



CLOSED CASE SUMMARY

ISSUED DATE: AUGUST 3, 2018

CASE NUMBER: 2018OPA-0302

Allegations of Misconduct & Director’s Findings

Named Employee #1

Allegation(s):		Director’s Findings
# 1	16.090 - In-Car Video System 5. Employees Recording Police Activity	Not Sustained (Training Referral)

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 Named Employee self-reported that she failed to record In-Car Video.

ANALYSIS AND CONCLUSIONS:

Named Employee #1 - Allegations #1

16.090 - In-Car Video System 5. Employees Recording Police Activity

Named Employee #1 (NE#1) was assigned as the use of force sergeant during a demonstration. In that capacity, she was required to investigate any uses of force that occurred. On the day of the demonstration, NE#1 was also informed that she would be in charge of prisoner processing. As described by the Lieutenant who oversaw the SPD response to this demonstration, there was insufficient staffing and NE#1 was tasked with a significant amount of responsibility for one sergeant. Indeed, on that day, NE#1 was required to process six arrests and six uses of force. When traveling from the scene of the demonstration to a precinct, NE#1 properly activated her Body Worn Video (BWV) but neglected to also turn on her In-Car Video (ICV). She later caught this error and self-reported to the Lieutenant. She also documented the reason for this error in an appropriate report. However, given that her failure to activate ICV constituted a technical violation of policy and one that is defined as serious misconduct under SPD Policy 5.002-POL-5, the Lieutenant referred this matter to OPA and this investigation ensued.

Given the content of the OPA referral by the Lieutenant, which detailed the challenges faced by NE#1 on this date, as well as based on NE#1’s self-reporting and documentation of this issue, OPA classified this case for Expedited Investigation.

It is undisputed that NE#1 was required to record ICV and that she did not do so in this instance. However, for several reasons, I believe that a Training Referral is the appropriate result. First, it is clear that she had tremendous responsibility on this date. Second, she properly recorded BWV, which fully captured her law enforcement activity. Third, she self-reported and took responsibility for her failure to record ICV. Fourth, she documented and explained the failure in an appropriate report. In taking these steps, NE#1 did exactly what OPA hopes and expects officers and, particularly, Department supervisors will do in such cases.



- **Training Referral:** NE#1's chain of command should discuss this matter with her. Her chain should ensure that she understands the requirement to record ICV in these types of cases, which appears certain from my review of the record. NE#1's chain of command should commend her for self-reporting and properly documenting this matter and no training need be provided. This counseling should be documented and this documentation should be maintained in an appropriate database.

Recommended Finding: **Not Sustained (Training Referral)**