

AJA Virtual Fall Summit 2026 Continued Professional Training



YOUR BLACK SWAN IS SOMEONE ELSE'S GREY RHINO **Some Thoughts on Sharing Institutional Knowledge**

**Presented by Gordon Graham
Oct. 1, 2026**

Thanks for inviting me here to this virtual conference. As I checked my past handout materials, I learned I have had the honor of addressing the AJA for more than 20 years. For those of you not familiar with my work what you will probably remember from the introduction is "He used to be a CHP motor cop and now he is a lawyer" – and that is true. But prior to law school I did my graduate work focusing on managing risk and that is truly my focus in my work.

Lawyers handle tragedies – and I have been in that role now for just over 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 event) – 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 chief of police or sheriff 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 IACP every year and I have addressed over 40 chiefs of police groups at their various state conferences and I have addressed other major law enforcement groups around our nation.

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 present at FDIC in Indianapolis (as I prepare these handouts I am also getting ready for my afternoon program at FDIC later in April) and I have asked that question to fire chiefs and most of the time no hands go up.

Now let’s get specific about jail operations. Walk up to any sheriff who has a jail and ask, “What were the lessons learned in the death of Jamal Sutherland in South Carolina?” and you will get the same 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 public safety.

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 60 minutes together today, I hope to demonstrate that there are ZERO “black swans” in the world of jail operations. All the tragedies you suffer in your operations 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 the public safety community (including jail operations) 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 later today I will provide seven different strategies to allow you to achieve this goal in your organization. More on this later on in this program.

For those of you I have never met, let me give you a bit of my history of my 75 years of life and how I ended up being here with you today. The California Highway Patrol was kind enough to hire me in 1973 and they made me a motorcycle cop in Central Los Angeles – one of the 105 CHP offices in the Golden State.

When I got off of probation in 1974 I went back to school – and spent two years at Cal State Long Beach picking up a “designated subjects” teaching credential. In 1975 I enrolled in the University of Southern California’s ISSM program – the Institute of Safety and Systems Management – a brilliant program developed post-World War II to improve safety in military operations.

Over the next three years I got hooked on the study of tragedies – and I since then I have spent way too much time studying tragedies in high-risk occupations, including maritime tragedies, mining tragedies, refinery tragedies, train tragedies, plane tragedies, bridge tragedies, building tragedies, power plant tragedies, and tragedies in law enforcement, correctional, and fire service organizations.

Allow me to digress here for a moment. The gurus in the world of risk were on the faculty of the ISSM, including Chaytor Mason and Ted Ferry. Another one of my professors was the affable and brilliant Harry Hurt and when he learned that I was a CHP motorcop he invited me to be an “investigator” on a project he was working on – now known as *The Hurt Report*.

Those of you who ride need to [read this report](#). Harry Hurt and his team studied over 900 motorcycle fatal collisions (and please stop calling them accidents) and very quickly they identified the number one cause of motorcycle fatalities – right-of-way violations.

Those of you who ride know exactly what I am talking about. You are going down the road and some idiot makes a left-hand turn directly into your path of travel. This regularly results in riders getting seriously hurt or killed. During the investigation of the fatality, the cops ask the driver of the errant vehicle what happened – and the most common response is “I did not see the motorcycle.”

So, the question became two-fold. Part one is “Why can’t people see motorcycles?” and part two is “What can we do about it?” The answer to the first part of the question was pretty easy. Back in the ‘70s, the motorcycle headlamp only activated with the action of the driver turning it on – in essence the driver had an option of using the headlight – and most only turned it on during hours of darkness.

As a result of findings of The Hurt Report (and undoubtedly some other work) – the option was taken away. Circa 1981 the federal government came up with a Federal New Vehicle Safety Standard (read: control measure) that changed things dramatically. After 1981 when you turned on your ignition on the motorcycle – the headlight came on – you no longer had an option – and guess what! Motorcycle fatalities decreased substantially in subsequent years!

Why am I boring you with this? Remember I was riding a motorcycle for the CHP way back then. When the CHP (and other law enforcement agencies) learned of the new federal law – they immediately requested a waiver from this new mandate! “We have to be able to turn our headlight off in case our officer is being shot at!” Well – let’s make a list of all the CHP officers who died because they could not turn their headlight off – and that number would be NONE! Now let’s make a list of all the CHP officer killed because of right of way violations – and that number is substantial.

Don’t get me wrong – I love the CHP – they were so good to me for 33 years and for that I am forever grateful. But way back in 1981 – they made a mistake. They got worked up on the wrong stuff. The gray rhino was the right of way violation – it was literally coming right at us – and we failed to properly address it. I knew what the problem was because of my work with Professor Hurt – it was a gray rhino to me and everyone else who worked on Harry’s team. But to too many decision makers – this problem snuck up on us – it was a black swan to them! As I finalize these handouts in April, I am sad to report that another CHP is in serious condition following a collision recently – an SUV made a left turn in front of him at an intersection.

If my calculations are right, I am now 30 minutes into my program – and I will further bore you with my focus in my teachings over the last 40 years – and what I mentioned earlier this morning. When you take a look at any tragedy in any profession and look for “What caused it?” – it is easy to spot the proximate cause, or the event that instantly precedes the tragedy. But real risk managers do not stop their search for cause with identifying the proximate cause. Real risk managers go back in time and look for problems lying in wait – that people knew about or should know about – yet these problems are oftentimes ignored until the tragedy occurs.

Your role (and the role of everyone in every job in your jail operations) is to take a daily look at your sphere of influence – your span of control – and ask these questions: Do we have problems lying in wait in our fleet? Do we have problems lying in wait in our infrastructure? Do we have problems lying in wait amongst our personnel? And if you identify such an issue – that needs to be addressed. And to go full circle on this – you can only spot these problems lying in wait if you are aware of them. Remember – your black swan is probably some else's gray rhino. They have already suffered the tragedy – so let us learn and share this information with others who are similarly situated.

If you fail to identify and address these problems lying in wait sooner or later all the holes in the Swiss Cheese (the thoughts of Dr. James Reason) are going to align – and when that happens the tragedy occurs – and then the lawyers take over and the problems lying in wait are then identified and addressed – after the fact. We have got to make the knowledge of all the knowledge of one. Individually you know a lot – collectively the group knows everything!

Now is the time to provide you with the seven strategies I mentioned earlier in this program. How can we make the knowledge of all the knowledge of one?

Strategy #1: We must fully investigate and document tragedies we experience in our organization.

Strategy #2: We must read and learn the final reports on tragedies in our respective professions.

Strategy #3: We must read and learn from final reports on tragedies involving other high-risk professions.

Strategy #4: We must learn from the close calls people experience in similarly situated organizations.

Strategy #5: The importance of bringing back the best of the best to share their institutional knowledge with those who have replaced them.

Strategy #6: Tapping into the personal knowledge base of people leaving our profession.

Strategy #7: We must make every day a training day sharing this knowledge with all who are similarly situated.

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 major UOF 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. Not to digress, but in the CHP we had tragedy, after tragedy, after tragedy with the same root cause – cops who were grossly fatigued because of some idiotic decision in August 2006 (I retired in July of that year) – allowing 12-hour shifts.

Each of the above referenced tragedy after tragedy after tragedy was linked to tired cops. Everyone knew and no one did a darn thing about it!

Strategy #2 – We need to learn from tragedies involving similarly situated organizations – aka other jail organizations. 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 [Officer Down Memorial Page](#) – 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?

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

You may know that Bruce Praet and I co-founded Lexipol more than 20 years ago. We had an idea to standardize policies and training in California law enforcement – and today every state in the nation uses Lexipol products and services in their police, sheriff, probation and fire departments.

Several years ago, Lexipol acquired Corrections1, Police1, FireRescue1, and EMS1. My goal (then and now) is to utilize these websites to summarize the final reports in their respective areas of focus so that everyone can know the lessons learned out of a given tragedy. If you have something you would like to contribute to this effort – please let me know at ggraham@lexipol.com.

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, 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, you'll see 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 actions of the worker. 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."

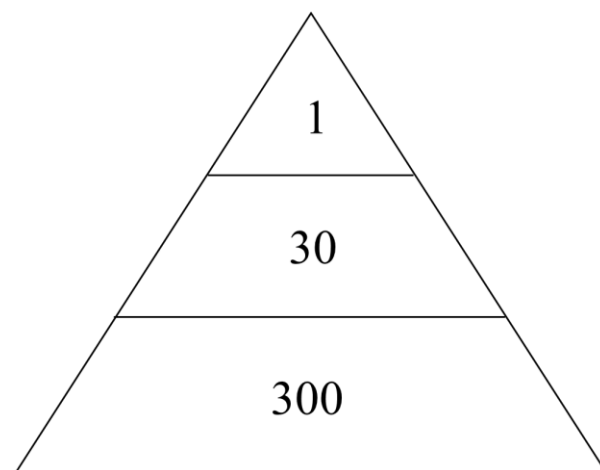
However, when you move out of the single factory site into the complex real world of public safety operations management, supervision, unions and the worker must work together and accept joint responsibility for safety in the workplace.

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) quote 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 as illustrated with the Triangle of Probability. Please take a look at it and we can fill in some information together.



Give me a group of people doing the same or similar task. When the group makes 300 mistakes, 30 will end up in a mishap and one will end up in the big one. We all 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. What is the answer?

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 [Firefighter Close Calls](#). Chief Billy Goldfeder and I built this site in the late 1990s. It became very popular and led to us assisting the IAFC in building their sister site (which is now a part of Firefighter Close Calls). There is a lot of great information on FFCC to assist you in “making the knowledge of all the knowledge of one.”

Strategy #5 – We must bring back “the best of the best” to share their institutional knowledge with those who have replaced them. In my long programs I refer to these people as “the five percenters.” 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 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 – We must tap into the personal knowledge base of people leaving our profession. Akin to Strategy #5, let's do something similar with great people (I like to call them “bow thrusters”) who are 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 many years ago on my morning walks on the beach near my home in Orange County I would 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 at 100 years old and when I asked him what he thinks about on his morning walk he said, “I relive every mission I had during World War II and how I would could have done it better.” He was a joy to talk with. Mrs. G and I went to his 102nd birthday party two years ago and he died a week later. I think the Navy would have been very wise to bring Joe back and talk to current Navy personnel about operational issues.

Strategy #7 – We must make “every day 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. When I brought this idea to the CHP – I was dismissed as a rambling psycho by my captain at the time.

In 1982 when the CHP promoted me, I instituted that training program with my B-shift cops in Central LA. Soon it spread to A watch and C watch. As new sergeants promoted into Central – they used it – and when they went back to where they came from – they asked me to send my training bulletins to them. The daily training program spread around the state and ultimately became the daily training program known as SROVT – Solid, Realistic, Ongoing, Verifiable, Training.

Let’s make every day 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 genesis for Lexipol Policy, in which all our client agencies’ 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 rules regarding the given training bulletin. I want to improve this even further, to allow the end-point user – the officer logging on – to learn something that will be very relevant to their specific job in their agency.

We are now in our last few minutes together. What can you do with the information provided so far? Allow me to briefly introduce you to the 10 Families of Risk. As I looked at the thousands of risks that people face in a given organization, I saw too many people who were overwhelmed by the volume of the issue. I wanted to make it easier to comprehend, so I broke up the thousands of risks into 10 families.

1. External Environment – risks arising from outside the organization that impact your organization. There are a number of these, and they are increasing in frequency and severity. Included here are natural disasters, pandemics (and don’t think I am pandering to you with this – but this topic has been in my handouts for decades), terrorist activities and conduct (both intentional and negligent) by members our public that impacts our operations. This is the most complex and difficult family of risk you face as your control of these risks is very limited. But these risks need to be recognized and addressed if possible.
2. Legal and Regulatory – risks arising from the complexity of or non-compliance with the legal framework imposed on organizations like yours in your state. If there is a law or ordinance in state or federal statutes that requires action or prohibits action – this rule must be known and followed. I am always amazed how many organizations – both private and public sector – including large ones with huge budgets – are not in compliance with the ADA, FLSA, and even the Public Records Act. And with the demand today for full transparency this could pose a major problem for you and your

department. Do you have all the policies in place that are required by state and federal laws and regulations?

3. Strategic – risks arising from the lack of priority setting and business planning leading to a reactive organization that is not prepared or flexible enough to deal with unforeseen events. This goes on a lot, particularly in smaller organizations that do not have sufficient personnel or time to plan for the future. Where will America be in 30 years? Where will your organization be in 30 years? If you think that it will look pretty much the same, you may be missing the boat.
4. Organizational – risks arising from not clearly defining roles and responsibilities, not demonstrating the values of your organization or not having monitoring processes in place. In a nutshell, we must be concerned with PEOPLE, POLICY, TRAINING, SUPERVISION and DISCIPLINE. These issues are oftentimes the root cause of so many tragedies.
5. Operational – how do we manage the risk of a specific task, incident or event? How do we manage the risks involved in this particular employee termination or employee threat of suicide? How do you manage the risks associated with a specific pathogen incident? Again, I must emphasize the importance of Recognition, Prioritization, and Mobilization of the high-risk, low-frequency, non-discretionary time tasks and the importance of daily training on these core critical tasks.
6. Information – we make decisions based on information. How do you know the information on which you are basing your decision is accurate and has not been vetted by someone for his or her own advantage? How do you separate the valuable information from all the data? In many organizations I have consulted with, I see that personnel are trained on how to do specific tasks – but very few organizations teach their personnel how to think. I strongly recommend training for all personnel on critical thinking skills, particularly on the specific tasks in a given job that have the highest probability of ending up problematic. Be aware of the dangers of ignorance, complacency and cognitive bias. Again, I stress the importance of decision-making training for all people in the high-risk world of public safety operations.
7. Human Resources – risks arising from the myriad issues involving personnel. This may well be the most expensive family of risk you face. Put a checkmark next to this one as it is causing us a ton of grief and needs your attention when you get back to work. If I were running an organization, I would not allow any supervisor, manager, or executive to make an employment law decision without first consulting with competent human resources personnel. All employment law is discretionary time so let's take the time to transfer the risk to those who do the task at the highest frequency.
8. Technology – this is the fastest growing family of risk we face. I have major considerations about hacking, malware, software, equipment purchases and updating, employee knowledge and training, terrorism, social media, equipment failure and many other issues. Is your CTO really a CTO? Or is your CTO just the smartest person in the room with respect to computers? There is a huge difference!

9. Financial and Reputational – risks arising from improper budgeting, forecasting and expenditure controls, including contracting, asset management, internal audits, improper salaries, theft of cash, misappropriation of resources, misuse of overtime and poor revenue oversight. We must be very concerned with anything dealing with money. Is your CFO really a CFO? Does she/he actually have any background in finance – or do they test well on promotional examinations? And what control measures do you have in place to prevent the theft of funds from your organization?
10. Political – all your personnel should stay out of the fray of politics. Please be careful in your dealings with elected officials – there is a lot of risk involved here. Also, your department mission should not be impacted by which political party is in control of the state.

With all of this in mind, your take back to work assignment is to identify the three (or if you are ambitious the five) greatest risks you face in each of these 10 families and then ask, “What control measures (systems) do we have in place to address these identified risks?” And please make this an ongoing process within your operations.

My internal clock tells me I am closing in on 1100 HRS. Remember the title of this program – “Your Black Swan Is Someone Else’s Gray Rhino” – and share this message with all who care in your public safety agency.

Thanks for coming to this program today and I wish you continued success in all you are doing.

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