 75-100 feet away from where the Raptor pulled to the shoulder.

Detective 1 stated he pulled the front quarter panel of the Yukon to block the Raptor, and as he did that, Detective 2 pulled up his badge and yelled, “police, shut it down” or “police, turn it

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3 WACIC is the Washington Crime Information Center. It is a database that provides criminal history and crime information to law enforcement.
off” to Chilcott. Detective 2 stated that he made eye contact with Chilcott, that he held his badge at chest level and that he believed his window was rolled down. Detective 2 stated that, at the moment they made eye contact, Chilcott grabbed the steering wheel and turned it left into the Yukon. At 11:52 a.m., Detective 2 broadcasted, “32, he just rammed us.”

Detective 1 stated that when the Raptor hit the Yukon, its trajectory was in the direction of where the children were standing. Because of that, Detective 1 stated that he intentionally used his vehicle to push into the Raptor. This caused the Raptor’s direction to be angled away from the children. Detective 2 recalled Detective 1 letting off the gas to ram the Raptor.

Detective 1 then pushed the Raptor on some large garden rocks. The Yukon was to the left of the Raptor, with the Yukon’s front right panel near or touching the Raptor’s front left panel. Approximately 18 seconds after broadcasting the Ford Raptor rammed them, Detective 2 advised radio, “he’s stuck.”

At that point, Detective 1 put the Yukon into park and both detectives exited their vehicle. Detective 1 stated that Detective 2 was in close proximity to the Raptor, and they were wedged in between the two vehicles. Detective 2 drew his firearm and yelled, “police, put up your hands.” Detective 1 stated that the Raptor’s driver side window was down a little, and he saw Chilcott put his hands out the window when Detective 2 yelled the orders. Chilcott then brought his hands back inside, and Detective 2 yelled the orders again. Detective 2 stated that Raptor’s tint was very dark, and he could not see Chilcott, but could see a dog jumping in the front seat.

Detective 1 stated he first tried to open the Raptor’s driver’s side door and then moved to the passenger side. Detective 1 stated that Chilcott looked possessed, and his eyes were like saucer pans. Detective 2 yelled out to Detective 1 that he could not see Chilcott’s hands. Detective 2 stated that he then heard the Raptor’s engine rev up, that the truck flew back in reverse, and that he could not see Detective 1. Detective 1 stated that, when the truck flew back in reverse, he was hanging on to the side mirror and thought that either he or Detective 2 were going to be dragged by the vehicle or killed. Detective 1 stated that Chilcott drove straight back in a trajectory towards the children, and he was worried Chilcott was going to fly right into the children or into the cross traffic. But Chilcott ended up getting stuck on the rocks.

At the point when Detective 1 noticed Chilcott was momentarily stuck on the rocks, Detective 2 resumed giving Chilcott orders and Detective 1 went to the back of the Yukon to retrieve a sledgehammer. Detective 1 hit the Raptor’s driver’s side window. Detective 2 was also on the driver’s side when this occurred. The window was damaged but did not shatter because the tint film held it together. One of the detectives pulled at the damaged window so that they could see Chilcott. Both detectives had their firearm in one hand and used the other hand to reach into the window to grab Chilcott. When the detectives were not successful at removing Chilcott, Detective 2 disengaged, went to the front passenger side door, and hit that window with the sledgehammer.
Meanwhile, Detective 1 had his left arm in the truck and had Chilcott pinned to the driver’s seat. At some point, Chilcott moved toward the center console. Detective 1 then used the muzzle of his firearm to punch the left side of Chilcott’s face. Detective 1 stated that Chilcott briefly put his hands up and then reached towards the center console. Detective 1 hit Chilcott again with his muzzle. Detective 1 stated that Chilcott responded “no” and, at some point, grabbed Detective 1’s gun. Detective 1 got his weapon free from Chilcott’s grasp, but Chilcott pulled Detective 1 about halfway into the truck and stepped on the accelerator.

Detective 1 told Detective 2, who was still on the passenger side, “hey, I need help! I’m losing the fight.” Moments later, Detective 1 shot Chilcott on the left side of his head. Shortly thereafter, Detective 2 shot Chilcott. At approximately 11:55 a.m., Detective 2 advised by radio, “shots fired. Roll us aid and a sergeant.”

A WSP patrol unit pulled behind the Raptor right after the shots were fired. The WSP in-car video shows Detective 1 re-holstering his firearm and Detective 2 near the passenger side of the Yukon. Detective 2 stated that, after shots were fired, he went back to the Yukon to dig around for the radio and then announced on the radio that shots were fired.

Later that day, Chilcott’s mother and cousin called 911 to inquire about the incident. Chilcott’s mother was told she would be contacted later. Chilcott’s cousin told the dispatcher she wanted a family member to be with her aunt when she received the news. Chilcott’s cousin was concerned for her aunt because she was in and out of sobriety and had lost other family members. She mentioned that Chilcott’s sister lived outside of Washington. It is unclear what information was given to the King County Medical Examiner’s Office prior to them contacting Chilcott’s mother.

**Tactics, Planning, and Decision-Making**

**Taking Law Enforcement Action During Foreseen Events**

Detectives knew of the possibility of an encounter prior to the incident. The detectives left the precinct with the intention of proactively looking for the stolen vehicle. They did not encounter Chilcott by accident or because of an emergency that required law enforcement action. The detectives knew at the time that there was probable cause to arrest Chilcott, and that he had a caution notice in WACIC.

There is currently no explicit KCSO policy prohibiting plainclothes detectives from taking law enforcement action. Rather, it is based on the detective’s discretion and addressed through KCSO’s policy on uniforms. When this incident occurred, KCSO’s General Orders Manual (GOM) 4.00.010(2) stated that “when not wearing the authorized uniform and when taking police action, acceptable identification is the authorized badge and identification card.”
To KCSO’s credit, in 2020 before the CIRB was held for this incident, it was in process of revising GOM 4.00.010 to provide plainclothes detectives with more clarity regarding uniform requirements when involved in planned and unplanned events.\(^4\) The revisions were adopted in October 2020 and now include uniform requirements for both a planned event, which is defined as a warrant service or arrest operation (GOM 4.00.010(b)), and an unplanned event, which is defined as responding to an emergency incident (GOM 4.00.010(c)). The revised GOM policies retain some discretion for plainclothes detectives to take law enforcement action without donning a vest if they are in a covert, supporting role alongside uniformed deputies during a planned event.

Based on discussion at the CIRB, however, KCSO’s policy should be further clarified and communicated to its personnel. At the CIRB for this incident, a member of the ART identified three types of responses: hasty responses (taken to mean emergency responses), pre-planned responses that require a formal briefing, and responses that fall in the middle. While the SET standard operating procedures discuss pre-planned events for plainclothes detectives, neither the SET procedures nor the current GOM includes explicit guidance on events where plainclothes detectives have existing knowledge about a suspect and set out to assist in surveilling an area without a formal arrest operation plan or uniformed officers ready to take law enforcement action like in this case.

It is OLEO’s position that this incident should be treated in the same manner as the “planned event” under the GOM and that this type of event should be added to the definition. Particularly, the policy should explicitly address situations where foreseen events occur in circumstances where there was no formal operations plan and briefing. A clear example of this is evident in the Chilcott matter, where there was clear prior knowledge of Chilcott, his offenses, and the potential for arrest. The event became “planned” when the detectives set out to look for Chilcott and/or the stolen vehicle. The way the incident unfolded does not change the fact that detectives were proactively looking for Chilcott and/or the stolen vehicle, and that an encounter with him was foreseeable. The lack of planning before they set out to look for Chilcott, albeit while conducting other work, led to poor decision making in the moment of the incident.

It is imperative that the GOM policy be further clarified in order to explicitly include this type of situation under planned events. Doing so ensures that training and practical application can be clear for plainclothes detectives. It also means that the department and supervisors can set clearer expectations around planned events, specifically that detectives are expected to discuss

\(^4\) These policy changes should have occurred following the ART recommendations after the 2017 officer-involved shooting death of Mi’Chance Dunlap-Gittens, which involved a similar issue of officers taking law enforcement action despite not being clearly identifiable as police. For this incident, OLEO acknowledges that KCSO began implementing changes before the CIRB was held.
a plan about what actions they can or cannot take without law enforcement markings and emergency equipment such as vehicle lights and sirens.

**Recommendation 1:** KCSO should revise the language in GOM 4.00.010(1) to include a definition for unplanned/unforeseen and planned/foreseen events to further clarify expectations on when detectives can take law enforcement action.5

**Recommendation 2:** KCSO should make explicit in its policy that plainclothes detectives are prohibited from taking law enforcement action unless there is a specific imminent threat of serious bodily harm or they are acting in a support role6 alongside uniformed personnel during a pre-planned event.

**Guidance for Driving Leased Vehicles**

The detectives involved in this incident were in plainclothes driving a leased, unmarked Yukon with no emergency equipment, such as sirens, emergency lights, or in-car radio. Detective 2 had a pool radio, which he reported was having reception issues throughout the incident.

Markings on KCSO vehicles alert suspects that detectives are part of a law enforcement entity and that subsequent commands should be followed to not escalate the situation. Chilcott was not provided this visual notification. Detective 2 stated that when the Yukon pulled up to the Raptor, he made eye contact with Chilcott, held up his badge, and said something similar to “police, shut it down,” which indicated to him that Chilcott knew they were law enforcement. However, the series of events at that point happened quickly and there is no way of knowing when and to what extent Chilcott processed that information. In fact, Detective 1 stated that he saw the Raptor pull to the right shoulder and had its left blinker on as if it might make a U-turn. The detectives stated that Chilcott saw them and intentionally rammed their vehicle to get away. But given the rapid event, it is also possible that Chilcott was starting to make a left U-turn when he hit an unknown vehicle that pulled up next to him, taking him by surprise.7

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5 In this report, OLEO uses the language “planned/foreseen” and “unplanned/unforeseen” to align with our previous recommendation to revise GOM 4.00.010(1)(c) in a December 1, 2020 memo from OLEO to KCSO. In that memo we recommended that “an unplanned and unforeseen event shall be defined as an emergency event where no knowledge that the event had the potential to occur was present prior to the event.” OLEO suggested editing the policy to ensure future events like this one involving Chilcott would be considered planned and/or foreseen.

6 For the purposes of this report, personnel acting in a support role during a pre-planned event include detectives working in a plainclothes capacity who are formally identified in an Incident Action Plan. During a pre-planned event, uniformed personnel are assigned the primary role of apprehension and plainclothes detectives become overt exclusively as a contingency plan.

7 As part of the criminal investigation, the Raptor’s infotainment system, which tracks a vehicle’s location, among other things, was downloaded and analyzed. The data did not provide information about which vehicle initiated contact. It showed the Raptor had stopped on the right shoulder for eight seconds before the impact between it and the Yukon. During Detective 1’s interview, he stated that after they initially saw Chilcott driving southbound toward them, he waited until they were out of Chilcott’s view before he made a U-turn to follow him.
Most eyewitnesses around the incident scene stated that they observed an impact between the Yukon and Raptor. Common themes throughout the civilian witness statements were that the Yukon hit or T-boned the Raptor, that the Yukon was the vehicle that was the aggressor, and that none of the witnesses knew the two men with firearms were Sheriff’s deputies.

OLEO agrees that it is possible the civilian witness’ attention was not drawn to the two vehicles until there was a sound from the collision. However, the detectives’ decision to engage with Chilcott while they were in a leased, unmarked, unequipped vehicle still created an unnecessary and highly dangerous situation. While one of the detectives’ stated reasons for engaging with Chilcott was to keep civilians out of harm’s way, there was no visual indication for the civilians to recognize the armed men they saw as law enforcement. The lack of readily available knowledge around the detectives’ authority created a dangerous environment for the witnesses who observed what seemed to be a fight between civilians. In an unmarked vehicle, the plainclothes detectives were unable to predict whether bystanders would intervene and put themselves in harm’s way. One of the civilian witnesses who was driving past the incident resorted to calling 911 because it was unclear that law enforcement was already involved.

Unless there is an imminent threat of serious bodily harm, having appropriate and sufficient markings before taking law enforcement action is imperative to ensuring the safety of all proximate parties. The presence of a marked law enforcement vehicle signals to civilian witnesses that they should not get involved, that trained professionals are handling the situation, and that uninvolved civilians should stay back.

The lack of obvious visual or auditory alert provided no opportunity for civilian witnesses to clear the area and failed to allow Chilcott to clearly recognize the detectives as such. This important signal was missing in this incident, and put innocent civilians, Chilcott, and the detectives themselves in an unnecessarily unsafe position.

**Recommendation 3**: KCSO should clearly communicate to its members expectations for taking law enforcement action in leased, unmarked, or unequipped vehicles during planned/foreseen events.

**Recommendation 4**: KCSO should review and revise its policies to ensure that members in a leased, unmarked, and/or unequipped vehicle shall not take law enforcement action unless there is a specific imminent threat to serious bodily harm.

**Guidance for Wearing Marked Vests**

Neither detective wore a vest during their encounter with Chilcott and only one vest was identified inside the Yukon by the Force Investigation Team after the incident. At the time of the incident, the GOM did not explicitly state the requirements for wearing a vest or having one available for specific events. It is OLEO’s understanding that KCSO was in the process of revising the GOM to respond to ART’s and OLEO’s previous recommendation that all personnel be required to don marked vests whenever there is a probability of a tactical encounter.
During this incident, witnesses stated that they did not recognize the armed men as law enforcement. Detective 2 stated that he verbally identified himself as law enforcement to the suspect and showed Chilcott his badge. However, given the rapid sequence of events after the detectives took initial law enforcement action, the loud sound of the Raptor’s engine after it was lodged on the rocks, and the lack of uniform markings, it cannot be ruled out that these factors may have contributed to Chilcott’s resistance to commands. When it is not clear to a suspect that they are being approached by law enforcement, there is an increased risk to both the suspect and the involved officers. The suspect may respond with aggression because they are acting in self-defense or may attempt to flee to protect themselves from perceived harm. Having clearly marked police uniforms reduces the confusion around whether actions and commands are law enforcement related.

Another reason that wearing a department-issued vest is important when contacting a suspect is that the uniform provides personnel access to less lethal force options and equipment to make an arrest should they need to take emergency action. Having a vest available and putting it on is within the control of the detective. Without it, detectives limit their access and ability to use less lethal force options and instead may need to rely on lethal force should force be necessary. Additionally, the use of a ballistic vest provides more protection from a potentially violent suspect. Given that the detectives had knowledge of Chilcott’s previous negative interactions with law enforcement, using protective gear would have been a prudent safety measure.

One issue raised during the Chilcott CIRB was the concern that current assigned vests are difficult to put on, especially when in a vehicle during high stress situations. ART previously recommended that SET detectives should be issued external vest carriers that have side openings, allowing for quick application. It is OLEO’s understanding that the requests for side-opening vests were denied by the former KCSO undersheriff, and that there are still internal efforts to have the side-opening vests be approved by KCSO’s Uniform and Equipment Board. Regardless of whether a vest is accessible, however, detectives should consider their mitigation options, such as choosing not to engage or contact a suspect altogether. The GOM is not currently clear on what alternatives personnel have when vests cannot be donned for protection.

**Recommendation 5:** KCSO should revise its policy to ensure that all personnel are required to don ballistic vests when taking law enforcement action unless there is a specific imminent threat of serious bodily harm that prevents personnel from donning the vest or personnel are acting in a support role alongside uniformed personnel during a pre-planned event.8

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8 This recommendation is in alignment with OLEO’s previous recommendation in its Review of the Officer-Involved Shooting of Mi’Chance Dunlap-Gittens published in February 2020.
**KCSO Does Not Currently Train on Donning and Doffing Vests in Vehicles**

During their interviews, both Detectives 1 and 2 stated that they did not have time to don their vests while inside their patrol vehicle before contacting Chilcott. They both stated that it would be difficult to do so due to the design of the vest.

Given the important role that wearing a vest plays in providing protection and identification, ART recommended during the CIRB that SET trainings should include scenarios where time is limited but donning and doffing vests is required. Doing so would give deputies the skills necessary to keep themselves and others safe when taking law enforcement action. OLEO agrees with the ART recommendation.

**Recommendation 6:** KCSO should hold regular, comprehensive trainings\(^9\) for plainclothes detectives that include mock scenarios involving decisions on whether to remain covert or take law enforcement action.

**Recommendation 7:** KCSO should hold regular, comprehensive trainings for plainclothes detectives that include mock scenarios where personnel are required to don and doff vests depending on whether they take law enforcement action.

**Choosing to Engage with the Suspect When No Specific Threat Exists**

After receiving information that there was incidental contact between Chilcott and a KCSO deputy, Detectives 1 and 2 were instructed by a sergeant over the radio that KCSO units could assist in trying to box in the Raptor, but they were not authorized to pursue the vehicle. In his account of this incident, Detective 1 explained that one of the reasons he decided to engage was because Chilcott’s vehicle was pointed in the direction of two children, an adult, and oncoming traffic.

However, it is OLEO’s position that Detective 1’s articulation was based on a generalized fear and not a specific threat. Based on a map of the Raptor’s location points and diagram drawn by one of the children, the two children and adult could have been approximately 75-100 feet away from where the Raptor pulled to the shoulder. Chilcott’s proximity to them or presence of potential oncoming traffic was not an imminent threat. Rather, it was the detectives’ decision to engage with Chilcott that escalated the situation, created the imminent threat, and caused the series of events that led to the multiple uses of deadly force.

Any need to apprehend Chilcott in that moment was far outweighed by the less confrontational alternatives that existed. This is especially true when, as here, the detectives had information that Chilcott had already eluded WSP and were put on notice that he might do the same if they

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\(^9\) In this report, recommendations that mention training refer to in-service or department-wide in-person training and communication. Communication in this context is intentional discussion from leadership to middle management to personnel on the ground. These discussions are not to be replaced by written communication.
took law enforcement action. Yet they continued to act without waiting for sufficient back-up, which increased the risk to all involved parties.

One alternative was to follow Chilcott from a safe distance, while remaining covert and waiting for marked law enforcement units with appropriate equipment and planning. KCSO trains that, before attempting to conduct a felony stop or apprehending a suspect with a history of being dangerous to law enforcement, deputies should call for back-up and wait for those reinforcements to arrive before initiating contact with the suspect. Specifically, SET strategically trains officers to stay back, make a plan, create a perimeter, and move in slowly. The detectives had the opportunity to call for assistance and wait for help. Instead, the detectives moved in and confronted Chilcott, who was in a higher performing vehicle than theirs. Even after Detective 2 broadcasted that Chilcott was “stuck,” the detectives moved in again instead of creating distance, using cover, and waiting for back-up.

Another alternative to seeking immediate apprehension of Chilcott was to act in a community caretaking capacity by ensuring the safety of nearby civilians. Approaching the civilians and removing them or staying with them to guard from potential danger would have reduced the need to confront the suspect. Since the detectives were in plainclothes and in an unmarked vehicle, this likely would not have tipped off the suspect. The decision to engage when safer alternatives existed created a rapidly evolving situation that endangered the detectives and contributed to the likelihood of Chilcott’s behavior escalating.

**Recommendation 8:** KCSO should train its members that speculative, generalized concerns about a subject harming innocent third parties is an insufficient basis to use force.10

**Approaching and Gaining Access to Suspects in Vehicles with Tinted Glass**

KCSO does not currently train deputies on breaching tinted glass. During the CIRB for this incident, it was mentioned that deputies would benefit from such training. OLEO does not disagree that this training would be helpful in the event that deputies find themselves in an emergency situation with no other option but to breach tinted glass. However, OLEO emphasizes that KCSO should also train personnel to take a step back and first determine whether breaching glass is warranted or necessary.

Before deciding to approach the vehicle, the detectives in the Chilcott matter knew that the Raptor had tinted windows. Detective 2 stated in his interview that the tint was dark enough that they could not see Chilcott clearly. The detectives’ limited ability to see what Chilcott was doing through the tinted glass compounded the safety threat posed by approaching the Raptor. Nevertheless, the detectives attempted to access Chilcott by breaking the driver’s side window of the Raptor after Chilcott refused to exit the Raptor. Detective 1 attempted to breach the glass with the sledgehammer retrieved from the Yukon, but it did not shatter the window,

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10 This recommendation is in alignment with OLEO’s previous recommendation in its Review of the Officer-Involved Shooting of Mi’Chance Dunlap-Gittens published in February 2020.
because the tinted film held the broken pieces of glass together. The deputies then sought to pull the glass down in order to contact Chilcott.

The time it took to retrieve the tool, attempt a break in, and contact the suspect could have provided a Chilcott an opportunity to arm himself or to flee because the detectives’ attention was on something else. The detectives’ failure to plan a tactical apprehension of Chilcott and inability to foresee that tinted glass may prevent quick access to the suspect resulted in the detectives placing themselves closer to danger and in the loss of time, distance, and shielding, which increased the likelihood that a higher level of force would need to be used.

The decision to approach a suspect behind tinted windows and attempt to breach the glass before back-up arrived left the detectives vulnerable to potential external threats that could not be fully recognized without diverting focus from the windows. Deputies should be trained to conduct a risk-hazard analysis that considers whether the timing and feasibility of their contemplated engagement, and the need to prevent immediate serious bodily harm, justify immediate action to carry out the mission at hand. Such training would equip officers with the decision-making skills necessary to avoid the dangerous situation that unfolded in this incident.

**Recommendation 9:** KCSO should consider training deputies on when and how to effectively and safely contact suspects who are inside vehicles with tinted windows.

**KCSO Does Not Train on Vehicle Extractions from Vehicles Higher Off the Ground**

With regards to resisting suspects, current KCSO training focuses on extracting suspects from a Ford Interceptor Patrol SUV (a modified Ford Explorer). This vehicle sits significantly lower to the ground than the Raptor in this incident. These trainings exclusively train on extraction techniques using a stationary vehicle with the vehicle door open and a deputy’s feet on the ground. While Detective 1 stated that he has successfully pulled suspects out of windows in the past, this is not a technique that KCSO trains.

Without a pre-determined plan and the support of back-up, the tactical disadvantage posed by reaching into the window of a vehicle that is higher off the ground outweighs the benefit of potentially apprehending the suspect. More specifically, when Detective 1 reached into the Raptor, he placed himself in a compromising position and provided Chilcott with positional leverage to pull him into the vehicle. Additionally, Detective 1 was holding a firearm while attempting to pull Chilcott out of the window. This increased the likelihood of accidental discharge. Any efforts to mitigate an accidental discharge may have diminished Detective 1’s ability to successfully extract Chilcott, as he only had one free hand. This circumstance increased the likelihood of deadly force being used. While training on extractions from vehicles that are higher off the ground would be one way to address the issue, obtaining the resources to do so poses a barrier especially in light of more pressing training priorities. Until KCSO implements regular training for extractions of resisting suspects in vehicles higher off the ground than the Ford SUV, these types of extractions should generally be prohibited.
**Recommendation 10:** KCSO should prohibit deputies from extracting suspects from vehicles that are higher off the ground than vehicles they train on unless their apprehension is part of a pre-planned TAC-30/SWAT arrest operation.

**KCSO Does Not Train Muzzle Strikes as a Pain Compliance Technique**

During the incident, Detective 1 stated that he used his firearm to strike Chilcott’s head to stop him from reaching for the center console. Specifically, Detective 1 used the muzzle of his firearm to punch the left side of Chilcott’s face. Detective 1 stated he did not know if Chilcott was reaching for a weapon or was going to put the truck in gear to drive. Chilcott briefly put his hands up and then reached towards the center console. Detective 1 hit Chilcott again with his muzzle. Detective 1 stated that Chilcott responded “no” and, at some point, proceeded to grab Detective 1’s gun.

During Detective 1’s interview, he initially acknowledged that using the muzzle of a firearm as an impact tool is not a standard pain compliance technique that is trained, and that the technique is used in life and death situations. Later in the interview, Detective 1 explained that he has been in several classes where using a muzzle strike is a standard technique that was briefly covered when discussing circumstances in which a suspect is fighting with an officer over a gun.

Muzzle strikes are not a KCSO trained technique, and Detective 1’s use of the of the firearm as an impact weapon appeared to escalate the situation further. It is not unreasonable to believe that in reaction to being struck in the head, Chilcott grabbed the gun to prevent additional strikes. By giving Chilcott access to the firearm, Detective 1 created a life or death situation.

Using other defensive tactics such as arrest, control holds, and pain compliance techniques could have prevented or, at minimum, reduced the need for deadly force.

**Recommendation 11:** Implement and mandate regular defensive tactics training, which is provided multiple times a year, that teaches deputies arrest, control hold, and pain compliance techniques to eliminate perceived threats posed by suspects inside vehicles.

**Administrative Investigation and Review Processes**

**Compelled Statements of Involved Personnel Not Signed**

The detectives involved in the Chilcott matter submitted compelled written statements as part of the investigation into this incident. After review of the compelled statements, OLEO noted that the documents were not signed by the respective personnel.

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11 This recommendation is intended prohibit deputies from extracting non-compliant suspects who do not respond to orders to exit their vehicle, but have the ability to do so.
Signatures on compelled statements alert investigators and reviewers of the investigation that the statement was prepared and approved by the personnel who submitted it as their independent account of the incident.

A signature attached to a statement helps maintain the integrity of the investigation, as it ensures transparency concerning the origin of the document. Signatures on statements involving a shooting are especially important, as they authenticate the words as true according to the author. This authentication is a means to establish trust with reviewers in the statement’s content. Given the seriousness of the incident, obtaining proper signatures on official investigative documents is of utmost investigative importance.

**Recommendation 12:** KCSO should revise its investigative protocols so that investigators require involved personnel to sign compelled statements or document the personnel’s refusal to do so before officially adding them to the investigative file.

**Timing and Medium of Interviewing Involved Personnel**

The detectives involved in the Chilcott matter were not interviewed immediately after this incident. While the GOM affords involved personnel 48 hours (or 72 hours in extenuating circumstances) to submit compelled written statements, the detectives involved in this incident prepared compelled written statements that were submitted to ART on December 3, 2019, approximately 192 hours (eight days) after the incident.

As OLEO has stated previously in other systemic and policy reviews, a written statement is never an adequate substitute for an interview that occurs before end of shift. The details provided in a written statement are left solely to the discretion of the author, and investigators are not given the opportunity to ask follow-up questions. Consequently, the actions and observations provided by the author are not a response to questions from an investigator, and critical areas of importance could be omitted entirely, leaving the investigation incomplete.

Allowing an investigator to determine the areas of inquiry allows for a thorough and objective account from the involved officer and ensures that essential pieces of the incident are not left out.

Additionally, there is no transparency regarding how compelled written statements are drafted. This leaves the process open to public distrust of whether personnel collaborated while preparing statements, or whether they received assistance drafting a statement from a legal representative before submission. Simply stating that collaboration does not happen is not sufficient. By contrast, a recorded interview allows those reviewing the investigation to hear whether a personnel’s attorney lodges an objection or advises the personnel not to answer a question asked of them. Video-recorded interviews additionally allow those reviewing to observe body language and other non-verbal cues that provide context for the statements.

Triggered solely by an IIU investigation, the involved deputies were eventually interviewed, but this occurred nearly eight months after the incident. OLEO monitored the IIU investigation and
understood that interviews of the involved deputies were delayed until the I-940 independent investigators had provided KCSO with the criminal investigation. OLEO acknowledges that during its monitoring of the IIU investigation, it did not explicitly state that interviews of the involved personnel should not be delayed. However, it has always been our position that in-person, recorded interviews be conducted immediately after the incident, as it is the best means for KCSO to learn about deputies’ actions and observations during an incident while details and recollections are still fresh. Even if KCSO does not have all the information at hand during this initial interview, a subsequent supplemental interview can be conducted if more information is needed from the involved personnel.

Relying on compelled written statements submitted more than a week after the incident and on recorded officer statements made eight months after the incident raises serious concern about the personnel’s ability to accurately recollect actions, details, and observations. A delay in obtaining a statement also increases the chances that personnel statements may be influenced by external input, even if inadvertent such as by hearing a news report or others speak about it. These possible influences have the potential to compromise accounts if the incident. Failing to promptly obtain a statement from involved personnel also decreases the public’s confidence that the investigative process will accurately determine what unfolded during the investigation into the incident and whether the actions reviewed were legitimately undertaken.

**Recommendation 13:** KCSO should revise its investigative protocols so that personnel involved in critical incidents are required to participate in in-person, audio recorded interviews.\(^\text{12}\)

**Recommendation 14:** KCSO should revise its investigative protocols so that personnel involved in critical incidents are required to participate in in-person, video recorded interviews.\(^\text{13}\)

**Recommendation 15:** KCSO should revise its investigative protocols so that an interview is conducted of personnel involved in critical incidents before the end of shift.\(^\text{14}\)

\(^\text{12}\) This recommendation is in alignment with OLEO’s previous recommendation in its Review of the Officer-Involved Shooting of Mi’Chance Dunlap-Gittens published in February 2020.

\(^\text{13}\) This recommendation is in alignment with OLEO’s previous recommendation in its Review of the Officer-Involved Shooting of Mi’Chance Dunlap-Gittens published in February 2020.

\(^\text{14}\) This recommendation is in alignment with OLEO’s previous recommendation in its Review of the Officer-Involved Shooting of Mi’Chance Dunlap-Gittens published in February 2020. That investigation report noted that KCSO routinely delayed interviews of involved personnel because according to the cognitive interview technique and research, memory recollection is improved after two sleep cycles. There is, however, research that calls into question the notion that officer recall is better after two days. See, e.g., Rebecca Hofstein Grady, Brendon J. Butler, and Elizabeth F. Loftus, (2016) “What Should Happen After an Officer-Involved Shooting? Memory Concerns in Police Reporting Procedures,” *Journal of Applied Research in Memory and Cognition*, vol. 5, pp. 246–251.
IIU Investigation Not Completed Before the CIRB

When the CIRB convened to discuss the Chilcott incident, the IIU investigation was ongoing, with fact-finding complete but findings not yet published. In spite of this procedural posture, the CIRB reviewed and opined on the allegations that the detectives violated performance standards and used excessive or unnecessary force.

The role of IIU investigations is to determine whether involved personnel engaged in misconduct. In this case, the IIU investigation was conducted to determine whether the involved personnel violated performance standards or used excessive or unnecessary force, and what, if any, discipline would result if allegations were sustained.

In contrast, KCSO’s CIRB exists to conduct enhanced administrative review of critical incidents. The conversation that occurs during such review results in findings and recommendations that are sent to the Sheriff, including the lessons learned during the review of the incidents and suggested measures that can be taken to mitigate future related issues within the department.

These separate functions of a law enforcement agency are meant to stand independent of one another. When these accountability functions operate simultaneously, the roles of participants become unclear and undermine the ability of the CIRB to focus solely on identifying deficiencies in training, tactics, equipment, and policies and creating strategies to address them.

Recommendation 16: KCSO should adopt protocols so that the CIRB does not review or opine on specific issues that are part of ongoing internal misconduct investigations.

Lack of Protocols for Independent Investigation

Initiative 940 (I-940) establishes that an independent criminal investigation must be conducted in officer-involved use of deadly force incidents that result in significant bodily harm or death. The Seattle Police Department’s Force Investigation Team was called out to investigate the Chilcott incident. This was the first I-940 independent investigation that was done for a KCSO officer-involved incident.

The CIRB identified the lack of I-940 protocols as an issue in this incident. OLEO agrees with ART’s recommendation to create a memorandum of understanding to address the concern. It is OLEO’s understanding that memorandums of understanding may now exist with those agencies that would be conducting independent, I-940 investigations for KCSO.

While the information in the investigative file provides a limited view of what evidence may not have been collected, it is clear that some evidence that would have provided a better understanding of tactical decision-making was not accounted for. For example, there was no log documenting what items were removed from the Yukon, and it appears that Seattle Police did not inventory items in the Yukon once they were on scene. There was also confusion about where Seattle Police vehicles should park when arriving on scene. In the Chilcott case, this resulted in Seattle Police parking on the shoulder of the road that Chilcott had pulled off on
before the detectives initially confronted him, possibly impacting the ability to properly view and assess the scene. Having protocols and pre-established mechanisms for communication between KCSO and the independent agency before and during processing of the scene is essential to ensuring a smooth independent investigation, maintains the intent of I-940, creating public trust in the process.

**Recommendation 17:** KCSO should create a memorandum of understanding for independent I-940 investigators to clarify the protocols of the I-940 team during critical incidents.

**Failure of the CIRB to Review Detective Tactical Options**

As noted earlier, there were several instances in the Chilcott matter where the detectives found themselves at a tactical disadvantage.

Adequate time was not spent by CIRB members evaluating how detectives could have repositioned themselves or responded differently to put themselves in safer positions that increased their tactical advantage. Circumstances in the Chilcott matter highlight the importance of such analysis. As Tactical decisions made by the Chilcott detectives led to the use of deadly force. This sort of evaluation was essential to have before the board’s vote on whether the detectives’ decisions leading up to the event were sound.

Perhaps more importantly, identifying alternative tactical options that were available to the involved personnel is an essential function of the CIRB that allows the department to understand other possible outcomes. Analyzing incidents with a critical lens that considers all training and tactics principles provides a means to ensure continued learning and to develop protocols to prevent or mitigate against similar decision-making or utilization of unsafe tactics in the future. The CIRB’s lack of analysis regarding alternative options resulted in an incomplete assessment that stymied prospects for departmental action to improve KCSO’s service to the community. When assessment of the incident falls short of considering all reasonable options, personnel are not given the opportunity to learn and avoid making similar mistakes.\(^\text{15}\)

**Recommendation 18:** KCSO’s investigative and review protocols should be revised so sufficient time is spent discussing whether alternative tactical options existed to reduce any threats presented to the involved personnel.\(^\text{16}\)

\(^\text{15}\) At the time of this report’s publication, KCSO’s CIRB memo for this incident had not been published.

\(^\text{16}\) This recommendation is in alignment with OLEO’s previous recommendation in its Review of the Officer-Involved Shooting of Mi’Chance Dunlap-Gittens published in February 2020.
**Recommendation 19**: KCSO should create policies and procedures to ensure that when an operation unnecessarily endangers its personnel, direction and guidance to prevent future similar scenarios from occurring is disseminated in a timely manner.\(^{17}\)

**Failure of KCSO to Communicate Expectations to Personnel**

When the CIRB identifies lessons learned from the review of critical incidents, it is imperative that expectations going forward be formally communicated to personnel in a consistent manner. As mentioned above, the CIRB review process is an opportunity for KCSO leadership to identify alternative tactical and decision-making options that it wants its personnel to utilize moving forward. KCSO does not have an explicit protocol to communicate CIRB-based expectations to officers on the ground, leaving those personnel vulnerable to making similar missteps going forward.

KCSO leadership should inform personnel of its expectations. Such information should be coordinated through various means and at all levels. For example, a previous CIRB identified the need for vests that can be easily donned and the need for detectives to have clear Sheriff uniform markings when taking law enforcement action during a planned event. Soon after the CIRB, KCSO should have formally communicated its expectations to personnel, determined what uniform changes and approvals they needed to make, ensured that training was provided, and required that all supervisors had explicit expectation-setting and ongoing conversations with the personnel they supervise.

Formalizing timely communication is essential to ensuring officer and community safety, as it allows personnel on the ground to modify their approach before encountering dangerous situations.

**Recommendation 20**: KCSO should revise its protocols to ensure that formal mechanisms for communicating expectations and revising training are established and reinforced by supervisors to quickly address lessons learned from critical incidents.

**Muzzle Strikes Not Analyzed as Deadly Use of Force at the CIRB**

The GOM categorizes a strike to the head by a hard object that is likely to cause serious physical injury or death as deadly force. The use of a firearm in this way during the Chilcott incident is reportable deadly force.

While CIRB members discussed and analyzed firearm discharges in the Chilcott incident as deadly force, the discussion around the muzzle strikes that Detective 1 applied to Chilcott’s

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\(^{17}\) This recommendation is in alignment with OLEO’s previous recommendation in its Review of the Officer-Involved Shooting of Mi’Chance Dunlap-Gittens published in February 2020. While KCSO subsequently attempted to address this recommendation, its revisions to the policy failed to specify a requirement for timely formal delivery of information to personnel and thus did not sufficiently address the issues posed. KCSO’s policy should make explicit that the dissemination of lessons learned which impact the safety of personnel and community members should not be delayed until the completion of the administrative review of the incident.
head were not analyzed as deadly force. It is essential that review boards accurately classify uses of force so that assessments of each type of force used during an incident are complete.

**Recommendation 21:** KCSO should develop protocols to ensure that all uses of force during an incident are properly classified and that the CIRB analyzes each use of force accordingly.

**Contacting Chilcott’s Mother**

After the incident, Chilcott’s mother and cousin spoke to dispatchers. One of the dispatchers told Chilcott’s mother that someone would contact her at a later time. Additionally, Chilcott’s cousin called and talked to a dispatcher to express her concern for Chilcott’s mother’s mental state. She asked that a relative be with Chilcott’s mother when she received the news of his death. It is not clear whether this information was conveyed to the King County Medical Examiner’s Office.

Although it is OLEO’s understanding that a KCSO investigator spoke at length to Chilcott’s mother later, during the CIRB, a member mentioned that Chilcott’s mother was upset that nobody from KCSO reached out to her initially, and she had to find out about her son’s death from the Medical Examiner’s Office.

The impact that officer-involved shooting has on family members cannot be overstated. While it is the Medical Examiner’s Office’s role to inform family members about the loss of a loved one with respect to the cause of death, this function does not preclude KCSO from reaching out to family members after an incident, or from coordinating with the Medical Examiner’s Office to do so. Among KCSO’s investigative and administrative protocols for responding to critical incidents, there should be direction regarding their response to family members. And these protocols should include what to do when they receive a specific request from a family member as they did in the Chilcott incident.

OLEO mentioned in a previous report that 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. This function would be beneficial to build trust and transparency, ensure coordination with the Medical Examiner’s Office, and to formally and expeditiously recognize KCSO’s role in communicating with families who have been impacted by KCSO actions. The lack of timely communication and resulting difficulties that occurred in the aftermath of this incident could have been avoided by designating a liaison with the appropriate skills to engage families after a tragedy.

**Recommendation 22:** KCSO and the County should consider having an individual assigned to serve as a family liaison in the aftermath of an officer-involved critical incident.18

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18 This recommendation is in alignment with OLEO’s previous recommendation in its Review of the Officer-Involved Shooting of Mi’Chance Dunlap-Gittens published in February 2020.
**Recommendation 23:** KCSO should devise protocols to advise personnel on when and how to communicate with family members in a trauma-informed manner.
List of Recommendations

Recommendation 1: KCSO should revise the language in GOM 4.00.010(1) to include a definition for unplanned/unforeseen and planned/foreseen events to further clarify expectations on when detectives can take law enforcement action.

Recommendation 2: KCSO should make explicit in its policy that plainclothes detectives are prohibited from taking law enforcement action unless there is a specific imminent threat of serious bodily harm or they are acting in a support role alongside uniformed personnel during a pre-planned event.

Recommendation 3: KCSO should clearly communicate to its members expectations for taking law enforcement action in leased, unmarked, or unequipped vehicles during planned/foreseen events.

Recommendation 4: KCSO should review and revise its policies to ensure that members in a leased, unmarked, and/or unequipped vehicle shall not take law enforcement action unless there is a specific imminent threat to serious bodily harm.

Recommendation 5: KCSO should revise its policy to ensure that all personnel are required to don ballistic vests when taking law enforcement action unless there is a specific imminent threat of serious bodily harm that prevents personnel from donning the vest or personnel are acting in a support role alongside uniformed personnel during a pre-planned event.

Recommendation 6: KCSO should hold regular, comprehensive trainings for plainclothes detectives that include mock scenarios involving decisions on whether to remain covert or take law enforcement action.

Recommendation 7: KCSO should hold regular, comprehensive trainings for plainclothes detectives that include mock scenarios where personnel are required to don and doff vests depending on whether they take law enforcement action.
**Recommendation 8**: KCSO should train its members that speculative, generalized concerns about a subject harming innocent third parties is an insufficient basis to use force.

**Recommendation 9**: KCSO should consider training deputies on when and how to effectively and safely contact suspects who are inside vehicles with tinted windows.

**Recommendation 10**: KCSO should prohibit deputies from extracting suspects from vehicles that are higher off the ground than vehicles they train on unless their apprehension is part of a pre-planned TAC-30/SWAT arrest operation.

**Recommendation 11**: Implement and mandate regular defensive tactics training, which is provided multiple times a year, that teaches deputies arrest, control hold, and pain compliance techniques to eliminate perceived threats posed by suspects inside vehicles.

**Recommendation 12**: KCSO should revise its investigative protocols so that investigators require involved personnel to sign compelled statements or document the personnel’s refusal to do so before officially adding them to the investigative file.

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**Recommendation 14**: KCSO should revise its investigative protocols so that personnel involved in critical incidents are required to participate in in-person, video recorded interviews.

**Recommendation 15**: KCSO should revise its investigative protocols so that an interview is conducted of personnel involved in critical incidents before the end of shift.

**Recommendation 16**: KCSO should adopt protocols so that the CIRB does not review or opine on specific issues that are part of ongoing internal misconduct investigations.

**Recommendation 17**: KCSO should create a memorandum of understanding for independent I-940 investigators to clarify the protocols of the I-940 team during critical incidents.
Recommendation 18: KCSO’s investigative and review protocols should be revised so sufficient time is spent discussing whether alternative tactical options existed to reduce any threats presented to the involved personnel.

Recommendation 19: KCSO should create policies and procedures to ensure that when an operation unnecessarily endangers its personnel, direction and guidance to prevent future similar scenarios from occurring is disseminated in a timely manner.

Recommendation 20: KCSO should revise its protocols to ensure that formal mechanisms for communicating expectations and revising training are established and reinforced by supervisors to quickly address lessons learned from critical incidents.

Recommendation 21: KCSO should develop protocols to ensure that all uses of force during an incident are properly classified and that the CIRB analyzes each use of force accordingly.

Recommendation 22: KCSO and the County should consider having an individual assigned to serve as a family liaison in the aftermath of an officer-involved critical incident.

Recommendation 23: KCSO should devise protocols to advise personnel on when and how to communicate with family members in a trauma-informed manner.