Seattle
Office of Police
Accountability

CLOSED CASE SUMMARY

ISSUED DATE: JUNE 13, 2023

FROM: DIRECTOR GINO BETTS
OFFICE OF POLICE ACCOUNTABILITY

CASE NUMBER: 2022OPA-0431

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	15.410 - Domestic Violence Investigation, 15.410-TSK-1 Patrol Officer Primary Investigation of a Domestic Violence Incident	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 (NE#1) inadequately investigated and reported a domestic violence (DV) incident.

ADMINISTRATIVE NOTE:

The Office of Inspector General certified OPA's investigation as thorough, timely, and objective.

During its intake investigation, OPA identified allegations against Witness Officer #1 (WO#1) and Witness Officer #2 (WO#2). The Complainant alleged that WO#1 was unprofessional when he told her she could be arrested for false reporting if she kept calling 9-1-1 for non-emergencies. The Complainant alleged WO#2 was unprofessional by referencing a prior interaction and covering his BWV. OPA returned those allegations to the chain of command for Supervisor Action.

The Complainant also alleged several officers violated policy by wearing "thin blue line" flags. OPA found those badges were Department-approved mourning bands. *See* SPD Policy 3.170-POL-1 ("Mourning Band: … the mourning band is solid black or black with a thin blue line in the middle."). Last, the Complainant alleged that officers failed to provide her with a protective detail. However, no SPD policy mandates assigning protective details, and the Complainant refused other safety accommodations. For those reasons, OPA did not classify those allegations.

SUMMARY OF INVESTIGATION:

The Complainant left a voicemail for OPA raising multiple allegations against officers who responded to a DV incident where she was the victim. As discussed above, several allegations were processed as Supervisor Actions or were not classified. OPA investigated the Complainant's allegation that NE#1 inadequately investigated the DV incident.

During its investigation, OPA reviewed the complaint, computer-aided dispatch (CAD) data, the incident report and supplements, body-worn video (BWV), and photographs. OPA also interviewed the Complainant and NE#1. NE#1's investigation and interactions with the Complainant were recorded on BWV.

In summary, the evidence showed the following:

The Complainant's neighbor called 9-1-1, reporting that the Complainant held two large knives while upset. NE#1, Witness Officer #3 (WO#3), and Witness Officer #4 (WO#4) were the first to arrive on the scene. The officers contacted the Complainant outside her apartment, who reported Community Member #1 (CM#1)—her roommate—assaulted her. The Complainant did not want to press charges. Instead, the Complainant emphasized that she wanted CM#1 committed under the Involuntary Treatment Act (ITA) and asked officers to help her retrieve her cat inside the apartment. WO#3 found two knives in the building's stairwell.

The Complainant said her keys were also inside the apartment. A building manager arrived with a spare key to the apartment, but officers were unsure whether they were authorized to enter. The Complainant asked whether they would enter, "If I say he pulled a knife on me, because he did, and I can show you." Three times on BWV, the Complainant told NE#1 that CM#1 was yelling in his room, banged on the Complainant's door, and entered. The Complainant said she screamed at CM#1 to leave. The Complainant said she left the room and grabbed a knife, which she held over her head and in front of her chest. The Complainant said she grabbed a knife because CM#1 approached her, screaming, "Give me my shit." The Complainant said CM#1 pinned her with a chair and tried to stab her. The Complainant said she broke free, grabbed two other knives, and left the apartment.

The Complainant grew agitated about having to repeat her story multiple times. NE#1 explained that he was trying to clarify the nature of the offense.

Eventually, WO#2 attempted to obtain a warrant to enter the apartment. CM#1's brother also arrived at the scene to try to de-escalate CM#1. While awaiting the warrant, CM#1 told his brother that he would "See [him] on the other side." The officers interpreted that as a suicidal threat. The officers entered the apartment and arrested CM#1. *See* SPD Policy 6.180-POL-1 (community caretaking is an exception to the warrant requirement.)

Witness Officer #4 (WO#4)—spoke with the Complainant. The Complainant pointed out the chair she alleged CM#1 assaulted her with and the knife she used in self-defense. WO#4 photographed the items but did not recover them.

The officers were on the scene for nearly three hours, from about noon until about 3:00 PM. Around 6:00 PM, NE#1 and WO#3 returned to the Complainant's apartment after she called to report more evidence needed to be collected. The Complainant pointed out the same chair and knife she had shown WO#4. NE#1 photographed the scene and text messages between the Complainant and CM#1. The officers also recovered the knife. Finally, the officer took a statement from the Complainant's father, who reportedly heard the incident over the phone.

The following morning, WO#1 responded to the Complainant's apartment after she called 9-1-1 to request additional evidence be collected. At the Complainant's request, WO#1 collected tinfoil and a jar of urine and took additional photographs.

ANALYSIS AND CONCLUSIONS:

Named Employee #1 - Allegation #1
15.410 - Domestic Violence Investigation, 15.410-TSK-1 Patrol Officer Primary Investigation of a Domestic Violence Incident

The Complainant alleged NE#1 inadequately investigated and reported a DV incident.

SPD Policy 15.410-TSK-1 sets forth the requirements for DV investigations. Officers must comply with SPD Policy 15.180, process the scene for evidence, and capture sufficient photographs of the scene and the victim's injuries.

Here, NE#1 was the primary officer for the call. NE#1 told OPA that the primary officer "…investigates the scene, documents the scene, and makes decisions on how the scene will go." OPA finds NE#1's investigation lacking in two respects. First, NE#1's incident report inaccurately reported the order of events reported by the Complainant. Specifically, NE#1 wrote that the Complainant retrieved one knife and two more *before* CM#1 used a chair to pin the Complainant. However, the Complainant consistently reported that she retrieved one knife, CM#1 used a chair to pin her, and then she escaped and retrieved two knives before fleeing the apartment. Similarly, NE#1 swapped the Complainant's description of her actions with the first knife as actions with the second and third knives. Second, NE#1 did not—by obtaining a warrant or determining whether a warrant was needed—recover the first knife during his primary investigation.

OPA notes that this complex scene involved shifting priorities and constitutional justifications for entering the apartment. Although NE#1 and WO#2 worked to obtain a warrant, that effort was abandoned after officers entered under the community caretaking exception. As NE#1 told OPA, "Normally, when entry is made under community caretaking, evidence is not gathered and collected." *See also* 6.180-POL-1 ("While entry may be justified under the emergency doctrine, a warrant will generally need to be obtained prior to further investigation or seizure of evidence."). Moreover, NE#1 and other officers spent hours engaging with the Complainant and speaking with CM#1 through the door. Ultimately, both mistakes were limited in effect. Regardless of how NE#1 wrote his report, the Complainant's statement was preserved multiple times verbatim on BWV. Also, the relevant evidence was ultimately collected by NE#1 on his second trip to the apartment.

OPA also notes that NE#1—who has worked less than four years as an SPD officer—has prior discipline in two cases for inadequate primary investigations. The first, 2021OPA-0317, involved failing to conduct a thorough and complete search for evidence in an assault investigation. The second, 2022OPA-0277, involved failing to thoroughly identify a suspect for the Charge-By-Officer Program. Unlike those prior cases, however, the investigatory lapses here were significantly less egregious and appeared more aligned with good faith mistakes during a confusing investigation than willful misconduct.

Accordingly, OPA recommends this allegation be Not Sustained – Training Referral.

- **Training Referral**: NE#1's chain of command should discuss OPA's findings with NE#1, review SPD Policies 15.410-POL-5 and 15.410-TSK-1 with NE#1, and provide retraining and counseling deemed appropriate. Retraining should emphasize the importance of complete, thorough, and accurate reports and

a thorough and complete search for evidence, especially in DV investigations. Retraining and counseling should be documented and maintained in Blue Team.

Recommended Finding: **Not Sustained - Training Referral**