Seattle
Office of Police
Accountability

CLOSED CASE SUMMARY

ISSUED DATE: MAY 14, 2023

FROM: DIRECTOR GINO BETTS
OFFICE OF POLICE ACCOUNTABILITY

CASE NUMBER: 2022OPA-0388

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	1.020 - Chain of Command, 1.020 POL 7 Command Employees Take Responsibility for Every Aspect of Their Command	Not Sustained - Unfounded
# 2	5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)	Not Sustained - Inconclusive

Named Employee #2

Allegation(s):		Director's Findings
# 1	1.020 - Chain of Command, 1.020 POL 7 Command Employees Take Responsibility for Every Aspect of Their Command	Not Sustained - Unfounded
# 2	5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)	Not Sustained - Inconclusive
# 3	8.400-TSK-18 Use of Force - Responsibilities of the FIT Captain During a Type III Investigation	Not Sustained - Inconclusive
# 4	8.400-POL-5 Use of Force - Type III Investigations 10. The FIT Captain Will Notify the Assistant Chief of Professional Standards if Information is Obtained at any Stage of the Investigation That Suggests Either a Serious Policy Violation or Criminal Conduct	Not Sustained - Inconclusive

Named Employee #3

Allegation(s):		Director's Findings
# 1	1.020 - Chain of Command, 1.020 POL 7 Command Employees Take Responsibility for Every Aspect of Their Command	Not Sustained - Unfounded
# 2	5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)	Not Sustained - Inconclusive

Named Employee #4

Allegation(s):		Director's Findings
# 1	5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)	Not Sustained - Inconclusive

# 2	1.020 - Chain of Command, 1.020 POL 7 Command Employees Take Responsibility for Every Aspect of Their Command	Not Sustained - Unfounded
# 3	8.400-TSK-16 Use of Force - Responsibilities of the FIT Unit Sergeant During a Type III Investigation	Not Sustained - Inconclusive
# 4	15.080-POL-1 Follow-Up Unit Notification 2. Sergeants of Primary Investigating Units are Required to Notify Appropriate Follow-Up Unit Sergeants of Certain Incidents on a 24-Hour Basis	Not Sustained - Inconclusive

Named Employee #5

Allegation(s):		Director's Findings
# 1	5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)	Not Sustained - Inconclusive

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 the Named Employees failed to investigate an in-custody death thoroughly and follow governing protocols.

ADMINISTRATIVE NOTE:

The Office of Inspector General (OIG) found OPA's investigation thorough and objective but untimely. Specifically, OIG determined notices of receipt of complaint were not sent to the Named Employees within five days as their collective bargaining agreements required. While OPA acknowledges the notices were sent untimely, it notes that the delay did not impact the investigation or negatively impact the Named Employees. Further, OPA's overall investigation was timely completed, within 180 days as required by ordinance and collective bargaining agreements. Therefore, OPA respectfully dissents from OIG's untimeliness determination.

SUMMARY OF INVESTIGATION:

a. Complaint

The Complainant—a captain—submitted an OPA complaint outlining her review of a FIT investigation. The complaint alleged that Named Employee #3 (NE#3)—an acting lieutenant—screened the incident but unjustifiably declined to respond. It suggested NE#3's decision constituted a lack of supervision and was inconsistent with FIT callout procedures. The complaint also referenced Named Employee #4's (NE#4)—an acting sergeant—note that a sergeant who screened the matter at the scene failed to report applications of force.[1] The Complainant acknowledged that NE#4 responded, photographed Community Member #1 (CM#1)—the arrestee who died in custody—and sat in on an interview but suggested that further investigation was required. Specifically, the Complainant said a death

[1] OPA investigated that allegation under 2022OPA-0122.

investigation callout requires interviewing all officers, nurses, and inmates who contacted the subject and those nearby cells. The complaint noted that Named Employee #5 (NE#5)—a FIT detective—responded, was briefed, took measurements, and interviewed Nurse #1—a King County Jail (KJC) nurse, but did nothing else.

Further, the Complainant noted that FIT did not attend CM#1's autopsy and failed to timely document the results, which showed CM#1 had broken vertebrae. Considering the autopsy results, the Complainant opined that the case should have been referred to SPD's homicide unit that day. The complaint also noted that the death investigation was assigned to Witness Employee #1 (WE#1)—an officer on a 30-day FIT assignment—who lacked FIT, homicide, and investigation training or experience. The case was later reassigned to Witness Employee #2 (WE#2)—a FIT detective. The Complainant indicated that on April 26, 2022, NE#4 scheduled to interview involved SPD officers on May 3, 2022, when they should have been interviewed the next available day: "…even calling people in off-duty if needed."[2] The complaint flagged that involved Seattle Fire Department (SFD) employees were untimely interviewed, only one of six involved KCJ nurses was interviewed, and some KCJ officer interviews were not transcribed. The Complainant opined that Named Employee #1 (NE#1)—FIT's acting lieutenant—should have responded to the callout rather than deferring decision-making to an acting sergeant. Similarly, the complaint suggested that Named Employee #2 (NE#2)—FIT's captain—knew about the issues with the case and failed to respond, write a statement, or review it.

b. Memorandum of Understanding (MOU)

The King County Department of Adult and Juvenile Detention and SPD executed an MOU. It states that SPD will investigate in-custody deaths at KCJ.

c. FIT interviews

FIT interviewed three SFD employees who provided medical aid to CM#1.

1. SFD #1

SFD #1—a paramedic student—described the scene as chaotic when he arrived. He said other SFD personnel performed CPR on CM#1. SFD #1 said KCJ staff did not clearly explain what preceded CM#1's medical emergency but said it occurred soon after his KCJ booking. KCJ staff described CM#1 as verbally aggressive and said he became unresponsive in his cell.

2. SFD #2

SFD #2—a medic—said other SFD personnel performed CPR on CM#1 when he arrived. SFD #2 said he twice tried to intubate CM#1. He also described other performed medical procedures. SFD #2 recalled uncertainty among those at the scene about whether CM#1's medical emergency occurred at KCJ or before his booking. He said SFD #1 could not get a straight answer from KCJ staff.

3. SFD #3

SFD #3's—a medic—account was consistent with SFD #1 and SFD #2's.

[2] Two interviews were rescheduled for May 11, 2022, and another to May 31, 2022.

d. Case Investigation Report (CIR)

WE#2 wrote the related CIR. It indicated that Nurse #1 examined CM#1, observed his legs, and accepted him for KCJ booking since CM#1's leg condition "was something that would not go away..." Nurse #1 confirmed she conducted CM#1's KCJ intake screening. KCJ staff said there was no video inside CM#1's cell, where his medical emergency occurred. KCJ staff could also not identify inmates in nearby cells since they did not track cell assignments during the booking process. WE#2's CIR included CM#1's autopsy findings, including his broken vertebrae, believed to be caused by intubation.

e. Email Correspondence

Witness Employee #3—the FIT captain who replaced NE#2—emailed NE#2 asking why involved officers were not interviewed until May 11, 2022, when the callout was April 19, 2022. NE#2 replied:

> *The arrest occurred during third watch hours, the subject died at the jail after guards used force to move him into a holding cell. By the time we were notified and responded, the officers had been off shift for approximately 4 hours. It did not seem necessary to call them in for an interview at that point in time. After reviewing the body worn video for the officers, they used minimal force to detain the subject going so far as to put a pillow under his head to keep him from injuring himself. During the booking process the guards had to do what is called a change out. They had to use force to get him into the cell, get his clothes off and left him with jail clothes. At that point it was noticed that the subject was not moving. Nursing staff tended to the subject, them medic 1 transported him to HMC where he was pronounced dead. The HMC staff stated that the subject appeared to have passed from a coronary event. Further the video from the scene showed the subject being resistive, lifting moving alert and communicating (although nonsensical). The transport was done by AMR and was video recorded. During the transport, the subject was moving lifting himself up and communicating. At the jail, the subject was resistive, mobile, and communicating with guards. Based on all the available information it was clear the subject was not injured during the arrest by SPD but that something occurred at the jail triggering the fatal event. Based on the available information it was more important to get the interviews from jail staff, and less imperative to get the SPD officer's statement.*

f. FIT's Death In-Custody Investigations

OPA reviewed FIT's in-custody death investigations from 2019 to 2022 (15 cases), comparing the manner of death, FIT response, and interviews conducted. OPA found seven instances where at least an acting lieutenant responded.[3] KCJ officer interviews were generally requested on the day of the callout and occurred no later than the day after. OPA found four cases where KCJ nurse interviews occurred nearly a month up to almost three months after the incident. Similarly, OPA found five instances where SFD interviews occurred 1-2 months after the incident. Several cases did not include transcripts.

[3] Two CIRs for 2022 cases did not list who responded. It was also unclear whether an acting lieutenant responded on a 2020 case.

g. FIT Manual

FIT's manual outlines the required steps for Type III investigations:

> *For investigations involving death or potential death of a subject in the custody of the Seattle Police Department, the King County Jail, or the King County Youth Service Center, the Force investigation response will include a Force Investigation Commander, the Force Investigation Sergeant, and an appropriate number of detectives….In-Custody death investigations will not include any incident where reportable physical force was used on the subject by sworn Seattle Police personnel prior to death, those incidents will be investigated consistent with the Type 3 Use of Force Investigation Protocols.*

Further, FIT detectives must timely canvass to identify civilian witnesses and request audio-recorded interviews from those witnesses. Detectives must also conduct interviews and walkthroughs with involved and witness officers. Delayed in-custody death investigations require:

> *The Seattle Police Department Force Investigation Unit will be responsible for the investigation into inmate deaths that occur at a King County Department of Adult or Juvenile Detention Facilities located in the City of Seattle, consistent with our Memorandum of Understanding (MOU). The Force Investigation response to these incidents will be tailored to the specific circumstances present.*

FIT detectives will request audio-recorded statements for delayed in-custody death investigations if "the circumstances dictate." FIT sergeants will coordinate with FIT investigators concerning investigative strategies and canvassing efforts. FIT's commander will ensure a major incident summary is completed, but there is no response requirement.

h. OPA Interviews[4]

1. Complainant #1

On February 8, 2023, OPA interviewed Complainant #1—a captain assigned to review FIT's investigation. Her interview was generally consistent with the complaint. Complainant #1 concluded FIT's investigation was unthorough, incomplete, and inadequately supervised. She suggested that had the on-scene sergeant properly screened and reported applications of force, a full FIT callout, rather than an in-custody death response, would have been triggered. Complainant #1 said FIT conducted an inadequate initial investigation since only Nurse #1 was interviewed and not all KCJ's involved staff. She suggested CSI should have responded and the homicide unit notified. Last, Complainant #1 said interviews should have been transcribed.

2. Complainant #2

Complainant #2 served as a FIT sergeant for about six years. He said FIT sergeants ensured investigations were thorough and complete before elevating them to a lieutenant for review. Complainant #2 flagged issues with SFD reports and interviews. Specifically, he noted a report described CM#1 as actively resistant "before he went down,"

[4] OPA also interviewed the named employees.

but another said they were monitoring him when he stopped breathing. Complainant #2 said the autopsy report reflected neck fractures, rib fractures, blunt head, and other traumas "all stood out as it being more than just somebody passing away in the jail." He told OPA that interviewing involved parties as soon as possible was critical: "You get the immediate recollection of the officers. There's no delay in the reporting, it shows transparency and thoroughness of the investigation. It shows that you take force seriously…." Overall, Complainant #2 concluded FIT's investigation left several unanswered questions, including whether CM#1 actively resisted preceding his death, whether CM#1 fought in the holding cell and his condition upon entering the holding cell. Like Complainant #1, Complainant #2 questioned NE#1 and NE#2's lack of response and involvement.

ANALYSIS AND CONCLUSIONS:

Named Employee #1 - Allegation #1
1.020 - Chain of Command, 1.020 POL-7 Command Employees Take Responsibility for Every Aspect of Their Command

The Complainant alleged NE#1 inadequately supervised a FIT investigation.

Employees in a supervisory role will coordinate and direct subordinates and allocate resources to achieve operations objectives. SPD Policy 1.020-POL-7. Employees in a supervisory role will perform the full range of administrative functions relying upon policy, direction, training, and personal initiative as a guide for themselves and their command in achieving the highest level of performance possible. *Id.*

Here, NE#1 told OPA he was on vacation when the case came in on April 19, 2022, and returned on April 26th. However, based on the information provided and the FIT manual's definition, FIT considered the case a delayed in-custody death and followed the related response protocol. Specifically, NE#1 suggested that deaths at KCJ were typically considered delayed in-custody deaths. That interpretation was consistent with OPA's review of prior FIT responses to in-custody deaths at KCJ. Further, since the on-scene sergeant did not screen force applications with FIT, there was no indication that force was used. Similarly, NE#1 explained the case was not referred to the homicide unit because there were no initial indications it was necessary, and FIT guidelines did not require it at that time. Upon NE#1's return and case review, he determined it was a Type III investigation rather than an in-custody death since body-worn video showed officers takedown CM#1 and struggling to control him.

Accordingly, OPA recommends this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained - Unfounded**

Named Employee #1 - Allegation #2
5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)

The Complainant alleged NE#1 failed to adhere to FIT policies.

Employees must adhere to federal, state, and city laws, city policies, the SPD manual, published directives, special orders, and applicable collective bargaining agreements. SPD Policy 5.001-POL-2.

Here, upon NE#1's return to work, he appeared to review the investigation and provide directions immediately. While the complaint indicates he failed to respond to the callout, the evidence showed he did not return to work until a week thereafter. On April 27th, the day after he returned, emails showed NE#1 worked with his assistant chief and SPD's legal unit to arrange their viewing of SPD's uses of force against CM#1. Emails further showed NE#1's involvement until NE#2's review on August 22nd. NE#1 and NE#2 told OPA that FIT's practice was to review in-custody deaths and screen questionable cases with local prosecutors rather than referring them to the homicide unit. OPA spoke with the assigned assistant prosecutor, who complimented FIT's interviews and confirmed their collaboration on in-custody death cases. However, despite FIT's purported practice, Department policy suggests the homicide unit should have been notified.[5] *See* SPD Policy 15.080-POL-1.

Accordingly, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**

Named Employee #2 - Allegation #1
1.020 - Chain of Command, 1.020 POL-7 Command Employees Take Responsibility for Every Aspect of Their Command

The Complainant alleged NE#2 inadequately supervised a FIT investigation.

Here, records showed NE#2 was notified and involved with FIT's response from the start, including a briefing from NE#4 before FIT responded. For the reasons at Named Employee #1 – Allegation #1, OPA recommends this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained - Unfounded**

Named Employee #2 - Allegation #2
5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)

The Complainant alleged NE#2 failed to adhere to FIT policies.

For the reasons at Named Employee #1 – Allegation #2, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**

Named Employee #2 - Allegation #3
8.400-TSK-18 Use of Force - Responsibilities of the FIT Captain During a Type III Investigation

The Complainant alleged NE#2 failed to perform the responsibilities of a FIT captain for a Type III investigation.

[5] However, that responsibility is listed as a sergeant's duty.

Upon notification of a Type III investigation, the FIT captain will control the scene's inner perimeter, compel officers who used force to give an in-person interview (if necessary), alert OPA, monitor the investigation, evaluate the incident for tactical concerns and threats, and present the investigation to the Force Review Board and command staff. SPD Policy 8.400-TSK-18.

Here, while NE#2 did not immediately perform the FIT captain's responsibilities for Type III investigations, it was initially unclear that a Type III investigation was triggered. Specifically, due to the on-scene sergeant's inaccurate FIT screening, FIT was initially unaware that officers used force against CM#1.

Accordingly, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**

Named Employee #2 - Allegation #4

8.400-POL-5 Use of Force - Type III Investigations 10. The FIT Captain Will Notify the Assistant Chief of Professional Standards if Information is Obtained at any Stage of the Investigation That Suggests Either a Serious Policy Violation or Criminal Conduct

The Complainant alleged NE#2 failed to alert the assistant chief of professional standards about indications of serious policy violation and possible criminal conduct.

When possible criminal conduct is revealed, the FIT captain will alert OPA, screen the case with a case master, and consult with local prosecutors. SPD Policy 8.400-POL-5(a). For policy violations, the FIT captain will alert OPA and the involved officer's captain and refer the policy violation to the officer's chain of command when required. SPD Policy 8.400-POL-5(b).

For the reasons at Named Employee #2 – Allegation #3, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**

Named Employee #3 - Allegation #1

1.020 - Chain of Command, 1.020 POL-7 Command Employees Take Responsibility for Every Aspect of Their Command

The Complainant alleged NE#3 inadequately supervised a FIT investigation.

For the reasons at Named Employee #1 – Allegation #1, OPA recommends this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained - Unfounded**

Named Employee #3 - Allegation #2

5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)

The Complainant alleged NE#3 failed to adhere to FIT policies.

For the reasons at Named Employee #1 – Allegation #2, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**

Named Employee #4 - Allegation #1
5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)

The Complainant alleged NE#4 failed to adhere to FIT policies.

For the reasons at Named Employee #1 – Allegation #2, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**

Named Employee #4 - Allegation #2
1.020 - Chain of Command, 1.020 POL-7 Command Employees Take Responsibility for Every Aspect of Their Command

The Complainant alleged NE#3 inadequately supervised a FIT investigation.

Here, NE#5 notified WE#1 about FIT's investigation into CM#1's death. Although WE#1 was temporarily assigned to FIT, he had conducted two prior in-custody death investigations. WE#1's initial work on CM#1's case included attending the autopsy, requesting medical examiner reports, following up with KCJ for statements, arranging SFD statements, reviewing body-worn videos, and requesting medical records. NE#3 and NE#4 told OPA that WE#1 was assigned preliminary tasks due to the workload of other FIT officers. NE#4 said he intended to reassign the case to a detective once those initial tasks were completed, which did occur—it was assigned to WE#2.

Due to the limited tasks, NE#1 thought sending NE#4 and NE#5 was appropriate, and deploying more resources would have been unbeneficial. NE#1 also believed NE#4 and NE#5 could manage the response since scene processing was unnecessary and there was only one present witness to interview—Nurse #1. Further, NE#2 knew about the callout and discussed it with NE#4 before NE#4 and NE#5 responded to KCJ.

For those reasons, and those at Named Employee #1 – Allegation #1, OPA recommends this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained - Unfounded**

Named Employee #4 - Allegation #3
8.400-TSK-16 Use of Force - Responsibilities of the FIT Unit Sergeant During a Type III Investigation

The Complainant alleged NE#4 failed to perform the responsibilities of a FIT sergeant for a Type III investigation.

During a Type III investigation, the FIT sergeant will ensure the scene is photographed and processed, confirm that involved officers upload in-car and body-worn videos, review computer-aided dispatch to determine whether responding officers used force, arrange recorded statements from involved officers, arrange witness statements, and oversee the investigation as outlined by the FIT manual. SPD Policy 8.400-TSK-16.

For the reasons at Named Employee #2 – Allegation #3, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**

Named Employee #4 - Allegation #4
15.080-POL-1 Follow-Up Unit Notification 2. Sergeants of Primary Investigating Units are Required to Notify Appropriate Follow-Up Unit Sergeants of Certain Incidents on a 24-Hour Basis

The Complainant alleged NE#4 failed to timely notify the appropriate follow-units about CM#1's death investigation.

SPD's Homicide and Assault Unit should be contacted for homicides, assaults with injuries likely to result in death, and death investigations involving questionable circumstances. SPD Policy 15.080-POL-1.

For the reasons at Named Employee #2 – Allegation #3, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**

Named Employee #5 - Allegation #1
5.001 - Standards and Duties, 5.001 POL 2 Employees Must Adhere to Laws, City Policy, and Department Policy (Force Investigation Unit Procedure Manual)

The Complainant alleged NE#5 failed to adhere to FIT policies.

For the reasons at Named Employee #1 – Allegation #2, OPA recommends this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained - Inconclusive**