




## CLOSED CASE SUMMARY

ISSUED DATE: AUGUST 3, 2023

FROM: DIRECTOR GINO BETTS   
OFFICE OF POLICE ACCOUNTABILITY

CASE NUMBER: 2023OPA-0069

### Allegations of Misconduct & Director’s Findings

#### Named Employee #1

Allegation(s):		Director’s Findings
# 1	5.001 - Standards and Duties POL-2. Employees Must Adhere to Laws, City Policy, and Department Policy	Not Sustained - Inconclusive
# 2	5.001 - Standards and Duties POL-10 Employees Will Strive to be Professional.	Not Sustained - Inconclusive

#### Named Employee #2

Allegation(s):		Director’s Findings
# 1	5.001 - Standards and Duties POL-2. Employees Must Adhere to Laws, City Policy, and Department Policy	Not Sustained - Unfounded

***This Closed Case Summary (CCS) represents the opinion of the OPA Director regarding the misconduct alleged and therefore sections are written in the first person.***

### EXECUTIVE SUMMARY:

The Complainants alleged that the named employees failed to remove a firearm from a home.

### ADMINISTRATIVE NOTE:

On June 13, 2023, the Office of Inspector General (OIG) certified OPA’s investigation as thorough and objective but untimely. OIG found it untimely because OPA sent the classification notices to the named employees after the 30-day timeline. Respectfully, OPA notes that the delayed 30-day classification notices did not prejudice the named employees. Moreover, OPA’s investigation was completed within the 180-timeline as required by the Accountability Ordinance and the governing collective bargaining agreement.

Also, the allegation against NE#1 was processed for supervisor action.

### SUMMARY OF INVESTIGATION:

The named employees were involved in three separate police responses to domestic disturbances at the incident location over three days.

- A. 2023-033381: Incident Report, Computer-Aided Dispatch (CAD), and Body-Worn Videos



Named Employee #1 (NE#1)—a probationary officer—wrote this incident report, describing officers' response to a domestic violence (DV) incident at the incident location. The CAD report indicated that Community Member #1 (CM#1) called 9-1-1 pm on February 4, 2023, at 12:04 PM. CAD remarks noted:

*[REPORTING PARTY] STATED HER [EX-BOYFRIEND] [ASSAULTED] HER LAST NIGHT AND ARE IN A [DISTURBANCE] NOW. [REPORTING PARTY] STATED HE HAS A RIFLE.*

Named Employee #3 (NE#3)—NE#1's field training officer—requested to take the primary role during the response for NE#1's training benefit. CAD updates indicated that CM#1 reported she was strangled and sexually assaulted by the offender—later identified as Community Member #2 (CM#2). An update also suggested CM#2 was "possibly high/intoxicated." Officers arrived, and another update noted a rifle at the home under a bed. The officers spoke with CM#2, who said CM#1 falsely accused him of physical and sexual assault. CM#2 also described CM#1 as mentally ill, suicidal, and intoxicated. Next, the officers spoke with CM#1, who was visibly upset. CM#1 admitted to drinking alcohol. She also reported an argument with CM#2, leading to a physical assault the prior night. CM#1 described CM#2 choking her during that incident, causing her to lose consciousness. CM#1 said CM#2's penis was inside her vagina when she regained consciousness. CM#1 said she told him to stop, but he continued. CM#1 asked whether officers could check the rifle's registration and remove it from the apartment if it was unregistered. NE#3 explained, "That is why you can't stay here. That's the whole point of your leaving. We can't take his rifle, it's legal."

NE#3 stepped into the hallway to confer with Witness Employee #1 (WE#1)—a DV detective and NE#3's wife—over the phone. NE#3 categorized the incident as DV with strangulation and rape. CM#2 was arrested and transported to the King County Jail. SPD's Victim Support Team (VST) responded to the incident location for CM#1. NE#1 spoke with CM#1 about going to a hospital for a rape and strangulation kit, to which she agreed. NE#3 called WE#1 again, asking whether they needed to confiscate the rifle since it was not used during the DV incident. They concluded it was not lawfully reasonable or necessary to seize the rifle. NE#1 told NE#3 that VST was concerned about the rifle in the apartment due to CM#1's alleged suicidal threats. NE#3 countered, "But [CM#1] did not say that." Instead, NE#3 noted that CM#1 expressed fear about CM#2 returning and using the rifle against her: "If [CM#2] comes back, he's probably going to hurt me with that gun." NE#3 spoke with VST members, detailing his conversation with WE#1. NE#1 told VST that CM#1 showed no signs of violence, erratic behavior, or a desire to self-harm. VST agreed to transport CM#1 to a hospital, but CM#1 indicated her mother would take her later that day.

#### B. 2023-034530: Incident Report, Computer-Aided Dispatch (CAD), and Body-Worn Videos

On February 5, 2023, Community Member #3 (CM#3)—CM#1's brother—called 9-1-1 to report that CM#1 was suicidal, threatened to shoot herself, and a firearm was in her home. Named Employee #2 (NE#2) was the primary officer for that call. NE#2 spoke with CM#3 and verified that CM#1 was at the same incident location as the prior response. CM#3 stated that CM#1 was alone in the apartment and had several previous hospitalizations for suicidal ideations. CM#3 said CM#1 texted him several times, threatening suicide. CM#3 asked NE#2 to meet with CM#1, suggesting he knock on the apartment door. NE#2 agreed to attempt to contact CM#1 but stated he did not want to "walk into a dangerous situation where he can be shot," cause CM#1 to commit suicide-by-cop, or trigger a SWAT response. NE#2 spoke with CM#1, who was crying and had slurred speech. CM#1 denied suicidal thoughts and declined transportation to a hospital. NE#2 offered additional resources, but CM#1 declined, stating she did not want to be around people. NE#2 asked to come to the apartment to talk, but CM#1 refused: "You



can't. No." NE#2 called CM#3 back to update him. NE#2 canceled AMR's services, who was at the scene. NE#2's report stated CM#1 did not meet the Involuntary Treatment Act criteria.

BWV showed that NE#2 was inside his patrol car for most of the response.

C. 2023-035315: Incident Report, Computer-Aided Dispatch (CAD), and Body-Worn Videos

On February 6, 2023, Community Member #4 (CM#4)—CM#1's mother—called 9-1-1 to report that CM#1 was suicidal, had access to a firearm, and no one could contact her. Officers, including NE#2, responded and found CM#1 deceased with an apparent gunshot wound. They requested the Seattle Fire Department and the King County Medical Examiner's Office.

D. OPA Interviews

OPA interviewed NE#2 on May 26, 2023. NE#2 said that on February 5, 2023, he responded to a crisis call involving CM#1. NE#2 said that after speaking with CM#3, who reported that CM#1 was heavily intoxicated, depressed, suicidal, and had access to a firearm, NE#2 thought it was safest to contact CM#1 by phone. However, NE#2 had American Medical Response (AMR) medics on standby. NE#2 said he requested AMR in case CM#1 voluntarily went to a hospital or he deemed her appropriate for an ITA. NE#2 said that after speaking with CM#1, he believed an ITA was unwarranted, largely since CM#1 denied a desire to self-harm. Further, there was no independent evidence corroborating CM#3's account. NE#2 said the apartment was in a "lockout building," which made it difficult to enter without keys. He also did not believe officers had the legal authority to enter forcefully. NE#2 said he did not screen the matter with a supervisor or the Crisis Response Unit because he believed the evidence was insufficient for an ITA.

OPA interviewed WE#1 on June 1, 2023. WE#1 said she was an expert in DV investigations, policies, and laws and frequently taught DV courses at the Post-Basic Law Enforcement Academy. WE#1 said that during his response, NE#3 called and briefed her on the situation, explaining that there was an alleged physical and sexual assault and that the suspect's firearm was there. WE#1 asked whether the firearm was used during the incident, to which NE#3 replied no. WE#1 told NE#3 she did not believe there were legal grounds to seize the firearm. WE#1 explained that firearms are typically seized when involved in the crime or with a warrant, extreme risk protection order, or a no-contact order directing for it. WE#1 said, during their conversation, NE#3 did not report CM#1's mental state, including suicidal ideations.

OPA interviewed NE#3 on June 2, 2023. His account was materially consistent with OPA's BWV review. Additionally, NE#3 said taking a firearm for safekeeping required CM#2's consent, citing SPD Policy 15.215. He also denied CM#1 exhibited signs of suicidal ideations. NE#3 also said a supervisor approved their decision and signed off on their report. NE#3 also noted that a later amendment to RCW 10.99.030, requiring officers' making DV arrests to "Seize all firearms in plain sight," was not in effect on the day in question.



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**ANALYSIS AND CONCLUSIONS:**

**Named Employee #2 - Allegation #1**

***5.001 - POL - 2. Employees Must Adhere to Laws, City Policy, and Department Policy.***

It was alleged that NE#2 violated laws and policies by not taking further action to assist CM#1.

Here, NE#2 arrived at the incident location with AMR and back officers on standby. He spoke with CM#1 over the phone, which he deemed safest. CM#1 denied a desire to self-harm and declined to allow him inside the apartment. Although NE#2 did not think CM#1 was a viable ITA candidate, unlike NE#3, NE#2 did not confer with a supervisor or expert. NE#2 had some crisis intervention experience, completing an 8-hour course. However, discussing the situation with some with greater experience would have been prudent in hindsight. During NE#2's initial response, there was more evidence that CM#1 intended self-harm, including CM#2's account from the night prior and CM#3's receipt of several text messages expressing suicidal ideations. NE#2 also acknowledged that CM#1 sounded intoxicated during their conversation. Those factors warranted more than NE#2's single-handed determination that CM#1 was not in danger. However, there is insufficient evidence that CM#1 blew off the call or violated the law or policy—particularly when he arrived with an AMR and backing officer should he establish sufficient grounds for an ITA and offered CM#1 additional resources, which she rejected.

Accordingly, OPA recommends a Not Sustained – Inconclusive finding.

Recommended Finding: **Not Sustained - Inconclusive**

**Named Employee #2 - Allegation #2**

***5.001 Standards and Duties- POL 10. Employees Will Strive to be Professional***

It was alleged that NE#2 was unprofessional by not taking further police action to assist CM#1.

Officers must strive to be professional. SPD Policy 5.001-POL-10.

OPA recommends a Not Sustained- Inconclusive finding for the reasons at Named Employee #2 – Allegation #1.

Recommended Finding: **Not Sustained - Inconclusive**

**Named Employee #3 - Allegation #1**

***5.001 - POL - 2. Employees Must Adhere to Laws, City Policy, and Department Policy.***

OPA recommends a Not Sustained- Unfounded finding for the reasons at Named Employee #1 – Allegation #1.

Recommended Finding: **Not Sustained - Unfounded**