




CLOSED CASE SUMMARY

ISSUED DATE: JULY 15, 2024

FROM: DIRECTOR GINO BETTS, JR. 
OFFICE OF POLICE ACCOUNTABILITY

CASE NUMBER: 2023OPA-0500

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	5.001 – Standards and Duties 10. Employees Shall Strive to be Professional (Effective March 1, 2018)	Not Sustained - Training Referral
# 2	6.180 – Searches-General, 6.180-POL-1 Community Caretaking Searches	Not Sustained - Lawful and Proper

Named Employee #2

Allegation(s):		Director's Findings
# 1	5.001 – Standards and Duties 10. Employees Shall Strive to be Professional (Effective March 1, 2018)	Not Sustained - Training Referral
# 2	6.180 – Searches-General, 6.180-POL-1 Community Caretaking Searches	Not Sustained - Lawful and Proper

Named Employee #3

Allegation(s):		Director's Findings
# 1	5.001 – Standards and Duties 10. Employees Shall Strive to be Professional (Effective March 1, 2018)	Not Sustained - Training Referral
# 2	6.180 – Searches-General, 6.180-POL-1 Community Caretaking Searches	Not Sustained - Lawful and Proper

Named Employee #4

Allegation(s):		Director's Findings
# 1	5.001 – Standards and Duties 10. Employees Shall Strive to be Professional (Effective March 1, 2018)	Not Sustained - Training Referral
# 2	6.180 – Searches-General, 6.180-POL-1 Community Caretaking Searches	Not Sustained - Lawful and Proper

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:

Named Employees #1, #2, #3, and #4 (NE#1, NE#2, NE#3, and NE#4) responded to a crisis call involving someone reportedly being thrown out an apartment window. The officers mistakenly entered the wrong apartment—a unit in



an adjacent building. The Complainant alleged that the named employees were unprofessional and unlawfully entered her apartment.

ADMINISTRATIVE NOTE:

On July 9, 2024, the Office of Inspector General certified OPA's investigation as thorough, timely, and objective.

SUMMARY OF INVESTIGATION:

A. OPA Complaint

On November 7, 2023, the Complainant filed a lawsuit against the City of Seattle, alleging that SPD officers responded "to an incident involving a person or persons, unknown to [the Complainant], who lived or resided in a different apartment ... building." The lawsuit alleged that officers "unlawfully broke down [the Complainant's] door, entered her apartment, and seized her person with drawn firearms."

OPA investigated the complaint, reviewing the computer-aided dispatch (CAD) call report, mobile data terminal (MDT) map, body-worn video (BWV), and police reports. OPA also interviewed the named employees. The Complainant's attorney did not respond to OPA's request to interview the Complainant.

B. Computer-Aided Dispatch (CAD) Call Report

On November 22, 2020, at 1:28 PM, CAD call remarks noted, "[REPORTING PARTY] SAYS HE IS IN A CRISIS, SAYS HE IS DRUNK AND HIGH ON METH[AMPHETAMINE] AND MARIJUANA, AND LAST NIGHT WAS FEELING SUIC[IDAL] AND WAS GOING TO CUT HIS WRIST BUT STOPPED. SAYS THERE ARE KNIVES INSIDE THE [APARTMENT], BUT NO[T] ARMED WITH ANY. HIS WIFE IS HERE WITH HIM. [REPORTING PARTY] SAYS HE WANTS A MENTAL HEALTH RESPONSE. [PERSONAL PROTECTIVE EQUIPMENT ADVISED]." CAD provided the street number for Building #1.

At 1:39 PM, dispatch noted a caller saying someone in an apartment was pushing another out a window. At 1:40 PM, dispatch noted another caller saying he heard yelling and a window breaking. The dispatcher also noted the caller saying someone had fallen from a window and was on the ground.

C. Maps – Mobile Data Terminal (MDT) and Aerial View





The left map depicted what responding officers saw on their computers (MDT). The red star marked the approximated incident location. The MDT map did not show building numbers. The map on the right depicted an aerial view of two adjoining buildings. Building #1 was the incident location.

D. Body-Worn Video (BWV)

The named employees responded to the incident location and activated their BWV, capturing the following:

NE#4 searched the side of a building and radioed that items, not a person, were on the ground. NE#4 radioed that officers would go to the apartment unit (Unit #1). NE#1, NE#3, and NE#4 arrived at Building #2's front door. NE#4 attempted to open the door, but it was locked. A resident opened the door for the officers, and they entered. NE#4 coordinated a contact team as they approached Unit #1. NE#1, NE#3, and NE#4 located Unit #1. NE#4 knocked and announced, "Seattle Police Department! Open the door, or we're coming in!" An inaudible female voice was heard. NE#4 announced, "Open the door now!" There was no response. NE#1 asked, "Should we kick it?" NE#4 knocked and announced, "Open the door, or we're kicking the door!" There was no response. NE#2 arrived at Unit #1. NE#1 breached the door with several mule kicks. NE#4 announced, "Seattle police!" The Complainant—unseen at this moment—asked, "What?" With weapons drawn, NE#1, NE#4, NE#3, and NE#2 entered Unit #1. NE#1 shouted, "Show me your hands!" In the kitchen, the Complainant asked, "Hello? What the fuck?" NE#1 asked, "Who else is inside?" The Complainant replied, "Nobody. I live alone. What the fuck? What the fuck are you doing?" The Complainant cried. NE#2 exited Unit #1 and responded to Unit #1 in Building #1. NE#4 radioed for the apartment number. NE#4 looked at the windows and told NE#1 they were not broken. NE#3 escorted the Complainant out of Unit #1. NE#1 and NE#4 searched Unit #1 and exited.

NE#3 explained to the Complainant why officers entered her apartment. NE#4 and NE#1 entered a back stairway and approached the courtyard. NE#4 told NE#1, "Oh shoot," and reapproached the Complainant and NE#3. NE#4 told NE#3, "This is the wrong address." The Complainant was shaking and crying. NE#4 told the Complainant, "Ma'am, we got a call that someone jumped out the window, okay?" The Complainant replied, "It's the wrong fucking address? Are you fucking kidding me? Oh my God!" NE#4 headed towards Building #2's front door as an officer asked for the floor number. NE#4 mentioned Unit #1 but said he thought this was Building #1. NE#4 exited Building #2, approached Building #1's front door, where Seattle Fire Department employees were present, and told NE#4 that the officers went to Unit #1. NE#4 and NE#3 entered Building #1, and NE#4 told NE#3, "Well, that ... was my bad, I..." NE#3 replied, "No, that's okay. I thought they [were] all connected." NE#4 said, "I was thinking, yeah, I was thinking it was the same one, too." NE#4 and NE#3 responded to the crisis incident in Unit #1 in Building #1.

NE#4 reapproached Building #2's front door [the building's number (circled in red below but redacted) was posted] where NE#1 and NE#3 were located:



NE#4 said, "I'm sorry, guys. That was 100 percent my bad." NE#3 pointed to the building number on the door and said, "Look at the number. It's like hidden."¹ NE#4 and NE#3 commented that they thought the buildings were connected. NE#4 said, "I'm glad it wasn't just me."

E. Police Reports

Named Employee #4's Incident Report

NE#4's incident report was consistent with BWV observations. NE#4 documented his justification for entering the Complainant's apartment unit:

Since there were reports of someone attempting to jump out the window and/or someone possibly being pushed out the window, officers made exigent entry into the apartment, believing that the subjects in the apartment were in danger, and kicked the door open.

Named Employee #1's Supplement Report

NE#1's supplement report was consistent with BWV observations. NE#1 documented his justification for entering the Complainant's apartment unit:

Due to the nature of the call, it was clear there was a life safety emergency occurring. Based on the updates to the call, several things appeared to be going on inside [...] the apartment. I believed an individual [might] have been purposefully pushed out of a 4-floor window in an attempted murder, that a domestic violence assault was occurring, the male party indicated he was currently bleeding out and dying, and there were glass shards/other debris raining down on the public sidewalk below endangering the public.... Due to the nature of the call and the now unresponsive occupant inside, I

¹ The building number was posted in the doorframes' upper-right corner.



determined that we needed to make [an] exigent entry to provide possible life-saving aid to the injured parties inside the unit.

Named Employee #3's Supplement Report

NE#3's supplement report was consistent with BWV observations. NE#3 documented his justification for entering the Complainant's apartment unit:

Based on the call updates, saying that a female subject was inside [...] the apartment, we believed we were at the correct location and with the correct subjects.... Officers and I believed we had exigent [circumstances] to make [forced] entry as there was [a] danger to possibly several people's [lives] and to preserve it. The call was reported as a suicidal male with his wife, and the updates we received [were] that someone had either fallen out the window or was in danger of falling out.

F. OPA Interviews

Named Employee #4

On February 19, 2024, OPA interviewed NE#4. NE#4 said he arrived at the southeast side of Building #2 and saw broken glass and items on the street but not a body. NE#4 expressed concern for the apartment residents because dispatch relayed that a male was suicidal and a female may have been pushed out the window. NE#4 denied seeing two entrances on the west of the buildings because he believed they were one building. NE#4 said he realized he entered the wrong building after he was in the courtyard and saw Building #1. NE#4 acknowledged that the number for Building #2 was in the upper right corner of the front door but denied seeing it because he was focused on the urgency of the call. NE#4 also acknowledged that had he walked around Building #2, he would have seen Building #1 but noted that walking around would have delayed his response to an urgent call.

Named Employee #1

On February 20, 2024, OPA interviewed NE#1. NE#1 believed the two buildings were one. NE#1 expressed concern for the apartment residents' safety and believed entry was necessary to protect life. NE#1 said he ensured the apartment unit number was correct before entering it. NE#1 said he found out he entered the wrong building when he followed NE#4 to the courtyard.

Named Employee #2

On February 26, 2024, OPA interviewed NE#2. NE#2 believed the two buildings were one. NE#2 noted that an apartment resident opened the front door for him, solidifying his belief that he was in the correct building. NE#2 said he found out he entered the wrong building when the Complainant expressed confusion about why officers entered her apartment.

Named Employee #3

On May 23, 2024, OPA interviewed NE#3. NE#3 said he arrived at the southeast side of Building #2 and entered without seeing the building number on the door. He expressed concern about the apartment residents' safety, so he



believed entry was necessary. NE#3 said he found out he entered the wrong building when the radio advised that officers were in another building.

ANALYSIS AND CONCLUSIONS:

Named Employee #1 – Allegation #1

5.001 – Standards and Duties 10. Employees Shall Strive to be Professional (Effective March 1, 2018)

The Complainant alleged that the named employees entered the wrong building, constituting unprofessionalism.

Employees shall “strive to be professional.” SPD Policy 5.001-POL-10 (effective March 1, 2018). Further, “employees may not engage in behavior that undermines public trust in the Department, the officer, or other officers.” *Id.*

There is no dispute that the named employees entered Building #2 when they should have entered Building #1. The building number for Building #1 was shown on MDT as the named employees responded to the incident location. The named employees could have verified the correct building number while they waited at the door before a resident opened it. The building number for Building #2, located in the upper right corner of the door, was visible on BWV. The named employees denied seeing the building number before entering Building #2, but they may have assumed it was the correct building because they followed NE#4’s lead. The named employees should have exercised greater diligence by confirming they were at the correct building before entry. This would have both avoided the intrusion on the Complainant and ensured the officers reached the area of actual need more quickly. Ultimately, OPA finds by a preponderance of the evidence that entry into Building #2 was based on a genuine misunderstanding. The named employees articulated their mistaken belief that the buildings were one. They also noted the urgency of the call, explaining why they failed to see the building number before entering. Given their mistaken but genuine belief, OPA finds there was a potential, but not willful, violation of policy that does not amount to serious misconduct. Under the circumstances, a training referral is warranted.

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

- **Training Referral:** The named employees’ chains of command should discuss OPA’s findings with them, including the importance of confirming the correct location when responding to a call, and provide any other retraining and counseling they deem necessary. Any retraining and counseling should be documented and maintained in Blue Team.

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

Named Employee #1 – Allegation #2

6.180 – Searches-General, 6.180-POL-1 Community Caretaking Searches

The Complainant alleged that the named employees unlawfully entered her apartment.

A community caretaking search does not require probable cause but shall be motivated solely by the perceived need to render aid or assistance. SPD Policy 6.180-POL-1. Officers will act under a community caretaking role in emergency action, not in their evidence-gathering role. *Id.* Officers may perform warrantless community caretaking searches when: (1) officers subjectively believe someone likely needs assistance for health or safety reasons; (2) officers



attempt to rouse anyone who may be unconscious before entering; (3) a reasonable person in the same situation would similarly believe there is need for assistance; (4) the place searched is associated with the need for the search; (5) there is an imminent threat of substantial bodily injury or substantial property damage; and (6) a specific person or property needs immediate health or safety assistance. SPD Policy 6.180-POL-1(1).

Here, OPA finds that the named employees acted under a valid community caretaking need, even though they searched the wrong apartment unit. The named employees subjectively believed the residents of Unit #1 needed assistance for health or safety reasons when they were dispatched to the call. This belief was reasonably based on multiple 911 callers reporting a disturbance involving yelling, a window breaking, and someone falling out a window. The named employees' police reports consistently documented a threat of substantial bodily injury and a person needing immediate health or safety assistance. NE#4's police report noted that "the subjects in the apartment were in danger." NE#1's police report documented a "life safety emergency" potentially involving attempted murder, domestic violence, and a male bleeding out and dying. NE#3's police report noted "danger to possibly several people's life and to preserve it." The emergency nature of the call is not in dispute.

Although the named employees mistakenly searched the Complainant's apartment, they had a good faith belief that her unit was the location where the reportedly suicidal male and the assaulted female were present. The named employees located the correct unit number, albeit in the wrong building, before entering that unit. When NE#4 knocked and announced himself at the Complainant's door, a female voice was inaudibly captured on BWV. Then, the Complainant remained silent and did not open the door despite repeated knocks and warnings that police would enter. NE#1's police report noted the "now unresponsive occupant inside" justified exigent entry "to provide possible life-saving aid to the injured parties inside the unit." Because the named employees acted in a community caretaking role in emergency action and were motivated by the perceived need to aid an injured person, OPA finds that they performed a valid community caretaking search, even though they searched the wrong unit.

Accordingly, OPA recommends this allegation be Not Sustained – Lawful and Proper.

Recommended Finding: **Not Sustained - Lawful and Proper**

Named Employee #2 – Allegation #1

5.001 – Standards and Duties 10. Employees Shall Strive to be Professional (Effective March 1, 2018)

For the reasons at Named Employee #1—Allegation #1, OPA recommends that this allegation be Not Sustained—Training Referral.

- **Training Referral:** The named employees' chains of command should discuss OPA's findings with them, including the importance of confirming the correct location when responding to a call, and provide any other retraining and counseling they deem necessary. Any retraining and counseling should be documented and maintained in Blue Team.

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

Named Employee #2 – Allegation #2

6.180 – Searches-General, 6.180-POL-1 Community Caretaking Searches



For the reasons at Named Employee #1—Allegation #2, OPA recommends that this allegation be Not Sustained—Lawful and Proper.

Recommended Finding: **Not Sustained - Lawful and Proper**

Named Employee #3 – Allegation #1

5.001 – Standards and Duties 10. Employees Shall Strive to be Professional (Effective March 1, 2018)

For the reasons at Named Employee #1—Allegation #1, OPA recommends that this allegation be Not Sustained—Training Referral.

- **Training Referral:** The named employees' chains of command should discuss OPA's findings with them, including the importance of confirming the correct location when responding to a call, and provide any other retraining and counseling they deem necessary. Any retraining and counseling should be documented and maintained in Blue Team.

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

Named Employee #3 – Allegation #2

6.180 – Searches-General, 6.180-POL-1 Community Caretaking Searches

For the reasons at Named Employee #1—Allegation #2, OPA recommends that this allegation be Not Sustained—Lawful and Proper.

Recommended Finding: **Not Sustained - Lawful and Proper**

Named Employee #4 – Allegation #1

5.001 – Standards and Duties 10. Employees Shall Strive to be Professional (Effective March 1, 2018)

For the reasons at Named Employee #1—Allegation #1, OPA recommends that this allegation be Not Sustained—Training Referral.

- **Training Referral:** The named employees' chains of command should discuss OPA's findings with them, including the importance of confirming the correct location when responding to a call, and provide any other retraining and counseling they deem necessary. Any retraining and counseling should be documented and maintained in Blue Team.

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

Named Employee #4 – Allegation #2

6.180 – Searches-General, 6.180-POL-1 Community Caretaking Searches

For the reasons at Named Employee #1—Allegation #2, OPA recommends that this allegation be Not Sustained—Lawful and Proper.



Recommended Finding: **Not Sustained - Lawful and Proper**