



CLOSED CASE SUMMARY

ISSUED DATE: MARCH 7, 2018

CASE NUMBER: 2017OPA-0031

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	13.030 - Emergency Vehicle Operations 4. Officers Are Responsible for the Safe Operation of Their Police Vehicle	Not Sustained (Training Referral)

Named Employee #2

Allegation(s):		Director's Findings
# 1	13.015 - Collision Review Board 13.015-PRO-1 Conducting a Collision Review Board (CRB) (8) & (9)	Not Sustained (Management Action)

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 alleged that Named Employee #1 (NE#1) rolled over a subject's legs with his vehicle, in potential violation of policy. OPA, during its intake investigation, further noted that Named Employee #2 (NE#2), the reviewing Assistant Chief, may have failed to complete tasks required by SPD policy.

ADMINISTRATIVE NOTE:

This incident occurred on April 5, 2016, and it was processed through the chain of command. On April 11, 2016, each level of NE#1's chain of command found the accident to be preventable. On September 2, 2016, the Collision Review Board (CRB) found that the accident was preventable and forwarded the case in Blue Team to NE#2 for a final finding. NE#2 concurred that the accident was preventable but took no further action.

The case was referred to OPA on January 11, 2017, by a concerned citizen who viewed the In-Car Video. By that time, the incident had been reviewed by several supervisors and found to have been out of policy. Therefore, the 180-day timeline for imposing discipline started at the time the first supervisor became aware of possible misconduct, which was on April 5, 2016. Based on this date, the date by which a sustained finding could be issued, even were it appropriate for OPA to reach such a finding in this case, expired in October 2017, three months before this case was referred to OPA and this investigation was initiated.



ANALYSIS AND CONCLUSIONS:

Named Employee #1 - Allegation #1

13.030 - Emergency Vehicle Operations 4. Officers Are Responsible for the Safe Operation of Their Police Vehicle

On the date in question, NE#1 responded to a call concerning a man with a firearm and followed the subject into a parking lot. When NE#1 got out of his vehicle to give the subject orders to get on the ground, he failed to place the vehicle in park or set the parking brake. His failure to take these basic safety measures resulted in the vehicle rolling forward over the subject's legs. Though the subject did not sustain any injuries, this does not change the fact that NE#1 failed to safely operate his vehicle.

By function of SPD policy, such incidents are reviewed by the CRB. The CRB is tasked with making recommendations to a Bureau Chief who either concurs or disagrees with the CRB's finding. The Bureau Chief then makes a recommendation to the Chief of Police as to whether an accident was preventable and also recommends possible discipline and/or re-training. The Chief is, in turn, tasked with meting out discipline and/or re-training to the involved officer.

Here, this accident was screened with a Sergeant assigned to the Traffic Collision Investigation Squad (TCIS) and the Captain of the Force Investigation Team (FIT). The chain of command found the collision to be preventable. The precinct chain of command completed their review on April 11, 2016. The CRB's ruling, which also deemed the accident preventable, was provided to NE#2 for his review on September 12, 2016. On November 17, 2016, NE#2 approved the CRB's ruling. However, as discussed more fully below, NE#2 apparently failed, after approving the finding that the accident was preventable, to recommend possible discipline or re-training, as well as failed to forward such a recommendation to the Chief. As such, the Chief did not have the opportunity to issue discipline and/or re-training as contemplated by the policy.

I find that NE#1's conduct in this case was a mistake and was not an intentional attempt to harm the subject. Had OPA believed differently, it would have classified allegations against NE#1 under SPD Policies 8.200-POL-1 (when force is permitted), 8.200-POL-2 (when force is prohibited), and 5.001-POL-2 (employees shall not violate law or policy). Moreover, OPA would have referred it criminally. That being said, it was an egregious mistake that could have catastrophically harmed the subject.

However, this allegation and the conduct discussed herein should be properly addressed and, if appropriate, discipline imposed by the chain of command and the Chief of Police, not OPA. The policy states that whether discipline should be meted out is the decision of the Chief after a review by both the CRB and the employee's Bureau Chief, as well as after recommendations are issued to the Chief by the Bureau Chief. OPA is explicitly not included in this process. As such, I defer a decision as to whether misconduct occurred and, if so, what discipline should be imposed to the Chief. Any other result would be, in my opinion, subjecting NE#1 to double jeopardy by requiring him to proceed through two separate possible disciplinary processes. Upon issuance of my recommended findings, I will also be formally referring this matter to the Assistant Chief of Patrol for him to conduct an additional review and to make a recommendation to the Chief as to whether she should concur with the CRB's findings and also make a recommendation on any re-training or discipline that should be imposed as a result of this incident.



That being said, I agree with the CRB that this accident was preventable and believe that NE#1 committed a substantial error in this instance. As such, while it is not within OPA's purview to sustain this case or to recommend discipline, I do find that a training referral is appropriate based on NE#1's conduct.

- **Training Referral:** NE#1 should receive additional training concerning the safe operation of his vehicle. NE#1 should also receive counseling from his chain of command concerning the severity of this incident and their expectations for NE#1's conduct in this regard. This re-training and related counseling should be memorialized in a PAS entry. Lastly, NE#1's chain of command should contact the subject, either by telephone or letter, and convey to him the Department's regret concerning this incident and its determination that the accident was deemed preventable.

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

Named Employee #2 - Allegation #1

13.015 - Collision Review Board 13.015-PRO-1 Conducting a Collision Review Board (CRB) (8) & (9)

During its intake investigation, OPA determined that NE#2 may have failed to follow SPD Policy 13.015-PRO-1. Specifically, it appeared that NE#2 failed, after approving the finding that the accident was preventable, to recommend possible discipline and/or re-training to the Chief of Police, as well as failed to forward such a recommendation to the Chief as required by this section of the policy. This failure to do so was in potential violation of SPD Policies 13.015-PRO-1(8) and (9).

As a starting point, I note that it is unclear why the CRB's finding was referred to NE#2 in the first place as he was not NE#1's bureau chief. NE#1 was assigned to the North Precinct at the time and the findings should have been referred to the Assistant Chief of Patrol. Regardless, as NE#2 reviewed the CRB's findings and opined that they were preventable, he should have made a recommendation as to discipline and/or re-training and forwarded that recommendation to the Chief.

I find that NE#2 violated policy by failing to comply with the requirements of SPD Policies 13.015-PRO-1(8) and (9). However, I do not feel that his conduct warrants a sustained finding for several reasons. First, this is a technical violation of policy. Second, the policy is complex and somewhat arcane. Third, it appears from my review of the record that NE#2's conduct constituted a mistake rather than intentional misconduct. As such, I recommend that this allegation be Not Sustained – Training Referral. However, given that NE#2 is no longer employed by the Department, I instead issue the following Management Action Recommendation that recommends re-training in this area for all SPD command staff.

- **Management Action Recommendation:** SPD's command staff should be reminded of their obligations under SPD Policy 13.015 generally, and, specifically, under SPD Policy 13.015-PRO-1. They should be informed that their failure to recommend potential discipline and/or re-training and to timely forward those recommendations to the Chief of Police can prevent such discipline and/or re-training from being imposed and, as such, decrease the legitimacy of SPD's administrative investigation processes and create mistrust in the community. Moreover, the Department should take steps to ensure that CRB rulings are properly forwarded to correct bureau chief, which did not occur in this case. I note that it is my 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 Management Action.



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



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
Assistant Chief Lesley Cordner, Standards and Compliance, Seattle Police Department
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