CITY OF SEATTLE

Seattle Police Department
Office of Professional Accountability
Semi-Annual Report of the Civilian Auditor

June – December, 2012

Judge Anne Levinson (Ret.)
OPA Auditor
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Introduction

This report is the semi-annual Office of Professional Accountability (OPA) Auditor report covering the seven-month period from June- 2012 through December- 2012[1]. In Seattle's police accountability system, OPA is the office within the Seattle Police Department (SPD or "the Department") responsible for addressing issues of alleged misconduct by SPD officers and employees. The OPA Director is a civilian who reports to the Chief of Police and serves on the Department's command staff. The bulk of OPA's work is in the investigations section, comprised of a Captain, a Lieutenant, seven Sergeants who handle intake and conduct investigations, and two administrative personnel.

The OPA Auditor is a civilian with legal expertise, independent of OPA and the Department, who provides outside oversight to help ensure that all complaints of possible misconduct are appropriately addressed and all investigations conducted are fair, thorough, objective and timely. The OPA Auditor also makes recommendations to City policymakers and the Department for systemic reforms and suggests ways to improve performance through changes to policies, procedures and practices.

The OPA Auditor is required by City ordinance to issue a public report twice per year. The ordinance sets forth that the Auditor reports, among other things: 1) the number of complaints and investigations reviewed; 2) those investigations where she requested additional investigatory work be conducted; 3) her requests for reclassifications of complaints ("classification" refers to the determination as to whether a complaint will be referred to a supervisor or investigated); 4) issues, problems and trends noted as a result of her reviews; 5) recommendations for additional officer training, including any specialized training for OPA investigators; 6) any recommendations for policy or procedural changes; 7) any findings from audits of OPA records for other purposes; and 8) any other activities.[2]

Policy, Procedure and Training Recommendations

An important aspect of the Auditor's independent oversight role is not only to assess each individual case, but also to point to needed changes in policies, systems and training that cases or trends highlight. I have made a number of recommendations since my tenure began in the third quarter of 2010.[3] One of the initial issues I raised was that the Department needed a

[1] This report covers seven months, rather than six, so that the Auditor's reports going forward will cover a calendar year, which will be more consistent with SPD's and OPA's statistical reports. Beginning this year, there will be a report covering January through June and a second report covering July through December.

[2] See SMC 3.28.850 et seq.

[3] Attached as Appendix A is a chart listing recommendations made in each of my prior four reports and this report.

timely and substantive response to Auditor recommendations[4] for policy, training and systemic improvements in order for the oversight process to be of most value. While I appreciate the array of competing demands and the number of recommendations that may come to the Department from different quarters, the Department should have a required protocol to respond to each Auditor report in a timely manner, with follow up to show progress in implementation. Within 30 days of receipt of an Auditor report, the Department should respond by indicating which recommendations the Department agrees with and intends to implement, which have already been partially or fully implemented[5]; which recommendations may present budget or legislative constraints that will have to be addressed or require bargaining; a specified time frame for implementation; and a lead responsible. If there are recommendations with which the Department disagrees, the reason for that disagreement should be noted and if further discussion is warranted, that should occur.

Similarly, the Department needs to follow up on recommendations made as part of case certification. As noted above, if the Auditor or Director, through the review of an individual case, determines that there is a policy, training or system issue that needs to be addressed, the Director will note what action is needed in her certification of the case. The Director in her closing letter lets the complainant know that this additional action will be taken but the Department should also include a mechanism to report back so that the public can see that the promised improvement or review has in fact occurred. Several investigations where the Department committed to review issues raised or conduct additional training during this reporting period are noted below.

Among the training and policy issues noted in investigations conducted in this reporting period that have been raised in previous reports are the need for:

- continued emphasis on training for best practices when multiple officers are involved in use of force, for ensuring officers know who is the primary officer at a scene, for understanding the difference between a Terry Stop and an arrest, and the current law with regard to search and seizure
- clarity in policy as to when officers should request the assistance of a Mental Health Professional or officers who have gone through Crisis Intervention Team training
- an accurate, comprehensive database of each officer's training history

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[4] Other recommendations were made as well by each of the prior OPA Auditors – Judge Terrence Carroll (Ret.); former U.S. Attorney Kate Pflaumer and Judge Michael Spearman.

[5] In each reporting period the Auditor will have made some recommendations through the investigation review process that will get incorporated into the Director's certification of cases as they are closed. These recommendations would have already been shared with the Department in real time, and then listed in the semi-annual report, so in fact may have already been analyzed, fully or partially addressed, or other action taken.

- changing the Basic Law Enforcement Academy training for new officers where it is inconsistent with Seattle's training and practices, particularly with regard to Use of Force, or if SPD remains unable to have the necessary changes implemented due to the statewide nature of the training, much clearer and stronger articulation from SPD command about what practices are not to be used despite the Academy training
- reconsideration of the previously existing policy for off-duty conduct, often referred to as Conduct Unbecoming an Officer or 'CUBO'
- addressing myriad In-Car Video (ICV) and secondary employment issues
- reconsideration of the SPOG contractual requirement that OPA must refer out to other SPD units, and may not coordinate the investigative approach for, any cases that involve an allegation of possible criminal conduct, and
- changes to the hiring and promotional practices so that judgment, performance and skills are the most important prerequisites, not testing,[6] and that test scores are not determinative of promotional opportunities.

New issues that arose in this reporting period were the need for:

- clarifying policy with regard to parental notification prior to interviewing juveniles who are victims
- prohibiting a lower-ranking officer from conducting the Use of Force (UOF) review when force was used by someone of a higher rank
- a pre-negotiated protocol with the Seattle Ethics & Elections Commission for investigating cases where OPA staff are named, such that there is a conflict that cannot be addressed by using other OPA personnel[7]
- clarifying roles and responsibilities between the newly instituted Use of Force Review Board and OPA for reviewing Use of Force tactical decisions and best practices in cases where possible misconduct is being investigated by OPA

[6] And with regard to testing, civil service requirements could be changed so that the balance of scoring could be changed to 60% skills-based and 40% test-based rather than 60% test-based.

[7] The case that arose during this reporting period is the first during my tenure where OPA staff were named. I recommended the investigation be conducted by the City's Ethics & Elections investigator rather than refer it to an outside agency. The Seattle Police Management Association raised objections that have delayed the investigation. Because it is still not closed as of this report I cannot comment further on it, except to say that there should be an agreed upon protocol in place for cases where there is a conflict that cannot be remedied with other OPA personnel.

- eliminating ambiguities between the Demonstration Management Policy and UOF polices as to permissible use of force, and
- replacing hard-copy reporting with electronic reporting for Patrol Traffic Collision Reports.

Based on the supervisory issues that were highlighted in complaints and investigations during this period, many prior recommendations related to supervisory accountability in particular remain priorities:

- enhanced Sergeants training
- every officer having a specific and consistent supervisor
- the Sergeant who screens the arrest should be the Sergeant who reviews and signs off on any related report, unless circumstances don't allow it
- implementation of protocols emphasizing listening, respect and dignity in citizen interactions
- thoroughness in reporting what has occurred in an interaction so that all physical contact is described regardless of the level, and
- rigorous screening of incidents by the chain of command so as to improve practices, not just find technical compliance.

Complaint Review

Complaints of possible misconduct can be made in-person at the OPA office, over the phone, by email, fax, in writing, or via the OPA website. Complaints can be made by a supervisor, a fellow officer, the person who was the subject of the action, a person who observed it, a family member, or even someone who heard or read about an incident. A complaint can also be initiated by the OPA Director if information is brought to her attention. Once a complaint is made, the identified employee(s), relevant Captain and union are notified of the general allegation[8] within 5 days and advised that within 30 days from the filing of the complaint, per the Police Guild contractual requirement, a determination will be made as to how the complaint will be classified and what specific violations of policy are being alleged. One of the system improvements made during this reporting period is that these notifications now occur electronically, rather than by hard copy.

To ensure the complaint is properly classified within 30 days, the investigator doing the intake begins by interviewing the complainant.

[8] There are instances where a criminal investigation needs to occur that notification would not be appropriate.

For those complainants interviewed by phone, I have recommended that investigators ask at the beginning of the interview whether anyone else is present, and if so, to inquire whether that person is a possible witness, and then request the interview be conducted without others present. Asking that no one else be present when a phone interview is conducted is not a guarantee, but every attempt should be made not to taint testimony.

During the intake process, the investigator gathers or makes production requests for any available evidence, particularly evidence that might be "perishable" with the passage of time (e.g., a private business' video that is recorded over after a period of time or text messages that can get deleted). Evidence usually includes digital and documentary information such as In-Car Videos (ICVs), 911 tapes, dispatch information, shift schedules, training records, Taser records, holding cell or precinct video, phone records, medical records (after securing permission), private videos, demonstration management protocols, photos and so on. At this initial stage, all physical evidence and documentation based on the complaint information should be identified and steps taken to secure it, any possible witnesses identified and, if time allows, a site visit made (if not, this step will be part of the investigative plan if the complaint is classified for investigation).

Based on the preliminary investigation done during intake, the Lieutenant makes a recommendation as to how each complaint should be classified. All of this must be completed within three weeks so the Director and Auditor can then approve the classification and ensure notification to the employee occurs within the contractual time limitation of 30 days. A system improvement implemented at the beginning of 2012 was to simplify classifications. Each week the OPA Director and Auditor review all cases and either confirm the recommended classification or reclassify, determining whether each complaint should be investigated, handled by a supervisor, can be resolved without referral or might instead be successfully mediated.

A recommendation I made previously that still needs to be fully implemented by all investigators is to offer complainants in those cases classified for investigation the opportunity to have an in-person interview rather rely only on the phone interview. In-person interviews can provide additional value in credibility determinations and also help ensure OPA is endeavoring to be even-handed in its approach since named and witness employees are interviewed in-person. Non-employee witnesses (e.g., others at the scene, passengers in the car, EMTs, firefighters, nurses, business employees, bus drivers) should also be afforded the opportunity for an in-person interview.

It does appear that many complainants and witnesses prefer the convenience of a phone interview, and some even prefer just to provide information by email, so we want to take care

not to inhibit participation by *requiring* in-person interviews. They should be offered, and the record should then note whether an in-person interview was offered and declined.

In the period covered by this report, the OPA Director and I reviewed 343 new complaints alleging misconduct (this compares to 300 in the prior 6-month reporting period). We agreed with the initial classifications recommended by OPA staff for all but 5. For those we reclassified, 3 we changed from Supervisor Action (SA) to IS (Investigation); 1 IS to SA; 1 SA to criminal. The final classification results were 106 classified for Investigation and 237 classified as Supervisor Action. Fourteen cases were recommended for mediation (this was down significantly from 31 in the last reporting period[9]). We also reviewed 316 inquiries that had been entered by staff into the OPA "contact log". These are requests for information or assistance, which we review to ensure none involved possible misconduct or warranted supervisory attention.

In reviewing the initial complaints to determine how they should be classified for follow up, we added 10 allegations. These included 7 related to professionalism, 1 for failure to use In-Car Video, 1 for bias and 1 related to ticketing procedures.

I reviewed the quarterly reports of alleged misconduct being prosecuted criminally or considered for prosecution (e.g., DUIs or domestic violence allegations). I also reviewed the 231 SAs completed in this period to review the actions taken by the supervisors. Having the OPA Auditor also review completed SAs in addition to reviewing Investigations is a system change we implemented in 2012. SAs most often involve situations where officers are perceived as unprofessional - either rude, not listening or explaining well or not being thorough. The supervisor will review the incident at issue, speak with the complainant, speak with the officer, and if appropriate, coach, counsel or offer training. In some situations there is available video that shows the complainant's recollection is incorrect. For those we might request that either OPA or the supervisor allow the complainant to watch the video. In several instances where an interaction highlighted a concern or issue that would be beneficial to review with other officers, we requested roll call training also be conducted. SA's conducted during this period were by and large done by the precincts or units within the required turnaround time, but as of the end of the year there were 22 outstanding well past the deadline.

Investigation Review

An important aspect of the OPA Auditor's role is to review each investigation before it is closed to make sure all relevant evidence was gathered, interviews were impartial and thorough, best investigatory practices were used, and that the findings and analysis were objective and

[9] As mentioned in my last report, a separate analysis of the mediation program was conducted in 2012 with recommendations for changes which the Director will be discussing in her next report.

grounded in the facts. During this seven-month reporting period I reviewed 98 investigations (as compared to 102 during previous six months). The overwhelming number of intakes and investigations during this period were objective, thorough and diligently conducted. Sergeants taking complaints and conducting investigations were always respectful and professional, regardless of the nature of the complaint, interviews were well done and summaries were well written. Investigators were also receptive to feedback for future investigations.

Where an aspect of an investigation did not appear to be done as thoroughly as it should have been, most often it was that the investigator did not indicate in the record why something was not included, as opposed to the investigator not being thorough. Information gathered, or actions taken but not reported, can tend to discredit the objectivity or thoroughness of an investigation so it is important for an investigator to note if someone was not interviewed, or if a piece of evidence was not obtained, why not. For example, if a witness refuses to participate, the investigator needs to note in the file the attempts that were made to reach the witness and his or her unwillingness to be interviewed. Where a witness was not contacted or certain evidence not included, my requests for an explanation to be noted, or if appropriate, additional investigation be conducted, were followed up. On occasion where additional evidence, such as site photos or shift schedules, might have further substantiated the record, if the record was strong enough without it, I would simply raise the issue for enhancing future investigations rather than direct that more work be done. In a few cases, the investigative plan and preparation were not of the usual quality, or the investigator did not appear to have actively listened and followed up inconsistencies or gaps in interview responses. These were discussed with supervisors and additional coaching was done. The few investigations that were not well done are addressed in detail below.

One aspect of the investigations that I have previously raised that came up again in this reporting period is the importance of an investigator being able to ascertain what training the named employee had in relation to the actions at issue (Crisis Intervention Training or O.C. pepper spray training for example), when the training was taken and what the training included. If in fact the officer's actions were problematic, but he or she articulates that was how he or she was trained, having this information is fundamentally important to the investigation and any recommended findings. Without this information, it is difficult to conclude that actions were in fact consistent with training. Exacerbating this problem is that the Department has not always had standardized training curriculum, meaning that the training an officer received might have differed depending on the trainer for that class at that time. Where relevant, the investigator should ask the employee his or her understanding of the policy at issue, and then whether his or her actions were consistent with training. The investigator should also be able to reference a database or request information from training personnel in order to confirm the information provided by the employee. An online database for training, allowing employees to

do e-learning, and allowing for a current, complete record of who has taken what training and when, is something I have previously recommended. As SPD brings such a database online, the Department needs to make sure OPA investigators have easy access to the appropriate information.

The timeliness of the review and discipline process after completion of the preliminary investigation still needs improvement. OPA is to be commended for meeting the contractually mandated 180-day timeline, but as I have said before, that is not the measure of timeliness to which we should aspire. When investigators complete their work, those in the chain of command involved in the review and in the disciplinary process need to more quickly conclude cases, both for complainants and those against whom allegations are made.

Below are investigations for which I either asked for additional investigation, made suggestions for improving future investigations, where I disagreed with the findings, or that highlighted one of the policy or training recommendations noted above.

I asked that additional interviews be conducted and disagreed with the analysis done by OPA and the chain of command in a case that arose from an incident last spring where officers were responding to a call that threats had been made by one man against another at the building where both lived. This case provides a good illustration of different expectations for and philosophies about OPA's role versus the role of chain of command review or Use of Force Board review, and how much of a role OPA should play in ensuring best practices are used in addition to its role of assessing whether misconduct has occurred.

The first officer who arrived in response to a 911 call met with the victim down the street away from the building. This was an hour or more after the underlying incident had happened. The victim relayed that while he and others were in the building's common area, a male had entered and joined their conversation. The man reportedly "ranted that Jesus and Mohammed were black, Anglo-Saxons were changing history because they are rapists and thieves, and that the victim was racist, a rapist, and a thief, himself." The man added that he had been in jail but was unchanged, and that he was going to take the victim into the bathroom to rape and beat him up. He said he was leaving to get beer and then would really hurt the victim. The victim left the building and called 911.

After the second officer arrived, the first officer briefly explained that based on his interview of the victim, they had probable cause to arrest the suspect (the complainant to OPA) for felony harassment. The officers proceeded to the common area of the building, where they spotted the suspect walking out of the bathroom. According to the officers, the suspect ignored their request to stop and talk to them. As they described it, the suspect walked toward them as if he was going to walk right between them and out of the room. The officers grabbed the suspect's arms and a struggle ensued.

I felt that the investigative approach should have included further inquiry as to the fact that there did not appear to be any exigency in the situation and that possible alcohol and mental health issues were at play given what the victim told dispatch and the responding officer about the nature of the suspect's threatening language. As well, there were differences between the statements made during the interviews and information in the Use of Force report, witnesses who should have been interviewed in-person, questions asked of each witness as to their relationship, if any, with either the victim or the suspect that might affect their credibility or bias, as well as questions directly on the point of any observation of verbal attempts to diffuse the situation.

I also requested that the Sergeant be interviewed since he had screened the arrest and had written that the officers told the suspect to stop and he disobeyed, while one officer and some of the witnesses did not mention that in their interviews and the other officer said he did *not* direct the suspect to stop. The Sergeant and officers all could have been asked whether they had reason to think the suspect was intoxicated or mentally ill, and if so, how that affected what the preferred approach was. The Sergeant could also have been asked about his screening of the officer's decision to arrest for felony harassment, for which the filing standards did not appear to be met. The Sergeant also stated the officers needed to act quickly because the building was not "police – friendly", but was not asked what made it so and whether the officers were aware of that. Neither officer mentioned that rationale for needing to move quickly in their original interviews.

Both officers and the Sergeant could have been asked whether they were familiar with the suspect or others involved, whether they checked his history before deciding how to proceed, whether based on the victim's description of the harassing statement they felt the suspect was violent, whether they should have waited for backup, asked for CIT assistance or whether they were CIT-trained. Similarly, they could have been asked whether they needed to discuss their tactical plan before entering the building and interacting with the suspect since there was no immediate threat when they arrived. There were also discrepancies in the interviews of the officers and the Sergeant as to when they spotted a knife on the counter which was mentioned as the underlying rationale for needing to quickly control the suspect and take him to the ground.

The Use of Force (UOF) review by the chain of command appeared perfunctory, suggesting that the officers had no choice but to go in hands-on, not addressing any of these issues or the discrepancies among the various written reports, whether there was probable cause for the charge of felony harassment, and that the alleged threat occurred more than an hour before the officers arrived so there was apparently no exigency and officers could have called for an officer with Crisis Intervention Training or a Mental Health Professional to assist.

In my view, there was an opportunity to assess the tactical decisions, the screening of the arrest and Use of Force, whether the officers understood the legal basis for contacting the suspect and the lack of clarity in SPD policy as to when the Crisis Intervention Team or a Mental Health Professional should be called in to assist, and whether they should have been called in this instance.

I asked that the Operations Commander responsible for the UOF Review Board review this incident again, that any training include the Sergeant as well as the officers, and that the Professional Standards Section review existing protocols to more clearly address when officers should wait for CIT/MHP assistance.

Another case from last spring also involving a suspect/complainant with mental illness, multiple officers and Use of Force, provided another example of whether the screening Sergeant, the Use of Force Review Board and OPA all have a role in reviewing tactical decisions and best practices. I was concerned in this case that the officers were unclear as to whom the primary officer was and whether the officers "went hands-on" prior to verbal commands and prior to identifying themselves. Again in this case I felt the initial screening, the UOF review and the OPA investigation could have been more thorough and directed at specific issues of multiple officers physically engaging a suspect without clarity about which officer was making decisions, what kind of verbal communication had preceded physical interaction, what kind(s) of impairment the subject had, and whether the reporting was detailed and accurate. There was also a failure to note that property was mishandled, which we have seen happen in cases with multiple officers involved and a lack of clarity about roles and responsibilities at the scene.

During this incident, the suspect's face was pushed against the car hood and he was physically controlled in the holding cell. In my view, both constituted force that needed to be written up and reviewed. The UOF report did not mention either. It was also not clear that the officers identified themselves and attempted to talk with the suspect prior to physical contact. The Sergeant did not screen the arrest at the scene (although she did return the next day to do follow up interviews).

Officers were not asked whether they were trained in how to communicate when multiple officers use force and, if so, what the training and policy for those situations is. Fire Department personnel and the Sergeant involved also could have been interviewed. The Sergeant should have been interviewed as to why she did not screen the arrest at the scene, whether she noted that the General Offense Report property description didn't match the property entered into evidence, why the UOF report did not mention the pushing of the subject's head on the car or the actions in the holding cell, why the box for subject impairment wasn't checked in the UOF report, and whether the officers were clear who was the primary officer.

This was another case where I asked the Operations Commander and UOF Review Board to address the issues raised, particularly the thoroughness of UOF and incident reports, on-site screening practices by Sergeants, communications and clarity about primary officers when multiple officers use force, and reviewers assessing the entirety of the incident to consider whether there are tactical decisions that led to force or the amount of force being used.

A third case involved an allegation of excessive force that was not borne out but highlighted a Use of Force reporting issue I have raised before. Where officers and others screening an incident do not believe reportable force was used, they do not complete a UOF report. But officers are also trained never to detail force in their General Offense Report (GOR), the theory being it should instead be detailed in the UOF report. So if there is not a UOF report, any physical interaction not seen under policy as required to be reported – push, shove, take down, multiple officers grabbing arms to cuff – is not detailed anywhere – but a third party observer and the subject would likely consider that level of physical interaction to be 'force'.

In this case the officer whom the complainant had accused of unnecessary force did not reference in his GOR any use of a "counter-joint technique" or a struggle with the subject that arose when officers were dispatched to the Seattle Children's Home (SCH) regarding a disturbance. After officers addressed the disturbance and the youth was being led away by SCH staff, the youth had assaulted a staff member.

The initial Sergeant indicated he would write the UOF report, but another Sergeant was asked to do so instead. He determined that, because there was no reportable use of force, there was no need for him to interview the complainant or witnesses. He noted that ICV and audio of the incident existed and included statements from the officers involved. The incident was reviewed and approved by the Precinct Commander, UOF Review Board, and the Patrol Operations Commander.

After reviewing the preliminary OPA investigation, I noted that the reporting Sergeant had failed to provide the name and contact information for the nurse at Harborview who initiated the call or the two witnesses, that he did not speak with medical staff at the hospital when he was there to take the subject's complaint of injury and that his statement was not written until several days later. Also, there was no indication as to why the Sergeant and acting Sergeant, who both screened the arrest, or the witness identified by the reserve officer in his interview, were not interviewed. Some other more minor corrections were needed as well.

Though I agreed with the finding that the force used was Lawful & Proper, the case highlighted some deficiencies in the UOF review process. A new policy regarding UOF review and the roles of the various reviewers was issued after this incident.

A case originally recommended for classification as a Supervisor Action (SA) highlighted another aspect of the debate over the breadth of OPA's role that I have mentioned in previous reports.

Some argue that OPA's role is to address whatever complaint has been made and that to go beyond that is a "fishing expedition". My perspective has been that this approach is not consistent with public expectations with regard to accountability and also puts an unfair burden on the complainant to be able to articulate his or her concern in a way that comports with the Department's Policy Manual. I view OPA's role as having a responsibility to assess the entirety of the interaction at issue and follow up on any aspect of it that needs to be addressed, regardless of whether the complainant has noted it.

In this case, the complainant's initial statement seemed to infer other issues not directly alleged. She had alleged that she was standing in her front yard observing officers interact with youth suspected of a theft and that the officers were rude and unprofessional to her. I reviewed the In-Car Video (ICV), which showed a number of officers interviewing two African American teenage boys in the street (in front of a patrol car) in a residential neighborhood in response to a 911 call about a package having been stolen from a front porch by a group of boys. Watching the ICV, I had concerns about professionalism, including the appearance of "bullying" due to the number of officers interacting with the two juvenile subjects, the number of police cars on the scene, the race of the officers vis-a-vis the subjects, and the wearing of sunglasses, hands on hips or weapons, the verbal interaction with the juveniles and the complainant, and the apparent lack of oversight at the scene by the Sergeant. I asked that the case be reclassified for investigation, that allegations be added to cover the interactions with the juveniles in addition to the complainant, and that other officers on the scene and the Sergeant be named so that everything could be addressed.

I asked that the investigation look at the nature of the officers' interaction with the juveniles (there was reference to strip searches, officers' comments along the lines of "You deaf?"; "pussy/going to cry now?" and so forth), how the bystander/witness (the complainant, also African American) who was concerned for the youths' well-being was treated (that no one, including the supervisor, asked her what her concerns were and instead saw her simply as a loud, interfering person to be directed away), the apparent lack of a Miranda advisement, and the totality of the interaction, including the role of the supervisor.

It appeared that there was not an investigative plan reviewed at the assignment of the case that addressed these issues. The case was then reassigned to a different investigator late in the process (due to a staff change), at which point the investigative plan was apparently not reviewed with the new investigator. As a result, the investigator focused only on the possible use of profanity and rudeness in the interaction with the complainant, which is what she had originally alleged.

Regarding the interviews, if one agrees that the role of OPA is to address the totality of the interaction and help improve practices of officers and supervisors, then the officers should have

been shown the video and asked whether their interactions were professional, whether they saw any problems with the way in which they interacted with the teenagers, if, or when, they gave a Miranda advisement, and whether there was timely parental notification.

They also should have been asked whether they could see what might have led the complainant to come out into the yard to ask what was happening and whether they could have taken other steps to understand her concerns. To the contrary, one officer commented that the neighbor/bystander/complainant needed to be treated the way she was because she was a possible threat, that she could be "calling in all her buddies." That is precisely the kind of assumption (often then leading to tactics that lead to escalation) that should have been pursued in the interview.

Also needing to be addressed in the analysis and final disposition were verbal comments by officers to the juvenile subjects, including one officer's self-described banter about "black people being good runners", the threat to strip search the juveniles as a way to try to get them to talk, and an inappropriate comment in the interview made by the Guild representative.

Regarding the allegation of profanity, the named officer stated in his interview that he spoke with other officers who were at the scene and "none of them" heard him swear. He was then asked which officers were those, and named only one officer. It should also have been noted that all employees are specifically ordered not to discuss OPA investigations. I noted there were several leading questions or questions where the investigator provided the information and informality in email correspondence and interview that was not appropriate in tone and content. Additionally, the Sergeant should have been named and interviewed and the issue of supervisory responsibility formally addressed by OPA.

A case involving use of pepper spray at a demonstration/street party highlighted the system recommendation noted above for the need to have an objective and expeditious way to ascertain what training an officer has had so as to be able to determine whether his or her actions were consistent with the training (and thus whether perhaps it is the training that needs to be addressed first and foremost). The complainant also alleged that there were batons used, shoving occurred, an officer said "stupid Dyke" and an officer refused to explain how to file a complaint. One concern was that the incident occurred soon after the Department had announced that as part of its 20/20 plan, policies governing use of pepper spray in demonstration management would be changed. The way in which the pepper spray was used in this case did not appear to be consistent with what the Department articulated. However, at the time of the incident (June 2012), the Department's demonstration management policy had not been revised. A new policy was issued the following October.

While the investigative interviews of the officers at the scene were thorough, I asked whether it might help to interview training personnel, show them the video and ask whether the use of

pepper spray was consistent with training and tactical considerations for that type of incident. Secondly, the review notes of those supervisors in the chain of command who had reviewed the force had seemed to indicate that they thought the actions were outside of policy, so they needed to be interviewed. The Captain was then interviewed and stated his notes were not intended to indicate that he believed the officer acted outside policy, but instead were intended to reflect his concern that the two sets of policies governing demonstration management and UOF created ambiguities. Also raised was that the individual who used the force was a Lieutenant who gave direction to the Sergeant who wrote the UOF report, so that is why the Sergeant did not order him to provide a statement. I expressed concern as to how that approach to review of force (where a Sergeant is reviewing the conduct of a superior and not able to require a statement from him) could be considered robust, thorough or appropriate.

The issues identified by this incident were to be further reviewed by the Use of Force Review Board and the Professional Standards Section to address these problems.

Failure to complete an accident report was at issue in a case where two officers responded to a traffic accident involving a bicyclist and a car, gathered information at the scene and then one of the officers completed a Police Traffic Collision Report (PTCR). The call was cleared indicating there had been an accident investigation, a report taken, and a traffic citation was not issued. The bicyclist made several requests to obtain a copy of the accident report for insurance to cover his medical costs, including calling the Sergeant, and never received a response. He filed an OPA complaint about the failure to write a report. The named officers were interviewed, but I requested that the Sergeant to whom the report had supposedly been submitted also be interviewed. Those interviewed stated that the collision report had been written and put in a box for a Sergeant to review. The Sergeant stated that he never saw it. It apparently was lost at some point and one of the officers wrote another PTCR a month later.

The Department should generate these reports electronically, instead of in hard copy. This case also provided yet another example of why each officer must have a single, clearly identified supervisor who works the same schedule as the officers they supervise.

In this instance, minor as it was, the Sergeant the bicyclist called to find out what had happened to the report had no knowledge of it and was not able to answer questions about why no citation had been issued. I have recommended in prior reports that the Department require either the Sergeant screening an incident or the supervising Sergeant to be the Sergeant who reviews and signs off on any related report, unless circumstances do not allow it.

Several cases highlighted the problems presented by the contractual requirement that when a complaint is made to OPA that might involve criminal conduct, OPA must first refer it to SPD's Criminal Investigation Bureau for the criminal investigation, is not allowed to communicate or cooperate in that investigation, and only when that investigation is complete can OPA begin its

investigation.[10] In my view, this process can and has resulted in delayed and at times less thorough investigations given the competing demands of other investigations already ongoing in those units; and, ironically, these are cases where if the allegations are true, the violations would be more serious than those over which OPA has complete investigative control.

In one case, the named officer, now retired, was in a King County courtroom observing proceedings related to a burglary at his house. The complainant in the case had been listed as a "subject" in the follow up report regarding the burglary. He was in the courtroom with family members regarding his arrest for a different burglary. He and his family members were sitting in front of the officer. The complainant and witnesses stated that the officer whispered to him to "keep smiling" and "If you (the complainant/burglary suspect) go outside I'm going to kill you and choke you to death." The officer also took a picture of the complainant and family and was in a section of the courtroom reserved for on-duty officers. The Department's Criminal Investigation Section investigated the alleged threats, and the King County Prosecutor's Office reviewed the case, concluding "that the facts would not meet their filing standards for a charge of either felony or misdemeanor harassment." The officer, having since retired, would not provide a statement to OPA.

I was concerned about several aspects of the investigation. There was no indication in the follow up or summary as to why the father and sister who were identified in the complainant and witness interviews as having heard the alleged threat were not interviewed. Similarly, neither the witness nor the prosecuting attorney were asked for the name of the defense attorney whom they identified as having been immediately told of the alleged threat and then discussing it with the prosecuting attorney. Nor was there any indication of why the defense attorney was not interviewed. The Courthouse sign-in sheet was included as an exhibit, and stated that only officers on official business may keep their weapon; while officers on personal business must check their weapon. Since at least two witnesses testified that the named officer was wearing his weapon on his person in the courtroom, I asked that the file indicate whether this exhibit had any bearing on the question of whether the named officer was acting in an official capacity at the time of the alleged threat. Likewise, whether the hours/time worked file for the named officer had bearing on whether he was on or off-duty, given his shift hours and his rank. There were some other issues, including that it did not appear that either the complainants or witnesses were offered the opportunity of in-person interviews by OPA. Both complainants were together at the time of the telephone intake, a problem noted previously.

[10] And because the referral by OPA is internal to SPD, the contractual limitation of 180 days to complete the investigation continues to run, meaning OPA is permitted only to use whatever time is left within that window to complete their investigation.

In another case, the complainant, whom the named officer had arrested, alleged the officer seized from him at the time of his arrest a state-issued Electronic Benefits Transaction (EBT) card and used the card on multiple occasions to fraudulently obtain cash. The Department's Fraud, Forgery, and Financial Exploitation Unit conducted a criminal investigation and concluded there was no evidence of any misconduct by the named officer. They took so long with the case that the 180-day deadline was missed[11]. The totality of their investigation was to determine that the officer could not have done it because some of the fraud occurred prior to the officer arresting the complainant and the complainant being in jail. While those facts did undermine the details of the complainant's allegation, that certainly was not conclusive. OPA received the case back and through a GPS analysis determined conclusively that the officer was on duty in other parts of the city at the time the EBT card transactions occurred.

The allegation in another case was that the complainant was stopped for a drug transaction, the officer took $2100 from his wallet and said he was taking it as part of the drug forfeiture. The complainant said he was not arrested, he was given a business card by the officer but lost it, and refused to cooperate with OPA after the initial allegation was made. He was not clear whether it was an SPD, King County or other officer. At a minimum, the criminal investigation should have included a search for video nearby to see if the complainant was where he asserted he was, or perhaps show him a photo montage of possible officers to see if he could identify the officer, refused to identify the officer, or picked out someone whose description did not match his allegation. The interview as part of the criminal investigation of the Sergeant who supervised bike officers in that location was not thorough. And the possible State Patrol officer was not interviewed at all (a supervisor asked him about it and he said it was not him, so no interview was conducted by the criminal investigators).

For a case involving an allegation of possible sexual assault of a minor in another county, I felt that the criminal investigation was not sufficiently thorough with regard to the mother, who had not been asked whether and when the daughter may have told her of inappropriate touching as had been alleged by the daughter, and that the officer needed to be re-interviewed. The resulting additional interviews were done, but several months had since passed and the allegation was neither proved nor disproved.

A search of a home was at issue when officers were dispatched to a call from a teenager reporting she had located her missing cell phone (via a GPS tracking device) at the neighbor's house. The complainant was the homeowner and mother of the 15-year old girl who was at the house when the officers arrived. The complainant was not there. The officers spoke with the daughter about the missing cell phone and entered the house without permission. Both the Director and I were concerned that there was insufficient evidence to support a warrantless

[11] Since the allegation was proven to be unfounded, missing the 180-day deadline did not affect the ability to impose discipline.

search under the circumstances of the case. Both officers said they suspected that the young people who were in house might have been trespassing, and stated that provided a basis for entry. Neither officer identified an emergency or other exigent circumstance. The line of command that reviewed the case also felt that the search was proper, which led to a decision not to sustain the allegation against the officers, but instead direct training referral for the officers and a precinct-wide training.

In a case where two SPD officers were helping King County Metro Transit Police deputies respond to a report of an assault on a Metro bus driver, the officers arrived after the deputies had already taken the suspect into custody, for allegedly assaulting the bus driver. One officer assisted the deputies in placing the suspect into the backseat of the deputies' patrol vehicle. It was later alleged that the officer punched the suspect in the face while he was in the backseat. The physical evidence (the suspect's bruises were on the side of the face that was facing away from where the officer allegedly punched him) indicated the injuries likely occurred during the physical altercation with the deputies taking the suspect into custody on the bus prior to SPD officers arriving. It would have been helpful for the investigator to try to enhance the available video/audio. Also, given the number of interviews, this would have been a good case to lay out in the summary each of the significant points made in the interview statements, the physical layout of the subject in the car and note whether the named officer was left or right-handed.

In a case stemming from a traffic stop where the In-Car Video (ICV) was turned off after having been on both before and after the incident, I requested that the investigator add an exhibit providing evidence as to the officer's ICV training and note in the case summary that the officer acknowledged in his interview that he never updated his Mobile Data Terminal (MDT) with ICV information and often did not upload ICVs at end of shift.

For a complaint involving a pedestrian who felt the officer over-reacted when the complainant walked near a construction area, one of the issues was that the complainant had not noticed the signage due to it being hard to spot. The investigation could have been further improved by including photographs of signage at the construction scene and a site map, in addition to the interviews. Because there was otherwise enough evidence without it, and the complainant, pleased with the follow up that had already occurred did not want mediation or further investigation, I did not require it but instead recommended the investigator be aware of the potential value of photographic evidence and site visits in future cases.

Where two officers had interacted with a 16-year old youth downtown at 1:00 am who had called 911 to report someone had grabbed his cell phone, I wanted the investigator to address whether any effort was made for parental notification. The investigator should have inquired as to the officers' understanding of Departmental policy regarding the obligations for notification, as well as inquired about the lack of clarity as to who was the primary officer, and when the

writing of a GOR or other update and use of ICV is required. Additions were also needed in the case summary, including highlighting inconsistencies between interview statements. I also asked that the investigator request and include relevant information from the appropriate technology or fleet personnel since one of the officers stated that the problem was due to this particular vehicle.

This was one of the first interviews this investigator did, so additional feedback from the Lieutenant included how questions that were asked in a leading manner could have been asked differently, how not to suggest rationale for the interviewee's actions (or non-actions), to take care not to interject comments, the need to follow through on a series of questions to get a specific answer when responses are vague, and the need to make sure officers are always asked what their understanding of relevant policy is and whether in their view their actions (or non-actions) were consistent with policy (and if not, why not).

In a case where there was a witness seated on either side of the subject at the scene who later alleged excessive force was used, the file indicated the investigator had made two calls to try to reach the second individual, and had also asked the complainant for any other way to reach him. But there was no mention of the third individual or attempts made to contact him. The complainant had said in his interview that he did not know who the third person was, but the officer had noted his name and contact information in the report. At my request, the investigator followed up, but the third individual was unwilling to speak to OPA.

A parking enforcement officer (PEO) was the named employee in case where the complainant felt the PEO had behaved unprofessionally[12]. The investigator interviewed the complainant and the PEO, but the business owner at the site had also mentioned that others had complained about the PEO and might be willing to talk with OPA. The investigator had asked the business owner to have any of these possible corroborating witnesses contact OPA. When none did, the preliminary investigation concluded with just the interview of the PEO and the complainant. I requested that the investigator follow up again with the business owner, and an additional corroborating witness provided a statement.

I disagreed with a finding of Training Referral in a case involving an allegation of mishandling property. I would have sustained the allegation, based on the officer’s actions of placing the complainant's wallet on a retaining wall ledge above his head where he could neither readily find it nor control it, as opposed to putting it directly into his hands or pocket, particularly given the complainant’s level of intoxication.

In two cases during this reporting period, one involving accessing a database for personal use and one involving notification of parents where a minor was involved, the incorrect manual

[12] Normally a complaint of rudeness would be referred for Supervisor Action rather than for an investigation, unless there is a more serious concern, or the employee has a history of complaints.

sub-section was cited in the notice to the officer so discipline could not attach, per the contract with the Seattle Police Officers Guild (SPOG). Training was ordered in each case. And in a third, the 180-day deadline also mandated by the contract was missed with regard to a DUI allegation because of an incorrect date used for the entry of the court judgment. The allegation was sustained and the Department took steps to address the issues via a settlement agreement.

A case that involved a required strip search at a precinct was referred to the Professional Standards Section to see if the Department needs to update its procedures and/or training on how to conduct these types of searches because the supervisors who had been interviewed stated there is only a general understanding of the approach to be taken. And a case alleging that a PEO worked an off-duty flagging job on a furlough day, which was bracketed by 3 work days she reported as sick time, highlighted the need to clarify that particular policy.

Other Auditor Activities

In addition to the work discussed above, during this reporting period, I also observed a training on "Race: the Power of an Illusion" led by the City of Seattle Office for Civil Rights. This training is part of the Race and Social Justice Initiative training for all City employees, but was done with SPD officers and members of the community together at a community facility.

I also observed a new impact weapons training held at the precincts. The Department is using a shorter training module approach that allows a trainer to be at the precinct throughout a shift for small groups of officers to cycle through. This makes it possible for more officers to attend without pulling them off the street to attend an off-site training. The focus of the training was how to use batons. While the training was intended to emphasize the techniques for proper use, I would have preferred to see that each training module begin with a reminder of the importance of verbal de-escalation skills and the factors to consider prior to using this weapon, before explaining proper techniques and impacts.

At the Washington State Criminal Justice Training Commission, I observed a training hosted by the Commission and the King County Sheriff's Office on essential interaction skills for law enforcement. The training included several real-world scenarios that provided participants an opportunity to see the effectiveness of good communication skills both for resolving problems and for officer safety.

Finally, I attended the annual conference for the National Organization for Civilian Oversight of Law Enforcement (NACOLE), which had a number of excellent presentations, including an examination of police response to public protests, a workshop exploring oversight practices in response to critical incidents, a review of officer-involved shooting investigations, federal intervention in local policing and the legal implications surrounding use of social media.

OPA Auditor Semi-Annual Report
June – December, 2012
Appendix A: OPA Auditor Recommendations as of Dec 31, 2012

	Recommendations – Training & Human Resources	Date Recommended
1	Return to the unity of command approach to shift assignments (rather than the in-squad relief system) so that Lieutenants and Sergeants are working together with their officers regularly, and that every officer has an assigned and consistent Sergeant.	1st Q 2011
2	Clarify what Sergeants are expected to do, for what they will be held accountable and how success will be measured. Provide necessary tools and training for priorities such as Use of Force (UOF) review; probable cause to stop; search & seizure; verbal communications skills; obligation for an officer to identify him/herself; best practices for use of ICV; review of General Offense Reports (GORs); screening arrests; and how to address problems in performance.	1st Q 2011
3	Develop opportunities for mentoring and transition of knowledge as those with expertise across the department retire.	4th Q 2010
4	Look for other ways for newer officers to be less isolated and have additional coaching and mentoring during first year.	2nd Q 2011
5	Develop ways to better utilize exemplars in the Department to mentor, coach and increase opportunities to share and highlight best practices.	1st Q 2011
6	Supervisors, command, field training officers (FTOs) and training staff should use In-Car Video as a teaching tool for individual officer coaching; roll-call and departmental scenario training, performance appraisal, review of force, promotional and hiring exams and other learning opportunities (and not limit its use to disciplinary investigations).	4th Q 2010
7	Review recruiting, hiring, testing and promotional criteria to ensure each is aligned with most important skills sets needed based on issues and trends seen by OPA, FTOs, training personnel, supervisors and command (e.g., communications skills, judgment, maturity, empathy).	4th Q 2010
8	Review hiring and promotional practices so that judgment, performance and skills are the prerequisite to testing, not the other way around, and that those without the requisite skills are not promoted, regardless of test scores.	4th Q 2012
9	Implement a standard practice for a robust information-sharing loop among training, hiring, recruiting, legal, OPA, H.R., Law Department, Precinct and command staff to maximize use of what each is seeing, spot trends, red flags and needed adjustments for training, hiring and promotions.	2nd Q 2011
10	Follow up on post-investigation employee reviews at the Precinct level with supervisors and command staff to assess what intervention has been done to date, effectiveness, and any suggested changes to recruiting, hiring, FTO training as a result.	2nd Q 2011

	Recommendations – Training & Human Resources	Date Recommended
11	Implement more swiftly and report out with clarity promised training enhancements. For each training, report when it is actually starting, who is taking it, what the deadlines for completion are - e.g., LEED, Sergeants' training, BLEA changes, Street Skills, on-line training, roll call scenario training; adolescent-focused /brain development training; DARPA, etc.	1st Q 2011
12	Work with executive and legislative branches to implement strategies for creating a segregated hiring budget to allow for year-to-year consistency in hiring at least 6-8 new officers and minimize bow-waves that can diminish ability to get best qualified personnel, result in a disproportionate percentage of newer officers in patrol or result in pressure to retain new recruits despite red flags.	2nd Q 2011
13	Reinstitute the policy regarding conduct unbecoming (CUBO), to address off-duty issues as well as performance concerns that do not fit neatly into a specific policy, but clearly reflect less than best practices.	4th Q 2010
14	Command staff should more quickly acknowledge and take appropriate steps when possible misconduct does occur; and better communication with the public about institutional changes that have been or are being made, even with required confidentiality of OPA investigations.	4th Q 2010
15	Centralize and modernize the Department's secondary employment system.	4th Q 2010; 2nd Q 2012
16	Clarify Secondary Employment Policies as to whether a permit is required for secondary employment in a non-law enforcement capacity and issues of permits for retired personnel.	4th Q 2010 (and 2008)
17	Clarify Secondary Employment Policies with regard to secondary employment obligations for civilian employees, including the prohibition against owning a private security firm.	2008 & 3rd Q 2011; 2nd Q 2012
18	Clarify policies with regard to any employee who owns and/or operates a traffic scheduling company to which he subcontracts and then is paid to flag as off-duty officer.	1st Q 2012
19	Review the Department's Illness and Injury Policy to clarify 1) whether all volunteer activities are prohibited; and 2) the hours employees are expected to remain at their place of recovery when out on sick leave.	4th Q 2010
20	Clarify the retaliation policy to ensure it covers retaliation for actions beyond the filing of an OPA complaint not otherwise covered by EEO policy and clearer delineates which types of workplace cases will be EEO as opposed to OPA investigations.	2nd Q 2012

	Recommendations – Training & Human Resources	Date Recommended
21	Re-issue a directive as to the duty of all employees to report to their supervisor changes to their driver's license status pertaining to expiration, revocation and/or suspension, along with noting the other bases for which reporting is required.	1st Q 2011
22	Clarify the policy with regard to wearing of SPD attire in personal I.D. photos such as a driver's license or passport.	1st Q 2011
23	Clarify the policy with regard to use of a Precinct address for a driver's license.	1st Q 2011
24	Clarify the policy with regard to presentation of an SPD I.D. when an officer is stopped off-duty.	1st Q 2011
25	Create a database of exemplary GORs, search warrants, etc. for easy use by officers (or other mechanism to help improve quality as needed).	2nd Q 2011
26	Provide notebooks in the field for officers ('green notebooks' as used to exist prior to electronic version) in addition to electronic version to make it easier for officers in their cars to look up most frequently used SMC, RCWs, etc.	2nd Q 2011
27	Implement an electronic database with accurate, comprehensive information of each officer's training history.	4th Q 2012
28	Change the Basic Law Enforcement Academy training for new officers where it is inconsistent with Seattle's training and practices, particularly with regard to Use of Force, or if SPD remains unable to have the necessary changes implemented due to the statewide nature of the training, much clearer and stronger articulation from SPD command about what practices are not to be used despite the Academy training.	4th Q 2012

	Recommendations – In-Car Video	Date Recommended
1	Implement ICV best practices. Maximize use of ICV so that it provides useful evidence as frequently as possible. Make sure Sergeants are clear they are to ensure ICV is used as it should be and they are to do quality review (as they are supposed to do in reviewing GORs). Address technical and training issues. Clarify policy. Use ICV as a scenario training tool.	4th Q 2010
2	Move forward with best practices for use of ICV - address training, policy and technical problems that are now well documented, make it clear to officers and Sergeants what is expected.	1st Q 2011
3	Officers should note in GORs that there is an ICV that provides visual and/or sound as required and if not, why not, i.e., to explain if there is a good rationale up front so OPA doesn't have to include an allegation and then investigate. (e.g., this incident was not ICV-recorded because…)	2nd Q 2011
4	Officers need to note in their GOR which officer recorded the ICV to make it easier to find it.	2nd Q 2012
5	Finish training all officers who are still not ICV-trained as of 2012.	2nd Q 2012
6	Consideration should be given to a requirement that officers turn off car radios (i.e., radio stations, not dispatch) when the ICV is activated for purposes of citizen interaction and transport of subjects who have been arrested. There are two reasons for this: 1) it interferes with the ability to hear what is being said, which then allows an officer to say he or she did turn on the ICV, even when the audio is then not useful; and 2) it can diminish the professionalism of the officer when he or she is transporting a subject.	2nd Q 2012
7	Issue a directive and make clear in policy that officers should not be using any DOC van that is not ICV-equipped while partnering with DOC.	1st Q 2011
8	Add to ICV technical issues list the issue that when Sergeants log-in while at the Precinct and then get in a vehicle, some believe the ICV system doesn't record them as logged in as it would have if they logged-in via the vehicle MDT.	3rd Q 2011
9	Add to ICV technical issues list the issue that if the vehicle is off for 45 minutes or more, the ICV can turn off automatically, and then it takes a while to boot up so may not be usable quickly.	1st Q 2012

	Recommendations – Use of Force	Date Recommended
1	UOF policies & training need to be consistent with community norms, which have evolved. The Department needs to modify the Academy training philosophy about force, with its command & control emphasis. The Department also needs to change the way it reviews force and ensure the policy encompasses actions leading up to the force being used. Technically the action may be consistent with policy, but did the officer make decisions and conduct him/herself in a way that created the situation that then required the force? Did the tactical decisions reflect problem solving, judgment, waiting for back-up, explaining reason for stop, empathy, listening skills, etc. What is the public safety problem being addressed and were there better alternatives?	4th Q 2010
2	UOF reporting needs to be accurate, thorough and ensure that the force that is used is per best practices. The Department should conduct an audit based on types of charge (e.g., obstruction) for accuracy and under-reporting. The Department needs to do this for cases beyond those seen in OPA since what OPA sees is only a small sample of all incidents where force is used.	4th Q 2010
3	SPD officers are trained that any force used is not to be detailed in the General Offense Report (GOR), but instead in the UOF report. But the current UOF policy sets the threshold for submitting a UOF report to be those interactions deemed likely to have possibly resulted in injury, in fact did result in injury or the subject complained of injury. If the physical interaction does not rise to this level, a UOF report is not written. In effect this means that where the resistance was not deemed to qualify as reportable force, it may not be described anywhere, including what the resistance was, what actions the officers took to make the arrest, how many officers it took and so on. Wherever the threshold is ultimately set, the GORs must thoroughly and completely describe what occurred to the extent the information is not provided in a UOF report. The GOR should not simply state 'subject was arrested', as opposed to 'subject refused three commands to get on the ground, I grabbed his arm and forced him to the ground, used my knee on his back to hold him there. When I was unable to get his arm out from underneath his body to handcuff him, Officer Smith assisted by...'. There should not be any gap between what actually occurred and the totality of the reporting (whether in a GOR, UOF report or other documentation) and the thoroughness of reporting should not be affected by which report is used.	2nd Q 2012

	Recommendations – Use of Force	Date Recommended
4	The UOF review by OPA as to whether the force used was appropriate and reasonable should always include assessing whether other options involving either no or less force did not exist, all steps and actions taken preceding the actual force were consistent with best tactics and policy. There should be a burden on the officer to describe the thinking and actions that led up to the force needing to be used. If other reasonable options existed for different decisions or actions preceding the use of force, they should be noted.	2nd Q 2012
5	Officers should always be required to write an ancillary report that describes the force used by a King County sheriff, State Patrol or other agency. Current policy is that no UOF report is written if another agency is the lead agency for the arrest. Without this obligation, an interaction can involve multiple officers and there is no report of what occurred by SPD officers who are involved. Again, this can leave the impression that officers are not being honest or thorough, and if there is resistance to a stop or an arrest, there is not a record that can be used for investigative, trial or performance review purposes.	1st Q & 2nd Q 2012
6	Continued need for training for ensuring officers know who is primary on site and best communications tactics when multiple officers are using force.	3rd Q 2012
7	Supervisors need training in how to conduct a UOF investigation to ensure the officer's UOF was appropriate.	2nd Q 2011
8	SPD policy requires each arrest to be screened by a Sergeant and each incident report (GOR) and UOF report to be signed off by a Sergeant. Officers often have a different Sergeant sign off on the incident report than the Sergeant who screened the arrest. Unless circumstances require otherwise, the Sergeant who screens the arrest should be the one to review and approve the GOR and UOF reports and the Sergeant should screen the arrest at the scene.	2nd Q 2012
9	UOF reviews by chain of command should include watching ICV of the incident to ensure consistency between the ICV and the written reports.	1st Q 2011
10	The UOF chain of command review form includes this statement above the signatures for the supervisors in the chain of command "I reviewed the Incident Report, Hazard report, Officer statement and Use of Force statement. Given the facts of the incident and the actions of the suspect during the incident it is my opinion that the Force Used was appropriate and within The Department's Use of Force Policy." Review of the In-Car or On-Person video is not listed as required and should be.	2nd Q 2012

	Recommendations – Use of Force	Date Recommended
11	Each incident report also includes an "incident narrative preliminary investigation summary", where the officers are required to check off what additional information they have submitted, including In-Car Video, photos, and various other reports. Officers are not using it consistently and it does not include any indication of whether a UOF report has been submitted. This should be included.	1st Q & 2nd Q 2012
12	Officers are not consistently following policy that they should submit digital photo discs to the lab after they make hard copies of photos for UOF reports.	4th Q 2011
13	The final UOF report that has been reviewed and approved - or not - by the UOF Review Board and all required reviewers should be included in every investigative file for OPA UOF cases. Because it takes time for the UOF review process to occur, the UOF report provided to OPA at the beginning of an investigation is often just the initial report and does not reflect the results of the review process. Whether supervisors thought the review was within policy is relevant, although certainly not determinative, so the complete record should be provided to OPA.	2nd Q 2012
14	Clarify protocol for when officers are to call/wait for CIT-trained officer or Mental Health Professional (MHP) to assist.	3rd Q 2012
15	Eliminate ambiguities with regard to UOF and O.C.(pepper) spray between UOF and Demonstration Management policies.	3rd Q 2012
16	Do not allow Sergeants to conduct a UOF review involving someone of a higher rank.	4th Q 2012

	Recommendations – Searches	Date Recommended
1	Ongoing recommendations as noted previously for additional training of officers and Sergeants with regard to search and seizure laws, Terry Stops, etc. to improve understanding.	4th Q 2012
2	Clarify the policy that requires all search warrants be screened and approved by a permanent Lieutenant. The policy is unclear as to arrest warrants involving non-consensual entry into private property and whether they can be screened by a Sergeant.	2nd Q 2011
3	Review the Consent to Search Form which is directed at searches of residences and vehicles and not at the street level, where a consensual search of personal property might take place.	4th Q 2010
4	Clarify policy for officers to document and screen residence searches involving warrantless, exigent circumstances. Policy should be clearer that a supervisor must be notified where officers determine that they mistakenly enter an individual's home and detain the occupants, even if only briefly and no other action occurred.	4th Q 2010
5	Ensure implementation of best practices for vehicle searches and safe storage of evidence; conduct re-training on proper evidence recovery techniques; and reduce the amount of time it takes to process vehicles taken into custody for a search warrant.	3rd Q 2011

	Recommendations – Domestic Violence	Date Recommended
1	Emphasize DV training in Street Skills or other regular training.	4th Q 2010
2	Develop a directive that, if in doubt about the need to report a potential DV situation, officers should always err on the side of documenting the incident. While making sure updated department-wide training on DV investigations is being provided through Street Skills (see above), the Training Unit should consider the feasibility of coordinating with the DV Unit to develop a video on primary investigative techniques that can be used for more immediate training.	2nd Q 2011
3	Clarify the policy with regard to the requirement that officers complete a GOR on *all DV calls* because the policy says "officers shall complete a GOR for all DV '*crimes or allegations*' ".	4th Q 2010
4	Re-issue the DV investigation protocol.	4th Q 2010
5	Issue a directive or include in training cultural issues that can arise in DV investigations.	4th Q 2010

	Recommendations – Information Technology & Communications	Date Recommended
1	Clarify public disclosure obligations, provide additional training for relevant staff and implement departmental practices that are consistent, timely and understood for public, media and litigation requests so as to improve responsiveness and transparency.	1st Q 2011
2	With regard to employees posting on sites, develop a social networking policy along the lines of "employees will not post items or information that may adversely affect the morale, confidence and public respect of the Department" (to whatever degree is allowed by current federal case law).	1st Q 2011
3	Clarify the policy with regard to Media Relations/Personnel Authorized to Speak to the Media. Though there is a prohibition against anyone other than the Chief or his designee speaking to the media about Departmental goals and policies, SPD policy recognizes that employees have free speech rights and can express opinions as long as they are identified as the speaker's. The policy should provide explicit language as to when an employee may or should speak with the media (or may not), and clearly delineate when chain of command authority is required.	3rd Q 2011
4	Clarify the policy with regard to Communication and Confidentiality/Representation of the Department. Employees are prohibited from expressing opinions that could be construed as representing the Department or Chief and only employees at the rank of Lieutenant or above can comment to the media on behalf of the Department. Yet, all employees are allowed to express their opinions about Department policy so as long as the opinions are clearly identified as belonging to the speaker.	3rd Q 2011
5	Move from hard copy to electronic Patrol Traffic Collision Reports.	4th Q 2012
6	Work with City Fleets with regard to need for vehicles to be left running in order not to have to re-boot equipment and seeming inconsistency with City's sustainability objectives.	4th Q 2010
7	Clarify officers' responsibility to input vehicle number when logging in so investigators and supervisors can more readily determine they were at a particular call.	4th Q 2011 & 1st Q 2012
8	Address the problem of officers not logging into the Computer Aided Dispatch (CAD) system using vehicle I.D. or logging out vehicles on a Precinct vehicle log in order to avoid GPS in their vehicles.	1st Q 2012

	Recommendations – Office of Professional Accountability	Date Recommended
1	Integrate into complaint review the EIS information, in addition to the OPA-specific history, with regard to the named employee.	4th Q 2010
2	Streamline the classifications & finding system so it is less cumbersome, easier to understand and shortens the time needed to resolve complaints in a way that is responsive to complainants and respectful of officers -streamline process, reduce number of classifications, re-name and re-define.	4th Q 2010
3	The role of OPA should not be limited to determining whether the particular alleged misconduct occurred, but to use what is learned through the complaints that are filed to help the Department ensure best practices in policing are used. The OPA Auditor and Director each issue reports and make policy and practice recommendations through the complaint certification process, but OPA could play a more robust role in by utilizing a best practices review approach throughout.	2nd Q 2012
4	Clarify roles and responsibilities between the newly instituted Use of Force Review Board and OPA for reviewing Use of Force tactical decisions and best practices in cases where possible misconduct is being investigated by OPA	4th Q 2012
5	OPA should update and enhance the training manual, new investigator and supervisor training, and provide orientation for OPA investigators, supervisors and intake personnel before they start. All should have same knowledge of best investigative practices, methods to obtain evidence unique to IS investigations, protocols for case processing and communications, the role of oversight, etc.	4th Q 2010
6	OPA needs the authority to compel testimony from witnesses other than officers for the production of key evidence such as texts or phone records from private cell phones, videos from private businesses or bank records.	2nd Q 2012
7	Assess obstacles to more frequent use of mediation.	4th Q 2010
8	The Department policy with regard to the complaint process needs to be updated to reflect the current process.	4th Q 2010
9	Create a tracking mechanism to make sure cases are timely transferred from other jurisdictions, prosecutors or other SPD divisions after criminal investigation or trial is completed.	4th Q 2010
10	Change the contractual requirement that complaints alleging criminal misconduct must be referred out to another unit of SPD and that no coordination, communication or concurrent investigation is permitted. (This separation was recommended by the Police Accountability Review Panel in 2008)	3rd Q 2012

	Recommendations – Office of Professional Accountability	Date Recommended
11	The administrative investigation should proceed unless there is a clear reason to wait for the conclusion of the criminal case. OPA should establish a protocol of referring cases simultaneously, rather than sequentially, to the County Prosecutor and City Attorney for possible criminal charges. Also, OPA should provide a deadline to the prosecutor for a filing decision, indicating that if a decision is not made by a date certain, the OPA administrative investigation will proceed. (The sequential approach was recommended by the Police Accountability Review Panel in 2008)	4th Q 2010
12	OPA should enhance its use of the AIM computer system for management, analysis and reporting tools to help with case management and trend identification. OPA should also work with I.T. to see what additional work can be managed electronically so as to allow quicker processing, more contemporaneous review, less need for copying, sending back & forth to Precincts, etc.	4th Q 2010
13	SPD should enhance the OPA website for better transparency and understanding, making it easier for the public to find information. SPD should also support a separate Auditor page on the site.	4th Q 2010
14	Recommendations made by the OPA Auditor should be included in searchable format on the OPA website.	4th Q 2010
15	OPA published monthly reports of complaint outcomes should include the policy or procedure changes that also resulted, in addition to discipline, findings, etc. so the public can see systemic changes made as a result of complaints.	4th Q 2010
16	Provide widgets for computers in a range of community locations along with the written materials to make it easier for citizens to file complaints electronically, with support from advocates as needed.	4th Q 2010
17	Create an on-line complaint tracking mechanism for complainants and employees (analogous to tracking vote on-line).	4th Q 2010
18	Review all OPA letters, email and written forms for understandability/clarity/accuracy.	4th Q 2010
19	Include underlying charges in allegation coding for tracking of concerns that tend to be charge-based, e.g., UOF-obstruction rather than just UOF.	2nd Q 2011
20	OPA can help ensure investigation file consistency by use of an investigator checklist as to evidence included and rationale provided where evidence not included.	4th Q 2010
21	OPA should look at the totality of the incident, not just the '4 corners' of the complaint in determining allegations, developing interview questions and investigative plan so that complaint is not limited by complainant's knowledge of policies and focus is on overall performance.	1st Q 2011

	Recommendations – Office of Professional Accountability	Date Recommended
22	Improve Proposed Disposition Memos by making sure they are unbiased, address all allegations, cite to policy at issue and fairly summarize evidence.	1st Q 2011
23	Improve investigator interview skills, e.g., eliminate use of leading questions, communications with officers that may appear to reflect bias; have more uniform use of short, open-ended questions, less interruption; drill down where question not answered, discrepancy in information or inconsistency among interviewees; don't offer rationale; ask their understanding of the policy; ask foundational questions about training; what they reviewed prior to interview, with whom they have spoken.	1st Q 2011
24	Improve intake, e.g., don't offer interviews by email, always offer to interview complainants in-person for those cases classified for investigation; ask about witnesses and contact information; ask if they have spoken to others.	1st Q 2011; 3rd Q 2012
25	Case summaries should clearly lay out inconsistencies among interviewees. Investigators should always ask officers if they are CIT-trained for cases involving mental illness and should always ask witnesses if they have any relationship to complainant/subject.	1st Q 2011 & 4th Q 2012
26	Command staff or others who will be reviewing discipline cases need to be familiar with current training (i.e., they should attend each new training or at least an overview of each).	1st Q 2011
27	Assess timeliness of notice to officers after investigations are certified, administratively closed or Loudermill complete.	2nd Q 2011
28	Ensure Line Investigations are timely, thorough and objective. Update and re-issue protocol for Precincts to address quality and timeliness. (Due to quality and timeliness problems, the Auditor and Director discontinued LI's in 2011)	4th Q 2010 (and before) ; 1st Q 2011
29	Use more tools at initiation of intake and investigation to close out cases where it can be quickly determined post-intake that investigation isn't warranted, to help focus resources on most significant allegations (e.g., show complainant the ICV at the start where helpful).	3rd Q 2011
30	Establish tighter deadlines to move cases to Auditor review of investigations after they are completed by Sergeants so as to more quickly identify issues needing further work or determine the investigation is thorough and more swiftly wrap up the investigation for complainants and officers.	3rd Q 2011
31	Aspects of investigations still needing continued improvement include the timeliness of case review by the Lieutenant after the initial investigation has been turned in by the investigator and timeliness of issuance of recommended findings. Investigative plans should always be reviewed by the Lieutenant prior to the investigation commencing and should specifically take into account the elements needing to be proven for each alleged policy violation.	2nd Q 2012

	Recommendations – Office of Professional Accountability	Date Recommended
32	Develop a protocol to address investigation delays caused by officers cancelling, not calling union reps until last minute so none are available and being out on leave delaying investigations. Determine if investigators can go interview them if they are unable to go to OPA, and if SPOG will grant on a case by case basis (contract requires 'police facility').	2nd Q 2012
33	Develop a protocol for handling cases where there is a conflict of interest because an OPA employee is named or has a conflict and other OPA personnel cannot be used. Consider using a process similar to Seattle Ethic & Elections and the School District.	3rd Q 2012
34	Ensure OPA-IS staff are trained in use of TTY line for hearing-impaired complainants.	3rd Q 2011

	Recommendations – Other Policies & Procedures	Date Recommended
1	Clarify the protocol with regard to when officers should handcuff.	1st Q 2011
2	Clarify the protocol with regard to ensuring all officers understand which officer is in charge of the scene and the obligation to announce or inquire.	1st Q 2011
3	Adopt a policy that more directly addresses the expectation that officers not act in ways that undermine public trust, whether on or off-duty. A 'conduct unbecoming' policy, as previously existed in Departmental policy, clearly articulates the expectation that officers' words and actions, whether they are on or off-duty, should not reflect poorly on the Department and undermine public trust.	4th Q 2010
4	Address the use of profanity.	3rd Q 2010
5	Biased policing policy - consider broadening the bias policing policy to encompass the range of decisions made from initial stops through prosecution (see San Jose policy).	1st Q 2011
6	Audit obstruction arrests for issues of bias.	2nd Q 2011
7	Clarify the policy with regard to reporting misconduct that requires reporting of only 'serious misconduct' so that all personnel understand what needs to be raised to OPA.	2nd Q 2011; 3rd Q 2011
8	Clarify, align and reaffirm the policy requirement for an officer to identify him or herself. The current policy is written in such a way that suggests there is only a clear, affirmative duty to I.D. for traffic stops, with the obligation for other types of stops less clear. The default for all interactions should be officer identification and explanation for why the person is being stopped, unless there is a safety, exigency, or an investigative reason not to. This can help minimize unnecessary escalation caused by confusion or mistaken assumptions that can escalate an otherwise minor interaction.	2nd Q 2011 & 2nd Q 2012
9	Develop a training directive on the issuance of 72-hour impound notices.	1st Q 2011
10	The Traffic Section's verbal direction to void citations where evidence of insurance is produced at some point during a traffic stop has not been incorporated into Departmental policy. Assess whether the policy on voiding tickets needs to more clearly address situations in which the driver who is stopped is not immediately able to produce insurance documentation but does so during the interaction.	2nd Q 2011

	Recommendations – Other Policies & Procedures	Date Recommended
11	A directive should be issued reminding all employees that accessing information through any criminal justice record system must be for legitimate law enforcement purposes, that employees shall not discuss or provide criminal history record information to any person who is not a member of the criminal justice system, and that inappropriate use or dissemination of such information can result in Departmental discipline and penalties under Federal and State law, including criminal sanctions.	4th Q 2011
12	A directive should be issued reminding all employees that running one's own name through the criminal justice records systems is prohibited unless for legitimate law enforcement purposes.	4th Q 2011
13	SPD's Court appearance/ FTA (failure to appear) policy needs to be updated since there is no longer a witness coordinator due to budget cuts.	2nd Q 2012
14	The policy requiring officers to get approval before appearing in court or as part of a legal action in official capacity covers only criminal matters and should also cover civil proceedings (e.g., an officer was asked to provide a declaration in her official capacity as part of a divorce proceeding).	2nd Q 2012
15	The Department should conduct a thorough review of its relationship with Crime Stoppers of Puget Sound (CSOPS) to clarify roles and functions of each organization. This review should include consideration of the original 2006 contract with CSOPS, to ensure that contract terms are being met by the parties and to determine if revisions are necessary. The Department should clarify its role in managing or facilitating the movement of CSOPS funds. Finally, a clear policy is required to address questions about access to and dissemination of potentially confidential SPD information by CSOPS.	3rd Q 2011
16	Conduct an audit of the administrative operation of the Undercover School to ensure there is no real or apparent conflict of interest given the interests of those associated with the School.	4th Q 2011
17	The connection between the Department and the Seattle Metropolitan Police Museum is problematic and needs prompt attention to correct actual and perceived conflicts of interest and possible inappropriate gifting of city services and/or funds.	2nd Q 2012
18	SPD uses the King County Courthouse security video camera system to observe drinking, using or dealing drugs, etc. in the Courthouse Park. Recordings of felony crimes are retained as evidence, while misdemeanors and citations are not. Determine if it would be feasible to retain recordings for these as well.	1st Q & 2nd Q 2012
19	Assess whether strip search procedures and/or training needs to be updated bases on supervisors' interviews.	3rd Q 2012
20	Provide more specific guidance for officers as to the preferred way to dispose of drug paraphernalia.	4th Q 2010

	Recommendations – Other Policies & Procedures	Date Recommended
21	Issue a directive with regard to the proper way of handling a prisoner's personal property that is either to be put into evidence or for safekeeping.	3rd Q 2011
22	The Harbor Patrol needs a manual or formal procedure to guide officers in recognizing and responding to boat engine problems, particular those that can result in damage or injury.	2nd Q 2012
23	Clarify policy as to whether odor of marijuana in car justifies a search, given current case law.	2nd Q 2011
24	Issue a directive with regard to proper use of spit socks.	4th Q 2011
25	Clarify policy with regard to whether parental notification is required prior to interviewing juveniles who are victims.	