Seattle Office of Police Accountability

Closed Case Summary

Case Number: 2025OPA-0109

Issued Date: September 24, 2025

From: Director Bonnie Glenn
Office of Police Accountability

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Allegations of Misconduct & Director's Findings

Named Employee #1

1. **Allegation #1: 15.180 – Primary Investigations, 15.180-POL 1. Officers Shall Conduct a Thorough and Complete Search for Evidence**
   Finding: Sustained
2. **Allegation #2: 15.180 - Primary Investigations, 15.180-POL-5, Officers Shall Document all Primary Investigations on a Report**
   Finding: Sustained
3. **Allegation #3: 15.260 - Collision Investigations, 15.260-POL 5. Officers Refer Felony Collision Investigations to TCIS**
   Finding: Not Sustained - Unfounded

- **Imposed Discipline: Oral Reprimand**

This Closed Case Summary (CCS) represents the opinion of the OPA Director regarding the misconduct alleged and therefore sections may be written in the first person.

Executive Summary:

Witness Officer #1 (WO#1) and Named Employee #1 (NE#1) responded to a three-vehicle collision incident, resulting in the hospitalization of two complainants (Complainant #1 and Complainant #2). The complainants alleged that NE#1 conducted an unthorough investigation and prepared an unthorough report. OPA also investigated whether NE#1 failed to refer this incident to the Traffic Collision Investigation Squad (TCIS).

Administrative Note:

On August 14, 2025, the Office of Inspector General certified OPA's investigation as thorough, timely, and objective.

Summary of the Investigation:

In this investigation, OPA reviewed the OPA complaints, body-worn video (BWV), police traffic collision report (PTCR), and interview statements from the complainants and NE#1.

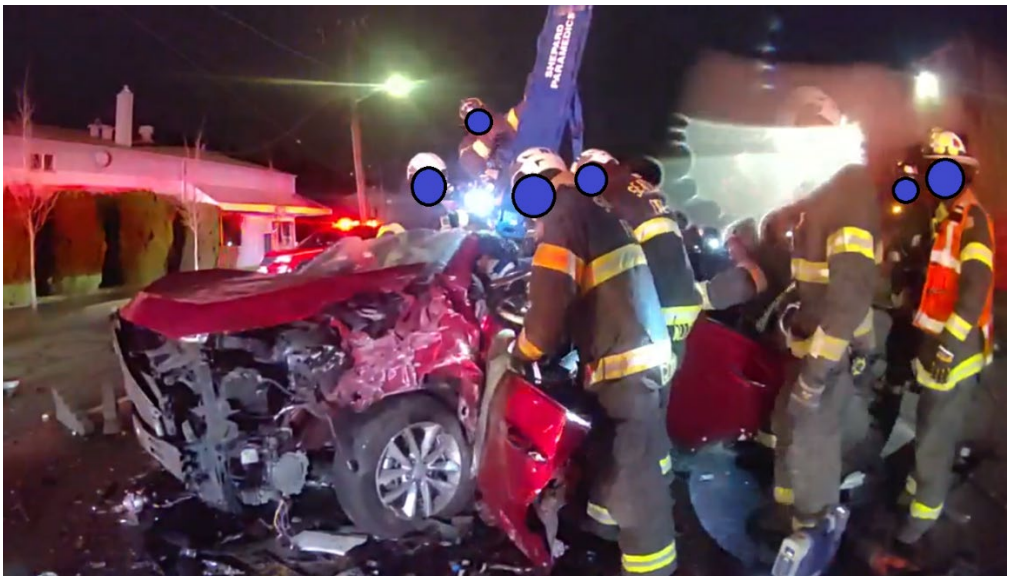
A. OPA Complaints

On March 28, 2025, two complainants submitted OPA complaints, stating that they were involved in a vehicular collision requiring their hospitalization. They wrote that Community Member #1 (CM#1), the party responsible for the collision, received only a citation when more serious charges could have been brought against her. They alleged that NE#1 conducted an unthorough investigation and prepared an unthorough report.

B. Body-Worn Video (BWV)

On December 22, 2024, BWV captured WO#1 driving to the collision site, with NE#1 in the passenger seat. Upon their arrival, Seattle Fire Department (SFD) personnel were already present.

The above image was taken from NE#1's BWV. SFD personnel removed Complainant #1, Complainant #2, and Complainant #1's stepson from this white vehicle.



The above image was taken from NE#1's BWV. CM#1, the driver of this red vehicle, allegedly caused the collision. SFD personnel cut the upper portion of this vehicle to remove CM#1.

NE#1 briefly interviewed Complainant #1 while he was being placed on a gurney and transported into an ambulance. Complainant #1 reported that CM#1 drove in the opposite lane, veered into his travel lane in what seemed to be an attempt to overtake another vehicle, and collided with him head-on. Complainant #1 said his brother (Complainant #2) and his stepson were in his vehicle. Complainant #1 provided a 1952 birth year.

NE#1 approached an American Medical Response (AMR) van, where CM#1 was secured to a gurney inside. NE#1 asked an SFD employee whether any alcohol had been found in CM#1's vehicle, to which she replied no. NE#1 then interviewed CM#1. CM#1 reported that she was driving home to change clothes. When NE#1 asked about the circumstances of the collision, CM#1 replied that she had "hydroplaned" while trying to exit. CM#1 did not respond to NE#1's question about whether she had consumed alcohol that day. NE#1 asked whether CM#1's nonresponse was due to her refusal to answer or due to pain, to which CM#1 replied that it was due to pain. NE#1 recounted Complainant #1's account to CM#1 and again asked whether CM#1 had consumed alcohol, to which CM#1 hesitated before replying, "Today I haven't." NE#1 sought clarification on whether CM#1 had attempted to change lanes. CM#1 began to answer but then fell silent. NE#1 handed a business card to CM#1 before leaving the van.

NE#1 told a backing officer that he lacked probable cause for a crime. NE#1 then contacted WO#1, who explained that CM#1 had rear-ended a vehicle, crossed the center lane, and collided head-on with Complainant #1's vehicle. WO#1 mentioned that a drug recognition expert was en route. WO#1 asked whether CM#1 was impaired, to which NE#1 replied that he could not determine that, while also noting that there was no alcohol in CM#1's vehicle. NE#1 approached an acting sergeant (Sergeant #1) on scene and asked whether he had contacted TCIS, which he confirmed. NE#1 explained to Sergeant #1 that he lacked probable cause for driving under the influence (DUI), as he observed no alcohol in CM#1's vehicle nor any indicators of impairment from CM#1, such as bloodshot or watery eyes. NE#1 also explained that

CM#1 denied consuming alcohol and appeared emotional and in pain. Based on this information, Sergeant #1 stated that this incident should be considered a "regular collision," which would result in an infraction for CM#1. Sergeant #1 explained that had CM#1 been impaired, she would have been charged with vehicular assault. Sergeant #1 instructed NE#1 to document the incident as a collision that was screened by a TCIS sergeant.

NE#1 photographed the scene. NE#1 then retrieved a plastic Ziploc bag containing multiple pills from the passenger side of CM#1's vehicle, identified their nature using his department-issued phone, and announced that they were alprazolam—an anxiety medication. Meanwhile, Community Member #2 (CM#2), who identified herself as a witness to the collision, was explaining her observations to WO#1, who had been seated in the driver side of his patrol vehicle at that moment. CM#2 reported that CM#1 was traveling 60 to 70 MPH, overtook her by driving in the opposite lane, halted well ahead of her, re-entered the opposite travel lane, and collided head-on with Complainant #1. CM#2 described CM#1 as driving "crazily" like a "fucking maniac." CM#2 expressed sympathy for Complainant #1.[1] NE#1 then approached the passenger side of the patrol vehicle, where CM#2 could be heard questioning, "What the hell [was CM#1] in such a hurry for?" CM#2 described CM#1 as a "dumb idiot" and wondered whether CM#1 was "drunk or something" or "unconscious." NE#1 replied that he was unable to disclose such information. CM#2 further inquired, "What the hell would someone need to drive like that for on a Sunday afternoon? Why didn't [CM#1] go to the right?" CM#2 then concluded her encounter with WO#1 and NE#1.

C. Police Traffic Collision Report (PTCR)

NE#1 prepared a PTCR in which he documented the collision. NE#1 wrote that CM#1 rear-ended a vehicle, veered into the opposite travel lane, and collided head-on with Complainant #1. NE#1 wrote that the complainants and CM#1 were transported to Harborview Medical Center (HMC) for treatment of their injuries, and their vehicles were towed. NE#1 wrote that CM#1 was cited for second-degree negligent driving due to the rear-end collision, the head-on collision, and multiple individuals requiring hospitalization.

D. OPA Interviews

<u>Complainants</u>

On April 10, 2025, OPA interviewed the complainants. Complainant #1 reported that his injuries were so severe that he needed a wheelchair and was suffering from ongoing complications. The complainants expressed frustration regarding NE#1's PTCR, which they believed did not adequately capture the incident. They expressed uncertainty about whether CM#1 had been evaluated for impaired driving,

[1] NE#1 did not hear this portion of the conversation. At that moment, NE#1 was approaching the patrol vehicle.

reckless driving, or any felony-level offenses. They believed NE#1 did not treat this incident with the seriousness it deserved and perceived a lack of diligence in NE#1's investigation.

Named Employee #1

On June 18, 2025, OPA interviewed NE#1. NE#1 said his first duty upon arrival was to secure the scene, which then shifted to investigation since SFD personnel were aiding the victims. NE#1 said Sergeant #1 screened the incident with TCIS, which decided against responding to the scene. NE#1 said he has conducted numerous DUI investigations and did not believe a drug recognition expert's presence was necessary. NE#1 said his investigation uncovered insufficient probable cause for DUI, as he did not find evidence in CM#1's vehicle and did not observe indicators of impairment from CM#1. NE#1 did not believe he had probable cause to seek a search warrant based on his investigation. Although NE#1 acknowledged finding anxiety medication in CM#1's vehicle, he believed it did not contribute to the collision. NE#1 said he would have developed probable cause if the medication had been narcotics. NE#1 felt that he was not required to check on the complainants at the hospital since TCIS declined to respond to this incident. NE#1 recalled hearing from the driver who was rear-ended that CM#1 drove erratically by weaving in and out of traffic and driving in the wrong lane. NE#1 said he reviewed the law and concluded that issuing a traffic infraction was the most suitable outcome, as he did not consider CM#1's conduct to be criminal. Although NE#1 said he could not recall CM#2 recounting her observations of the collision to WO#1, he believed he had already gathered sufficient information for his investigation at the time.

Analysis and Conclusions:

Named Employee #1 – Allegation #1

15.180 – Primary Investigations, 15.180-POL-1. Officers Shall Conduct a Thorough and Complete Search for Evidence

The complainants alleged that NE#1 conducted an unthorough investigation.

In primary investigations, officers must conduct a thorough and complete search for evidence. SPD Policy 15.180-POL-1. Sworn personnel must know how to collect the most common physical evidence that might be encountered in a primary investigation. *Id.*

NE#1's investigation involved interviewing the parties to the extent feasible, investigating whether CM#1 was impaired, photographing the scene, assessing the damage to the vehicles, consulting with SFD personnel and Sergeant #1, and discovering alprazolam in CM#1's vehicle. OPA finds that NE#1's investigation could have been improved and thorough for the following reasons.

First, NE#1 could have investigated further into the possibility of CM#1's impairment. CM#1's behavior during questioning indicated evasiveness, as evidenced by her incoherent responses or moments of silence. Moreover, the manner of NE#1's questioning was problematic, as he might have influenced CM#1's responses by recounting Complainant #1's narrative to her before obtaining her own account. At this point, NE#1 might have reasonably concluded that CM#1 was not impaired, especially since SFD personnel neither found any alcohol in CM#1's vehicle nor reported any observations to NE#1 that would indicate impairment. However, NE#1's discovery of anxiety medication in CM#1's vehicle should have warranted further investigation into the possibility of CM#1's impairment. Aside from identifying the medication as alprazolam, NE#1 did not investigate its circumstances, such as alprazolam's side effects, the possibility of CM#1 having overdosed, the rationale for it being stored in a plastic Ziploc bag rather than a prescription bottle, or the effects of alprazolam on the human body. At the very least, the discovery of alprazolam under questionable circumstances should have warranted further investigation. NE#1's belief that alprazolam did not contribute to the collision lacked any factual basis without such investigation.

Second, NE#1 had the opportunity to obtain a full account from a witness who not only observed the collision but also observed CM#1's driving before the collision. Before NE#1 reached his patrol vehicle, where CM#2 was detailing her observations to WO#1, NE#1 had only a limited understanding of the incident; specifically, he did not have information about CM#1's driving behavior before the collision. CM#2 had pertinent information on this matter, which might have guided NE#1's evaluation of CM#1's possible impairment. After NE#1 arrived at his patrol vehicle, he had already heard several statements from CM#2 suggesting she had observed the collision, particularly as she remarked that CM#1 was in a hurry, a "dumb idiot," and driving "like that" on a Sunday afternoon. NE#1 had the opportunity to further inquire with CM#2, an independent witness to the collision, but he chose not to do so.

Third, NE#1 might have uncovered additional facts for his investigation had he visited HMC to understand the extent of the parties' injuries. The collision was so severe that SFD personnel had to cut the upper portion of CM#1's vehicle to remove CM#1. Given this fact, as well as NE#1's discovery of anxiety medication under questionable circumstances, CM#1's reluctance or refusal to answer questions, and an independent witness stating that CM#1 was speeding, a medical evaluation of the parties' injuries could have provided further insight into the circumstances surrounding the collision.

To the extent that NE#1 classified this incident as a collision and only cited CM#1 for an infraction, OPA recognizes that Sergeant #1 had instructed NE#1 to proceed in that manner. However, Sergeant #1's decisions were based on the information he received from NE#1, who at the time conducted an incomplete investigation. Overall, OPA finds NE#1's investigation was not thorough or complete, based on the evidence provided, by a preponderance of the evidence. Thus, OPA finds this allegation sustained.

Accordingly, OPA recommends that this allegation be Sustained.

Recommended Finding: **Sustained**

Named Employee #1 – Allegation #2

15.180 – Primary Investigations, 15.180-POL-5. Officers Shall Document all Primary Investigations on a Report

The complainants alleged that NE#1 prepared an unthorough report.

Officers must document all primary investigations in a report. SPD Policy 15.180-POL-5. All reports must be complete, thorough, and accurate. *Id.*

This incident was a significant motor vehicle collision. Three people were transported to the hospital and two people were extracted out of vehicles. The significance of this incident was not reflected in detail in his police report. NE#1 accurately documented a general account of how the collision occurred based on the information he received. However, NE#1's PTCR was not complete, thorough, or accurate. It did not include specific details, such as the parties' injuries, Complainant #1's advanced age (73), NE#1's rationale for declining a DUI or vehicular assault charge, NE#1's observations of CM#1's behavior, NE#1's discovery of alprazolam in CM#1's vehicle and his reasoning for why it did not contribute to the collision, CM#1's reported speeding before the collision, and CM#2's witness statement. Overall, OPA finds NE#1's police report was not complete, thorough, or accurate, based on the evidence provided, by a preponderance of the evidence. Thus, OPA finds this allegation sustained.

Accordingly, OPA recommends that this allegation be Sustained.

Recommended Finding: **Sustained**

Named Employee #1 – Allegation #3

15.260 – Collision Investigations, 15.260-POL-5. Officers Refer Felony Collision Investigations to Traffic Collision Investigation Squad (TCIS)

OPA alleged that NE#1 failed to refer this incident to TCIS.

Officers must refer felony collision investigations to TCIS. SPD Policy 15.260-POL-5. Officers should not issue tickets in a felony collision investigation. *Id.* Investigations requiring no TCIS response at the time of an on-scene investigation, but might develop into a felony, must be referred to TCIS.

This allegation is unfounded since NE#1 screened this incident with Sergeant #1, who then screened the incident with TCIS. Although there appeared to be facts suggestive of vehicular assault, a felony offense, NE#1 believed the facts did not amount to vehicular assault—a belief predicated on NE#1's incomplete investigation. Had NE#1 conducted a more thorough investigation, Sergeant #1 would have likely conveyed a more comprehensive account to TCIS, which might have responded to the scene. Ultimately, TCIS was consulted about this incident.

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

Recommended Finding: **Not Sustained – Unfounded**