Independent Critical Incident Review and Analysis of the Officer-Involved Shooting Death of Stacy W. Kenny

March 2021

Presented by:
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It's not how we make mistakes, but how we correct them that defines us.

Rachel Wolchin

Introduction

On March 31, 2019, Stacy W. Kenny was shot and killed by Springfield Police Sergeant R.A. Lewis following a traffic stop. On September 18, 2020, a lawsuit filed by Kenny's parents was settled for $4.55 million dollars, believed to be the largest dollar settlement in Oregon history for a police shooting case. One of the terms of the settlement agreement was that the surviving family members could commission a critical incident and analysis of the incident with which the relevant authorities would cooperate. Subsequently and through the family's attorney, Michael Gennaco of OIR Group[1] was contracted to conduct the analysis and prepare a written report setting out findings and recommendations.

This report focused on the investigation conducted by the Interagency Deadly Force Investigation Team ("IDFIT")[2] investigation and the Springfield Police Department's ("SPD") subsequent administrative review mechanisms. The goal is to assess the objectivity and thoroughness of fact collection and the rigor of the subsequent internal review of involved officers' actions.

In furtherance of that goal, Mr. Gennaco reviewed the investigative materials to determine whether IDFIT's investigative policies and practices allowed for the development of a body of evidence that was adequate to the task of appropriately scrutinizing the involved officers' actions and decision-making. He further reviewed those materials to learn whether current IDFIT protocols provided for effective and timely collection of evidence.

Mr. Gennaco also examined SPD's incident review materials and protocols in order to learn whether those systems properly facilitated the ability of the Department to learn from critical events and adjust its practices to strengthen future performance. Finally, and based on an evaluation of the attributes and limitations in the current model, he devised recommendations to improve relevant SPD policies, practices, and protocols – thereby

[1] Since 2001, Michael Gennaco of OIR Group has 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 OIR Group's oversight responsibilities for numerous jurisdictions, Mr. Gennaco has reviewed scores of officer-involved shootings and devised recommendations to improve attendant investigative and review practices.

[2] Under Oregon state law, the initial investigation of an officer-involved shooting is to be turned over to an interagency investigative team.

promoting not only appropriate accountability but also the identification and dissemination of beneficial "lessons learned."

Based on this review, Mr. Gennaco found that there were significant gaps in the IDFIT investigation into the officer-involved shooting of Stacy W. Kenny. The report accordingly includes responsive recommendations. Additionally, and in light of the fact that no single entity controls the quality of IDFIT's work product, OIR Group suggests that SPD (as a member of the interagency team) communicate these observations to partner agencies so that potential improvements can be adopted for the future.

Moreover, because the focus of the IDFIT investigation is limited to the use of deadly force, other issues critical to SPD – such as the use of force by officers preceding the shooting, their tactics and decision-making during the event, and crime scene maintenance – fall to the Department to consider and address when such incidents occur. IDFIT's structurally narrow focus means that it is even more imperative that SPD collect the facts necessary to perform the wide-ranging analysis that is warranted by these incidents.

To SPD's credit, during its internal review of the incident, it did identify a handful of "training issues." However, the Use of Force Review Board did not provide a detailed summary of its proceedings that explained the context for its identified issues. Moreover, even though SPD's Chief of Police expressly asked it to do so, the Review Board did not consider the approach, tactics, and decision-making by the three other officers (besides Sergeant Lewis) involved in the incident. Nor did the Review Board, contrary to its charge, assess the appropriateness of the force that the three additional officers used on Kenny. The Review Board also failed to opine on the appropriateness of the uses of force inflicted on Kenny by Sergeant Lewis prior to his deployment of deadly force. And when the Chief received the report from the Review Board that failed to consider his specific instructions, he did not return it to the Board to address these gaps.

Finally, with regard to the performance issues that were identified by the Review Board, there was no apparent plan to use the identification of performance issues in any systemic or meaningful way. The evidence is virtually nonexistent that SPD incorporated these issues into future training or learning or to even debrief the involved officers on the issues identified.

These shortcomings in SPD's review process cast doubt on both the substantive legitimacy and the lasting value of the Department's internal outcomes. In short, they create skepticism as whether any accountability, learning or remediation actually resulted from the agency's review of the Kenny shooting. This report is intended to delineate these gaps and identify significant issues that could and should have been the focus for the Use of Force Review Board. The report also recommends remedial actions that *should* have

sprung from SPD's internal review process and devises recommendations to improve both the investigative and review process.

It is important to note that the current investigative and review structures have the capability to accomplish both a thorough and objective factual record and a robust, constructive review. However, our review of this incident finds that the initial investigation by the multi-agency team had significant investigative deficiencies. And SPD fell far short of reaching this potential and producing the sort of accountability, learning and remediation that an agency should demand of those entrusted with these critical functions.

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

Methodology

For this review, OIR Group reviewed the investigative file produced during the discovery stage of the litigation. We reviewed reports, photographs, statements, and the interviews of witnesses and involved officers. We also reviewed depositions of key individuals, including the involved officers that were produced pursuant to the lawsuit. Finally, we had an opportunity to speak with representatives of the City and the Police Department to have a better understanding of some processes that were not entirely spelled out in writing.

Factual Summary

Several months prior to the officer-involved shooting, Kenny's parents had met with a Springfield officer to advise that their son Patrick Kenny had a history of schizophrenia, that he had not been taking his medication for approximately six to eight weeks, that he was engaging in odd behavior, that he was not hostile, that neither he nor any family member possessed firearms and that they were alerting law enforcement so that law enforcement would have situational awareness and react appropriately, were they to encounter him.[3] The officer who met with the parents placed an "alert" in SPD's database in order to provide that situational awareness to Springfield police officers who might come into contact with Kenny.

At about 9 p.m. on March 31, 2019, Stacy W. Kenny was driving in the City of Springfield when Officer Kraig Akins started to follow her (without emergency lights), and Kenny immediately pulled over to the side of the street. Officer Akins stopped his patrol vehicle behind Kenny's vehicle, activated his overhead lights and exited his patrol car, but did not speak to Kenny, nor approach.

After standing outside his patrol car for approximately 30 seconds, Officer Akins observed Kenny slowly roll down the driver's window, toss a small sound-making device towards him, wait a few more seconds, and drive away at the posted speed limit. Officer Akins requested back up, returned to his car, followed Kenny with his overhead lights and siren activated, and Kenny pulled to a stop a second time. Officer Akins again exited his vehicle, drew his firearm, and yelled at Kenny to put her hands out of the window. Officer Akins observed Kenny roll down her window and heard her ask why she was being followed. Officer Akins continued to yell orders at Kenny to put her hands out of the

[3] Since that meeting, Patrick Kenny transitioned to Stacy Kenny and began identifying as a female.

window and turn the car off. He then observed and heard Kenny sound an air horn, roll her window back up and again drive away at or below the posted speed limit.

Officer Akins returned to his car, followed behind Kenny with lights and siren activated and observed Kenny pull over to the curb and stop a third time. As Kenny did so, Sergeant Richard "R.A." Lewis stopped his police vehicle a few feet in front of and facing Kenny's vehicle, in an attempt to block it. Sergeant Lewis immediately exited his vehicle, drew his firearm, and approached the passenger side of Kenny's vehicle. As he did so, dispatch announced via radio that Kenny was on the phone with a 911 operator. Sergeant Lewis observed Kenny talking on her cell phone but neither he nor any other responding officer claimed to have heard this radio transmission.

Officer Akins approached the driver's side window of Kenny's vehicle, directed Sergeant Lewis to "smash out the windows" and immediately began breaking out the driver's side window. After Officer Akins smashed the driver's side window, he ordered Kenny to come out of the vehicle and show him her hands. Officer Akins said he then attempted to pull Kenny from her vehicle by her hair and, after being unable to do so, punched her 7 to 13 times in the face. Officer Akins said that Kenny activated an air horn twice in Akins' ear during this interval.

While Officer Akins was punching Kenny, additional backup Officer Robert Rosales arrived at the driver's side window, grabbed Kenny by the hair and attempted to pull her from the vehicle. After he was unsuccessful in doing so, Officer Rosales struck Kenny multiple times with his fists. Officer Rosales told investigators that as he and Officer Akins were striking Kenny with "focused blows", Kenny was "fighting back". Officer Robert Conrad then arrived and joined Officers Akins and Rosales at the driver's window. Officer Conrad grabbed one of Kenny's arms and attempted to pull her out of her vehicle, but instead pulled off Kenny's sweatshirt. Officer Conrad then said "Taser" and activated his Taser with multiple deployments. Officer Akins also deployed his Taser multiple times at Kenny.[4]

Meanwhile, Sergeant Lewis broke the passenger window of Kenny's vehicle, unlocked the door and entered the vehicle. After Sergeant Lewis entered Kenny's car, he immediately punched Kenny several times in the face. Sergeant Lewis said it appeared as if Kenny were striking back at the officers at the driver's side of the vehicle. According to Sergeant Lewis, the officers advised him to cut the seatbelt. Sergeant Lewis said he then pulled out his flashlight and attempted to locate the keys to disable the vehicle but could not locate any as a result of the vehicle being electric. Sergeant Lewis said that while he was looking for the keys, the car lurched forward, struck his patrol car, and continued around his car.

[4] Officer Conrad stated that he and Officer Akins deployed their Tasers on Kenny simultaneously.

Sergeant Lewis said he had one of his legs outside of the car but as the car accelerated forward, he placed his leg entirely within the car.

Sergeant Lewis said that he then punched Kenny two more times to the face and tried to grab the steering wheel but to no effect. Sergeant Lewis said that he then struck Kenny with the butt end of a knife, but the car continued to accelerate toward a row of trees. Sergeant Lewis advised that he pleaded with Kenny to stop the car and that she was going to kill them both, but there was no reaction from Kenny. Sergeant Lewis said he then fired three rounds at Kenny's side torso, causing her to flinch once but displaying no other reaction. Sergeant Lewis then said he shot Kenny once in the head, but the car kept going toward the trees.[5] Sergeant Lewis stated he tried to again grab the steering wheel, but the car hit the trees, crossed the road, struck a fence, and finally crashed into a van.

Kenny died as a result of the gunshot wounds to her head. Sergeant Lewis was treated for a broken arm and other injuries while Officer Akins was treated for a fracture to his hand.

[5] Sergeant Lewis indicated that he had fired four rounds, when in actuality he fired six, with three striking Kenny in the torso and two in the head. One round missed striking Kenny.

Investigative Issues

As indicated above, the investigation of officer-involved shootings in Lane County are conducted by the County's Interagency Deadly Force Investigation Team ("IDFIT"), comprised of contributing law enforcement investigators from within the County. The lead IDFIT investigator for the Kenny shooting was a detective from the Eugene Police Department. The IDFIT protocols allow for participation of an investigator from the agency of the involved officers; accordingly, a detective from SPD participated in the investigation.

A review of the investigative file revealed significant gaps in the IDFIT investigation, a lack of investigative protocols and resulting lack of uniformity in fact collection, and existing protocols that are inconsistent with best practices.

No Crime Scene Log Prepared

It is standard investigative practice to seal off and preserve a crime scene while photographs and collection of evidence are undertaken. As part of that practice, a crime scene log is prepared in which individuals within the crime scene perimeter are identified, and any additional entries or departures of individuals into the crime scene are noted. In this case, there were apparently no attempts to establish a crime scene log. Accordingly, there are no precise records on who was at the initial crime scene, what individuals subsequently entered the scene, and when individuals departed from the scene. Nor does IDFIT apparently provide direction to participating agencies on the need to develop a crime scene log. This significant gap in investigative protocols must be addressed.

> RECOMMENDATION ONE: SPD should develop protocols to ensure that a crime scene log is maintained for any officer-involved shooting that occurs in its jurisdiction.
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> RECOMMENDATION TWO: SPD should advocate that IDFIT improve its protocols to require each agency to maintain a crime scene log after an officer-involved shooting that occurs in its jurisdiction.

Inadequate Scope of IDFIT Investigation

The IDFIT investigation focused almost exclusively on the use of deadly force by Sergeant Lewis. However, Sergeant Lewis' uses of force earlier in the incident as well as the uses of force by the other three responding officers were necessarily relevant to a full understanding and assessment of the eventual decision to use deadly force. Each preceding

instance of tactical decision-making and force by the officers set in motion the sequence of events that eventually resulted in the tragic outcome of this incident. It is incumbent upon any effective investigation of an incident such as this to explore the rationale for the various and interrelated decisions and force deployments by each participating officer.

The IDFIT interviews had each of the officers narrate their story but did not delve into the critical decision-making and tactics each deployed. As a result, the investigation does not provide the facts necessary to better understand the origins of the incident and allow full evaluation of Sergeant Lewis' decision to use deadly force.

> RECOMMENDATION THREE: SPD should advocate that the IDFIT protocols be modified to ensure a broad scope of initial fact collection, including a full exploration of any tactical decision-making and related force options preceding the use of deadly force.

Failure to Segregate Involved Officer and Witness Officers

The investigative reports reveal that after the shooting, Sergeant Lewis and Officer Akins were transported to the hospital for treatment of their injuries. Officer Rosales rode with Sergeant Lewis to the hospital and remained with him while he was being treated for his injuries. As a result, when the IDFIT team arrived at the hospital to interview witnesses and obtain a public safety statement[6] from Sergeant Lewis, the witness officers and the involved officer had the opportunity to share accounts of the event before being formally interviewed.

Basic investigative practices require segregation of witnesses and involved officers prior to formal interviews so that recollection of events is not contaminated by exposure to others' accounts. The need for such a practice is acute in the officer-involved shooting context because of concern that involved police personnel will either intentionally or inadvertently collude by sharing accounts of the event with each other. For that reason, all progressive police agencies have policies requiring that involved and witness officers are immediately segregated and chaperoned by an uninvolved officer until a "pure" statement can be obtained from the officers. SPD apparently has no such protocols and needs to adopt them to ensure that involved personnel do not share information about the event prior to being interviewed.

[6] A public safety statement is a rudimentary account of the event from the involved officer in order to ensure all potential exigencies have been or are being addressed. Sample issues include accounting for all rounds in both number and direction, and determining whether additional suspects might be at large.

RECOMMENDATION FOUR: SPD should develop officer-involved shooting policies to ensure that involved and witness officers are segregated from each other and chaperoned until interviews of them can be accomplished.

Inordinate Delay in Interviewing the Officer Who Used Deadly Force

Current IDFIT written protocols do not allow an interview of involved officers until at least 48 hours after the incident, unless the involved officer waives the requisite waiting period. In this case, Sergeant Lewis was not formally interviewed about his use of deadly force until five days after the incident. While there are indicia in the file of IDFIT's interest in interviewing him three days after the incident, the attorney representing him asked for a greater delay because he was out of town. This extension magnified the issue, but the current IDFIT protocol and Lane County practice is itself inconsistent with basic investigative principles of effective and objective fact collection.

It is critical for detectives conducting an officer-involved shooting investigation to learn immediately about the officers' actions, decision-making, and observations. Accordingly, obtaining a "same shift" statement is essential to any effective officer-involved shooting investigation. This is true because of the value of a "pure" statement that is contemporaneous and untainted by subsequent input. Obviously, the five-day passage of time before Sergeant Lewis was interviewed prevented the IDFIT team from obtaining a pure and contemporaneous statement. Moreover, such delays are so contrary to normal investigative protocols, these special procedures for officers involved in shootings fuel the perception among many segments of the community that police investigating police provide their colleagues with advantageous treatment not extended to members of the public.

Special rules such as these only serve to reinforce skepticism about the rigor and objectivity of such investigations. The investigative process in Lane County must provide for more timely interviews of officers involved in a shooting. Until it does so, much of the public that County law enforcement serves will quite reasonably not have confidence in its approach or outcomes.

Agencies that have imposed a 48-hour rule and have routinely delayed interviews of involved personnel have reportedly done so under the supposition that recollection is improved over time. However, objective research has debunked this notion. See, for example, "What Should Happen After an Officer-Involved Shooting? Memory Concerns in Police Reporting Procedures," Journal of Applied Research in Memory and Cognition, 5

(2016) 246–251, Rebecca Hofstein Grady, Brendon J. Butler, and Elizabeth F. Loftus. The proponents of the delayed approach are largely limited to either police associations or those who regularly defend police in officer-involved shootings. And importantly, none of them contend that a five-day delay, as occurred here, provides the best time frame for conducting such interviews to maximum effect.

We understand that as one participant in an interagency group, SPD has a voice but not the final authority in how the protocols are developed. Nonetheless, we urge SPD to exercise that voice in getting the protocols modified to align with best investigative practices. And if IDFIT insists on delaying the criminal interview for multiple days, there is no apparent prohibition to SPD's conducting an administrative interview[7] of the involved officer before the end of the officer's shift.[8] For that reason, until the IDFIT interview is modified to be consistent with best investigative standards, we recommend that SPD administratively interview officers involved in shootings prior to end of shift.

> RECOMMENDATION FIVE: SPD should work with its County partners to modify the IDFIT protocols so that same shift interviews of officers involved in deadly force incidents occur.
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> RECOMMENDATION SIX: Until the IDFIT protocols are appropriately modified, SPD should conduct administrative interviews of involved officers prior to the end of shift.

Inconsistency in Collection of Witness Officer Accounts

The IDFIT protocols do not provide for consistency in how accounts of witness officers are collected. As a result, there is a wide variation on how those accounts are obtained, which is not consistent with best investigative practices. For example, a tape-recorded interview was conducted of Officer Akins and that interview was transcribed. Yet the interview of Officer Rosales was not tape recorded, and only a summary of this interview was prepared. As for Officer Conrad, his interview was not tape recorded, but an initial summary was prepared and provided to Officer Conrad several days later – at which time he was able to review and provide "additions," which he did. Moreover, as noted above, there was no consistency in where the witness interviews were obtained: Officer Conrad's

[7] While the criminal investigation into an officer-involved shooting addresses the legality of an officer's use of deadly force, an agency's administrative review relates to issues of compliance with internal policy. As discussed below, it ideally also takes a holistic look at operational issues that potentially merit a broader agency response.

[8] We recognize that exceptions to the "same shift" timeline may be necessary in the (rare) case of an officer having been hospitalized and seriously injured. That was not the case here.

interview was conducted at the scene, while the interviews of Officers Akins and Rosales were conducted at the hospital.

The significance of officer-involved shooting investigations demand consistency in how and where officer witness information is collected. Witness officer statements should be obtained in an interview room at a law enforcement facility with video-taping capability. And those interviews should take advantage of those interview room capabilities so that witness officers' demonstrations of movements and positioning can be captured. Finally, all witness officer recorded statements should be transcribed and both the recording and transcription included in the investigative file.

> RECOMMENDATION SEVEN: SPD should advocate that IDFIT adopt consistent witness officer interview protocols as follows:
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> a. Statements should be obtained in an interview room equipped with video-taping ability.
> b. Statements should be video recorded.
> c. Statements should be transcribed and both recordings and transcriptions included in the investigative file.

No Follow Up Interview of Witness Officer

The investigative file reflects that, after Officer Akins was interviewed, he reached out to the SPD member of the IDFIT team and advised that he had forgotten to tell the initial interviewer about significant parts of the event: specifically, that Kenny had repeatedly struck him as he tried to pull her from the car. While the SPD officer documented this encounter in a supplemental report, there was no subsequent interview of Officer Akins by the IDFIT team.

Standard investigative practices instruct that whenever a witness wishes to provide additional information, the investigative team should oblige and formally capture it. The IDFIT investigative team did not do so in this investigation. Training and protocols need to be devised so that such information is collected for future investigations.

> RECOMMENDATION EIGHT: SPD should advocate that IDFIT provide training and develop protocols for its members to ensure that all information volunteered about an officer-involved shooting is formally and systematically collected.

Interview of Involved Officer Not Tape Recorded

When Sergeant Lewis was eventually interviewed, his interview was contemporaneously transcribed, but no recording of the interview was made. This technique is inconsistent with best investigative practices; virtually all law enforcement investigative interviews are tape-recorded. While a transcription of an interview is vastly preferable to a summary, an actual recording captures non-verbal cues that provide important context to any interview. For that very reason, in our twenty years of reviewing officer-involved shooting investigations, we have found value in listening to the tape recording of key interviews rather than simply relying on the transcript. In short, there is no investigative justification for not making the recording, and significant argument in favor of it.

Additionally, body movements are often critical to an understanding of an officer-involved shooting incident, and such movements are often demonstrated by interview subjects when describing what occurred. Neither a transcript nor an audio recording captures such information. But video recording does and is routinely used in civil depositions for that reason. Similarly, witnesses in court hearings appear in person so that the finders of fact can evaluate those non-verbal cues.

Adopting these best practices to the officer-involved shooting investigation context ensures a more effective and complete collection of information from witnesses. For that reason, SPD should work with its regional partners on adoption of video interviews of involved officers and witnesses to officer-involved shootings.

> RECOMMENDATION NINE: SPD should advocate for developing IDFIT's protocols to require video interviews of involved officers to deadly force events.

Delayed Capture of Officer Response and Involvement

When an officer-involved shooting investigation is commenced, one of the fundamental responsibilities of investigators is to identify the involved officers as well as witness officers to the incident. Another expectation is that officers who are not directly involved in the incident but responded to the scene are asked to document their involvement in a written report. However, in this case, records indicate that responding officers did not contemporaneously document such involvement and observations. In fact, it appears that several days passed before the IDFIT team requested the preparation of such reports. And, as noted above, because no crime scene log was maintained, it was impossible for IDFIT investigators to ensure that all responding officers did provide the requested reports.

This delayed preparation of reports is another indication of the need to modify the IDFIT protocols to ensure that all law enforcement members that respond to an officer-involved shooting scene or have any involvement in the incident prepare a contemporaneous report

documenting observations and tasks. And SPD should similarly create written protocols ensuring that any personnel who respond to an officer-involved shooting prepare written reports of their activity.

> RECOMMENDATION TEN: SPD should advocate that IDFIT revise their officer-involved investigative protocols to ensure contemporaneous preparation of reports by law enforcement personnel that respond to an officer-involved shooting or are otherwise involved in collateral responsibilities relating to the investigation.
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> RECOMMENDATION ELEVEN: SPD should create written protocols indicating its expectation that personnel who respond or carry out tasks relating to the officer-involved shooting investigation and who are not going to be interviewed contemporaneously document their observations and any duties.

Missed Analysis of Taser Deployment

The investigative files reveal that after the incident, the two Tasers deployed in this incident were downloaded for some basic informational data. The downloaded information revealed that one Taser was deployed four times for 5, 6, 4 and 22 seconds respectively; the other Taser was deployed three times for 5, 5, and 29 seconds respectively.[9] The extended deployments identified by the data show that the last deployment by both Tasers were for an unusually long period and not in accord with the recommended five second deployment by the manufacturer.

Besides downloading this data and including it in the investigative file, there was no further analysis of the information by either the IDFIT investigators or SPD. As part of its contractual services, the manufacturer will provide a detailed analysis of Taser uses that provides helpful information about efficacy and other aspects of the deployment. Neither IDFIT nor SPD took advantage of this service; as a result, neither the criminal nor the administrative investigation benefited from the insight that such an analysis could reveal. Both entities should have ensured that a full Taser analysis was obtained from the manufacturer.

> RECOMMENDATION TWELVE: Whenever a Taser is deployed in relation to an officer-involved shooting incident, investigative authorities should request a full analysis from the manufacturer.

[9]Significantly and unfortunately, the investigation did not match the deployment patterns to the respective officers (though it easily could have).

Deadly Force Review Issues

SPD's Failure to Conduct an Administrative Investigation

Progressive police agencies recognize that there is a need to conduct an administrative investigation in order to fully address issues of accountability. Moreover, those agencies also recognize that an internal investigation will provide additional salient facts with which to identify training and policy issues. A robust internal investigation will involve, at a minimum, interviewing witness and involved officers to inquire of tactics, force options deployed, the consideration of de-escalation, and other decision making. Such a process facilitates not only individual performance analysis but also the identification of learning opportunities and other adjustments that could enhance the handling of future critical events.

Current SPD policy allows for the Department to conduct a separate administrative investigation. In the policy, it notes that involved officers shall be treated "with sensitivity." The policy further instructs that "any in-depth interview shall take place in a non-coercive, neutral environment, removed from the scene." The policy further indicates that the "interview site shall be chosen taking the emotional and physical state of the involved officer into account." And the policy instructs that "every effort shall be made to minimize the number of interviews conducted."

With due respect for the cautions and parameters mentioned above, we advocate supplemental interviews of involved officers as a matter of course. This is primarily because the focus of a criminal review is inevitably narrower than the full range of potentially significant performance and operational issues that such an incident encompasses.

The Kenny matter is one for which such a full-fledged review was particularly warranted. The incident featured several different officers, several critical inflection points, and several uses of force preceding the fatal shots; whole swaths of decision-making was not covered by the IDFIT investigation. However, despite policy that allows for and anticipates administrative investigations, SPD chose to conduct no further inquiry whatsoever of the involved sergeant and the three other officers. The failure of SPD to conduct any administrative interviews of its personnel resulted in a serious deficiency of facts with which to evaluate the performance of each of its involved officers and improve the agency's response to future events.

> RECOMMENDATION THIRTEEN: As a matter of course in a critical incident review, SPD should conduct administrative interviews of witness and involved

> officers to gain insight regarding tactics, decision-making, and other performance issues including the role of de-escalation techniques in the response.

Other Limitations in SPD's Administrative Review Process

Overview

Currently, SPD's Review of Deadly Force provides for the convening of a Use of Force Review Board after deadly force incidents. In accord with this policy, and less than a month after the incident, Chief Lewis prepared a memo instructing a lieutenant to chair a use of force board to determine findings of fact as to the circumstances surrounding the incident involving Sergeant Lewis.[10] The memorandum advises:

> The board shall consider the reasonableness of all the officers' actions regarding the entire event from the initial contact to the conclusion of the incident.

The memo indicates that the board will also include SPD's use of force instructor, firearms instructor, and an officer selected by Sergeant Lewis. The memo instructs the board to make a written recommendation to the Chief and a final conclusion as to whether the use of force was within policy, plus any training recommendations deemed appropriate.

Approximately six weeks later, the board was convened. In a memo reporting the results of the board meeting, it noted that the board had unanimously found that the actions of Sergeant Lewis was found to be consistent with SPD's use of deadly force policy.

The memo also indicated that the board had identified training issues to be addressed with staff and to be forwarded to defensive tactics and firearms instructors. The memo listed the following training issues discussed by the board:

- Walking between patrol car and suspect car.
- Entering a suspect vehicle in an attempt to push a subject out.
- Having patrol car parked in front of suspect vehicle.
- Tools to use to cut seatbelts for removal of the suspect.
- Making sure all past mental health issues are entered into the law enforcement data bases.
- If the Taser deployment does not work what other use of force options are available.

Following the use of force review board's memorandum, Chief Lewis authored a memorandum to Sergeant Lewis indicating that he had found Sergeant Lewis' use of deadly force appropriate and justified per SPD policy.

[10] Chief Lewis and Sergeant Lewis are not related.

Use of Force Review Board Should Not Include Officer Advocate

Current policy provides for the involved officer to select an SPD representative to serve on the board as an apparent advocate for him or her. This protocol raises several concerns, most of which arise from the opportunity of this representative to vote on the outcome of the review as well as participate on the officer's behalf.

The officer being reviewed presumably chooses a person who will advocate for his or her interests in the discussion. Structural problems arise when that representative is also allowed to serve as one of the formal decision-makers – a role requiring an objectivity that advocacy precludes by its very nature. This clash of responsibilities has the potential to undermine fairness as well as public perceptions of the legitimacy of the process.

> RECOMMENDATION FOURTEEN: SPD should modify its review policy to eliminate the ability of the involved officer to select a department member for the Use of Force Review Board.

Lack of Sufficient Documentation of Review Board Meeting

The Review Board memo was a little over a page in length and provided no insight whatsoever into the analysis that caused the board to conclude that Sergeant Lewis' use of deadly force comported with SPD policy. No facts are cited in support of that conclusion, and the ten factors that SPD policy requires a body to consider in determining the reasonableness of any use of force are neither identified nor discussed. In short, the board's conclusion is not supported by facts or analysis and is accordingly not helpful in explaining – or justifying –the decision that was reached.

As significantly, while six training issues were identified, there again was no discussion on why the issues were identified and the type of training anticipated that would appropriately address these issues. Other than the listing of the issues, there was no discussion on how the issues impacted the incident and how training would improve future responses.

In sum, the Use of Force Review Board memorandum provided no real insight for the Chief of Police into why the board came to its conclusion on the propriety of deadly force and what issues concerned the board so that six items were identified as training issues. More guidance and greater expectations should be set out in writing with regard to documentation of Review Board deliberations.

RECOMMENDATION FIFTEEN: (A) SPD should set out in writing minimal expectations for documentation of its Use of Force Review Board deliberations, including requirements that each use of force event go beyond the mere question of the appropriateness of the force and considered in terms of:

- Tactical and other decision-making
- Policy
- Supervision
- Training
- Equipment

(B) SPD should require that the facts and analysis for any decision be set out in writing, and that any recommendations that are identified clearly describe the concerns that prompted them.

Review Board's Failure to Address Specific Questions Requested by Chief of Police

As noted above, in the Chief's memo to the designated Review Board Chair, the board was to consider the reasonableness of all the officers' actions regarding the entire event, from the initial contact to the conclusion of the incident. However, a review of the subsequently produced memo demonstrates that the board only considered the reasonableness of Sergeant Lewis' actions –and these only as to his use of deadly force. The memo includes absolutely no reference to the uses of force and tactical decision-making of the other three involved officers. The memo includes absolutely no reference to the initial contact made by Officer Akins. And the memo includes absolutely no reference to the prior uses of force and decision-making by Sergeant Lewis in the lead up to the use of deadly force.

Even though the Board fell far short on what it was directed to do by its Chief of Police, when the Chief received the Board memo, he accepted it rather than send it back for fulfillment of his instructions. As a result, the Chief's assignment was not followed and the important internal analysis and insight that the Chief apparently initially requested and anticipated did not happen.

RECOMMENDATION SIXTEEN: In a deadly force event, the Use of Force Review Board should be tasked with reviewing all decision-making and uses of force from the inception of the incident and consider the performance of all involved officers, and any shortcomings or gaps in the analysis should be rectified through executive direction.

Lack of a Mechanism for Implementation and Follow Through

As noted above, six items were identified as training issues but with little guidance on what training regimen would appropriately address those issues. And the litigation

revealed that no systemic after action had actually been developed to address the identified issues. Rather, the identified training issues were allowed simply to evanesce into the ether.

It is also apparent that SPD's current deadly force review process has no ability to ensure implementation and follow through of any recommendations advanced by the use of force review. The Review Board process provides no structure for developing an "action plan" with regard to training issues and assigning the development of a training curriculum designed to address the identified issues. There is also no mechanism for ensuring that any assignments – and their subsequent fulfillment – 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.

Without subsequent action, the most insightful identification of issues and potential solutions is of no lasting benefit to a law enforcement organization. Someone must chart a path forward and ensure that the talk results in improvement. Unless there is a mechanism for ensuring that constructive suggestions are turned into action, those ideas are destined to die on the vine.

Accordingly, we recommend that SPD's General Orders be modified as follows:

> Upon the conclusion of the Review Board meeting, and conditional on their approval by the Chief, the Chair will designate to a specified attendee the responsibility of implementing any recommended actions or identified training needs, along with a time certain for completion of the task.
>
> The Chair (or a designee with command authority) will be personally responsible to ensure that the assigned measures are completed in both an effective and a timely manner.
>
> RECOMMENDATION SEVENTEEN: SPD should devise protocols to ensure that any accepted recommendations or identified training issues emerging from the Use of Force Review Board (and endorsed by the Chief) are implemented by:
>
> - Assigning the responsibility of implementation or development of training domains to specific SPD personnel.
> - Delegating to an SPD command staff member the responsibility of ensuring effective and timely implementation.

Providing Feedback to Involved Personnel

In addition to developing training to identify issues identified that could improve a law enforcement agency's response to future similar challenges, it is also critical that involved personnel receive the insight of the Review Board's assessment of the case through targeted debriefing. However, the litigation revealed that in this case, none of the involved officers, including Sergeant Lewis, received any formal feedback regarding their performance. It is true that, as detailed above, the board's narrowly scoped analysis would have limited the value of such a step. However, a fact-specific debrief with each involved officer could at least have pursued the identified training issues in an individualized way. But even this potential learning opportunity did not occur.

There is significant value to a process of providing information to involved personnel regarding specific issues considered and addressed by the SPD Use of Force Review Board. To effectuate this important feedback loop, we suggest that one Board member be assigned to provide an objective, unvarnished debriefing to involved personnel at the end of the process. In that same forum, the involved individuals could share their own perspective on the investigative and review process, as well as suggestions for improved future performance and readiness.

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

> The Chair will also designate to a specified attendee the responsibility of meeting with involved members and providing both a complete debriefing of issues raised during the Review Board process and an opportunity for members to provide their insights and perspectives.
>
> The Chair (or designee with command authority) will be personally responsible for ensuring that this step occurs in a timely manner.
>
> RECOMMENDATION EIGHTEEN: SPD should incorporate a debriefing phase into its Use of Force Review Board process that would provide involved officers with a forum for hearing the board's findings and analysis as well as an opportunity for the officer to share his or her own perspective.

Further Gaps in SPD Analysis

Use of Force Board's Failure to Consider Officer Akins' Failure to Access Kenny's Prior Mental Health Information

As noted above, several months prior to the officer-involved shooting, Kenny's family members had reached out to meet with an SPD officer to advise the Department of their son's mental illness and its potential implications. To that officer's credit, he entered the information into SPD's record management system.

As the investigation and subsequent litigation revealed, Officer Akins (the initial responding officer) claimed to have no inkling that he was dealing with a mentally ill person, yet he described some of Kenny's initial actions as "weird." Had Officer Akins taken the time to do so, he could have requested access to any prior contact history regarding Kenny – at which point the earlier information provided by the parents could potentially have been provided. Accessing that information would have provided Officer Akins a much fuller understanding of who he was dealing with and suggested the need for a tailored approach. Instead, Akins opted to engage by smashing out the driver's side window once Sergeant Lewis arrived on scene.

A fuller internal review could have explored the issue of officer access to information such as that which recently had been entered about Kenny's condition. If a request would have readily produced applicable information, SPD should have considered whether Akins' initial observations should have prompted him to make such an inquiry. Conversely, if a request from the field would *not* have easily yielded the information, SPD could have considered ways in which such information was more readily available to its officers. Yet SPD chose not to consider this issue at all during its internal review process, forfeiting the ability to refine protocols and expectations for the sake of future encounters.[11]

> RECOMMENDATION NINETEEN: In relevant cases, SPD's Use of Force Review Board should expressly consider whether the officer met agency expectations for accessing available background information about subjects and

[11] Curiously and as noted above, a "training issue" identified by the Use of Force Review Board was to make sure that all past mental health issues are entered into the law enforcement data bases. However, this training issue seemingly missed the point; the information is that the past mental health information provided by Kenny's family *was* entered into SPD's report management system. The larger issue that was not addressed by the Review Board was how accessible that information was and whether Officer Akins could have and should have taken the time to seek access to it.

should identify and remedy any systemic impediments to access of such information.

Failure to Fully Consider Issues With 911 Call Center

During the litigation, it was learned that SPD had raised issues with the regional 911 service and the repeated failures to transfer SPD calls that involved SPD. Specifically cited as one of the examples of this problem was the Kenny officer-involved shooting, in which 911 received the call from Kenny and did not transfer it to SPD. While an email communication was sent expressing concern about this apparently structural and reoccurring problem, there is no further evidence that the systemic issue was fully addressed.

And while this issue was identified prior to SPD's internal review process, it was not apparently raised or considered by the Use of Force Review Board. Because of that omission, the board did not consider the implications of the failure to transfer the call and whether a timely transfer would have provided improved opportunities for the field officers to learn about Kenny's 911 call for help. And the use of force review team could have potentially devised a more structural "fix" to the failure to transfer calls that went beyond a mere memo expressing exasperation about the issue – which was the apparent sum and substance of the actual SPD response.

> RECOMMENDATION TWENTY: SPD's Use of Force Review Board should consider any potential dispatch issues as part of any officer-involved shooting review and address any systemic issues identified.

Failure to Consider Force in Terms of De-Escalation

In evaluating any use of force, police agencies are increasingly considering whether officers deployed de-escalation techniques. Officer are taught to consider techniques such as time, distance, reasoning, and talking with individuals in order to achieve voluntary compliance. When force is deployed, officers are asked, and supervisors are tasked with considering, whether (or why not) de-escalation options were considered or used prior to the force occurring.

In this case, there is no evidence that the responding officers considered de-escalation techniques; instead, each responding officer immediately resorted to force. At the outset of the third and final encounter, Officer Akins made no effort to speak with Kenny or advise her what to do. As noted above, after Officer Akins approached Kenny's vehicle, he immediately began to break out the driver's side window, directed Sergeant Lewis to do the same on the passenger side, and *then* ordered Kenny to show him her hands and exit the vehicle. After Officer Akins successfully broke the window, he grabbed Kenny by the hair and attempted to pull her out of the window. When that proved unsuccessful – likely

in part because Kenny remained seat belted – Officer Akins then repeatedly punched Kenny in the head.

After Sergeant Lewis entered the passenger side of the car, his first action was to repeatedly punch Kenny in the head. And when Officer Rosales joined the fray, his own first response was to grab Kenny's hair and punch her repeatedly in the head. Finally, when Officer Conrad arrived, his first response was also to grab Kenny, resulting in pulling a sweatshirt off of her, He then deployed his Taser, and was joined in doing so by Officer Akins.

Officer Akins decision to immediately break the windows of the car left Kenny no time to ascertain what the officer wanted her to do and was in fact presumably agitating in a way that actually *countered* principles of de-escalation. And the near immediate severity, variety and intensity of force delivered to Kenny provided her little time to comply with officer commands. Moreover, after the officers finally recognized the futility of trying to pull a belted individual through a broken car window, there were no concerted efforts to put a pause on the physical aggression so that the belt could be unbuckled or cut away.[12]

A more disciplined approach by officers deploying de-escalation techniques could have resulted in a vastly different outcome. Had responding officers taken the time to do so, they may have ascertained the mental illness issues previously reported by the family and factored them into their approach. Had responding officers approached the vehicle more deliberately, they would have learned that Kenny was on the phone with a 911 dispatcher. With that knowledge, officers could have formulated a plan that took advantage of the communication initiated by Kenny to achieve compliance. And had the officers made an effort to reason with Kenny instead of overpowering her, they might have achieved their objectives without the need to resort to any force.

Despite SPD officers being trained on de-escalation techniques, SPD's use of force board apparently did not consider the incident in terms of whether responding officers could have and should have deployed such strategies in dealing with Kenny. As a result, there was no assessment of whether responding officers performed consistent with Departmental expectations regarding use of such alternative strategies, or whether such deployment could have altered this tragic outcome. As a result, a potential accountability and learning tool with regard to these issues was forfeited by SPD.

[12] While the litigation revealed that Sergeant Lewis had a knife that could have been used to cut away the seat belt, and while he was instructed by officers to do so, he did not use the knife in that way. Instead, he deployed the butt of the knife to strike Kenny in the head.

RECOMMENDATION TWENTY-ONE: SPD should develop policy requiring its officers to deploy de-escalation techniques prior to resorting to force when feasible.

RECOMMENDATION TWENTY-TWO: SPD should develop policy requiring its Use of Force Review Board to consider as part of its review whether involved officers followed its de-escalation training and policy.

No Analysis Regarding Use of "Focus" Blows

The involved officers who repeatedly punched Kenny in the head prior to the use of deadly force referred to their use of force as "focus" blows. Also sometimes referred to as "distraction strikes," hitting the subject in this manner has the purported aim of distracting the individual so that officers can then effectively grab arms and successfully bring the individual into custody. However, no involved officer articulated the goal of the focus blows in this way; rather, one officer indicated that one potential outcome of the punches to the head would be to render Kenny unconscious.

Police agencies have recognized the repeated, closed-fist punching of the head of a subject as presenting a significant danger of injury to both subject and officer alike. As a result, they are increasingly prohibiting its use or at least restricting it to strikes to the torso or less sensitive areas of the body. Moreover, to minimize any injury to both officers and subjects, officers are trained to use open palm strikes instead of closed fists. Finally, as with any option, if repeated use of the force option is not achieving the desired result, officers are instructed to stop – as opposed to the roughly 7-13 blows to the head that Officer Akins acknowledged delivering.

The Use of Force Board did not consider whether the "focus blow" force option used by three of the four involved officers was effective, advisable, or worthy of reconsideration. It should have. The board could have and should have recognized that the force option did not achieve the desired outcome in this case, and instead made it more likely that Kenny would take action to flee the continued pummeling of her face and head. The board could and should have recognized that the option caused a fracture of Officer Akins's hand, and that Akins had similarly been injured when he repeatedly punched another subject in the head in a prior incident.[13] And the board could and should have either banned or restricted the use of focus blows to be more in concert with progressive principles of use of force for the safety of subject and officer alike.

[13] Even Officer Akins himself apparently recognized this fact; in a City of Springfield form prepared for apparent worker's compensation issues, he acknowledged that open palm strikes would reduce injuries to the hands of officers.

RECOMMENDATION TWENTY-THREE: In evaluating a deadly force incident, the board should consider and analyze the efficacy and appropriateness of all uses of force within the incident.

RECOMMENDATION TWENTY-FOUR: SPD should consider whether to eliminate the use of "focus blows" as a force option or at least restrict their use as follows:

a. Prohibit focus blow strikes to the head
b. Require focus blows to be delivered with palm strikes
c. Require focus blows to be restricted to no more than three strikes

No Analysis Regarding Sergeant Lewis' Decision-Making

While, as detailed above, in identifying "training issues", the SPD Use of Force Board made an oblique reference to Sergeant Lewis' ill-advised decisions to park his vehicle whereby Kenny still had a viable escape route, to run between cars in his approach to Kenny, and to enter the passenger side of the vehicle, the Board did not tie the identification of these issues in any meaningful way to Sergeant Lewis. As a result, these and other problematic decisions by Sergeant Lewis failed to receive the attention they were due:

Deferring to Officer Akins regarding tactical approach of Kenny's vehicle: As noted above, Sergeant Lewis arrived as Officer Akins began to approach Kenny's vehicle. Immediately, Officer Akins instructed Sergeant Lewis to break out the passenger's side window, escalating the approach in a way that eventually led to the tragic use of deadly force. It is unusual and curious that a supervisor would defer to the tactics set out by a subordinate officer rather than assume a command presence regarding the best way to respond to the situation. Moreover, a supervisor would be expected to want to learn more about the situation before rushing to perform a task dictated by his subordinate officer that would certainly escalate the encounter. Yet Sergeant Lewis did precisely as he was told to by Officer Akins and never exhibited supervisory control over the event. The Use of Force Board failed to consider these supervisory lapses.

Sergeant Lewis' decision to immediately use force on Kenny: Sergeant Lewis reported that his first decision upon entering the vehicle was to strike Kenny repeatedly in the head. Because Sergeant Lewis was not asked, it is unclear why he did not precede the use of force with instructions to Kenny or otherwise try to de-escalate the situation. And it is also unclear what observations by Sergeant Lewis even justified the blows he delivered to Kenny's head.

Sergeant Lewis' failure to consider de-escalation techniques or deploy any learning resulting from his designation as SPD's crisis intervention team coordinator. At the time

of the incident, Sergeant Lewis was responsible for the Department's crisis intervention training and the crisis intervention team coordinator. Yet at no time in the incident did Sergeant Lewis deploy any de-escalation techniques until the very end of the situation when he said he pleaded with Kenny to stop the car. And this plea came only after Sergeant Lewis had smashed the window of Kenny's car, struck Kenny repeatedly in the head, struck Kenny in the head with the butt of a knife, and tried to wrest the steering wheel from her and was subsequently followed by gun shots to Kenny's torso and head. The Use of Force Board failed to consider Lewis' total failure to use the techniques he had been specially designated to promote within the Department.

Sergeant Lewis' decision not to attempt to unbuckle Kenny from her seat belt: Sergeant Lewis reported that he heard from other responding officers that they were having difficulty extracting Kenny because she was still buckled in with her seat belt. Sergeant Lewis further reported hearing the request to cut the seat belt. While Sergeant Lewis was carrying a tool he could have used to cut the seat belt, he chose not to do so. As noted above, the Use of Force Board mentioned the seat cutter device as a "training issue", but did not engage in any analysis regarding why the Sergeant failed to assist in releasing Kenny from her seat belt.

Sergeant Lewis' decision to again strike and shoot Kenny as the car moves forward: As detailed above, Sergeant Lewis said that as he observed the car moved forward, he punched Kenny two more times to the face. This was not an action that promoted the safe operation of the motor vehicle; if anything, it increased the likelihood that Kenny would lose control of the car. Sergeant Lewis then said he struck Kenny with the butt end of a knife, again based on the unlikely premise and a seemingly irrational notion that disabling the driver would decrease the peril faced by both as the car moved forward. Sergeant Lewis said he then tried to grab the steering wheel, again a decision that, if successful, would likely have increased the likelihood of lost control of the car.

Sergeant Lewis said that it was at that point that he pleaded with Kenny to stop the car. Unfortunately, Sergeant Lewis seemed to have adopted a strategy to use de-escalation options only *after* force options had proven ineffective, in an upside-down approach to what he had been taught as the Departmental expert in crisis intervention. Finally, Sergeant Lewis decided to shoot Kenny, with the seeming idea that a car being driven by a fatally disabled operator is somehow safer than a car being driven by an individual not so incapacitated. And Sergeant Lewis' use of deadly force on Kenny ended up not placing him in any better situation and likely resulted in him being worse off; fatally disabling the operator, causing the car to go completely out of control, and resulting in a horrific crash that resulted in his own injuries.

Because Sergeant Lewis was not asked about any of these decisions, little was ascertained about his rationale for the choices he made. Moreover, the Use of Force Board apparently

did nothing to independently evaluate these questionable decisions and consider whether other options existed that could have prevented this tragic result.

> RECOMMENDATION TWENTY-FIVE: When a supervisor is involved in a deadly force incident, SPD should evaluate whether the supervisor's performance is in line with Departmental expectations for a supervisor on scene.
>
> RECOMMENDATION TWENTY-SIX: In evaluating the use of deadly force, SPD should consider whether its use would effectively eliminate any threat presented as well at its own potential to increase the threat to officers and the public.

Insufficient Explication of Responding Officers' Tactical Deficiencies

As noted above, the Review Board identified as a training issue the notion of entering a suspect vehicle in an attempt to push a subject out. While quite cryptic, the apparent message is that such a technique is disfavored. There is no question that the idea of an officer even reaching into an occupied vehicle creates serious safety issues should the car move forward. For an officer to completely enter a vehicle creates the specter of precisely what occurred in this case: the driver travels forward, placing the unbelted officer in peril. And this is not an unprecedented occurrence; we are aware of at least two other incidents where an officer reached in or inserted himself in a vehicle, precipitating responsive deadly force when the driver moved forward. Considering the potential officer safety issues involved and the likelihood of an ensuing deadly force incident, mere training is insufficient to address this issue. Rather, specific policy should be devised that prohibits officers from reaching into or entering a vehicle unless there is certainty that the driver cannot readily proceed forward.

The Review Board entirely failed to consider the efficacy of the officers' attempt to pull Kenny through a broken window in order to extract her from the car. Considering the physics of such a maneuver, even a cooperative individual would have difficulty being extracted in the fashion that the officers tried in this case. SPD should devise policy and training specifically disapproving of this technique for extractions.

> RECOMMENDATION TWENTY-SEVEN: SPD should devise policy and training instructing officers not to reach into or enter a civilian vehicle unless there is certainty that the operator cannot move the vehicle forward.
>
> RECOMMENDATION TWENTY-EIGHT: SPD should devise policy and training addressing the inadvisability of trying to extract an individual through a vehicular window.

Failure to Identify Issues Relating to Taser Use

As noted above, neither IDFIT nor SPD requested a full workup of the Taser data by the manufacturer. Moreover, while there was a training note about considering other force options if a Taser deployment does not effectively neutralize a subject, the board did not consider the actual deployment of the Taser by Officers Conrad and Akins and whether their use met departmental expectations.

As noted above, while the board was asked by the Chief to evaluate the uses of force by all involved individuals, the board made no such explicit evaluation with regard to the use of the Tasers. First, there was no assessment whether the use of the Taser was the appropriate force option, considering the attendant circumstances. Moreover, as noted above, the evidence suggests that the officers deployed their Model X26 Tasers[14] on Kenny simultaneously. And, perhaps most significantly, the extended deployment of 22 and 29 seconds is not consistent with manufacturer recommendations or medical studies on the dangers of extended or multiple Taser uses.

Perhaps the most definitive compendium of research on Taser use was undertaken by the National Institute of Justice in 2011: Study of Deaths Following Electro Muscular Disruption: https://www.ojp.gov/pdffiles1/nij/233432.pdf. In that abstract, the panel reviewed the available research and found that as a result of the increased risk of death, "multiple or prolonged activations of [Tasers] as a means to accomplish subdual should be minimized or avoided." Id. at p 26. As a result, police agencies have devised policy to limit deployment duration to five-second intervals, limited Taser use to three activations, and have advised against simultaneous Taser uses by multiple officers. In this incident, there were a total of seven activations, two activations went longer than 20 seconds, and two Tasers were reportedly simultaneously deployed on Kenny. While SPD's current Taser policy has no such limiting language, the review of this incident could have (and should have) resulted in a revision of policy to ensure safer Taser deployments.

> RECOMMENDATION TWENTY-NINE: Whenever the use of a Taser accompanies a deadly force event, SPD Use of Force Review Board should consider the propriety of its use and whether deployment met Departmental expectations.
>
> RECOMMENDATION THIRTY: SPD should revise its Taser policy to limit deployment to three cycles, prohibit activations longer than five seconds, and prohibit simultaneous Taser activations by multiple officers.

[14] The Model X26 Taser was the most powerful device ever sold by the manufacturer. In 2014, the manufacturer stopped selling the device, replacing it with a model marketed as safer than the X26.

Additional Issues/Concerns

No Formal Tracking of Force by Individual Officer

The litigation revealed that while aggregate use of force data is compiled and sent regularly to the Chief of Police, that data is not broken down by officer, and there is no formal analysis or identification of officers who are outliers in their frequent use of force. While, to the credit of the Department, the litigation did discover one officer who was identified by SPD as having problematic uses of force (resulting in monitoring of that officer through a body-worn camera), there is no systemic review of force used by all SPD officers. Smaller agencies such as SPD should not have as pressing a need for more formal early identification systems, but the Chief and his command staff should at least be provided with regular use of force reports broken down by individual officers. With such data, inordinate use of force by a particular officer can be more readily identified and remediated.

> RECOMMENDATION THIRTY-ONE: SPD should create a written directive assigning the task of analyzing uses of force by officer, identifying any outlier officers in using force, and providing the analysis to the Chief and command staff.

District Attorney Press Conference with Springfield Chief of Police

The District Attorney held a press conference to announce her opinion that she found no criminality with regard to Sergeant Lewis' use of deadly force. SPD's Chief of Police was at the District Attorney's side when she announced her decision. The optics of the Chief of Police at the table of the District Attorney when she closed the case significantly undercut any belief that the investigation and review was independent. It also causes one to wonder whether the Chief would have been invited to sit with the District Attorney had the decision been made to file charges against the officer.

If an investigation of an officer-involved shooting is intended to convey the message that it was a truly independent process with an interagency investigative team and an independent prosecutive authority, there is no reason for the Chief of the agency to which the involved officer is employed to be sitting at the presentation table. Better that the head of the interagency investigative team be invited to sit at the table to provide a better demonstration of independence. Moreover, to the degree that questions are asked about the investigation, that individual should be more knowledgeable to field such questions than the Chief of the involved officer's agency, who is presumably insulated from the investigation.

RECOMMENDATION THIRTY-TWO: In the context of its own officer-involved shooting matters, SPD should refrain from sitting at the table of any press event announcing the results of a District Attorney review.

SPD Offered No Condolences to Kenny's Surviving Family

The parents' loss of a loved one as a result of a police-initiated shooting is devastating. Progressive leaders of police agencies recognize this and are increasingly offering expressions of sympathy, both private and public, to surviving family members for their loss. In this case, the Chief of SPD did not reach out to the family in any way to express condolences.

The explanation suggested during the litigation process for this failure to extend sympathies was that the family had retained an attorney and was determined to sue the City. The specter of litigation is a poor excuse for not reaching out in an expression of human empathy. And to express regret for the loss of a family member does not equate to an acknowledgement of fault or liability.

The Chief of SPD should reconsider his approach in future officer-involved shooting circumstances.

RECOMMENDATION THIRTY-THREE: In the immediate aftermath of a fatal officer-involved shooting, the Chief of Police should reach out to surviving family members and offer condolences for the loss.

Conclusion

The police-involved death of a person in crisis, as the consequence of events that also endangered and injured officers themselves, is inherently a matter of significant public interest. Along with our feelings of sympathy and concern there are questions: what happened, could it realistically have been avoided, will people be accountable, and what changes will occur as a result of the tragedy?

The death of Stacy W. Kenny implicates all of these responses. The family's struggle to contend with Kenny's mental health issues – as manifested in its outreach to the Springfield Police Department months prior to the incident – surely has resonance for countless families who fear for the well-being of troubled relatives. Law enforcement's role in this dynamic is itself the subject of tremendous scrutiny and reconsideration.

All of this is to say that a legitimate, meaningful investigative and review process is never more crucial than in the aftermath of such an event. The use of deadly force is rightly

scrutinized for its legal justifications – a process that occurred here, if imperfectly in ways that this report discusses above. However, given the applicable legal standards and the latitude that the system gives to officers when they reasonably perceive a threat to themselves or others, it is very unusual for officers to face prosecution. An actual conviction is even more rare.

Because of this, and the "bottom line," either/or nature of the criminal process, the more comprehensive evaluations of critical incidents such as Kenny's death can – and must – occur administratively. The most effective law enforcement agencies, therefore, are those that recognize that such events demand the most rigorous levels of review.

There are two components to this – both equally important. One relates to accountability: a clear-eyed determination as to whether and how involved officers met the standards of the agency in terms of policy, tactics, training, and other performance variables. Agencies should not be reticent in the appropriate instances when officer conduct is egregious enough to warrant separation from the agency. And measures should be deployed to correct individual deficiencies and to reinforce the agency's standards and expectations. While formal discipline is one vehicle for this, training, counseling, or other remedial measures also exist to address substandard performance.

The second component to robust internal review is systemic. It involves a holistic examination of every aspect of the agency's response in order to look for strengths that it wishes to highlight and shortcomings that it wishes to improve upon. The potential benefits of such a process for enhancing department-wide future performance are what makes this exercise so worthwhile.

There are traditional obstacles to this in some law enforcement cultures. They include a reluctance to second-guess and an inclination to support officers who have been involved in deadly force incidents. But many progressive police organizations have moved beyond this paradigm. They have come to see the importance of the process as outweighing those other considerations. And they have framed it as a constructive reckoning with the very real challenges of modern policing.

OIR Group appreciates the opportunity to contribute to that dynamic in Springfield through this report. Our hope is that is provides the family of Stacy Kenny with some consolation in the form of a careful evaluation and answers to some of the lingering questions it may have. We also hope though, that it will be embraced by the Police Department as an opportunity to revisit some of its own protocols and improve upon them in the future. If public and officer safety is strengthened in Springfield as a result, then the family's interest in this review will have been validated in the best of ways.