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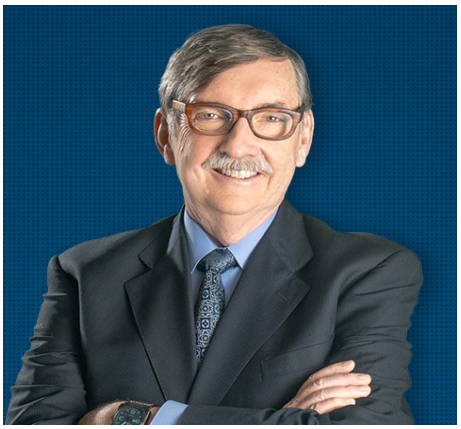

YOUR BLACK SWAN IS SOMEONE ELSE'S GREY RHINO
SOME THOUGHTS ON SHARING INSTITUTIONAL KNOWLEDGE

Presented by Gordon Graham
March 2, 2026

Thanks for inviting me here to Reno for this conference. It is my honor to be with you this morning and I am hopeful that my comments will be of benefit to you. For those of you not familiar with my work what you will probably remember from the introduction is he used to be a CHP officer and now he is a lawyer – and that is true. But prior to law school I did my graduate work on managing risk and that is truly my focus in my work.

Lawyers handle tragedies – and I have been in that role now for 44 years. Risk managers do not handle tragedies – we study them and we look for cause. It is pretty easy to spot the proximate cause of any given tragedy (the event that instantly precedes the tragedy) – but real risk managers go left of bang and look for the real problems lying in wait that ultimately caused the tragedy.

Once you identify these problems lying in wait you can then build control measures (policies, procedures, protocols, directives, initiatives – call them what you want) and if these control measures are properly designed, kept up to date and fully implemented – you can prevent future similar tragedies.

With the above in mind, let me start off with this. Walk up to any sheriff or chief of police and ask, "So what were the lessons learned from Ferguson, Missouri in 2014?" Trust me, you will get a blank stare. Since the Ferguson Incident I have addressed the NSA, MCSA and IACP many times. When I pose that question to a group of 200 law enforcement executives (with my promise to them that I will not ask any questions to try to embarrass them) I will get a maximum of five hands going up – and most of the hands that go up are black hands! So the only people who learned from Ferguson are black law enforcement executives?

If you think I am picking on law enforcement executives – guess again! Walk up to any fire chief and ask, "So what were the lessons learned out of the Coleraine Township Fire that killed Captain Robin Broxterman and Firefighter Brian Schira in Ohio in 2008?" – and you will get a blank stare. For the last 10, years I have been fortunate to address the

FDIC International (and I will be there in April) – and I have asked that question to fire chiefs – and most of the time no hands go up!

Let me move on to school shootings. Walk up to anyone in the world of education and ask them, "What were the specific lessons learned out of Oxford, Michigan school shooting in 2021?" – and you will get a blank stare.

But walk up to any pilot – ANY PILOT – and mention the name "Sullenberger" – and that pilot will tell you exactly how to land a plane on the Hudson River. My point is this: The Learning Management System (LMS) in the aviation world is much more robust than it is in the world of municipal operations.

All the above brings us to the title of my program today concerning Black Swans and Gray Rhinos. Nassim Taleb's great book *The Black Swan* is a fantastic read. In a nutshell the black swan is the unknown unknown – something that ended up in a tragedy that just snuck up on us and no one saw it coming.

Conversely, Michele Wucker's wonderful work, *The Gray Rhino*, focuses on these massive 4,000 pound beasts that are running right at us – yet we do not see them coming and we fail to get out of the way – thus resulting in some tragedy.

By the end of our brief time together today, I hope to demonstrate that there are ZERO black swans in law enforcement operations. All the tragedies you suffer in your professions are gray rhinos – we should have seen them coming but we did not see them coming and we have the death, major injury, embarrassment, lawsuit, indictment and loss of public trust – the tragedies that I regularly talk about.

Some of you may have attended past iterations of my seminars during which I provided some thoughts on Ethical Decision Making. In these past programs I have provided a 10-Step Decision Making process. For those of you who were not present at one of those conferences, here is an overview of that process.

1. Identify and clarify the issue. If it is a preservation of life event – act immediately. Short of that, identify what needs to be decided.

2. Do I have time to think? If so, move on to #3. If not, hopefully you picked this up on your risk assessment and have been providing the constant, ongoing training.

3. Jurisdictional – Can I handle this event? If so – move to #4. If not, get it to someone who can handle it and follow through to make sure it got done.

4. If so, what is the policy of your agency re this event? Follow the policy. If no policy, what is the mission statement of your organization and make sure your action is consistent with this statement.

5. If so, what is our past practice in this event type? You may not have handled this event before, but maybe someone in your organization has. Consistency is critical.

6. If so, what are the ethical issues involved in this event? We have to be concerned about not just doing things right but doing the right thing right.

7. If so, what are the consequences of my actions? Smart people consider consequences before they occur.

8. Make and implement your decision. And it is not too late to go back to #1 to make sure you are still headed in the right direction.

9. Document as necessary why you did what you did.

10. If you learned something new – share it with your peers.

Please note Step 10 above. If you learn something new – share it with your peers. The aviation community is big on this sharing yet government in general – and specifically the public safety community does not do as well. As a result, we make mistakes that others in similarly situated organizations have made and we end up with the same tragic outcome and somehow we are surprised.

Our public deserves better than this. Our personnel deserve better than this. Our profession(s) deserve better than this! There has got to be a better way to make the knowledge of all the knowledge of one – and today I will provide seven different strategies to allow you to achieve this goal in your organization.

Let's take them one at a time.

Strategy #1 – We need to adopt the NTSB approach to the investigation of our tragedies. We need an independent, non-political, in-depth investigative process. Not to be rude – but law enforcement investigations of LODDs or OIS events are lacking in quality and information. We address the proximate cause but not the root cause and we need to learn from our agency tragedies and ensure that we now have appropriate control measures in place to prevent that tragedy from recurring. It is maddening that an agency will allow the same problems lying in wait to cause another tragedy. Another issue of great importance is the wellness component – both physical and mental. Too many agencies are not addressing or fully addressing this critical area – and as a result we have problems lying in wait that will ultimately lead to another tragedy. Please take a look at CORDICO.com for some great strategies regarding wellness and mental health.

Strategy #2 – We need to learn from tragedies involving similarly situated organizations – a.k.a. other cities operations, other fire departments and other law enforcement agencies. Just because it hasn't happened here does not mean it can't happen here. How do you learn from the tragedies involving other law enforcement agencies? I love the ODMP.org website – they do great work. BUT – if you look at this site regularly, they say the cause of death was "run off road" or "shot by suspect." I know they are not in the business of investigations – just reporting the LODD of a given cop – but again we need to get past the proximate cause and learn what really caused the tragedy. Wouldn't it be nice to have some national repository of summaries of these final reports that was easily searchable? More on that as we move forward.

Strategy #3 – We need to learn from tragedies in other high-risk professions. Let's take a look at my aforementioned tragedies involving aircraft. There is a lot we can learn from the NTSB investigation of the death of Kobe Bryant in 2020. The final report goes well beyond the proximate cause and identifies the root cause so that other pilots can learn

from this. We in law enforcement can also learn from these final reports – and not to beat a dead horse but how many tragedies in other high-risk professions involved grossly fatigued employees?

The fire service (using the good people at NIOSH) occasionally investigates LODDs in the fire service, but it is not done for every LODD. Frankly, if I was a fire chief who ran a sloppy organization and had a LODD – I would not want anyone coming in to tell me how shoddy my department was.

You may know that I am (along with the finest police defense lawyer in America today – Bruce Praet) the co-founder of Lexipol. We had an idea 20+ years ago to standardize policies and training in California law enforcement – and today every state in the nation uses Lexipol products and services in their fire and police organizations.

Many years ago, Lexipol acquired Police1.com and FireRescue1.com. My goal is to utilize these websites to summarize the final reports in their respective areas of focus so that everyone can know, “What were the lessons learned out of (a given tragedy)?” If you have something you would like to contribute to this effort – please let me know.

Strategy #4 – We must learn from the close calls people in similarly situated organizations have experienced. During my tenure at the USC – ISSM I was introduced to the work of H.W. Heinrich. Ultimately this became the focus of my theses in partial fulfillment of my work to be graduated. Here are some thoughts for your consideration.

I learned this concept in 1975 from Chaytor Mason at USC. He enlightened me to the writings of H.W. Heinrich, the great risk management guru of the ‘30s. If you get the chance, run his name through your search engine. His thoughts of the 1930s are still being discussed today, and if you take the time to read the sites that speak of him, he was extremely controversial.

He developed some thinking called BBS or Behavior Based Safety. Since he was with the Traveler’s Insurance Company, it was his belief that most injuries were caused by the workers’ actions. The company could do no wrong. He studied tens of thousands of injury reports (mostly prepared by supervisors) and concluded that 88% of them were caused by worker error.

This theory inflamed some people, who blamed the work environment for the problems, not the individual worker. Unions were particularly upset with his research and over the years many continue to assault his theories. I have some problems with his BBS theory also, specifically when it addresses single site factory jobs.

It is my belief that most of the injuries there are caused by the environment of the workplace, not the worker. If people are regularly getting hurt doing the same tasks in a controlled setting, there is something wrong with the working environment. The workplaces should be designed with safety in mind, and even if a worker gets careless, this should not result in an injury.

I recently had a conversation with a Volkswagen executive, and he told me, “The only way you can get hurt in our assembly plant is to do something purposefully to cause the injury.”

However, when you move out of the single factory site into the complex real world of public safety operations Management, Supervision, Unions and the Worker must work together and accept joint responsibility for safety in the workplace.

The complex, continually changing dynamics of your job require that workers regularly access their loaded hard drive to stay safe and avoid problems up front. Over time, your individual hard drive will load up with the experiences you have in public safety operations. Some of the experiences involve close calls in which you almost got hurt or worse. You learned a lesson from this incident, one that you will never forget. Your hard drive is permanently loaded. Who did you share this new information with? Probably no one, because of fear of embarrassment or discipline. This is sad. Had you killed yourself or lost a leg, then everyone learns from your tragedy.

Here is a Chaytor Mason (the great risk manager of the '60s and '70s) quotation for you:

The only time you learn from the mistakes of another is when they end in tragedy.

This is unacceptable. Waiting for people to die so we can learn a lesson from the death is simply un-American. Heinrich had a theory on how mistakes end up in tragedy. Capsulizing what he said regarding people, activities and mistakes, here is my take on his work.

Give me a group of people doing the same or similar task. All of you in this audience today are part of a group of people who do the same or similar tasks. When the group makes 300 mistakes, 30 of these mistakes (1 in 10) will end up in a mishap and one (1 in 300) will end up in the big one – death of Great Bodily Injury. This Triangle of Probability will be of some benefit to you. Here it is. For those of you familiar with the work of H. W. Heinrich you will note that I have modified his numbers slightly to make it easier to do the math. Please take a look at it and we can fill in some information together.

We all need to learn from the mistakes of a public safety professional if they are seriously injured or killed. This is a good idea. It is important to study the tragedies that occur in your profession. There are many sources for this data, and it is good that you study them to see how things go really bad.

The better idea is to learn when it was just a mishap – the sprain, tear, rip, bruise, or property damage only type of event. They are much more frequent and much less

serious so we don't hear about them. There is great value in reporting, documenting, and studying mistakes that end up in minor consequences – and then sharing this information.

The best idea is to learn when it was just a mistake. They are much more frequent with no consequences – just a close call with no adverse consequences. What is the answer? This Triangle of Probability.

Developing a non-punitive close call reporting system allows others to learn from the non-disastrous mistakes of another prior to major injury, death or disaster. This program can work within your department, or within a group of departments so we can take advantage of the greater volume of mistakes. Optimally, we can learn from the whole group (i.e., all law enforcement professionals in America). How can we collect this data on a national level? Here are a couple of thoughts.

Take a look at this web site - www.firefighterclosecalls.com. Chief Goldfeder and I built this site in the late 1990s. There is a lot of great information on to assist everyone in any fire department in making the knowledge of all the knowledge of one. Pulling this site up every now and then and clicking on your area of concern will allow you to read what is going on with others. And most importantly, if you have a close call of your own, you can share it with webmaster.

On the cop side of things, you can check out the work of the National Police Foundation and check out www.LEOnearmiss.org site. There is a lot of information that you can learn and share with others in law enforcement operations.

Strategy #5 – The importance of bring back the best of the best to share their institutional knowledge with those who have replace them. I truly believe that I had the best sergeant in the history of the CHP – the guy was a genius. He seemed to know everything about sergeanting and I learned so much from him. If anyone accuses me of being a good sergeant (1982-1992) I blame it on Sergeant Jack Becker.

He has retired from the CHP many years ago. When is the next time the CHP has contact with him? His funeral? All that institutional knowledge (things he learned over his 20 years in his sergeant position) goes out the door with him. Why don't we have a formal program to bring back the best of the best to help train, mentor, develop the new generation of supervisors?

Strategy #6 – Tapping into the personal knowledge base of great people (I like to call them the 5%ers) leaving our respective professions. Akin to Strategy #5, let's do something similar with great people who are leaving honorably leaving our respective professions.

When they announce their retirement give them an assignment prior to their date of separation. "Mary/John – you have had two different jobs in your career here – line and supervision. I would like you to think about the three (or more) most unique and/or important events you encountered in those two jobs – how you performed the task when it occurred – and more importantly how you would do it better if it occurred again?"

We could put these learnings into three-to-five-minute digital recordings and label them so they could be accessed by others who want to further their knowledge. Not to bore

you but on my morning walks on the beach near my home in Orange County I used chat with a retired navy guy – take a look at him online by Googling “Mayor of Bolsa Chica Joe Bush.”

He was sharp as a tack and when I asked him what he thought about on his morning walk he said, “I relive every mission I had during World War II and how I could have done it better.” It would have benefitted the U.S. Navy to bring Joe back and talk to younger people and share his institutional knowledge with the newer generation.

Strategy #7 – We must make everyday a training day to share knowledge with all who are similarly situated. In 1975 whilst in the ISSM program I learned a better way to train people in high-risk organizations.

Where should we focus our training? “Gordon, there are thousands and thousands of things we do in each and every job description in our city – and we just can’t train for everything. Where should we focus our efforts?” There is a chart for your consideration below – and please do not give me credit for inventing it. I learned about this way back in 1975 and even then I had a question. Why did I have to wait for a specialized course in grad school to learn about this chart? This chart is the genesis of Strategy #7.

This chart is known as the risk/frequency analysis. Everything that gets done in every job in your operations (and specifically in your job description) can be put into one of these four boxes. And if you understand this chart, you can predict where most mistakes will occur. And please remember that mistakes cause too many law enforcement tragedies.

The good news is that most of the things you and your people do in your organization are High Frequency, and your past experience will show you how to do it right the first time. This brings up the topic of RPDM, or Recognition Primed Decision-Making. If you want to read all about this, please pick up a book by Dr. Gary Klein, *Sources of Power* and read all about it. The principals of RPDM are as follows.

Consider your mind as a hard drive or, for those of you over 50, a slide tray. Your daily experiences help load this drive. Everything you do and experience is loaded into your hard drive. When you get involved in any task or incident, your magnificent brain quickly

scans your hard drive and looks for a close match or what Dr. Laurence Gonzales calls a “memory marker,” “mental model,” or a “behavioral script.”

Bottom line: Give me a good woman or man and put them in a high-frequency event, and there is a darn high probability that they will do the task right this time.

There are exceptions to this rule. Occasionally you will find that errors occur on high-frequency events. When this occurs and you look for what caused the tragedy, there are five issues that keep on popping up. They are:

Complacency, Fatigue, Distractions, Hubris, Risk Homeostasis

If any of these are present in your operations – you have a problem lying in wait.

But even when you factor these in, rarely do mistakes occur on the high-frequency events. However, if you put a good person in a low-frequency event – particularly one that is high risk in nature, and I hear trains coming. When you get back to work later this week, I want you to start practicing RPM – Recognition, Prioritization, and Mobilization.

First, you must recognize the tasks that fall into the top left box in the job description(s) that you manage. This requires the actuarial risk assessment I spoke of earlier. Now you must prioritize these risks. Here are some thoughts on this process.

Please recognize that this top left box has been divided into two areas. Some tasks need to be done immediately (Non-Discretionary Time - NDT), and some give us time to think (Discretionary Time - DT). The top left portion of the top left box scares me a lot, as these tasks truly give you no time to think.

Included here are workplace violence incidents, chemical spills, bomb threats, shoot don’t shoot, pursue don’t pursue, intervention when witnessing inappropriate behavior by another officer, earthquakes and other natural disasters, and similar events. These are the tasks that have higher priority in my way of thinking, as they have a higher probability of getting you in trouble. These are the events (tasks) that need the regular and ongoing training.

This is the mobilization component of RPM and it is very important that every day is a training day and you must focus your efforts on the core critical tasks – those tasks in the top left portion of the top left box.

The good news here is that in an average career of 30 years, less than one shift is really spent on this type of task. The bad news here is that in an average career of 30 years, less than one shift is really spent on this type of task.

With this in mind, and because of the high risk level involved in the given task that falls into the top left corner of the top left box, these need to be covered regularly to make sure people know what to do if they ever get involved in the HR/LF/NDT family of tasks.

The excellent news is that most of the tasks in the top left box are not NDT, but rather DT meaning that you have time to think before you act. That may include asking someone who does the task at a higher frequency (and that may mean only once more than you) how to do it so it gets done right.

Public safety operations can be very complex. However, most of the incidents you get involved in are ones that you have done a lot (high frequency) or ones that give us total discretionary time. If you have the time to think, please use it. Failure to use discretionary time when available is overrepresented in subsequent problems.

Here are another two great books on my recommended reading list: Blink vs. Think.

Your role as a leader in your sheriff's office operations is making sure that you and all of your people in each and every job description in your department are fully and adequately trained for the tasks that give you no time to think (the Core Critical Tasks that are present in every job in your organization), and that you (and they) understand the value of thinking things through when they are involved in a discretionary time task.

Let's make everyday a training day and focus the training on the core critical tasks that are present in every job description on public safety. This was the foundation for the Lexipol KMS (knowledge management system) in which all Lexipol client agency personnel get trained every day when they log in at the start of their shift.

This training is followed up with a test question to make sure that people truly know the issues from the given training bulletin. I want to improve this LMS to allow the end point user – the specific deputy, cop, teacher, or firefighter logging on, to learn something that will be very relevant to their specific job in their organization.

One last thought – and a very important thought it is. Last year I delivered five eulogies at funerals and memorial services for friends I have made over my lifetime in public safety. I have already delivered a eulogy this year for Fire Chief Sam DiGiovanna out of Monrovia FD and later Verdugo Fire Academy. Like everything else I do – I have a system on how to deliver a talk that summarizes the life of a given person.

Years ago, Linda Ellison wrote a poem called "The Dash" – and later Mac Anderson wrote a book with the same title. Visit any cemetery in America and on the headstone between the date of birth and the date of death is "The Dash." Ms. Ellison's poem sums it up very nicely – and I encourage you to read it and understand what she is saying.

Please recognize that your work in public safety is making a difference in the lives of so many people. The benefit to you is that every day you work you are enhancing the value of your dash. I am so grateful to have been part of the public safety community since 1973 – and I thank each and every one of you for your continued work.

Gordon Graham
ggraham@lexipol.com | 844-312-9500
gordongraham@earthlink.net | 714-374-9326

ABOUT LEXIPOL
Lexipol is the leader in advancing total readiness for public safety agencies, helping leaders reduce risk, ease administrative burdens, and strengthen community trust. Trusted by more than 12,000 agencies nationwide, Lexipol delivers a unified platform that integrates policy, training, wellness, and reporting to simplify operations and support data-informed decisions. By

equipping leaders and teams with the tools, insights, and support they need, Lexipol makes readiness possible—today and for whatever comes next. Learn more at www.lexipol.com.

info@lexipol.com
www.lexipol.com
844-312-9500