Seattle
Office of Police
Accountability

CLOSED CASE SUMMARY

ISSUED DATE: MAY 10, 2019

CASE NUMBER: 2019OPA-0025

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	13.030 - Emergency Vehicle Operations 2. Officers May Drive in an Emergency Response Only When the Need Outweighs the Risk	Not Sustained (Training Referral)
# 2	15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a General Offense Report	Not Sustained (Training Referral)
# 3	5.001 - Standards and Duties 6. Employees May Use Discretion	Not Sustained (Training Referral)

Named Employee #2

Allegation(s):		Director's Findings
# 1	15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a General Offense Report	Not Sustained (Training Referral)
# 2	5.001 - Standards and Duties 6. Employees May Use Discretion	Not Sustained (Training Referral)

Named Employee #3

Allegation(s):		Director's Findings
# 1	15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a General Offense Report	Not Sustained (Training Referral)
# 2	5.001 - Standards and Duties 6. Employees May Use Discretion	Not Sustained (Training Referral)

Named Employee #4

Allegation(s):		Director's Findings
# 1	15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a General Offense Report	Not Sustained (Training Referral)
# 2	5.001 - Standards and Duties 6. Employees May Use Discretion	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 Complainant alleged that Named Employee #1 engaged in impermissible driving that resulted in his causing an accident. It was also alleged that Named Employee #1's decision-making during this incident constituted an abuse of his discretion. It was further alleged that Named Employee #1's reporting of this incident may have been inaccurate. Lastly, it was alleged that the other Named Employees, who constituted Named Employee #1's chain of command, failed to properly investigate and document this case, as well as that their decisions that the accident was non-preventable was not supported by the evidence.

SUMMARY OF INVESTIGATION:

The Complainant initiated this matter with OPA alleging that Named Employee #1 (NE#1) caused a traffic accident with her vehicle. She stated that, at the time of the accident, NE#1 made an illegal left turn, was driving too fast, and did not have his patrol vehicle's emergency equipment activated. The Complainant made other allegations concerning fraudulent reporting on the incident and that a witness identified by SPD was working with officers to cover up NE#1's misdeeds. These latter allegations were deemed unfounded by OPA and were not investigated as part of this case.

The accident was captured by NE#1's In-Car Video (ICV). The video indicated that, prior to the accident, NE#1 engaged in emergency vehicle operations to catch up with a Metro bus. Once he did so, he retrieved a bicycle from the bus, which he secured to the front of his patrol vehicle. NE#1 proceeded onto Mary Avenue NW and he had his emergency equipment activated when he turned left onto NW 85th Street. The ICV showed that he accelerated and then turned his emergency equipment off as he began to merge into the eastbound lane of travel. NE#1 then struck the Complainant's car as it pulled away from the curb. From OPA's review of the video, NE#1's vehicle did not appear to be established in the eastbound lane of travel at the time of the accident. OPA determined that NE#1 struck the Complainant's car approximately 1.5 seconds after entering the eastbound lane.

As part of its investigation, OPA reviewed the documentation created concerning the accident, which included the General Offense Report (GOR) written by Named Employee #2 (NE#2) and the Traffic Contact Report (TCR). The TCR was generated by two other officers who are not named in this case. The narrative of the TCR stated that NE#1 was driving eastbound on NW 85th Street when the Complainant pulled into traffic and struck NE#1's vehicle. The diagram of the incident, which is included in the TCR, reflects the narrative.

NE#1 also wrote a statement and drew a sketch. In his statement, NE#1 reported that he took a left on Mary Street NW to turn onto NW 85th Street. He wrote the following: "I activated my emergency lights and slowly pulled into the westbound lane. I observed eastbound traffic slowing and pulling to the right side of the road. I changed lanes and once established in the eastbound lane of traffic, turned off my overhead lights. Maybe a few short seconds later, I felt my vehicle jerk to the left." NE#1's sketch reflected his description of the incident. NE#1's ICV audit trail indicated that he viewed his ICV at 1434 hours and 1738 hours on the date of the incident. His statement indicated that it was written at 1408 hours and his sketch indicated that it was drawn at 1500 hours.

The ICV audit trail also indicated that NE#2, Named Employee #3 (NE#3), and Named Employee #4 (NE#4) reviewed portions of NE#1's video. NE#2 approved NE#1's report and sketch. NE#2 wrote that: "Once [NE#1's] patrol vehicle fully occupied the EB lane on NW 85th St, he deactivated his emergency lights and accelerated up to speed." This is inconsistent with the ICV. NE#2 also provided the following analysis concerning NE#1's driving: "Emergency lights activated (no siren), during a left turn, and then returned to a normal driving pattern (emergency lights deactivated)." This also appears to be inconsistent with the ICV. NE#2 deemed the collision to be non-preventable. NE#4, who was NE#1's Lieutenant, indicated that he reviewed the paperwork relating to the accident, as well as the ICV and photographs. NE#4 also deemed the accident to be non-preventable. Lastly, NE#3, who was NE#1's Captain at the time, reviewed the ICV and other documentation. He concurred with NE#2 and NE#4 that he accident was non-preventable. NE#3 noted concerns with NE#1 "signaling a left lane change" and NE#1 attaching a bicycle to the front of his vehicle. NE#3 wrote that he would confer with NE#2 and NE#4 concerning addressing these matters with NE#1.

This accident was later reviewed by the Department's Collision Review Board (CRB). The CRB, like NE#1's chain of command, found the collision to have been non-preventable. There is no indication why they believed this to be the case in the letter the CRB sent to NE#1.

ANALYSIS AND CONCLUSIONS:

Named Employee #1 - Allegations #1
13.030 - Emergency Vehicle Operations 2. Officers May Drive in an Emergency Response Only When the Need Outweighs the Risk

At his OPA interview, NE#1 stated that he contacted a man who was swinging a guitar case and appeared to be intending to smash the guitar. When NE#1 spoke to the man, who he believed to be in crisis, the man stated that his bicycle was affixed to a Metro bus that had driven away. NE#1 then made the decision to engage in emergency driving to catch up to the bus and recover the bicycle. NE#1 explained that he made this decision in order to expedite the retrieval of the bicycle, which he believed would de-escalate the man.

After retrieving the bicycle, NE#1 engaged in emergency vehicle operations for a second time when he turned into an oncoming lane of traffic and then accelerated into the eastbound lanes. At that point, he got into the accident. He again rationalized his emergency driving on the fact that he wanted to quickly return the bicycle to the man.

SPD Policy 13.030-POL-2 states that officers may drive in an emergency response only when the need outweighs the risk. The policy further states that: "The preservation of life is the highest priority." (SPD Policy 13.030-POL-2.)

At the time that NE#1 engaged in emergency driving, he was not responding to or investigating a crime. Instead, he was trying to quickly retrieve a bicycle in order to de-escalate an individual. Based on OPA's review of the evidence and under the circumstances of this case, I do not believe that his engaging emergency driving was consistent with policy. Most notably, I find that the risk of doing so, particularly when NE#1 had a bicycle attached to the front of his vehicle that at least partially obstructed his view, outweighed the articulated need. Indeed, the emergency driving during this incident resulted in an accident.

The above being said, I do not believe that a Sustained finding is warranted here. Instead, I recommend that NE#1 receive the below Training Referral. I reach this decision because I believe that, even though NE#1 did not exercise the best judgment when he engaged in emergency driving, he had good intentions and was trying to do the right thing.

- **Training Referral**: NE#1 should receive retraining concerning when it is appropriate to engage in emergency vehicle operations and when the risk to himself and the community outweighs the benefit of doing so. As part of that retraining, NE#1's chain of command should review the video of this incident with him. This should include a review of the inception of the emergency driving, as well as the driving that led to the accident. Lastly, while it should be recognized that NE#1 was trying to do the right thing in this case, he should be encouraged to more fully consider whether emergency driving is necessary where he is not responding to a crime or a call for service. This retraining and counseling should be documented and this documentation should be maintained in an appropriate database.

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

Named Employee #1 - Allegation #2
15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a General Offense Report

SPD Policy 15.180-POL-5 states that officers are required to document all primary investigations on a General Offense Report. The policy further requires that all reports be "complete, thorough and accurate." (SPD Policy 15.180-POL-5.)

OPA's review of the ICV reveals a number of inconsistencies between the video and NE#1's report. Those inconsistencies are detailed above in the Summary of Investigation. When asked at his OPA interview whether his reporting matched the video, NE#1 responded: "After 20/20 vision of watching the video, it doesn't look like it, but that's the best…from what I can recollect." When asked whether his GOR was complete, thorough, and accurate, NE#1 told OPA: "After watching this video, it doesn't appear to be as accurate as the video shows."

Given the above, OPA finds that NE#1's reporting in this case fell short of the expectations of this policy. That being said, OPA believes that this is a mistake and not a deliberate intent on NE#1's part to inaccurately document this incident. OPA notes that there is no evidence that NE#1, or any other officer, falsified any reporting as the Complainant suggested. However, given the shortcomings of NE#1's reporting in this case, I recommend that he receive the below Training Referral.

- **Training Referral**: NE#1 should be reminded of the Department's expectation that his reporting is thorough, complete, and accurate. He should be counseled concerning the inaccuracies of his reporting of this incident and should be reminded that, not only did his documentation negatively affect the investigation of this matter, but that such reporting could also serve to undermine public trust and confidence both in him and in SPD's administrative review processes. This retraining and counseling should be documented and this documentation should be maintained in an appropriate database.

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

Named Employee #1 - Allegation #3
5.001 - Standards and Duties 6. Employees May Use Discretion

As indicated in SPD Policy 5.001-POL-6, "[e]mployees are authorized and expected to use discretion in a reasonable manner consistent with the mission of the department and duties of their office and assignment." This policy further states that "[t]he scope of discretion is proportional to the severity of the crime or public safety issue being addressed." (SPD Policy 5.001-POL-6.)

As discussed in the context of Allegation #1 above, I find that NE#1 did not exercise the best judgment when he engaged in emergency vehicle operations during this incident. That decision-making resulted in NE#1 getting into an accident and potentially subjecting both himself and the Complainant to the risk of injury. In this respect, I find that NE#1 did not appropriately exercise his discretion on the date in question.

However, for the same reasons discussed herein, I recommend that this allegation be Not Sustained and refer to the Training Referral set forth above. (*See* Named Employee #1, Allegation #1.)

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

Named Employee #2 - Allegations #1
15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a General Offense Report

As discussed above, NE#2 conducted the supervisory investigation of this matter. This included reviewing portions of the ICV relating to this matter, as well as reviewing the documentation generated by NE#1. He also completed reports concerning this matter.

NE#2 reported to OPA that be believed that NE#1's documentation was thorough, complete, and accurate. He acknowledged, however, that he later determined that the portion of NE#1's report concerning the status of his emergency lights at the time of the collision was inaccurate. NE#2 did not identify this at the time. Moreover, NE#2 failed to identify the other inaccuracies identified by OPA above. In addition, NE#2's reporting, like NE#1's, was also inaccurate in part.

As a supervisor, NE#2 is tasked with making sure that the reports that he ultimately approves are thorough, complete, and accurate. NE#2 did not do so here. He is also expected, like NE#1, to complete his own accurate reports. That being said, I recommend that he receive the below Training Referral rather than a Sustained finding, as I believe that this was a mistake rather than misconduct.

- **Training Referral**: NE#2 should be counseled that it is his responsibility as a supervisor to ensure that the paperwork that he reviews, approves, and relies upon to make findings of fact and policy is thorough, complete, and accurate. His chain of command should explain that failing to do so can serve to undermine public trust and confidence. NE#2's chain of command should also remind him of the expectation that the reports he generates are accurate. This retraining and counseling should be documented and this documentation should be maintained in an appropriate database.

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

Named Employee #2 - Allegation #2
5.001 - Standards and Duties 6. Employees May Use Discretion

NE#1's entire chain of command perceived the traffic accident to have been non-preventable. The CRB agreed with the chain of command's decision.

From OPA's review of the video, it is difficult to understand how this accident was deemed to be non-preventable. NE#1 was emergency driving with a bicycle strapped to the front of his vehicle, he turned into an oncoming lane of traffic, accelerated, and then struck a car moving away from the curb that had its blinker on. Notably, NE#1's immediate reaction after getting into the accident was: "Shit. What the hell happened?" He did not appear to have any understanding that a vehicle was pulling out in front of him, either due to the bicycle partially blocking his view or his rate of speed.

Moreover, the risk of emergency driving under these conditions outweighed the benefit of quickly returning the bicycle to the male. However, this was apparently not considered by any of the supervisory Named Employees. Certainly, this should have had some weight in evaluating the collision.

As discussed above, it does not appear to OPA that this accident was evaluated as critically as it should have been by any level of the chain of command, including the CRB. OPA finds this unfortunate. Moreover, OPA is concerned that seemingly cursory and outcome determinative investigations could serve to undermine public trust in the Department and its administrative investigative processes.

However, OPA does not believe that any of the supervisory Named Employees engaged in purposeful misconduct during this incident. Accordingly, OPA issues them the below Training Referral.

- **Training Referral**: NE#2, NE#3, and NE#4 should be counseled by their respective chains of command concerning this matter. They should review this DCM and evaluate the inaccuracies between NE#1's documentation and the video of the accident. These Named Employees should be encouraged to more critically review collisions moving forward. This retraining and associated counseling should be documented and this documentation should be maintained in an appropriate database.

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

Named Employee #3 - Allegations #1
15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a General Offense Report

Similar to NE#2, both NE#3 and NE#4, reviewed the documentation generated by NE#1 relating to the collision and portions of the ICV. Both further believed that NE#1's documentation was thorough, complete, and accurate.

However, as discussed above in the context of NE#2, and as acknowledged by NE#1, the documentation relating to the collision was inaccurate in several respects. While this was the case, neither NE#3 nor NE#4 identified and rectified these issues. I find that, as reviewing supervisors, it was their responsibility to do so. Moreover, had they more critically reviewed the documentation, it is possible that they would not have concluded that the collision was non-preventable. That being said, I recommend that they receive the below Training Referral rather than a Sustained finding, as I believe that this was a mistake rather than misconduct.

- **Training Referral**: NE#3 and NE#4 should be counseled that it is their responsibility as supervisors to ensure that the paperwork that they review, approve, and rely upon to make findings of fact and policy is thorough, complete, and accurate. Their chains of command should explain that failing to do so can serve to undermine public trust and confidence. This retraining and counseling should be documented and this documentation should be maintained in an appropriate database.

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

Named Employee #3 - Allegation #2
5.001 - Standards and Duties 6. Employees May Use Discretion

I recommend that this allegation be Not Sustained and refer to the above Training Referral. (*See* Named Employee #2, Allegation #2.)

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

Named Employee #4 - Allegations #1
15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a General Offense Report

I recommend that this allegation be Not Sustained and refer to the above Training Referral. (*See* Named Employee #3, Allegation #1.)

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

Named Employee #4 - Allegation #2
5.001 - Standards and Duties 6. Employees May Use Discretion

I recommend that this allegation be Not Sustained and refer to the above Training Referral. (*See* Named Employee #2, Allegation #2.)

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