Seattle
Office of Police
Accountability

CLOSED CASE SUMMARY

ISSUED DATE: FEBRUARY 3, 2022

FROM: INTERIM DIRECTOR GRÁINNE PERKINS
OFFICE OF POLICE ACCOUNTABILITY

CASE NUMBER: 2021OPA-0292

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	5.001 - Standards and Duties 6. Employees May Use Discretion	Not Sustained (Lawful and Proper)
# 2	16.130 - POL - 2 Officers Providing Medical Aid 1. Recognizing the Urgency of Providing Medical Aid...	Not Sustained (Lawful and Proper)
# 3	15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a Report	Not Sustained (Training Referral)

Named Employee #2

Allegation(s):		Director's Findings
# 1	5.001 - Standards and Duties 6. Employees May Use Discretion	Not Sustained (Lawful and Proper)
# 2	16.130 - POL - 2 Officers Providing Medical Aid 1. Recognizing the Urgency of Providing Medical Aid...	Not Sustained (Lawful and Proper)
# 3	15.180 - Primary Investigations 5. Officers Shall Document all Primary Investigations on a Report	Allegation Removed

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:

It was alleged that the Named Employees failed to document their interaction with a community member who had been shot in the leg. It was further alleged that the Named Employees failed to provide medical treatment to this community member and failed to exercise reasonable discretion by not detaining the community member under the Involuntary Treatment Act.

SUMMARY OF INVESTIGATION:

OPA received a complaint from the Named Employees' chain of command through Blue Team. The complaint alleged that the Named Employees failed to document their primary investigation after responding to a gunshot victim (Community Member #1). OPA commenced this investigation and added allegations against both Named Employees for failing to provide medical treatment to Community Member #1 and failing to exercise reasonable discretion for not detaining Community Member #1 under the Involuntary Treatment Act (ITA).

OPA reviewed Seattle Fire Department (SFD) documentation, Computer Aided Dispatch (CAD) reports, independent security video, and Body Worn Video (BWV). OPA also spoke with the Medical Examiner's office to ascertain the cause of death of Community Member #1. As part of its investigation, OPA interviewed both Named Employees and two

Witness Officers. Witness Officer #1 (WO#1) is the EMS coordinator for SPD and is also an instructor in the advanced training unit. Witness Officer #2 (WO#2) is the Sergeant in charge of the Crisis Response Team. Both Witness Officers were interviewed concerning SPD medical aid training and crisis intervention responses. Finally, OPA interviewed two additional witness officers who responded to a second call.

The Named Employees' interaction with Community Member #1 were recorded by NE#2's BWV and the facts underlying this interaction are not in dispute.

Named Employee #1 (NE#1) and Named Employee #2 (NE#2) were dispatched to assist SFD with a report of a conscious man whose pant leg had "a lot of blood on it." When the Named Employees arrived on scene, SFD employees had already contacted Community Member #1, who was standing up with blood visible on his pant leg and shirt. Community Member #1 informed NE#1 and SFD employees that he had been shot the previous night, but Community Member #1 refused any medical treatment. While the Named Employees where at the scene, Community Member #1 signed a consent form refusing any medical treatment. Because Community Member #1 refused to be evaluated, SFD was unable to determine if Community Member #1 was still bleeding and requested that the Named Employees keep an eye on him and to contact them to return if his condition deteriorated further. The Named Employees closed the call on CAD, citing it as an assistance call with SFD. NE#1 also noted in CAD that they spoke with a friend of the Community Member #1 who agreed to contact 911 if Community Member #1's condition worsened. Later that day, SPD officers responded to a separate call for an unconscious man—Community Member #1. Community Member #1 was pronounced dead later the same day. The Medical Examiner's Office determined that Community Member #1's death was a homicide caused by a gunshot wound of an extremity.

WO#1 opined that, from his BWV review of the incident, the Named Employees followed SPD training because they handed off care to a higher level of medical provider, *i.e.* the Seattle Fire Department, and removed themselves from the situation to allow SFD to treat Community Member #1 without fear of a police response.

WO#2 was interviewed to determine whether Community Member #1 could have been involuntarily detained given the circumstances. WO#2 opined that it was difficult to determine any apparent mental health justification for an involuntary detention based on the BWV. On his review of the BWV, any of the physical signs of this mental health deterioration, such as the Community Member #1 rolling his eyes, could be attributed to shock and his loss of blood. Conversely, WO#2 explained that the fact that Community Member #1 willingly refused medical treatment weighed against an involuntary detention.

ANALYSIS AND CONCLUSIONS:

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

It was alleged that NE#1 exercised unreasonable discretion by not detaining Community Member #1 under the ITA to compel him to receive medical treatment.

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.)

On leaving the scene, SFD informed the Named Employees that Community Member #1 was "a little bit off. So, he's got some weird shit going on. He doesn't trust any of us. He doesn't want to….go to the hospital." SFD further indicated that Community Member #1 would not go with SFD to the hospital. Community Member #1 was, however, able to provide his name and date of birth to SFD. While it could be argued that his refusal for medical treatment could be interpreted as someone who was suffering from a behavioral health disorder, his provision of personal information would somewhat negate this. Indeed, just because a patient refuses a treatment does not in itself mean the patient is not competent to make their own medical decisions. Competent patients have the right to refuse treatment, even treatments that may be lifesaving.

When interviewed, NE#1 stated that, in her opinion, Community Member #1 did not meet the appropriate criteria which would warrant an involuntary detention. Nothing about Community Member #1's demeanor suggested that he had any mental health deficiencies. A stated by the NE#1, "just because somebody is off doesn't mean there's, you know, a behavioral or mental health component that necessitates an ITA." Given the circumstances and way the Community Member #1 was engaging with SFD, OPA finds that NE#1's decision was not unreasonable.

OPA believes that there is another discretion component which should be considered. Both Named Employees left the scene after SFD had requested SPD to keep an eye on Community Member #1. SFD indicated that they could not determine whether Community Member #1 was still bleeding or not and assumed that he would eventually pass out and their services would again be required. No timeframe or parameters were given by SFD concerning this request. Review of NE#2's BWV however shows a member of SFD speaking with the friend of Community Member #1 and detailing what to do should his friend's condition worsen. This discussion happened after SFD spoke with the Named Employees asking them to do the same thing. OPA believes that it would be unreasonable to require the Named Employees to continue observing Community Member #1 indefinitely in case his condition worsened. The friend with Community Member #1 was alert and responsive to what SFD was telling him, and Community Member #1 had already clearly refused treatment.

Accordingly, OPA believes that the NE#1 used discretion in a reasonable manner in the circumstances and recommends that this allegation be Not Sustained (Lawful and Proper).

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

Named Employee #1 - Allegation #2
16.130 - Providing Medical Aid POL - 2 Officers Providing Medical Aid 1. Recognizing the Urgency of Providing Medical Aid

It was alleged that NE#1 failed to recognize the urgency of providing Community Member #1 with medical aid.

SPD Policy 16.130-POL-2(1) states that employees assisting a sick or injured person will seek to determine the nature and cause of a person's injury or illness and provide first aid or call for Emergency Medical Services as needed, with an exception for injuries that can be treated with basic first-aid. SPD Policy 16.130-POL-2(1). The policy goes on to state that "[a]fter requesting a medical aid response, officers will render aid within the scope of their training unless aid is declined." *Id*. Officers are required to provide medical assistance consistent with their training, with priority being given to officers certified as EMTs. *Id*. The consent of unconscious subjects is presumed under the policy. *Id*. Employees are expected to follow SPD standing orders from the SPD/SFD Medical Director, as well as their training and the SPD Manual, with respect to applying certain forms of first aid. *Id*.

It does not appear that the NE#1 was deliberately indifferent to Community Member #1's medical condition. Ultimately, OPA finds that the officers took sufficient steps to treat him by referring to SFD who were able to provide a higher level of medical care. Although the NE#1 has basic casualty care training, SPD officers do not receive a level of training which would supersede that of their SFD colleagues. In addition to this handover of care, the NEs also removed themselves from the scene to try and dilute the police presence in case this was an influential factor in his declination to receive treatment. Community Member #1, however, still refused medical assistance.

At the scene, NE#1 was made aware that the initial injury may have occurred over 12 hours previously. Based on this information NE#1 assumed that had it been a more serious injury, such as an arterial bleed, Community Member #1 would have more than likely succumbed to his injury earlier. Based on the available information at that time, OPA finds that this was a reasonable assumption to make.

Accordingly, OPA finds that the NE#1 complied with the terms of this policy and recommends that this allegation be Not Sustained (Lawful and Proper).

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

Named Employee #1 - Allegation #3
15.180 – Primary Investigations: 5. Officers Shall Document all Primary Investigations on a Report

It was alleged that NE#1 did not document her primary investigation of this incident in a report.

SPD Policy 15.180-POL-5 states that all officers shall document their primary investigations on a report.

Standard Operating Practices within SPD indicate that the responsibility for documenting primary investigations in a report rest with the Primary Officer. NE#1 was the Primary on this call.

OPA finds that NE#1 did not complete a report when it would have been appropriate to do so. OPA believes that this is concerning for two reasons. Firstly, the nature of the known injury, a gunshot, suggests the occurrence of a more serious, previous, incident. Failing to document this incident could jeopardize other investigations in which Community Member #1 was may have played a significant role.

When interviewed by OPA, NE#1 indicated that she believed that her informational update to CAD was sufficient in negating the documentation of the incident in a report. Of note is that this was the NE's first incident in which she was the primary officer in a gunshot incident. Indeed NE#2, who was more experienced than NE#1, indicated that although there was limited information available about the incident, it would have been a more cautious approach to have completed a report given the circumstances of Community Member #1's injury.

This was the first time that the NE#1 was the primary officer on a gunshot wound incident. OPA believes that her failure to document this incident was not a willful violation of policy amounting to misconduct, but a result of her inexperience in dealing with incidents of this nature.

Given this, OPA recommends that this allegation be Not Sustained (Training Referral).

- **Training Referral**: NE#1's chain of command should discuss OPA's findings with her, review SPD Policy 15.180-POL-5 with her, and provide any further retraining and counseling that it deems appropriate. The retraining and counseling conducted should be documented, and this documentation should be maintained in Blue Team.

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

Named Employee #2 - Allegation #1
5.001 - Standards and Duties 6. Employees May Use Discretion

When NE#2 was asked about his decision not to involuntarily detain Community Member #1, he stated that he determined that he was not dealing with someone in behavior crisis. NE#2 reasoned that Community Member #1 was able to make decisions and was not unable to care for himself. The NE#2 stated that although SFD indicated that Community Member #1 was "a bit off" it did not rise the level of a mental health disorder as his behavior at the time was not "completely outlandish."

For the same reasons stated above at Named Employee #1 – Allegation #1, OPA recommends that this allegation be Not Sustained (Lawful and Proper).

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

Named Employee #2 - Allegation #2
16.130 - Providing Medical Aid POL - 2 Officers Providing Medical Aid 1. Recognizing the Urgency of Providing Medical Aid

As with NE#1, NE#2 indicated that his medical treatment of the Community Member #1 would not supersede that of SFD, who were already in attendance. NE#2 also stated that his reasoning for not rendering medical attention to Community Member #1 was based on Community Member #1's demeanor and the fact that Community Member #1 did not consent to getting medical treatment. NE#2 felt that Community Member #1's demeanor was combative and had he forced medical treatment on him there was a possibility that the situation would have escalated.

OPA recommends that this allegation be Not Sustained (Lawful and Proper).

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

Named Employee #2 - Allegation #3
15.180 – Primary Investigations: 5. Officers Shall Document all Primary Investigations on a Report

NE#2 was the Secondary Officer in this incident. Standard operating practices indicate that the responsibility for primary investigation reporting rests with the Primary Officer on the call. Accordingly, this allegation is most appropriately made against NE#1 only.

For these reasons, OPA recommends that this allegation be removed as against NE#2.

Recommended Finding: **Allegation Removed**