Seattle
Office of Police
Accountability

CLOSED CASE SUMMARY

ISSUED DATE: JANUARY 4, 2018

CASE NUMBER: 2017OPA-0751

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	8.400 - Use of Force Reporting and Investigation 3. The Sergeant Will Review the Incident and Do One of the Following	Sustained
# 2	5.002 - Responsibilities of Employees Concerning Alleged Policy Violations 5. Supervisors Will Investigate or Refer Allegations of Policy Violations Depending on the Severity of the Violation	Not Sustained (Unfounded)

Imposed Discipline

Oral Reprimand

Named Employee #2

Allegation(s):		Director's Findings
# 1	8.200 - Using Force 1. Use of Force: When Authorized	Not Sustained (Lawful and Proper)
# 2	16.090 - In-Car and Body-Worn Video 5. Employees Recording Police Activity	Not Sustained (Management Action)
# 3	8.400 - Use of Force Reporting and Investigation 1. Officers Shall Report All Uses of Force Except De Minimis Force	Not Sustained (Lawful and Proper)

Named Employee #3

Allegation(s):		Director's Findings
# 1	8.200 - Using Force 1. Use of Force: When Authorized	Not Sustained (Lawful and Proper)
# 2	16.090 - In-Car and Body-Worn Video 5. Employees Recording Police Activity	Not Sustained (Management Action)
# 3	8.400 - Use of Force Reporting and Investigation 1. Officers Shall Report All Uses of Force Except De Minimis Force	Not Sustained (Lawful and Proper)

Named Employee #4

Allegation(s):		Director's Findings
# 1	8.400 - Use of Force Reporting and Investigation 3. The Sergeant Will Review the Incident and Do One of the Following	Not Sustained (Unfounded)
# 2	5.002 - Responsibilities of Employees Concerning Alleged Policy Violations 5. Supervisors Will Investigate or Refer Allegations of Policy Violations Depending on the Severity of the Violation	Sustained

Imposed Discipline

Written Reprimand

Named Employee #5

Allegation(s):		Director's Findings
# 1	11.030 - Guarding Detainees at a Hospital 2. Hospitalized Detainees Arrested for a Felony, Felony Warrant, Repeat DUI Offense, or Domestic Violence Related Crime Require a Hospital Guard	Not Sustained (Inconclusive)

Named Employee #6

Allegation(s):		Director's Findings
# 1	8.400 - Use of Force Reporting and Investigation 1. Officers Shall Report All Uses of Force Except De Minimis Force	Not Sustained (Unfounded)

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

EXECUTIVE SUMMARY:

The Complainant, a Department Lieutenant, alleged various misconduct relating to a use of force investigation. The misconduct included the failure to conduct a thorough investigation, the failure to refer potentially serious misconduct to OPA, and the failure to properly record In-Car Video (ICV).

During its intake investigation, OPA also added allegations concerning the failure to assign a hospital guard as required by policy and the potential failure to report a complaint of injury.

ANALYSIS AND CONCLUSIONS:

Named Employee #1 - Allegation #1
8.400 - Use of Force Reporting and Investigation 3. The Sergeant Will Review the Incident and Do One of the Following

NE#1 was referred to OPA for failing to conduct a thorough and complete Type II force investigation. On July 9, 2017, NE#1 engaged in a force investigation premised on bleeding caused to NE#1's wrist when handcuffs irritated a previously existing scab. The investigation was classified as a Type II. NE#4 was the original screening sergeant; however, he deferred the use of force investigation to NE#1 based on work load and the fact that NE#1 was the direct supervisor of NE#2 and NE#3. NE#1 then conducted the investigation, during which he spoke with the officers, spoke with the subject, and photographed the subject's injuries.

This force investigation was reviewed for completeness by a Lieutenant on July 25, 2017. On that date, she noted a number of deficiencies with NE#1's investigation, as well as potential issues with the conduct of the other Named Employees in this case. She referred NE#1 to OPA for failing to conduct a thorough and complete Type II force investigation.

The Lieutenant identified the following deficiencies in NE#1's force investigation: NE#1's failure to take photographs of the scene and to upload those photos into DEMS; NE#1's failure to ask the subject follow-up questions after the

subject indicated that he had been injured on another date; NE#1's failure to take an audio recorded statement from the subject; and NE#1's failure to take a statement from Officer Hay, who was a witness officer.
The Lieutenant itemized a number of other deficiencies with NE#1's investigation that she deemed performance issues rather than misconduct. She further noted that NE#1 had previously been counseled for failing to properly document and investigate uses of force and had received remedial training in this area. She stated that a Captain (then a Lieutenant) had offered to assist with the investigation, but NE#1 did not accept that assistance.

In his later review, the Captain also indicated that NE#1's investigation appeared not to be thorough or complete.

During his OPA interview, NE#1 stated that he classified the force as a Type I; however, this is undercut by the fact that a review of Blue Team indicated that a Type II investigation was completed and that the involved officers completed Type II use of force reports. This is further undercut by the fact that NE#4's ICV captured him informing NE#1 before NE#1 arrived on the scene that it was a Type II investigation. NE#1 contended that the investigation was upgraded from a Type I to a Type II later at the precinct. Even if this was the case, NE#1 should have then gone back and then completed the elements of the Type II investgiation that were outstanding. He did not do so.

NE#1 also asserted his belief that he took photographs of the scene the evening of the incident; however, the timestamp on the photographs indicated that they were not taken until more than two weeks later and after the Lieutenant requested them. NE#1 stated that he did not take an audio recorded statement from the subject because: "he didn't wanna to talk to us"; however, a conversation between NE#1 and the subject was capured on ICV, the subject was never asked to consent to a recorded interview, and, accordingly, he never refused to participate in one. Lastly, while NE#1 contended that an officer was not a witness to the force and no statement was required, the officer viewed the handcuffing.

SPD Policy 8.400-POL-3(1) requires that, when conducting a Type II force investigation, the sergeant will respond to the scene and thoroughly investigate the incident. The expected scope of that investigation is set forth both in this policy and in SPD Policy 8.400-TSK-6.

As explained above, here NE#1 did not thoroughly investigate this incident in violation of policy. As such, I recommend that this allegation be Sustained.

Recommended Finding: **Sustained**

Named Employee #1 - Allegation #2
5.002 - Responsibilities of Employees Concerning Alleged Policy Violations 5. Supervisors Will Investigate or Refer Allegations of Policy Violations Depending on the Severity of the Violation

SPD Policy 5.002-POL-5 requires that "supervisors will investigate or refer allegations of policy violations depending on the severity of the violation." As a general matter, allegations or minor misconduct may be investigated by the chain of command while allegations of serious misconduct must be referred to OPA. (SPD Policy 5.002-POL-5.)

During his conversation with the subject, which was captured by ICV, NE#1 asked him whether the injury to his wrist was his only injury. The subject stated: "from you guys, yeah today." NE#1 did not probe the subject's statement or ask any follow-up questions to clarify what he was talking about. From my review of the ICV, there is no indication

that NE#2, NE#3, or NE#4 ever informed NE#1 of the subject's earlier statements, which included: "You already beat me up once. You wanna do it again?" and "beat me up by Seattle police before."

While NE#1 certainly should have further explored the subject's statement to him during the investigatory screening, his failure to do so was an element of the sustained finding recommended above for the lack of a thorough force investigation. It does not also provide a basis to sustain this allegation. Ultimately, at the time, NE#1 was apparently unaware of the subject's allegations of potential serious misconduct that had been made to NE#2, NE#3, and NE#4. Moreover, I find that the statement made by the subject to NE#1, on its face, did not require an OPA referral.

For these reasons, I recommend that this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained (Unfounded)**

Named Employee #2 - Allegation #1
8.200 - Using Force 1. Use of Force: When Authorized

SPD Policy 8.200(1) requires that force used by officers be reasonable, necessary and proportional. Whether force is reasonable depends "on the totality of the circumstances" known to the officers at the time of the force and must be balanced against "the rights of the subject, in light of the circumstances surrounding the event." (SPD Policy 8.200(1).) The policy lists a number of factors that should be weighed when evaluating reasonableness. (*See id.*) Force is necessary where "no reasonably effective alternative appears to exist, and only then to the degree which is reasonable to effect a lawful purpose." (*Id.*) Lastly, the force used must be proportional to the threat posed to the officer. (*Id.*)

With regard to the handcuffing itself, NE#2 and NE#3 were legally justified in handcuffing the subject and did not appear to have used any excessive force while doing so. The injury to the subject's wrist appears to have simply been caused by the friction of the handcuffs, not by any affirmative act of either NE#2 or NE#3. When an injury was noticed to the subject's wrist, the officers properly reported that injury to a supervisor.

For these reasons, I recommend that this allegation be Not Sustained – Lawful and Proper.

Recommended Finding: **Not Sustained (Lawful and Proper)**

Named Employee #2 - Allegation #2
16.090 - In-Car and Body-Worn Video 5. Employees Recording Police Activity

NE#2 and NE#3 were alleged to have de-activated their ICV when following the subject who was being separately transported in an ambulance to the hospital. They remained with him at the hospital and when they again followed the subject who was being separately transported in an ambulance to the jail, they did not activate their ICV.

NE#2 and NE#3 reasoned that they, themselves were not transporting the subject, but were merely following an ambulance that was transporting him. As such, they opined that this was not activity that was required to be recorded under SPD's ICV policy.

SPD Policy 16.090-POL-1(6) requires that employees record police activity including transports. SPD Policy 16.090-1(8) further states that "once a recording has begun, employees shall not stop recording until the event has concluded." The policy defines an event as concluding when: (1) "the employee has completed his or her part of the active investigation"; (2) "there is little possibility that the employee will have further contact with any person involved in the event"; and (3) "the employee is leaving the area of the event." (SPD Policy 16.090-POL-1(8).)

This same issue has arisen in several recent cases. While I do not believe that the NE#2's and NE#3's decision to not activate their ICV was best practice, I recognize that it was borne out of their confusion with this aspect of the policy. For this reason, I issued a Management Action Recommendation regarding this issue in OPA case 2017OPA-0504, which was submitted to the Chief of Police on December 5, 2017. That recommendation remains under consideration by the Department. For the same reasons, I issue a Management Action here and refer to the previously issued recommendation.

Recommended Finding: **Not Sustained (Management Action)**

Named Employee #2 - Allegation #3
8.400 - Use of Force Reporting and Investigation 1. Officers Shall Report All Uses of Force Except De Minimis Force

SPD Policy 8.400-POL-1 requires that officers report and document uses of force or complaints of pain. Here, NE#2 and NE#3 reported the subject's injury to a supervisor. As such, they complied with this section of the policy.

I note that while NE#2 and NE#3 also reported the subject's contention that he had previously been beat up by police to a supervisor, they failed to refer this potential serious misconduct to OPA as was required by SPD Policy 5.002. Moreover, their reporting to a supervisor was not until a day after the initial allegation, also potentially in violation of policy. However, that section of the policy was not classified in this case and, even if the officers acted contrary to the policy in these regards, there can be no sustained finding based on that misconduct.

With regard to the allegation that was classified in this investigation, I find that NE#2 and NE#3 complied with SPD Policy 8.400-POL-1 by properly reporting the subject's injuries to a supervisor. For this reason, I recommend that this allegation be Not Sustained – Lawful and Proper.

Recommended Finding: **Not Sustained (Lawful and Proper)**

Named Employee #3 - Allegation #1
8.200 - Using Force 1. Use of Force: When Authorized

For the same reasons as state above (*see* Named Employee #2, Allegation #1), I recommend that this allegation be Not Sustained – Lawful and Proper.

Recommended Finding: **Not Sustained (Lawful and Proper)**

Named Employee #3 - Allegation #2
16.090 - In-Car and Body-Worn Video 5. Employees Recording Police Activity

For the same reasons as provided above (*see* Named Employee #2, Allegation #2), I refer to the Management Action Recommendation that was issued in OPA case 2017OPA-0504 on December 5, 2017.

Recommended Finding: **Not Sustained (Management Action)**

Named Employee #3 - Allegation #3
8.400 - Use of Force Reporting and Investigation 1. Officers Shall Report All Uses of Force Except De Minimis Force

As explained above (*see* Named Employee #2, Allegation #3), I recommend that this allegation be Not Sustained – Lawful and Proper.

Recommended Finding: **Not Sustained (Lawful and Proper)**

Named Employee #4 - Allegation #1
8.400 - Use of Force Reporting and Investigation 3. The Sergeant Will Review the Incident and Do One of the Following

Based on his work load, NE#4 requested that NE#1 conduct the force investigation at issue. As such, NE#4 was not responsible for the ultimately deficient Type II investigation that NE#1 conducted.

For this reason, I recommend that this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained (Unfounded)**

Named Employee #4 - Allegation #2
5.002 - Responsibilities of Employees Concerning Alleged Policy Violations 5. Supervisors Will Investigate or Refer Allegations of Policy Violations Depending on the Severity of the Violation

SPD Policy 5.002-POL-5 requires that "supervisors will investigate or refer allegations of policy violations depending on the severity of the violation." As a general matter, allegations or minor misconduct may be investigated by the chain of command while allegations of serious misconduct must be referred to OPA. (SPD Policy 5.002-POL-5.)

When he was at the scene, NE#4 was informed by NE#2 and NE#3 of statements that the subject had made. Specifically, NE#4 was informed that the subject stated: "You need to step off me or back off ok? You guys already beat me up once. You wanna go?" NE#4 was also told about a previous interaction the subject purportedly had with Redmond Police that resulted in injuries to the subject. In response, NE#4 said "ok," but asked no follow-up questions of either the officers or the subject. Moreover, he did not convey the information he had been told to NE#1, who took over the force investigation.

Even though he ultimately did not conduct the force investigation, NE#4 was still obligated to report any potentially serious misconduct that he was aware of to OPA. Here, the information conveyed to NE#4 suggested the possibility

of potentially serious misconduct. While NE#4 plausibly could have believed that the subject was referring to the misconduct of another police agency, he did not know that definitively. He thus had the obligation to either further investigate this issue, or at the very least to brief another sergeant who would investigate it, and/or to refer the matter to OPA. NE#4 did none of the above.

For these reasons, I recommend that this allegation be Sustained.

Recommended Finding: **Sustained**

Named Employee #5 – Allegation #1
11.030 - Guarding Detainees at a Hospital 2. Hospitalized Detainees Arrested for a Felony, Felony Warrant, Repeat DUI Offense, or Domestic Violence Related Crime Require a Hospital Guard

NE#5, who was an Acting Sergeant on the date in question, was named in this case based on his alleged failure to assign a guard to watch the subject while the subject was at the hospital. NE#5 contended that he did not believe that it was feasible or necessary to assign a hospital guard based on staffing issues. This was the case even though NE#5 knew that the subject had been arrested on a felony warrant. NE#5 recounted screening this issue with an Acting Lieutenant and stated that, as a result of that conversation, he received approval to not assign a guard.

The Acting Lieutenant was interviewed by OPA. He did not recall the specifics of his conversation with NE#5. He affirmatively stated, however, that he "never heard anything about a felony warrant." The Acting Lieutenant confirmed that a hospital guard might not be assigned based on staffing shortages.

SPD Policy 11.030-POL-2 requires that "hospitalized detainees arrested for a felony, felony warrant, repeat DUI offense, or domestic violence related crime require a hospital guard." The policy builds in an exception, however, if a watch lieutenant determines that a hospital guard is not warranted under the circumstances. (SPD Policy 11.030-POL-2.)

Here, NE#5 stated that he received the Acting Lieutenant's informed approval that a hospital guard was not needed. The Acting Lieutenant, however, denied ever hearing about a felony warrant. If NE#5 did not disclose that the subject had been arrested on a felony warrant to the Acting Lieutenant prior to obtaining his consent, he would have acted contrary to policy. Given that the record is unclear on this point, I cannot conclude that this allegation should be sustained. Instead, I recommend that this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained (Inconclusive)**

Named Employee #6 – Allegation #1
8.400 - Use of Force Reporting and Investigation 1. Officers Shall Report All Uses of Force Except De Minimis Force

SPD Policy 8.400-POL-1 requires that officers report and document uses of force or complaints of pain.

This allegation appears to have been classified against NE#6 based on his failure to report the subject's statement that his hands had fallen asleep. However, I agree with NE#6 that this was not an allegation of pain from handcuffing that required reporting or documenting.

As such, I recommend that this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained (Unfounded)**

City of Seattle

Office of Police Accountability

April 5, 2018

Chief Carmen Best
Seattle Police Department
PO Box 34986
Seattle, WA 98124-4986

RE: MANAGEMENT ACTION RECOMMENDATIONS – FIRST QUARTER 2018

Dear Chief Best:

I write to inform you of a number of Management Action Recommendations (MAR) that have been recently issued by OPA. This is the first of what will be ongoing quarterly MAR notifications. OPA hopes that one letter will be easier to review and respond to than numerous communications received throughout a quarter.

The MARs contained herein are for the following cases: 2017OPA-0031; 2017OPA-0318; 2017OPA-0420; 2017OPA-0667; 2017OPA-0705; 2017OPA-0751; 2017OPA-0755; 2017OPA-0813; 2017OPA-0820; 2017OPA-0909; 2017OPA-0937; 2017OPA-0967; 2017OPA-1015; and 2017OPA-1131.

1. **2017OPA-0031 – *Clarifying the Responsibilities of Bureau Chiefs Regarding Recommended Findings from the CRB***

This case arose out of a patrol vehicle accident, in which a Department employee failed to put his vehicle in park when he got out and, as a result, the vehicle rolled over the legs of the subject. While this did not result in significant injuries to the subject, it was still a significant error by the employee and an easily avoidable accident. The accident was reviewed by the Collision Review Board (CRB) and then referred – apparently in error – to the former Assistant Chief of the Investigations Bureau. While the Assistant Chief approved the CRB's finding and agreed that the accident was preventable, he failed to forward his approval and his recommendations for any discipline and/or re-training to the Chief of Police. As such, the Chief at that time did not have the opportunity to issue any such discipline and/or re-training that may have been warranted.

As a result of its investigation and the concerns identified, OPA recommends that SPD's command staff be reminded of their obligations under SPD Policy 13.015 generally, and 13.015-PRO-1 specifically, to recommend potential discipline and/or re-training and to forward those recommendations to the Chief of Police in a timely manner. Without this clarification, the Department risks harming the legitimacy of SPD's administrative investigation processes and creating mistrust in the community. Moreover, the Department should take steps to ensure that CRB rulings are properly forwarded to the correct bureau chief. It is OPA's understanding that this policy is currently being re-evaluated and revised by the Department. If this is the case, it may obviate the need for this MAR.

2. 2017OPA-0318 – *Using Tasers on Fleeing, Non-Violent Subjects*

In this case, one of the allegations was that the Named Employee utilized his Taser in potential violation of policy. The subject upon whom the Taser was used was fleeing from the officer at the time and was running on the pavement. The subject had previously been involved in a vehicle pursuit that had resulted in a crash. Prior to the Taser being used, the subject had tried to climb a fence and had been pulled backwards by the Named Employee. The Named Employee described that he and the subject circled each other, the subject ran away, and the Taser was then used. The Named Employee did not allege that the subject ever attempted to assault him, raised his fists, or engaging in any violent behavior towards him. The Named Employee justified his application of the Taser based on his belief that the fleeing subject represented a threat to himself, the Named Employee, other officers, and the public. The Named Employee further stated that he believed that, if he was required to go hands on with the subject, it was likely that both he and the subject would suffer injuries.

Initially, OPA recommended that this allegation be Sustained because the risk of harm caused by the subject's actions and fleeing were outweighed by the risk of potential injury to the subject when he was Tased while running on pavement. In reaching this conclusion, OPA cited Ninth Circuit case law, recommendations from the Police Executive Research Forum (PERF), and the training materials generated by Taser International. Notably, Taser International's training materials warn that the use of a Taser on a fleeing subject can result in an elevated risk of harm. This appears to be even more so when the subject is fleeing on a hard surface.

However, at the discipline meeting on this matter, the Named Employee's chain of command disagreed with OPA's finding and asserted their belief that the Named Employee had acted consistent with his training. As such, and with the Guild's agreement to an extension, OPA further investigated the matter, which included reviewing training materials and interviewing three members of the Department's Training Unit, including a designated Taser expert.

OPA's additional investigation revealed that the Training Unit deemed the Named Employee's conduct to have been consistent with his training. As such, OPA reversed its finding. Nonetheless, OPA has significant concerns with the training being provided by the Department, as well as with the Taser policy itself and its application to the facts presented in this case.

First, case law in this area appears to be relatively unsettled. However, recent decisions by district courts within the Ninth Circuit appear to be trending towards a determination that using a Taser on a non-violent fleeing subject is a potential violation of that individual's Fourth Amendment rights. Given this, as well as the risk of serious injury that could be incurred under these circumstances and the guidance from both PERF and Taser International, OPA recommends that the Department reconsider the guidance it is providing to officers concerning Tasing fleeing subjects and that the Department make an informed decision as to whether, given the significant risk and potential liability, this is conduct in which it wants its officers to continue to engage.

Second, regardless of the determination made by the Department, OPA recommends that the Training Unit consider amplifying the Taser training to include the following:

- Additional scenarios involving fleeing subjects;
- More robust education on the potential risks of harm when a Taser is used on a fleeing subject and particularly a suspect running at full speed on a hard surface;
- Clearer guidance as to what constitutes an imminent risk of harm justifying use of a Taser;
- More explicit explanations of what constitutes the "public safety interests" that are referenced in the second prong of the Taser policy and what conduct is sufficient to meet the requisite "level of resistance" from the subject; and
- Clearer instruction as to the Department's expectations in this area and an evaluation of whether a bright-line rule can be applied, rather than having the decision as to whether to use a Taser on a fleeing subject be a completely subjective determination.

Third, based on OPA's review of this case, there appears to be a lack of clarity as to when Taser warnings are required or when they are excused under the circumstances. OPA recommends that the Training Unit provide refresher training to Taser operators in this area and make it abundantly clear in which situations Taser warnings are required. This could be appropriately integrated into planned upcoming trainings.

3. 2017OPA-0420 – *Clarifying When Officers Are "Involved" in a Pursuit*

This case involved an out of policy pursuit in which several officers were engaged. One of the officers told OPA during his interview that he was only involved in the pursuit, which he realized was out of policy, because he was trying to ensure the safety of another officer, who was, for a period of time, the only unit involved in the pursuit. The officers' supervisor failed to have the trailing officer complete a Blue Team Vehicle Pursuit Entry. In explaining why he failed to do so, the supervisor told OPA he did not believe this officer was required to complete documentation because he was not "involved" in the pursuit as indicated by the policy. In support of this assertion, the supervisor contended that the officer was not pursuing but was only trying to ensure the safety of a fellow Department employee.

OPA does not view this language as being as ambiguous as both the trailing officer and supervisor appear to believe. However, OPA recognizes that "involved" officer could be further defined to make clear that it refers to any officer engaging in conduct that constitutes a pursuit under the policy, regardless of the purpose for engaging in this conduct. The policy should make it clear that all such officers should document their actions in a Blue Team Vehicle Pursuit Entry.

4. 2017OPA-0667 – *Generating a Policy Governing High-Risk Vehicle Stops and Clarifying When Provision of Identification May Be Required from a Handcuffed and Detained Individual*

OPA investigated a case in which a Terry stop was effectuated on a car. The stop was requested by two officers who viewed the car drive away from the scene, but was effectuated by four other officers who received a dispatch asking that the stop occur. OPA determined, and the chain of command agreed, that there was insufficient reasonable suspicion supporting the stop.

During the stop, which was carried out as a high-risk vehicle stop, the four occupants were removed from their car, handcuffed, frisked, and placed in the rear of a locked patrol vehicle. After that point,

it became clear to the officers that the detained individuals were not involved in the underlying crime; however, they were kept handcuffed in the rear of the patrol vehicle and officers requested their identifying information. The officers provided conflicting information as to why this information was requested. One officer indicated that it was requested so that the officers could determine whether the detained individuals were related and to get their contact information. Another officer said the information was requested to run the individuals for warrants.

SPD Policy 6.220-POL-6 states that "officers cannot require subjects to identify themselves or answer questions on a Terry stop" and that "in general, subjects are not obligated to provide identification upon request and have the right to remain silent." The policy provides for three exceptions to this rule (*see id.*), none of which applied in this case. Here, the officers contended that they did not require identification, they simply requested it. While that is true, it ignores the fact that virtually no one who is handcuffed in the back of a patrol vehicle would feel that this request could be refused. Moreover, while Fourth Amendment case law provides legal authority for a request for identification during a Terry stop, the request must be "reasonably related to the detention." It is unclear how the request for identification in this case was reasonably related to the detention given that the reasonable suspicion for the stop had already dissipated at the time it was made.

In general, this case further raised concerns for OPA regarding the lack of any mention of high-risk vehicle stops in policy and the absence of formal guidance concerning requirements and limitations of such stops. Accordingly, OPA recommends that the Department draft a policy governing when it is appropriate for officers to conduct high-risk stops and what conduct officers may engage in during those stops. It would make sense for this policy to be included in Title 6 of the SPD Manual. The Department should also clarify in policy and in training whether, once the reasonable suspicion for a Terry stop has dissipated, an officer remains permitted to request identifying information from a handcuffed and detained individual.

5. 2017OPA-0705 – *Allowing Officers to Sign Themselves Up for Trainings*

OPA investigated an allegation that an officer failed to attend a mandatory training in potential violation of SPD Policy 5.001-POL-3. At his OPA interview, the officer contended that he did not attend the training on the date for which he was scheduled because he was sick. He further stated that he informed his sergeant that he missed the training and was unaware of what steps his sergeant took to reschedule him for a subsequent training.

During this investigation, OPA learned that officers are not able to register themselves for training, but, instead, are required to request that supervisors do so. It is unclear to OPA why this is the case. It seems, in my opinion, that this system is inefficient and wastes valuable supervisor time. Moreover, I believe that officers, not their supervisors, should be responsible for managing their own calendars and accountable when they fail to attend trainings. It may very well be that there is a reason for why the Department has supervisors register officers for training, but this reason has not been evident in any of the investigations that OPA has conducted into missed trainings.

For these reasons, OPA recommends that the Department consider shifting the responsibility for registering for trainings from supervisors to officers. To the extent there is a reason why this is not feasible or is inadvisable, please provide that information to OPA.

6. 2017OPA-0751 and 2017OPA-1131 – *Recording ICV When Following an Ambulance Transporting a Subject to a Hospital*

In both of these cases, Department employees failed to activate their In-Car Video (ICV) systems when they were following ambulances transporting subjects to Harborview Medical Center.

These cases were virtually identical to another case (2017OPA-0504) in which OPA issued a MAR requesting that the Department clarify the ICV policy regarding whether it expects its officers to record in these situations. In that same MAR, issued on December 7, 2017, OPA requested that the Department also evaluate the current list of law enforcement activities that are required to be recorded and determine whether that list needs to be amplified or clarified. It is OPA's understanding that the Department is presently working on modifications to this policy consistent with OPA's recommendations; however, OPA renews this MAR herein.

7. 2017OPA-0755 – *Logging in and out of Secondary Employment at Large-Scale Events*

In this case, OPA investigated an employee's failure to have a valid secondary work permit for his employment at Safeco Field. During its investigation, OPA determined that the Named Employee did not log in and out via radio, as required by SPD Policy 5.120(II). OPA discussed this matter with the Named Employee's chain of command and was informed that, even though this was a requirement of the policy, officers were instructed that they were not required to do so when working secondary employment at large-scale events, such as baseball, football, or soccer games.

The reason for this modification of the log in and out requirement makes sense – where numerous officers are working an event, it is more practical and time efficient to have one supervisor log all the employees in and out at one time. Indeed, the Department has a form that is utilized for exactly that purpose. OPA agreed with the chain of command that this modification of the policy was appropriate, but asked that the policy be updated to reflect that this was an acceptable practice.

After this discussion and the issuance of the Director's Certification Memo containing this MAR, this policy was, in fact, updated to formalize an exception for large-scale events. The new language is consistent with OPA's recommendation. As such, no further action needs to be taken.

8. 2017OPA-0813

OPA's investigation into this case resulted in two MARs. The first concerned foot pursuits that resulted in uses of force and officers' decision-making regarding the potential consequences of their actions. The second concerned reconciling the policy on mandatory reporting of potential misconduct with the current training and guidance being provided to officers by the Department.

a. Foot Pursuits and Officer Decision-Making When Using Force

In this case, officers stopped a subject who had been urinating on the side of a building. When the officers attempted to detain him, the subject fled. The officers chased after him, and the Named

Employee tackled the subject from behind onto the pavement. As a result, the subject suffered lacerations and bleeding to his face and body.

During his OPA interview, the Named Employee contended that he tackled the subject from behind onto the pavement in order to prevent the subject from running into traffic. First, this threat was entirely speculative. There was no evidence that the subject was at imminent risk of running into traffic. Second, the Named Employee's logic appeared to be that he put the subject at risk of substantial physical harm in order to prevent him from being hit by a car, thus ultimately protecting the subject. Third, the Named Employee appeared to put little to no thought into the potential consequences of the force he used. He was chasing a subject who had committed a non-violent, citable offense and had not posed or caused any harm to the Named Employee.

OPA initially recommended that the allegations concerning the use of force and the Named Employee's discretionary decision to tackle the subject to the ground both be sustained. The Named Employee's chain of command disagreed. The primary reason for their disagreement was their belief that, in acting as he did in this case, the Named Employee conducted himself consistent with the Department's expectations and his training. Thus, while OPA found that his actions were contrary to policy and constituted poor decision making, OPA reversed its Sustained findings and, instead, issued a MAR.

OPA noted that SPD policy provides no guidance on when it is appropriate for an officer to engage in a foot pursuit. By not providing any policy governing when a foot pursuit is appropriate and under what circumstances the risk of harm to the officer, the subject, and the public outweighs the interests in effectuating an arrest, it places officers in a tenuous and unenviable position of uncertainty.

As such, OPA recommends that the Department consider developing a policy concerning when foot pursuits of suspects are appropriate. OPA believes that the Department should evaluate whether it expects its officers to engage in such pursuits when the subject is suspected of a misdemeanor or of only committing a citable offense. This policy should optimally provide guidance as to when the risk of harm to officers, the subject, and the public outweighs the law enforcement interest in effectuating an arrest. This policy should further consider what force is appropriate during such pursuits. Specifically, the Department should evaluate whether it is in its interests, both as a matter of potential civil liability and in upholding constitutional policing, for officers to be permitted to tackle at full speed individuals who have committed non-violent, non-felony offenses, and who pose no substantiated risk to officers, civilians, or themselves.

Lastly, OPA strongly advises the Department to include in training a discussion of officer decision-making when using force. Specifically, OPA believes that the Department needs to better train its officers to consider the downstream consequences of their actions prior to using force. Whether an officer decides to tackle onto the pavement a person suspected of a citable offense who is running from the police, Tasers from behind a subject who is sprinting away on the sidewalk, or pushes someone with an outstanding warrant for a non-violent felon offense off of her moving bicycle, potentially subjecting her to catastrophic injuries, OPA has evaluated a number of cases where these necessary calculations have not been made. OPA contends that this informed decision-making is a trained skill like anything else and that it should be stressed by the Department in the 2018 use of force and/or defensive tactics training.

b. Reporting Potential Misconduct

This case also involved allegation of excessive force that was made by the subject in the presence of an officer. The officer claimed that he relayed this allegation to a supervisor, but the supervisor denied that this occurred. Even assuming that he did report the allegation to a supervisor, OPA found that the officer still violated policy because he also did not report the claim of excessive force to OPA. Notably, SPD Policy 5.002-POL-6 requires that officers report allegations of serious misconduct – which includes excessive force – to both a supervisor *and* OPA.

At the discipline meeting in this case, the Named Employee's chain of command told OPA that, while they agreed that the policy compelled reporting to both a supervisor and OPA, officers were being trained that they only needed to report to one or the other, not both. While this direction may make practical sense, it is telling officers to do something that is contrary to the explicit language of the policy.

Given this, OPA recommends that the Department do one of the following: (1) train and instruct its officers to do what the policy says; or (2) amend the policy to remove the requirement that an officer report misconduct to both a supervisor and OPA, with the understanding, however, that other protections are built into the policy. With regard to the latter course of action, OPA also recommends that the Department establish procedures to ensure that misconduct is still ultimately reported to OPA. For example, OPA believes that the Department could require that officers record their reporting of misconduct to a supervisor on video or, in the alternative, that they memorialize and report the allegation in an email sent that same day to a supervisor. This would ensure that there were no situations where an officer claimed that they reported and the supervisor denied that this occurred.

9. 2017OPA-0820 – *Department Re-Training on DUI Investigations and Arrests, BAC Machines and Tickets, and the Requirements for the Content and Submittal of DUI Packets*

This case involved an arrest of an individual for suspected DUI. A Student Officer and his Field Training Officer (FTO) effectuated the stop and arrest. At the scene, the Student Officer conducted the DUI investigation with some difficulty. Upon their return to the precinct, the Student Officer was tasked with generating the DUI paperwork, using the Blood Alcohol Content (BAC) machine, and printing a BAC ticket. There were a number of deficiencies with the DUI paperwork, and an incomplete DUI packet was submitted to the prosecutor, even though it was reviewed and approved by the FTO. There was also a significant anomaly with the use of the BAC machine and the printing of the BAC ticket, which resulted in OPA investigating both officers for potential dishonesty (these allegations were Not Sustained – Inconclusive for the Student Officer and Not Sustained – Unfounded for the FTO).

Based on OPA's investigation into this case and on OPA's discussions with the Named Employees' chain of command, it appears that the vast majority of patrol officers lack experience and sufficient training in conducting DUI stops and arrests and the resulting paperwork that must be generated. Given this, OPA recommends that the Department consider retraining all patrol officers, or at the very least those officers expected to engage in DUI investigations, on the following:

- DUI arrests, generally;
- How to conduct sobriety tests;
- The usage of Preliminary Breath Tests;
- The usage of BAC machines and the printing of BAC tickets; and
- The mandatory requirements for the contents and submittal of DUI packets.

10. 2017OPA-0909 – *Making Revisions, Clarifications and Improvements to the De-Escalation Policy*

In this matter, the Named Employee was involved in a use of force with a woman who was riding a bicycle without a helmet. Officers had attempted to stop and arrest this woman (who had an outstanding felony warrant for a non-violent offense) and she fled from them on her bicycle. The supervisor chased the woman on foot, while the Named Employee and another officer drove behind her. The Named Employee got out of the patrol vehicle and positioned himself in front of the woman with the intent to stop her. The woman, who was driving the bicycle towards the Named Employee traveling between 10 and 15 miles per hour, swerved to the left of the Named Employee, at which point he pushed her off of her bicycle, causing her to fall to the ground and suffer various injuries, including a separated shoulder.

OPA initially found that the Named Employee used force inconsistent with policy and failed to de-escalate prior to using force. While the Named Employees' chain of command agreed that the force used was outside of policy, the chain disagreed that the Named Employee had failed to de-escalate. In support of their argument in this regard, the chain asserted that, under the circumstances of this case, no de-escalation was safe or feasible. The chain noted that containment, which was referenced as an option in OPA's initial recommendation, was not possible with a moving target such as a person on a bicycle. They further noted that there was no way to place a barrier to stop the woman from riding away under the circumstances of this case. While the chain recognized that it could have been possible to summon more resources, they noted that this would have necessitated calling numerous officers away from other equally if not more important calls and would not have conclusively resulted in stopping the woman and placing her under arrest. OPA found this argument convincing and agreed to amend its finding. However, OPA also raised its concerns with the subjectivity and application of this policy, which were largely shared by the chain.

This case was the most recent of a number of cases in which OPA and the Department either disagreed as to whether an officer properly de-escalated or where it was simply unclear whether the officer de-escalated consistent with policy, even when the relevant facts of the cases were fully explored and illuminated during OPA's investigation and were agreed to by all the parties.

At the outset, it is important to note that OPA strongly supports the concept of de-escalation and believes it to be absolutely essential to constitutional and equitable policing. SPD's commitment to de-escalation is a product of and requirement of the Consent Decree and it is a practice that puts SPD head and shoulders above most other police departments nationwide.

That being said, the de-escalation policy is consistently one of the most challenging policies to apply and evaluate. When looking at it, OPA generally has a number of questions. Do all the suggested

de-escalation tools called out in the policy need to be used before force can be applied? If not, how many? How long do officers need to try to de-escalate before they can use force? 2 minutes? 5 minutes? 1 hour? 2 hours? When is physical confrontation "immediately necessary" to permit force to be used? What is meant by the phrase "without compromising law enforcement priorities"? If effectuating an arrest is always a compelling law enforcement priority, does that not potentially unworkably expand the policy?

This policy, like many others, is subjective. In that respect, I recognize the difficult place that officers are put in. On one hand, they are told that, in order to preserve public order and safety, it is essential to make arrests and, with some arrests, to use a degree of force. On the other hand, the de-escalation policy, if read literally, could be construed to dissuade such active policing and instead encourage officers to not take action that could result in force unless all other possible options are exhausted and the force is immediately necessary. OPA worries that the policy, while incredibly important and well-intentioned, has the potential to create unclear standards and expectations for officers, thus risking affecting the officers' procedural due process during the disciplinary stage.

Unlike most MARs, OPA does not have what it believes to be an immediate fix to the policy. Instead, OPA is simply identifying some concerns and its belief that it may be time to look at revising, clarifying and improving this policy. To be clear, OPA is not calling for the policy to be removed or in any way undermined; however, now that the Department is five-years into the Consent Decree, OPA believes it is necessary to evaluate the policy to determine whether changes are warranted and, if so, what those changes should be. OPA also believes that the Department should reevaluate training on de-escalation and related tactics to ensure that it is providing needed clarity and rules of conduct for officers. OPA further believes that the evaluation of both the policy and associated training should be led by the Department, but should intimately involve OPA, the Community Police Commission and the Inspector General at the research, deliberation and drafting stages.

11. **2017OPA-0937 – *Clarifying How Officers Are to Verify That Their ICV Systems Are Working Prior to Their Shifts and Including in Policy the Sergeants' Obligations Regarding Ensuring That Wireless Microphones Are Charged Prior to Assigning to Officers***

During its investigation of this case, OPA determined that the Named Employee's ICV system recorded video but failed to record audio. At his interview, the Named Employee stated that he logged into his system, synched his microphone, and engaged in all other necessary steps to ensure that both his ICV video and audio were working. He further stated that he saw no evidence from his review of his microphone that it was low on battery. However, OPA found that the battery of the wireless microphone was not fully charged and the failure to fully charge the microphone, potentially coupled with distance of the microphone from the receiver, resulted in the lack of audio.

The previous iteration of this policy required that each officer conduct a ICV system check before beginning their shift. This system check, which was recorded, was purposed to verify that the system was working and to catch any problems. The amended policy removed the system check and, thus, created a potential gap in policy that was exemplified by this case. Moreover, it was unclear, based on OPA's reading of the policy, how officers were now expected to verify that their ICV systems were working prior to beginning their shifts.

During its investigation, OPA also learned that sergeants were now expected to assign ICV wireless microphones to officers prior to their shifts and to verify that these microphones were fully charged. However, that obligation was not contained in policy and it was unclear whether it occurred in this case.

As such, OPA recommends that the Department consider amending SPD Policy 16.090-TSK-1 to explain how officers are expected to verify that their ICV wireless microphones and BWV systems are fully charged and to inform officers what the appropriate level of charging is prior to them utilizing those systems in the field. This will, in OPA's opinion, provide clarity to both officers and OPA. Moreover, if it is the Department's expectation that sergeants will bear some responsibility for verifying that the wireless microphone batteries are charged, it should also consider memorializing those specific obligations and expectations in policy.

12. **2017OPA-0967 –** ***Documenting All Terry Stops Using a Terry Template, Regardless of Whether Officers Had Probable Cause to Arrest at the Time of the Stop and Detention***

In this case, the Named Employees detained an individual who was in a City park after hours. The officers did not arrest this individual and, instead, released him after requesting and obtaining his identification and running his name for warrants. Even though the individual was detained for a prolonged period of time, the officers did not document the detention using a Terry Template. The officers explained to OPA that, at the time of the detention, they had probable cause to arrest the individual for trespassing. As such, they believed that they had no obligation to generate a Terry Template.

While OPA does not believe that these officers intended to violate policy, their failure to document this detention anywhere not only violated SPD policy but also City law. Accordingly, OPA recommends that the Department clarify SPD Policy 6.220-POL-10 to make it abundantly clear that when officers perform a Terry stop, a Terry template is required to be completed each and every time. The Department should further clarify that this is the case regardless of whether the officers had probable cause to arrest at the time of the Terry stop. What ultimately controls for the purpose of reporting is the nature of the stop. Lastly, the Department should include in its policy that this requirement is a requirement under City law and should cite to SMC 14.11.060(C).

13. 2017OPA-1015 – ***Clarifying Expectations for the Quality and Thoroughness of Follow-Up Investigations and Associated Reports***

This case involved an investigation by the Sexual Assault Unit into a rape allegation. At the time of the investigation, the case was past the statute of limitations and the investigator reported that she was informed by a prosecuting attorney that it would not have been prosecuted regardless due to burden of proof issues. Nonetheless, the Department's expectation was that the investigation conducted would be comprehensive and high quality. Unfortunately, that did not occur.

The investigator's deficient investigation and reporting was evaluated under SPD Policy 15.080-POL-1(2), which concerns investigations conducted by follow-up units. The policy sets forth the

minimum components of follow-up investigations and includes: "When appropriate, the case detectives will contact and interview listed suspects, witnesses, and victims"; and "Case files shall be prepared to satisfy standards established by the prosecuting attorney's office. The Criminal Investigations Bureau will publish these standards."

First, both OPA and the investigator's chain of command agreed that the documentation that she generated, which included a Supplemental Report and a memorandum, was not complete, thorough, and accurate. However, there was no requirement that reports generated during follow-up investigations be complete, thorough, and accurate. This was the case even though SPD policy specifically required that General Offense Reports completed during primary investigations had to meet those standards. It was unclear and illogical to OPA why follow-up investigations should be held to a lower standard than primary investigations. This was especially the case given the specialized training given to investigators in follow-up units.

Second, the investigator failed to complete a Case Investigation Report (CIR). At her OPA interview, she claimed that there was no requirement in policy that she do so and that it was unnecessary, as she knew the case was never going to be prosecuted. Both OPA and her chain of command disagreed with the investigator's latter assertion, but recognized that there was no explicit requirement in policy that a CIR be generated in each follow-up investigation.

Third, the investigator failed to include in her report an itemization of the interviews that she conducted or unsuccessfully attempted to conduct. Here, this resulted in the victim believing and alleging that the investigator deliberately included misleading information in her reports and in turn led to OPA investigating whether the investigator was dishonest.

Fourth, OPA's investigation yielded the conclusion that investigators in follow-up units lacked sufficient guidance concerning the expectations for investigations and the associated documentation.

As a result, OPA suggested, and the investigator's chain of command, including the Assistant Chief of the Investigations Bureau, agreed, that the Department take the following steps to ensure that reports generated during follow-up investigations are held to the same standards of those written during primary investigations and are complete, thorough and accurate: (1) SPD Policy 15.080-POL-2 should be amended to require that reports generated during follow-up investigations be complete, thorough, and accurate; (2) SPD Policy 15.080-POL-2 should also be amended to require that a CIR be completed in every follow-up investigation, regardless of whether the assigned investigator or an investigations supervisor believes that the case will be prosecuted; (3) SPD Policy 15.080-POL-2 should be modified to include the requirement that all witness interviews or the fact that a witness interview was attempted be documented; and (4) the Investigations Bureau should provide all investigations personnel with a manual setting forth examples of reports that meet the expectations of the Department and standards for what information should be contained in follow-up investigation paperwork.

During its investigation, OPA also determined that the investigator conducted a video recorded interview of the victim, but that the fact that this interview occurred was not documented in the investigative file. The policy governing such documentation – SPD Policy 7.110-POL-6, only referenced documenting audio recorded interviews and was silent on video recorded interviews.

OPA believes that the Department should encourage investigators to take video statements and believes that the Department must ensure their documentation.

Similarly, in reviewing SPD Policy 7.110-POL-5, which governs the uploading of audio recorded statements to the Department's evidence management system (DEMS), OPA discovered that the policy is silent as to where and how video recorded statements are to be stored. It is OPA's understanding, based on its investigation, that DEMS does not accept the uploading of video recorded statements, as only audio files or .jpg files can be uploaded into that system. In this case, the Named Employee stated that she saved the video recorded statement in the Sexual Assault Unit's "vault" and "drive." OPA recommends that the Department provide more formal guidance in policy concerning the expectation for how and where video recorded statements should be stored.

Consistent with the above, OPA further recommends that the Department amend SPD Policy 7.110 to account for the practice of video recording interviews. Specifically, SPD Policy 7.110-POL-6 should be updated to require Department employees to document in an appropriate report when they have conducted and created a video recorded interview.

Thank you very much for your prompt attention to these matters. Please inform me of your responses to these recommendations and, should you decide to take action as a result, the progress of these actions.

Please also feel free to contact me with any questions or concerns.

Sincerely,

Andrew Myerberg

Andrew Myerberg
Director, Office of Police Accountability

cc: Deputy Chief Chris Fowler, Seattle Police Department
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