Seattle
Office of Police
Accountability

CLOSED CASE SUMMARY

ISSUED DATE: OCTOBER 30, 2017

CASE NUMBER: 2017OPA-0318

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	13.031 - Vehicle Eluding/Pursuits 19. Supervisors Will Review Video and Each Officer's Blue Team Entry	Sustained
# 2	13.031 - Vehicle Eluding/Pursuits 20. Eluding Incidents Ending in a Vehicle Collision Trigger Notifications	Not Sustained (Lawful and Proper)
# 3	8.400-POL-1 Use of Force - Reporting and Investigation Type III	Not Sustained (Inconclusive)
# 4	8.400 - Use of Force Reporting and Investigation 3. The Sergeant Will Review the Incident and Do One of the Following:	Not Sustained (Inconclusive)
# 5	8.300 - Use of Force Tools 8.300-POL-10 Use of Force - Neck and Carotid Restraints	Not Sustained (Unfounded)
# 6	8.400-TSK-6 Use of Force - Responsibilities of the Sergeant During a Type II Investigation 13. Evaluates the incident for any concerns (tactical, threat assessment, etc.)	Not Sustained (Inconclusive)

Imposed Discipline

Oral Reprimand

Named Employee #2

Allegation(s):		Director's Findings
# 1	8.200 - Using Force 1. Use of Force: When Authorized	Not Sustained (Lawful and Proper)
# 2	8.300-POL-3 Use of Force - CEW/Conducting Electric Weapons (Taser) 4. Officers Shall Only Deploy CEW When Objectively Reasonable.	Not Sustained (Management Action)
# 3	8.300-POL-3 Use of Force - CEW/Conducting Electric Weapons (Taser) 6. Officers Shall Issue a Verbal Warning to the Subject and Fellow Officers Prior to Deploying the CEW	Not Sustained (Management Action)
# 4	8.300-POL-10 Use of Force - Neck and Carotid Restraints 1. Officers Are Prohibited From Using Neck and Carotid Restraints Except When Deadly Force is Justified	Not Sustained (Unfounded)

Named Employee #3

Allegation(s):		Director's Findings
# 1	13.031 - Vehicle Eluding/Pursuits 3. Officers Will Not Pursue Without Justification	Not Sustained (Training Referral)
# 2	13.031 - Vehicle Eluding/Pursuits 18. All Officers Involved in a Pursuit will complete a Blue Team Vehicle Pursuit Entry	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 there was an out of policy pursuit initiated and not reported by Named Employee #3 (NE#3) and the reviewing sergeant, Named Employee #1 (NE#1), failed to ensure all officers involved complete a Blue Team Vehicle Pursuit Entry and follow appropriate policy given that the eluding incident ended in a vehicle collision. The Complainant further alleged that Named Employee #2 (NE#2) may have used a neck restraint and CEW (Taser) application in violation of SPD policy and that NE#1 failed to classify and properly report the Type III (use of neck restraint reported by officer) and ensure FIT was notified of a neck restraint as required by policy, and failed to identify the CEW (Taser) application as an out of policy application.

ANALYSIS AND CONCLUSIONS:

Named Employee #1 - Allegation #1
13.031 - Vehicle Eluding/Pursuits 19. Supervisors Will Review Video and Each Officer's Blue Team Entry

SPD Policy 13.031-POL-19 sets forth supervisors' responsibilities in the context of documenting a pursuit. With regard to sergeants, these include, but are not limited to: reviewing ICV and/or other video to determine whether a pursuit did, in fact, occur; ensuring that all officers involved in the pursuit complete a Blue Team Vehicle Pursuit entry and that the involved officer complete a General Offense Report; and reviewing each such entry and report. (*See* SPD Policy 13.031-POL-19.)

In the aftermath of the incident, NE#1 consulted with a witness sergeant concerning whether a pursuit had occurred. The sergeant stated that while he was not completely sure whether it was a pursuit, he was inclined to have the involved officers complete pursuit entries. (Witness Sergeant OPA Interview, at pp. 2-3.) The witness sergeant, who at that point was intending on handling the pursuit and collision, anticipated watching the video upon his return to the precinct and making a final decision. (*Id.* at p. 3.) He recalled that a witness lieutenant was also at the scene and the witness lieutenant indicated his belief that it was likely a pursuit. (*Id.* at pp. 3-4.) This was confirmed by the witness lieutenant at his OPA interview. (Witness Lieutenant OPA Interview, at pp. 2-3.) While the witness lieutenant did not order the sergeants to go forward with documenting the incident as a pursuit (*Id.* at p. 3), the witness sergeant had the impression that he was "leaning" in that direction. (Witness Sergeant OPA Interview, at p. 4.) In explaining why he did not definitively direct the sergeants to document the incident as a pursuit, the witness lieutenant explained that even though he believed it to be a pursuit he thought it was the sergeants' responsibility to review the policy and make their own decisions. (Witness Lieutenant OPA Interview, at pp. 3-4.)

The witness sergeant then volunteered to contact the Traffic Collision Investigation Squad (TCIS) based on the collision. (Witness Sergeant OPA Interview, at p. 4.) After doing so, he was informed by TCIS that the determination of whether it was a pursuit was ultimately up to Patrol. (*Id.* at pp. 4-5.) The witness sergeant then spoke with NE#1, who indicated that he would take over the investigation. (*Id.* at p. 5.) The sergeant also spoke with NE#3. (*Id.* at p. 5-6.) He recalled telling NE#3 that NE#1 was taking over the investigation and that it was probably going to "end up" as a pursuit. (*Id.*)

NE#1 stated that he spoke to NE#2 and NE#3 at the scene and obtained their accounts of the incident. (NE#1 OPA Interview, at pp. 2-3.) He later watched the ICV of the incident when he returned to the precinct. (*Id.* at p. 3.) After doing, so NE#1 did not believe that a pursuit had occurred. (*Id.*) This was the case even though the lieutenant had previously indicated his belief that it was, in fact, a pursuit. (*Id.* at pp. 4-5.) He decided, however, to take the issue to another lieutenant. (*Id.* at pp. 3-4.) In his use of force review, NE#1 indicated that he and the lieutenant agreed that NE#3's actions did not constitute a pursuit. (*Id.* at p. 4; *see also* NE#1 Use of Force Review.) During his OPA interview, the lieutenant indicated that NE#1 only provided him with limited information concerning NE#3's actions

and then NE#1 asked him to opine as to whether it was a pursuit. (Lieutenant OPA Interview, at p. 3.) Specifically, the lieutenant recounted that he was only told that NE#3 switched on her emergency lights to make a U-turn to follow the subject vehicle and when she re-acquired the vehicle it had crashed. (*Id.*) Based on these facts, the lieutenant stated that he had no reason to believe that it was a pursuit. (*Id.*) The lieutenant conveyed that he later spoke to the witness lieutenant and learned that the witness lieutenant was at the scene. (*Id.* at p. 4.) The witness lieutenant indicated to the lieutenant his belief that it was a pursuit and that he conveyed this information to NE#1 at the scene. (*Id.* at pp. 4-5.) The lieutenant reported that he was "dismayed" that NE#1 did not disclose this during their screening conversation. (*Id.* at p. 4.)

As explained more fully below, I find that NE#3 engaged in a pursuit (*see* NE#3, Allegation #1), and, as such, NE#1 was obligated to satisfy the requirements of this policy.

While NE#1 stated that he reviewed video of the incident, he indicated that he did so by reviewing it with NE#3. (NE#1 OPA Interview, at p. 3.) NE#1 stated that he did not, himself, log into the system to view the video. (*Id.*) Moreover, it was unclear from NE#1's OPA interview how much of the video he watched. As NE#1 stated at his OPA interview: "And I, I don't know that I watched everything from the very beginning to the, to the very end of the video itself but I watched, you know, the part where the vehicle crashed and all that stuff." (*Id.*) It is also unclear how NE#1 deemed the incident to not rise to the level of a pursuit, but still screened and approved the request for a charge of felony eluding in the General Offense Report.

Even if NE#1 did satisfy the portion of the policy concerning review of video, he failed to ensure that the officers involved in the pursuit completed Blue Team Vehicle Pursuit entries. Indeed, NE#1 specifically instructed NE#3 not to do so. (*Id.* at p. 5.) This constitutes a violation of the policy.

Lastly, I find the miscommunications between the supervisors involved in this incident to be concerning. Until the matter was elevated to the lieutenant, no supervisor seemed willing to make a definitive determination as to whether the incident was a pursuit. The witness lieutenant, who was the highest-ranking supervisor at the scene, believed it was a pursuit but abdicated any decision making by pushing this question back on to the sergeants. While I recognize the importance of sergeants being empowered to make decisions, there was obvious confusion at the scene and the witness lieutenant should have filled that void by definitively finding that the incident was a pursuit and instructing the sergeants to ensure that the incident was documented as such.

For these reasons, I recommend that this allegation be Sustained.

Recommended Finding: **Sustained**

Named Employee #1 - Allegation #2
13.031 - Vehicle Eluding/Pursuits 20. Eluding Incidents Ending in a Vehicle Collision Trigger Notifications

SPD Policy 13.031-POL-20 states that when an eluding vehicle is involved in a collision, a sergeant will respond to the scene regardless of whether a pursuit of the eluding vehicle had been initiated by an officer. The responding sergeant is further required to notify TCIS. (SPD Policy 13.031-POL-20.)

Here, NE#1 coordinated with the witness sergeant to have him contact TCIS while NE#1 handled the investigation into the use of force. (*See* NE#1 OPA Interview, at p. 6; Witness Sergeant OPA Interview, at p. 2.) The witness sergeant did so and screened the incident with a sergeant from TCIS. (Witness Sergeant OPA Interview, at p. 2; Witness Sergeant ICV.) Ultimately, TCIS declined to respond to the scene of the collision. (Witness Sergeant OPA Interview, at p. 2.) After that point, NE#1 volunteered to all take over the pursuit investigation, to which the witness sergeant agreed. (*Id.* at pp. 2-3.)

As NE#1 coordinated with the witness sergeant to ensure that TCIS was notified, he acted in compliance with this portion of the policy. Accordingly, I recommend that this allegation be Not Sustained – Lawful and Proper.

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

Named Employee #1 - Allegation #3
8.400-POL-1 Use of Force - Reporting and Investigation Type III

When an officer uses Type III force or where the force involves serious misconduct, the reviewing sergeant is required to call the Force Investigation Team (FIT) Captain and screen a Type III response by FIT. (*See* SPD Policy 8.400-POL-1.)

Here, NE#1 screened the force used by NE#2 at the scene, which included contact made between NE#1's arm and the subject's neck and a Taser application. (NE#1 OPA Interview, at pp. 6-7.) He spoke to NE#2 and received his account of the force. (*Id.*) NE#1 later spoke to the subject concerning the level of force used. (*See* Subject Use of Force Interview.) NE#1 did not initially contact and screen this incident with FIT because, based on his preliminary investigation, he did not believe that NE#2 had used Type III force and he apparently did not believe that any of the force was outside of policy. (*See* NE#1 OPA Interview, at pp. 7-10; *see also* NE#1 Use of Force Review.)

I find that NE#2 did not apply a neck or carotid hold, as such, I do not believe that NE#1 was required by policy to screen this matter with FIT.

While I believe NE#2's Taser application to have been questionable, I do not believe that it was so clearly serious misconduct so as to provide NE#1 notice that he was required to call FIT and screen a Type III response. While that may have been best practice, I cannot conclusively find that NE#1's failure to do so violated policy.

As such, I recommend that this allegation be Not Sustained - Inconclusive.

Recommended Finding: **Not Sustained (Inconclusive)**

Named Employee #1 – Allegation #4
8.400 - Use of Force Reporting and Investigation 3. The Sergeant Will Review the Incident and Do One of the Following:

For the same reasons as stated above, I recommend that this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained (Inconclusive)**

Named Employee #1 - Allegation #5
8.300 - Use of Force Tools 8.300-POL-10 Use of Force - Neck and Carotid Restraints

NE#1 did not apply a neck or carotid restraint against the subject. For this reason, I recommend that this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained (Unfounded)**

Named Employee #1 - Allegation #6
8.400-TSK-6 Use of Force - Responsibilities of the Sergeant During a Type II Investigation 13. Evaluates the incident for any concerns (tactical, threat assessment, etc.)

SPD Policy 8.400-TSK-6(13) requires a sergeant screening a Type II use of force to evaluate the incident for any concerns. Where, for example, "it appears that serious misconduct may have been involved with the use-of-force, the sergeant will ensure that OPA is contacted and consult the FIT team regarding reclassification of the incident as Type III." (SPD Policy 8.400-TSK-6(13).)

From the Type II investigation conducted by NE#1, it is evident that he did not believe that either NE#2's Taser application or the incidental contact NE#1 made with the subject's neck constituted serious misconduct. (*See* NE#1 Use of Force Review.) However, in her review, the administrative lieutenant noted concerns with NE#2's use of force statement, particularly the lack of information concerning the active resistance prior to the Taser application and the fact that, at the time the force was used, the subject was running away from the officer. (*See* Administrative Lieutenant Use of Force Review.) The lieutenant disagreed with NE#1's finding that the force was within policy and referred to OPA the Taser application and NE#1's failure to notify OPA of potential misconduct. (*See* Initial Complaint Summary.)

While I find that the contact with the subject's neck was inadvertent and did not constitute either potential misconduct or Type III force, I conclude that the Taser application was questionable. As indicated above, however, I cannot conclusively find that the Taser application was so clearly serious misconduct that NE#1 was on notice that he was required to contact OPA and consult with FIT. Accordingly, I cannot recommend that this allegation be Sustained based on his failure to do so.

For these reasons, I recommend that this allegation be Not Sustained – Inconclusive.

Recommended Finding: **Not Sustained (Inconclusive)**

Named Employee #2 - Allegation #1
8.200 - Using Force 1. Use of Force: When Authorized

Based on OPA's review of this case, it appears that NE#2 used force two separate times. The first was that force used to attempt to take the subject into custody, which included the incidental contact made with the subject's neck. The second was the Taser application to the subject. Whether the Taser application was reasonable, necessary and proportional is discussed below. (*See* NE#2, Allegations #2 & #3.) As such, I only evaluate the first use of force here.

Manual Policy 8.200(1) requires that force used by officers be reasonable, necessary and proportional. Whether force is reasonable depends "on the totality of the circumstances" known to the officers at the time of the force and must be balanced against "the rights of the subject, in light of the circumstances surrounding the event." (8.200(1).) The policy lists a number of factors that should be weighed when evaluating reasonableness. (*See id.*) Force is necessary where "no reasonably effective alternative appears to exist, and only then to the degree which is reasonable to effect a lawful purpose." (*Id.*) Lastly, the force used must be proportional to the threat posed to the officer. (*Id.*)

Here, I find that the first force used by NE#2 to take the subject into custody was reasonable, necessary, and proportional, and thus consistent with policy.

First, with regard to reasonableness, NE#2 had probable cause to believe that the subject had engaged in reckless driving, had eluded police, and had been involved in a hit and run. When the subject ran from NE#2, it was reasonable for NE#2 to grab the subject and use de minimis force in order to secure the subject and place him under arrest.

Second, with regard to whether the force was necessary, I find that, at the time the force was used, NE#2 believed that there was no reasonably effective alternative and that the degree of force was reasonable to effect the lawful purpose of placing the subject under arrest and preventing him from fleeing again.

Third, with regard to the proportionality of the force, NE#2 used de minimis force commensurate with the subject's conduct, and only that level of force needed to attempt to control the subject and place him under arrest.

As such, I recommend that this allegation be Not Sustained – Lawful and Proper.

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

Named Employee #2 - Allegation #2

8.300-POL-3 Use of Force - CEW/Conducting Electric Weapons (Taser) 4. Officers Shall Only Deploy CEW When Objectively Reasonable.

When this DCM was originally submitted on September 20, 2017, I recommended that this allegation be Sustained. My recommendation was based on my belief that the Taser application in question was outside of policy and that NE#2 failed to appropriately balance the need to use the Taser to take the subject into custody and prevent a potential physical confrontation against the significant threat of harm to the subject under the circumstances. The main substance of my previous conclusion is set forth below:

> *Instead, based on my review of the evidence and applying a preponderance of the evidence standard, I find that NE#2's Taser application was not objectively reasonable and was contrary to policy. First, I do not find any evidence suggesting that the subject posed an imminent threat of harm to NE#2 or to any other member of the public. The subject did not assault or attempt to assault NE#2, NE#2 had no reason to believe that the subject was armed, and, based on the information known to NE#2, the subject was not involved in any crime of violence. Notably, no charge of assault or any other crime of violence was identified in the General Offense Report. (See*

General Offense Report.) Second, I further conclude that NE#2 did not establish that it was likely that injury would have occurred had he attempted to use other tactics to take the subject into custody. Indeed, the subject and NE#2 had several prior physical interactions none of which resulted in injuries. In order to meet this standard, I conclude that there needs to be some actual evidence that injury is likely. Based on NE#2's statements, I do not believe that such evidence was presented here.

The Ninth Circuit has recognized that, based on "[t]he physiological effects, the high levels of pain, and foreseeable risks of physical injury" attendant with Taser usage, Tasers represent "a greater intrusion than other non-lethal methods of force." Bryan v. McPherson, 630 F.3d 805, 825 (9th Cir. 2010). This seems particularly the case when the Taser is used on a subject who is running away from an officer on a hard surface and, if Tased, could fall and suffer serious injuries. Notably, Taser's training materials warn that the use of a Taser on a fleeing subject can result in an elevated risk of harm. Consistent with that caution, the Police Executive Resource Forum (PERF) recommends engaging in an analysis of the risk of injury to a fleeing subject (as well as an analysis as to the severity of the offense and the subject's level of threat to the officer and others) prior to using a Taser.

Here, it is unclear whether NE#2 evaluated the risk of potentially serious injury to the subject from the application of the Taser. I find that this risk outweighed the possibility that injury might have occurred had NE#2 instead made physical contact with the subject to take him down to the ground. While there are certainly scenarios where the use of a Taser on a fleeing subject would be permissible and consistent with policy, I conclude that it was not under the specific facts of this case.

At the discipline meeting in this matter, NE#2's chain of command raised the issue of NE#2's training. Specifically, the chain of command indicated their belief that NE#2 acted consistent with his training when he utilized his Taser in this instance. If this was, in fact, the case, I agreed with the chain of command that it would warrant a revisiting of my previous recommendation. OPA and the chain of command agreed to request an extension of the 180-day deadline in order to conduct additional interviews to determine what training NE#2 received regarding the use of a Taser on a fleeing suspect and whether, in the view of the Training Unit, NE#2 acted consistent with his training in this case. The Seattle Police Officers' Guild agreed to extend the 180-day deadline for 45 days to allow for this further investigation.

OPA then conducted review of Department training materials and interviewed an officer, lieutenant, and captain assigned to the Training Unit.

The Training officer is designated as the Department's Taser coordinator and subject matter expert. He explained that officers are trained that they can only use a Taser on a fleeing subject if there is an imminent threat of harm. The Taser coordinator detailed the specific training scenario involving a fleeing subject. In that scenario, the subject pulls away from officers and is observed running away towards a flight of stairs prior to being tased. After watching the training scenario, the coordinator asks the officers questions about what they have seen and they engage in "a very good discussion." He recounted that some officers believe the Taser application in the training scenario to be within policy and some do not. He does not provide a definitive answer to this question. When teaching Taser usage,

the coordinator uses an acronym – RABIES – that stands for "Risk And Benefit In Every Situation." He expects that officers will evaluate the risks and benefits before using a Taser, and if the benefits "are far above" the risk then the application is then justified and consistent with policy. SPD does not provide training on the specific injuries that could result from using a Taser on a fleeing subject.

The Taser coordinator informed OPA that he was unfamiliar with the fact pattern in this case. When OPA provided him with a description, he asserted his belief that NE#2's Taser application was consistent with training and, in his opinion, consistent with policy.

The Training lieutenant is also a Taser instructor. As part of FIT's investigation into this matter, he provided a memorandum that opined on whether the Taser application was consistent with training. The memorandum concluded that it was. As explained in my original DCM, I believe that this memorandum was premised on facts that were not necessarily established. First, there is no evidence in the record that I have found indicating that the subject "pulled the microphone earpiece" from NE#2's ear. Second, while NE#2 described the subject's movements as that of a boxer skipping around the corner of a ring, there is no evidence suggesting that the subject ever raised his fists or took any affirmative actions that indicated that he was in a fighting stance or that a physical fight was imminent. Lastly, while NE#2 did not have a backup SPD officer assisting him at the time he used the Taser, a Fish and Wildlife officer was present and actively trying to help.

When interviewed by OPA, the Training lieutenant reaffirmed his belief that NE#2's Taser application was consistent with training. He stated that officers are trained regarding using a Taser on a fleeing subject. While such use is not discouraged, officers need to clearly articulate the need for that action and what imminent threat is posed by the subject. While the Training lieutenant recognized that subjects could suffer significant injuries if their bodies locked up when tased while running, he was unsure whether such injuries would be more or less severe than if the subjects were tackled. He did not know what, if anything, Taser advised or cautioned in the context of fleeing subjects.

The Training captain is currently the head of the Training Unit. He stated that he has general familiarity with the Taser classroom instruction and training materials. He further stated that the Taser training is consistent with SPD policy. While the captain was not familiar with the specific circumstances of this case, he was aware of the Training lieutenant's memorandum. The Training captain did not review the memorandum prior to it being disseminated, but reviewed it afterwards and agreed with the conclusions therein. He was aware that the Training officer believed this Taser application to be consistent with training and policy and concurred with that determination.

As the Training Unit is clear that it believes that NE#2 acted consistent with his training in this case, a reversal of my prior Sustained finding is warranted. It would be unfair to sustain an allegation against an officer whose conduct, whether right or wrong in my opinion, was consistent with the Department's training and expectations.

That being said, that this Taser application was deemed to be in compliance with training does not change my belief that it was inconsistent with policy. I still conclude that there was no imminent threat of harm to NE#2 that warranted the use of the Taser. I further believe that there was a significant risk of injury in applying the Taser to the subject when he was running away from NE#2 on a concrete surface. In my opinion, this risk of harm was not outweighed by the need to take the subject into custody or by the speculative belief that NE#2 would have suffered harm had he gone hands on. Moreover, while the law is admittedly unsettled in this area, I view the case law as trending towards finding such an application to be inconsistent with the Fourth Amendment.

Ultimately, however, the Department needs to make a judgment call here. Weighing all of the risks of Taser applications to fleeing subjects that have not been involved in a crime of violence and who have not assaulted or otherwise harmed an officer, is this the behavior that it expects its officers to engage in? If so, while I believe it to be inadvisable and a possible risk management concern (particularly given the cautionary instructions provided in Taser's own training materials), I defer to the Department's prerogative in this regard. However, I strongly suggest that the Department consider the following amplified training:

- additional scenarios involving fleeing subjects;
- more robust education on the potential risks of harm when a Taser is used on a fleeing subject and particularly a suspect running at full speed on a hard surface;
- clearer guidance as to what constitutes an imminent risk of harm justifying use of a Taser;
- more explicit explanations of what constitutes the "public safety interests" that are referenced in the second prong of the Taser policy and what conduct is sufficient to meet the requisite "level of resistance" from the subject; and
- providing officers, if possible, with clearer instruction as to the Department's expectations in this area and evaluating whether a bright-line rule can be applied, rather than having the decision as to whether to use a Taser on a fleeing subject be a completely subjective determination.

Recommended Finding: **Not Sustained (Management Action)**

Named Employee #2 - Allegation #3
8.300-POL-3 Use of Force - CEW/Conducting Electric Weapons (Taser) 6. Officers Shall Issue a Verbal Warning to the Subject and Fellow Officers Prior to Deploying the CEW

SPD Policy 8.300-POL-3(6) requires that officers provide a verbal warning (to both the subject and other officers) prior to using their Tasers and that they give the subject a reasonable amount of time to comply with the warning. Where, however, providing a warning would "compromise the safety of the officer or others," a warning is not required. (SPD Policy 8.300-POL-3(6).) If a warning is not provided, the officer must document the reasons for not doing so in the use of force report. (*Id.*)

In his Use of Force Report, NE#2 stated that he did not give a warning prior to using his Taser based on perceived "imminent danger." (NE#2 Use of Force Report; *see also* NE#2 OPA Interview, at p. 8.) At his OPA interview, NE#2 reiterated his belief that he did not have time to issue a Taser warning. (*See* NE#2 OPA Interview, at p. 8.) In support of this contention, NE#2 stated the following: it was a dynamic situation; there was active resistance; the officers were subjected to the threat of harm; he needed to act decisively; and that he did not have time to allow the subject to recognize and potentially comply with the warning. (*See* NE#2 OPA Interview, at p. 8.) NE#2 further stated that he believed his safety would have been compromised by issuing a warning because he needed to take the subject into custody at that point and could not let him run away into traffic. (*See id.*)

I do not believe that NE#1 was in imminent danger at the time he utilized his Taser. Moreover, based on my review of the evidence, it is unclear how providing a warning would have put NE#2, or anyone else for that matter, at an increased risk of harm or in a more unsafe position. Notably, the subject was running away from NE#2 at that time and there was no evidence that the subject was running toward or in the vicinity of a member of the public or

another officer. I do not believe that issuing a warning so would have compromised NE#2's safety. In fact, a warning might very well have ended the situation with the subject's voluntary compliance.

That being said, I believe the policy and training is unclear as to whether NE#1 was expected to issue a warning prior to using his Taser in this situation. As discussed more fully above, the Training Unit believed that NE#1 acted consistent with his training in utilizing his Taser and that, here, there was a public safety risk and the threat of harm to NE#1. While I do not agree, that this disagreement exists is evidence that the policy and training in this regard warrant re-review and potential modification.

For these reasons, I recommend the following:

- **Management Action Recommendation**: The Department should review its training to ensure that officers are properly instructed as to when a warning is required to be issued prior to use of a Taser, as well as the reporting requirements where a warning is not provided. The Department should consider providing more training as to the specific scenarios where the warning would comprise the safety of the officers or others.

- **Training Referral**: NE#1, himself, should receive additional training as to the requirements of SPD Policy 8.300-POL-3(6). Specifically, NE#1 should receive additional training from the Training Unit as to when a warning must be provided and what documentation NE#1 is expected to complete when he fails to do so.

Recommended Finding: **Not Sustained (Management Action)**

Named Employee #2 - Allegation #4
8.300-POL-10 Use of Force - Neck and Carotid Restraints 1. Officers Are Prohibited From Using Neck and Carotid Restraints Except When Deadly Force is Justified

SPD Policy 8.300-POL-10 governs the use of neck or carotid holds by SPD officers. The policy indicates that these tactics are strongly disfavored by the Department and may not be used unless deadly force would be justified. (SPD Policy 8.300-POL-10.) The policy further requires that the use of such tactics will result in a FIT investigation. (*Id.*) While the policy does not clearly define neck or carotid holds, it logically follows that they are purposeful applications of force by an officer to a subject's neck. Accordingly, I find that inadvertent contact with the neck, especially where there is no evidence that any force was actually applied, does not constitute a neck or carotid hold.

In his Use of Force Report, completed shortly after the incident, NE#2 reported that after the subject crashed his vehicle, NE#2 began to pursue him. (*See* NE#2 Use of Force Report.) The suspect tried to climb a fence, but NE#2 was able to pull him down. (*See id.*) NE#2 believed that he did so by grabbing the subject's shoulders. (*See id.*) The subject continued to try to elude NE#2 by attempting to run forward. (*See id.*) NE#2 stated that he instinctively slipped his arm around the subject's neck, so that the crook of his elbow was at the subject's Adam's apple. (*See id.*) NE#2 recounted that he immediately realized that applying pressure in this position would be considered deadly force and he did not do so. (*See id.*) He kept his elbow loosely situated in that area for approximately one to two seconds and did not constrict the subject's breathing at any time. (*See id.*) The subject was able to slip away from him at that time. (*See id.*)

NE#2 provided later statements to FIT and to OPA. NE#2's accounting of the contact made with the subject's neck remained consistent over these interviews. (*See* NE#2 OPA Interview; *see also* NE#2 FIT Interviews.)

The subject was interviewed as to the force used against him and recalled that the officers were trying to get a hold of him, he was tased, and that he was then slammed to the ground. (*See* Subject Use of Force Interview.) The Complainant stated his belief that the officers were fair to him with the amount of force that was used and they were not trying to kill him. (*See Id.*) While the subject did not state that he was choked, he was not explicitly asked whether this occurred during the interview. (*See Id.*) Further, the Seattle Fire Department Medical Incident Report does not indicate any complaints of being choked or that the subject had any injuries to his neck areas consistent with a neck or carotid hold. (*See* SFD Medical Incident Report.)

As such, while I find that NE#2 inadvertently made contact with the subject's neck, I do not find by a preponderance of the evidence that he used a neck or carotid hold. Accordingly, I recommend that this allegation be Not Sustained – Unfounded.

Recommended Finding: **Not Sustained (Unfounded)**

Named Employee #3 - Allegation #1
13.031 - Vehicle Eluding/Pursuits 3. Officers Will Not Pursue Without Justification

SPD Policy 13.031 governs pursuits by SPD employees. The policy defines a pursuit as "when an officer, operating an authorized police vehicle with emergency lights and siren activated, proceeds in an effort to keep pace with and/or immediately apprehend an eluding driver." (SPD Policy 13.031-POL-1.) Eluding is defined as when a driver is given a signal to stop and after a reasonable amount of time to permit the compliance with the signal to stop, the driver either increases speed, takes evasive actions or refuses to stop. (*Id.*)

The policy states that an officer may not engage in a pursuit without justification. (SPD Policy 13.031-POL-3.) The policy further mandates that "[o]fficers will not pursue solely for any of the following: Traffic violations/Civil infractions; Misdemeanors; Gross misdemeanors; Property crimes; the act of eluding alone." (*Id.*)

I find that based on my review of NE#3's ICV, she was engaged in a pursuit. NE#3 and NE#2 were driving on Aurora Avenue when they viewed the subject's vehicle. (NE#3 OPA Interview, at p. 2.) NE#2 asked her to make a U-turn to follow the vehicle. (*Id.*) NE#3 turned on her emergency lights and made a U-turn. (*See* NE#2 and NE#3 ICV.) After doing so, she turned off her lights. (See *id.*) NE#3 then increased speed in order to catch up to the subject vehicle. (*See id.*) At this point NE#3 was driving in the bus lane, and she again turned on her emergency lights to move around traffic. (*See id.*) The officers noticed that the vehicle took a right on 86th Street and they followed it. The emergency lights were still activated at that point. (*See id.*) At that point, the officers spotted the vehicle. (*See id.*) NE#3 drove closer to the vehicle and the vehicle then took a right turn and started driving onto the sidewalk. (*See id.*) NE#3 stated over her radio that the vehicle was "fleeing." (*See id.*) At that point the patrol cars emergency lights were on. (*See id.*) NE#3 activated her siren and accelerated, while the subject vehicle continued to drive on the sidewalk. (*See id.*) The officers followed the vehicle until it veered back onto 86th Street. (*See id.*) The subject vehicle then took as sharp left turn and when the officers took a left to follow the subject vehicle, they observed that the vehicle has crashed head-on into an oncoming vehicle. (*See id.*) The driver had also gotten out of the vehicle and run away. (*See* NE#3 OPA Interview, at pp. 2-3.)

Even prior to the pursuit being initiated, the subject vehicle was almost certainly clearly aware that the officers were following him. First, when the officers made the initial U-turn they activated their emergency lights, which presumably prompted the vehicle to turn onto 86th Street. Second, the officers then activated their lights again when they approached 86th street and turned right, which would have also likely been observed by the vehicle. In addition, when he veered onto the sidewalk, it should have been evident to the officers that the subject was not going to stop his vehicle and his intent was to evade them. This is evidenced by NE#3's contemporaneous statement that the vehicle was "fleeing." (NE#3's ICV captures her later repeating her belief that the subject was fleeing to her supervisors.) Once the subject did so and the officers turned on their lights and followed him, it was a pursuit. That the pursuit lasted only a matter of seconds is of no moment. Had the subject vehicle not immediately crashed, it appears certain that the officers would have continued pursuing.

Accordingly, I find that this situation was a pursuit as defined by SPD policy. NE#3, with her lights and sirens activated, made the decision to accelerate and follow the eluding vehicle in an attempt to keep pace with the vehicle and immediately apprehend the driver. Here, however, the pursuit was not justified as the officers were pursuing based on traffic violations (reckless driving) and the act of eluding. These are not appropriate justifications under the policy.

While I find that this pursuit violated policy, I am cognizant of how quickly it unfolded. NE#3 had approximately four seconds to make the decision to pursue or not pursue and, from a review of the video, it was clear how chaotic the situation was. Accordingly, based on the unique circumstances of this case, I conclude that a Training Referral, rather than a Sustained finding, is the appropriate determination.

- **Training Referral**: NE#3 should receive additional training concerning when a pursuit exists and under which circumstances a pursuit is justified. I further recommend that NE#3 receive counseling from her chain of command that is documented in a PAS entry.

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

Named Employee #3 - Allegation #2
13.031 - Vehicle Eluding/Pursuits 18. All Officers Involved in a Pursuit will complete a Blue Team Vehicle Pursuit Entry

SPD Policy 13.031(18) requires all officers involved in a pursuit to complete a Blue Team Vehicle Pursuit entry.

At the conclusion of the pursuit, NE#3's ICV captured the witness sergeant stating that he believed she would need to complete a Blue Team entry. (*See* NE#2 & NE#3 ICV; *see also* Witness Sergeant OPA Interview, at pp. 2-3.) However, shortly thereafter, NE#3 was told by NE#1 that he would consult with a supervisor to determine whether the incident was, in fact, a pursuit and a Blue Team entry was not required to be completed. (NE#3 OPA Interview, at p. 7.) During his OPA interview, NE#1 stated that he told NE#3 that the incident did not rise to the level of a pursuit and instructed her that she did not need to generate a Blue Team entry. (NE#1 OPA Interview, at p. 5.) Neither the witness sergeant or witness lieutenant, both of whom were interviewed by OPA, indicated that they told NE#1 to complete a Blue Team entry. (*See* Witness Sergeant OPA Interview, at pp. 5-6; *see also* Witness Lieutenant OPA Interview, at p. 6.) At her OPA interview, NE#3 further stated that had she been directed to complete a Blue Team entry she would have done so. (NE#3 OPA Interview, at p. 7.)

While I find that a pursuit occurred and that NE#3 should have known that a Blue Team entry was required, she was entitled to rely on the direction of her immediate supervisor to not complete one.

Accordingly, I recommend that this allegation be Not Sustained – Training Referral.

- **Training Referral**: NE#3 should receive additional training concerning pursuits, generally, and when she is required to complete a Blue Team Vehicle Pursuit entry.

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

City of Seattle

Office of Police Accountability

April 5, 2018

Chief Carmen Best
Seattle Police Department
PO Box 34986
Seattle, WA 98124-4986

RE: MANAGEMENT ACTION RECOMMENDATIONS – FIRST QUARTER 2018

Dear Chief Best:

I write to inform you of a number of Management Action Recommendations (MAR) that have been recently issued by OPA. This is the first of what will be ongoing quarterly MAR notifications. OPA hopes that one letter will be easier to review and respond to than numerous communications received throughout a quarter.

The MARs contained herein are for the following cases: 2017OPA-0031; 2017OPA-0318; 2017OPA-0420; 2017OPA-0667; 2017OPA-0705; 2017OPA-0751; 2017OPA-0755; 2017OPA-0813; 2017OPA-0820; 2017OPA-0909; 2017OPA-0937; 2017OPA-0967; 2017OPA-1015; and 2017OPA-1131.

1. **2017OPA-0031 – *Clarifying the Responsibilities of Bureau Chiefs Regarding Recommended Findings from the CRB***

This case arose out of a patrol vehicle accident, in which a Department employee failed to put his vehicle in park when he got out and, as a result, the vehicle rolled over the legs of the subject. While this did not result in significant injuries to the subject, it was still a significant error by the employee and an easily avoidable accident. The accident was reviewed by the Collision Review Board (CRB) and then referred – apparently in error – to the former Assistant Chief of the Investigations Bureau. While the Assistant Chief approved the CRB's finding and agreed that the accident was preventable, he failed to forward his approval and his recommendations for any discipline and/or re-training to the Chief of Police. As such, the Chief at that time did not have the opportunity to issue any such discipline and/or re-training that may have been warranted.

As a result of its investigation and the concerns identified, OPA recommends that SPD's command staff be reminded of their obligations under SPD Policy 13.015 generally, and 13.015-PRO-1 specifically, to recommend potential discipline and/or re-training and to forward those recommendations to the Chief of Police in a timely manner. Without this clarification, the Department risks harming the legitimacy of SPD's administrative investigation processes and creating mistrust in the community. Moreover, the Department should take steps to ensure that CRB rulings are properly forwarded to the correct bureau chief. It is OPA's understanding that this policy is currently being re-evaluated and revised by the Department. If this is the case, it may obviate the need for this MAR.

2. 2017OPA-0318 – *Using Tasers on Fleeing, Non-Violent Subjects*

In this case, one of the allegations was that the Named Employee utilized his Taser in potential violation of policy. The subject upon whom the Taser was used was fleeing from the officer at the time and was running on the pavement. The subject had previously been involved in a vehicle pursuit that had resulted in a crash. Prior to the Taser being used, the subject had tried to climb a fence and had been pulled backwards by the Named Employee. The Named Employee described that he and the subject circled each other, the subject ran away, and the Taser was then used. The Named Employee did not allege that the subject ever attempted to assault him, raised his fists, or engaging in any violent behavior towards him. The Named Employee justified his application of the Taser based on his belief that the fleeing subject represented a threat to himself, the Named Employee, other officers, and the public. The Named Employee further stated that he believed that, if he was required to go hands on with the subject, it was likely that both he and the subject would suffer injuries.

Initially, OPA recommended that this allegation be Sustained because the risk of harm caused by the subject's actions and fleeing were outweighed by the risk of potential injury to the subject when he was Tased while running on pavement. In reaching this conclusion, OPA cited Ninth Circuit case law, recommendations from the Police Executive Research Forum (PERF), and the training materials generated by Taser International. Notably, Taser International's training materials warn that the use of a Taser on a fleeing subject can result in an elevated risk of harm. This appears to be even more so when the subject is fleeing on a hard surface.

However, at the discipline meeting on this matter, the Named Employee's chain of command disagreed with OPA's finding and asserted their belief that the Named Employee had acted consistent with his training. As such, and with the Guild's agreement to an extension, OPA further investigated the matter, which included reviewing training materials and interviewing three members of the Department's Training Unit, including a designated Taser expert.

OPA's additional investigation revealed that the Training Unit deemed the Named Employee's conduct to have been consistent with his training. As such, OPA reversed its finding. Nonetheless, OPA has significant concerns with the training being provided by the Department, as well as with the Taser policy itself and its application to the facts presented in this case.

First, case law in this area appears to be relatively unsettled. However, recent decisions by district courts within the Ninth Circuit appear to be trending towards a determination that using a Taser on a non-violent fleeing subject is a potential violation of that individual's Fourth Amendment rights. Given this, as well as the risk of serious injury that could be incurred under these circumstances and the guidance from both PERF and Taser International, OPA recommends that the Department reconsider the guidance it is providing to officers concerning Tasing fleeing subjects and that the Department make an informed decision as to whether, given the significant risk and potential liability, this is conduct in which it wants its officers to continue to engage.

Second, regardless of the determination made by the Department, OPA recommends that the Training Unit consider amplifying the Taser training to include the following:

- Additional scenarios involving fleeing subjects;
- More robust education on the potential risks of harm when a Taser is used on a fleeing subject and particularly a suspect running at full speed on a hard surface;
- Clearer guidance as to what constitutes an imminent risk of harm justifying use of a Taser;
- More explicit explanations of what constitutes the "public safety interests" that are referenced in the second prong of the Taser policy and what conduct is sufficient to meet the requisite "level of resistance" from the subject; and
- Clearer instruction as to the Department's expectations in this area and an evaluation of whether a bright-line rule can be applied, rather than having the decision as to whether to use a Taser on a fleeing subject be a completely subjective determination.

Third, based on OPA's review of this case, there appears to be a lack of clarity as to when Taser warnings are required or when they are excused under the circumstances. OPA recommends that the Training Unit provide refresher training to Taser operators in this area and make it abundantly clear in which situations Taser warnings are required. This could be appropriately integrated into planned upcoming trainings.

3. 2017OPA-0420 – *Clarifying When Officers Are "Involved" in a Pursuit*

This case involved an out of policy pursuit in which several officers were engaged. One of the officers told OPA during his interview that he was only involved in the pursuit, which he realized was out of policy, because he was trying to ensure the safety of another officer, who was, for a period of time, the only unit involved in the pursuit. The officers' supervisor failed to have the trailing officer complete a Blue Team Vehicle Pursuit Entry. In explaining why he failed to do so, the supervisor told OPA he did not believe this officer was required to complete documentation because he was not "involved" in the pursuit as indicated by the policy. In support of this assertion, the supervisor contended that the officer was not pursuing but was only trying to ensure the safety of a fellow Department employee.

OPA does not view this language as being as ambiguous as both the trailing officer and supervisor appear to believe. However, OPA recognizes that "involved" officer could be further defined to make clear that it refers to any officer engaging in conduct that constitutes a pursuit under the policy, regardless of the purpose for engaging in this conduct. The policy should make it clear that all such officers should document their actions in a Blue Team Vehicle Pursuit Entry.

4. 2017OPA-0667 – *Generating a Policy Governing High-Risk Vehicle Stops and Clarifying When Provision of Identification May Be Required from a Handcuffed and Detained Individual*

OPA investigated a case in which a Terry stop was effectuated on a car. The stop was requested by two officers who viewed the car drive away from the scene, but was effectuated by four other officers who received a dispatch asking that the stop occur. OPA determined, and the chain of command agreed, that there was insufficient reasonable suspicion supporting the stop.

During the stop, which was carried out as a high-risk vehicle stop, the four occupants were removed from their car, handcuffed, frisked, and placed in the rear of a locked patrol vehicle. After that point,

it became clear to the officers that the detained individuals were not involved in the underlying crime; however, they were kept handcuffed in the rear of the patrol vehicle and officers requested their identifying information. The officers provided conflicting information as to why this information was requested. One officer indicated that it was requested so that the officers could determine whether the detained individuals were related and to get their contact information. Another officer said the information was requested to run the individuals for warrants.

SPD Policy 6.220-POL-6 states that "officers cannot require subjects to identify themselves or answer questions on a Terry stop" and that "in general, subjects are not obligated to provide identification upon request and have the right to remain silent." The policy provides for three exceptions to this rule (*see id.*), none of which applied in this case. Here, the officers contended that they did not require identification, they simply requested it. While that is true, it ignores the fact that virtually no one who is handcuffed in the back of a patrol vehicle would feel that this request could be refused. Moreover, while Fourth Amendment case law provides legal authority for a request for identification during a Terry stop, the request must be "reasonably related to the detention." It is unclear how the request for identification in this case was reasonably related to the detention given that the reasonable suspicion for the stop had already dissipated at the time it was made.

In general, this case further raised concerns for OPA regarding the lack of any mention of high-risk vehicle stops in policy and the absence of formal guidance concerning requirements and limitations of such stops. Accordingly, OPA recommends that the Department draft a policy governing when it is appropriate for officers to conduct high-risk stops and what conduct officers may engage in during those stops. It would make sense for this policy to be included in Title 6 of the SPD Manual. The Department should also clarify in policy and in training whether, once the reasonable suspicion for a Terry stop has dissipated, an officer remains permitted to request identifying information from a handcuffed and detained individual.

5. 2017OPA-0705 – *Allowing Officers to Sign Themselves Up for Trainings*

OPA investigated an allegation that an officer failed to attend a mandatory training in potential violation of SPD Policy 5.001-POL-3. At his OPA interview, the officer contended that he did not attend the training on the date for which he was scheduled because he was sick. He further stated that he informed his sergeant that he missed the training and was unaware of what steps his sergeant took to reschedule him for a subsequent training.

During this investigation, OPA learned that officers are not able to register themselves for training, but, instead, are required to request that supervisors do so. It is unclear to OPA why this is the case. It seems, in my opinion, that this system is inefficient and wastes valuable supervisor time. Moreover, I believe that officers, not their supervisors, should be responsible for managing their own calendars and accountable when they fail to attend trainings. It may very well be that there is a reason for why the Department has supervisors register officers for training, but this reason has not been evident in any of the investigations that OPA has conducted into missed trainings.

For these reasons, OPA recommends that the Department consider shifting the responsibility for registering for trainings from supervisors to officers. To the extent there is a reason why this is not feasible or is inadvisable, please provide that information to OPA.

6. 2017OPA-0751 and 2017OPA-1131 – *Recording ICV When Following an Ambulance Transporting a Subject to a Hospital*

In both of these cases, Department employees failed to activate their In-Car Video (ICV) systems when they were following ambulances transporting subjects to Harborview Medical Center.

These cases were virtually identical to another case (2017OPA-0504) in which OPA issued a MAR requesting that the Department clarify the ICV policy regarding whether it expects its officers to record in these situations. In that same MAR, issued on December 7, 2017, OPA requested that the Department also evaluate the current list of law enforcement activities that are required to be recorded and determine whether that list needs to be amplified or clarified. It is OPA's understanding that the Department is presently working on modifications to this policy consistent with OPA's recommendations; however, OPA renews this MAR herein.

7. 2017OPA-0755 – *Logging in and out of Secondary Employment at Large-Scale Events*

In this case, OPA investigated an employee's failure to have a valid secondary work permit for his employment at Safeco Field. During its investigation, OPA determined that the Named Employee did not log in and out via radio, as required by SPD Policy 5.120(II). OPA discussed this matter with the Named Employee's chain of command and was informed that, even though this was a requirement of the policy, officers were instructed that they were not required to do so when working secondary employment at large-scale events, such as baseball, football, or soccer games.

The reason for this modification of the log in and out requirement makes sense – where numerous officers are working an event, it is more practical and time efficient to have one supervisor log all the employees in and out at one time. Indeed, the Department has a form that is utilized for exactly that purpose. OPA agreed with the chain of command that this modification of the policy was appropriate, but asked that the policy be updated to reflect that this was an acceptable practice.

After this discussion and the issuance of the Director's Certification Memo containing this MAR, this policy was, in fact, updated to formalize an exception for large-scale events. The new language is consistent with OPA's recommendation. As such, no further action needs to be taken.

8. 2017OPA-0813

OPA's investigation into this case resulted in two MARs. The first concerned foot pursuits that resulted in uses of force and officers' decision-making regarding the potential consequences of their actions. The second concerned reconciling the policy on mandatory reporting of potential misconduct with the current training and guidance being provided to officers by the Department.

a. Foot Pursuits and Officer Decision-Making When Using Force

In this case, officers stopped a subject who had been urinating on the side of a building. When the officers attempted to detain him, the subject fled. The officers chased after him, and the Named

Employee tackled the subject from behind onto the pavement. As a result, the subject suffered lacerations and bleeding to his face and body.

During his OPA interview, the Named Employee contended that he tackled the subject from behind onto the pavement in order to prevent the subject from running into traffic. First, this threat was entirely speculative. There was no evidence that the subject was at imminent risk of running into traffic. Second, the Named Employee's logic appeared to be that he put the subject at risk of substantial physical harm in order to prevent him from being hit by a car, thus ultimately protecting the subject. Third, the Named Employee appeared to put little to no thought into the potential consequences of the force he used. He was chasing a subject who had committed a non-violent, citable offense and had not posed or caused any harm to the Named Employee.

OPA initially recommended that the allegations concerning the use of force and the Named Employee's discretionary decision to tackle the subject to the ground both be sustained. The Named Employee's chain of command disagreed. The primary reason for their disagreement was their belief that, in acting as he did in this case, the Named Employee conducted himself consistent with the Department's expectations and his training. Thus, while OPA found that his actions were contrary to policy and constituted poor decision making, OPA reversed its Sustained findings and, instead, issued a MAR.

OPA noted that SPD policy provides no guidance on when it is appropriate for an officer to engage in a foot pursuit. By not providing any policy governing when a foot pursuit is appropriate and under what circumstances the risk of harm to the officer, the subject, and the public outweighs the interests in effectuating an arrest, it places officers in a tenuous and unenviable position of uncertainty.

As such, OPA recommends that the Department consider developing a policy concerning when foot pursuits of suspects are appropriate. OPA believes that the Department should evaluate whether it expects its officers to engage in such pursuits when the subject is suspected of a misdemeanor or of only committing a citable offense. This policy should optimally provide guidance as to when the risk of harm to officers, the subject, and the public outweighs the law enforcement interest in effectuating an arrest. This policy should further consider what force is appropriate during such pursuits. Specifically, the Department should evaluate whether it is in its interests, both as a matter of potential civil liability and in upholding constitutional policing, for officers to be permitted to tackle at full speed individuals who have committed non-violent, non-felony offenses, and who pose no substantiated risk to officers, civilians, or themselves.

Lastly, OPA strongly advises the Department to include in training a discussion of officer decision-making when using force. Specifically, OPA believes that the Department needs to better train its officers to consider the downstream consequences of their actions prior to using force. Whether an officer decides to tackle onto the pavement a person suspected of a citable offense who is running from the police, Tasers from behind a subject who is sprinting away on the sidewalk, or pushes someone with an outstanding warrant for a non-violent felon offense off of her moving bicycle, potentially subjecting her to catastrophic injuries, OPA has evaluated a number of cases where these necessary calculations have not been made. OPA contends that this informed decision-making is a trained skill like anything else and that it should be stressed by the Department in the 2018 use of force and/or defensive tactics training.

b. Reporting Potential Misconduct

This case also involved allegation of excessive force that was made by the subject in the presence of an officer. The officer claimed that he relayed this allegation to a supervisor, but the supervisor denied that this occurred. Even assuming that he did report the allegation to a supervisor, OPA found that the officer still violated policy because he also did not report the claim of excessive force to OPA. Notably, SPD Policy 5.002-POL-6 requires that officers report allegations of serious misconduct – which includes excessive force – to both a supervisor *and* OPA.

At the discipline meeting in this case, the Named Employee's chain of command told OPA that, while they agreed that the policy compelled reporting to both a supervisor and OPA, officers were being trained that they only needed to report to one or the other, not both. While this direction may make practical sense, it is telling officers to do something that is contrary to the explicit language of the policy.

Given this, OPA recommends that the Department do one of the following: (1) train and instruct its officers to do what the policy says; or (2) amend the policy to remove the requirement that an officer report misconduct to both a supervisor and OPA, with the understanding, however, that other protections are built into the policy. With regard to the latter course of action, OPA also recommends that the Department establish procedures to ensure that misconduct is still ultimately reported to OPA. For example, OPA believes that the Department could require that officers record their reporting of misconduct to a supervisor on video or, in the alternative, that they memorialize and report the allegation in an email sent that same day to a supervisor. This would ensure that there were no situations where an officer claimed that they reported and the supervisor denied that this occurred.

9. 2017OPA-0820 – *Department Re-Training on DUI Investigations and Arrests, BAC Machines and Tickets, and the Requirements for the Content and Submittal of DUI Packets*

This case involved an arrest of an individual for suspected DUI. A Student Officer and his Field Training Officer (FTO) effectuated the stop and arrest. At the scene, the Student Officer conducted the DUI investigation with some difficulty. Upon their return to the precinct, the Student Officer was tasked with generating the DUI paperwork, using the Blood Alcohol Content (BAC) machine, and printing a BAC ticket. There were a number of deficiencies with the DUI paperwork, and an incomplete DUI packet was submitted to the prosecutor, even though it was reviewed and approved by the FTO. There was also a significant anomaly with the use of the BAC machine and the printing of the BAC ticket, which resulted in OPA investigating both officers for potential dishonesty (these allegations were Not Sustained – Inconclusive for the Student Officer and Not Sustained – Unfounded for the FTO).

Based on OPA's investigation into this case and on OPA's discussions with the Named Employees' chain of command, it appears that the vast majority of patrol officers lack experience and sufficient training in conducting DUI stops and arrests and the resulting paperwork that must be generated. Given this, OPA recommends that the Department consider retraining all patrol officers, or at the very least those officers expected to engage in DUI investigations, on the following:

- DUI arrests, generally;
- How to conduct sobriety tests;
- The usage of Preliminary Breath Tests;
- The usage of BAC machines and the printing of BAC tickets; and
- The mandatory requirements for the contents and submittal of DUI packets.

10. 2017OPA-0909 – *Making Revisions, Clarifications and Improvements to the De-Escalation Policy*

In this matter, the Named Employee was involved in a use of force with a woman who was riding a bicycle without a helmet. Officers had attempted to stop and arrest this woman (who had an outstanding felony warrant for a non-violent offense) and she fled from them on her bicycle. The supervisor chased the woman on foot, while the Named Employee and another officer drove behind her. The Named Employee got out of the patrol vehicle and positioned himself in front of the woman with the intent to stop her. The woman, who was driving the bicycle towards the Named Employee traveling between 10 and 15 miles per hour, swerved to the left of the Named Employee, at which point he pushed her off of her bicycle, causing her to fall to the ground and suffer various injuries, including a separated shoulder.

OPA initially found that the Named Employee used force inconsistent with policy and failed to de-escalate prior to using force. While the Named Employees' chain of command agreed that the force used was outside of policy, the chain disagreed that the Named Employee had failed to de-escalate. In support of their argument in this regard, the chain asserted that, under the circumstances of this case, no de-escalation was safe or feasible. The chain noted that containment, which was referenced as an option in OPA's initial recommendation, was not possible with a moving target such as a person on a bicycle. They further noted that there was no way to place a barrier to stop the woman from riding away under the circumstances of this case. While the chain recognized that it could have been possible to summon more resources, they noted that this would have necessitated calling numerous officers away from other equally if not more important calls and would not have conclusively resulted in stopping the woman and placing her under arrest. OPA found this argument convincing and agreed to amend its finding. However, OPA also raised its concerns with the subjectivity and application of this policy, which were largely shared by the chain.

This case was the most recent of a number of cases in which OPA and the Department either disagreed as to whether an officer properly de-escalated or where it was simply unclear whether the officer de-escalated consistent with policy, even when the relevant facts of the cases were fully explored and illuminated during OPA's investigation and were agreed to by all the parties.

At the outset, it is important to note that OPA strongly supports the concept of de-escalation and believes it to be absolutely essential to constitutional and equitable policing. SPD's commitment to de-escalation is a product of and requirement of the Consent Decree and it is a practice that puts SPD head and shoulders above most other police departments nationwide.

That being said, the de-escalation policy is consistently one of the most challenging policies to apply and evaluate. When looking at it, OPA generally has a number of questions. Do all the suggested

de-escalation tools called out in the policy need to be used before force can be applied? If not, how many? How long do officers need to try to de-escalate before they can use force? 2 minutes? 5 minutes? 1 hour? 2 hours? When is physical confrontation "immediately necessary" to permit force to be used? What is meant by the phrase "without compromising law enforcement priorities"? If effectuating an arrest is always a compelling law enforcement priority, does that not potentially unworkably expand the policy?

This policy, like many others, is subjective. In that respect, I recognize the difficult place that officers are put in. On one hand, they are told that, in order to preserve public order and safety, it is essential to make arrests and, with some arrests, to use a degree of force. On the other hand, the de-escalation policy, if read literally, could be construed to dissuade such active policing and instead encourage officers to not take action that could result in force unless all other possible options are exhausted and the force is immediately necessary. OPA worries that the policy, while incredibly important and well-intentioned, has the potential to create unclear standards and expectations for officers, thus risking affecting the officers' procedural due process during the disciplinary stage.

Unlike most MARs, OPA does not have what it believes to be an immediate fix to the policy. Instead, OPA is simply identifying some concerns and its belief that it may be time to look at revising, clarifying and improving this policy. To be clear, OPA is not calling for the policy to be removed or in any way undermined; however, now that the Department is five-years into the Consent Decree, OPA believes it is necessary to evaluate the policy to determine whether changes are warranted and, if so, what those changes should be. OPA also believes that the Department should reevaluate training on de-escalation and related tactics to ensure that it is providing needed clarity and rules of conduct for officers. OPA further believes that the evaluation of both the policy and associated training should be led by the Department, but should intimately involve OPA, the Community Police Commission and the Inspector General at the research, deliberation and drafting stages.

11. **2017OPA-0937 – *Clarifying How Officers Are to Verify That Their ICV Systems Are Working Prior to Their Shifts and Including in Policy the Sergeants' Obligations Regarding Ensuring That Wireless Microphones Are Charged Prior to Assigning to Officers***

During its investigation of this case, OPA determined that the Named Employee's ICV system recorded video but failed to record audio. At his interview, the Named Employee stated that he logged into his system, synched his microphone, and engaged in all other necessary steps to ensure that both his ICV video and audio were working. He further stated that he saw no evidence from his review of his microphone that it was low on battery. However, OPA found that the battery of the wireless microphone was not fully charged and the failure to fully charge the microphone, potentially coupled with distance of the microphone from the receiver, resulted in the lack of audio.

The previous iteration of this policy required that each officer conduct a ICV system check before beginning their shift. This system check, which was recorded, was purposed to verify that the system was working and to catch any problems. The amended policy removed the system check and, thus, created a potential gap in policy that was exemplified by this case. Moreover, it was unclear, based on OPA's reading of the policy, how officers were now expected to verify that their ICV systems were working prior to beginning their shifts.

During its investigation, OPA also learned that sergeants were now expected to assign ICV wireless microphones to officers prior to their shifts and to verify that these microphones were fully charged. However, that obligation was not contained in policy and it was unclear whether it occurred in this case.

As such, OPA recommends that the Department consider amending SPD Policy 16.090-TSK-1 to explain how officers are expected to verify that their ICV wireless microphones and BWV systems are fully charged and to inform officers what the appropriate level of charging is prior to them utilizing those systems in the field. This will, in OPA's opinion, provide clarity to both officers and OPA. Moreover, if it is the Department's expectation that sergeants will bear some responsibility for verifying that the wireless microphone batteries are charged, it should also consider memorializing those specific obligations and expectations in policy.

12. **2017OPA-0967 – *Documenting All Terry Stops Using a Terry Template, Regardless of Whether Officers Had Probable Cause to Arrest at the Time of the Stop and Detention***

In this case, the Named Employees detained an individual who was in a City park after hours. The officers did not arrest this individual and, instead, released him after requesting and obtaining his identification and running his name for warrants. Even though the individual was detained for a prolonged period of time, the officers did not document the detention using a Terry Template. The officers explained to OPA that, at the time of the detention, they had probable cause to arrest the individual for trespassing. As such, they believed that they had no obligation to generate a Terry Template.

While OPA does not believe that these officers intended to violate policy, their failure to document this detention anywhere not only violated SPD policy but also City law. Accordingly, OPA recommends that the Department clarify SPD Policy 6.220-POL-10 to make it abundantly clear that when officers perform a Terry stop, a Terry template is required to be completed each and every time. The Department should further clarify that this is the case regardless of whether the officers had probable cause to arrest at the time of the Terry stop. What ultimately controls for the purpose of reporting is the nature of the stop. Lastly, the Department should include in its policy that this requirement is a requirement under City law and should cite to SMC 14.11.060(C).

13. **2017OPA-1015 – *Clarifying Expectations for the Quality and Thoroughness of Follow-Up Investigations and Associated Reports***

This case involved an investigation by the Sexual Assault Unit into a rape allegation. At the time of the investigation, the case was past the statute of limitations and the investigator reported that she was informed by a prosecuting attorney that it would not have been prosecuted regardless due to burden of proof issues. Nonetheless, the Department's expectation was that the investigation conducted would be comprehensive and high quality. Unfortunately, that did not occur.

The investigator's deficient investigation and reporting was evaluated under SPD Policy 15.080-POL-1(2), which concerns investigations conducted by follow-up units. The policy sets forth the

minimum components of follow-up investigations and includes: "When appropriate, the case detectives will contact and interview listed suspects, witnesses, and victims"; and "Case files shall be prepared to satisfy standards established by the prosecuting attorney's office. The Criminal Investigations Bureau will publish these standards."

First, both OPA and the investigator's chain of command agreed that the documentation that she generated, which included a Supplemental Report and a memorandum, was not complete, thorough, and accurate. However, there was no requirement that reports generated during follow-up investigations be complete, thorough, and accurate. This was the case even though SPD policy specifically required that General Offense Reports completed during primary investigations had to meet those standards. It was unclear and illogical to OPA why follow-up investigations should be held to a lower standard than primary investigations. This was especially the case given the specialized training given to investigators in follow-up units.

Second, the investigator failed to complete a Case Investigation Report (CIR). At her OPA interview, she claimed that there was no requirement in policy that she do so and that it was unnecessary, as she knew the case was never going to be prosecuted. Both OPA and her chain of command disagreed with the investigator's latter assertion, but recognized that there was no explicit requirement in policy that a CIR be generated in each follow-up investigation.

Third, the investigator failed to include in her report an itemization of the interviews that she conducted or unsuccessfully attempted to conduct. Here, this resulted in the victim believing and alleging that the investigator deliberately included misleading information in her reports and in turn led to OPA investigating whether the investigator was dishonest.

Fourth, OPA's investigation yielded the conclusion that investigators in follow-up units lacked sufficient guidance concerning the expectations for investigations and the associated documentation.

As a result, OPA suggested, and the investigator's chain of command, including the Assistant Chief of the Investigations Bureau, agreed, that the Department take the following steps to ensure that reports generated during follow-up investigations are held to the same standards of those written during primary investigations and are complete, thorough and accurate: (1) SPD Policy 15.080-POL-2 should be amended to require that reports generated during follow-up investigations be complete, thorough, and accurate; (2) SPD Policy 15.080-POL-2 should also be amended to require that a CIR be completed in every follow-up investigation, regardless of whether the assigned investigator or an investigations supervisor believes that the case will be prosecuted; (3) SPD Policy 15.080-POL-2 should be modified to include the requirement that all witness interviews or the fact that a witness interview was attempted be documented; and (4) the Investigations Bureau should provide all investigations personnel with a manual setting forth examples of reports that meet the expectations of the Department and standards for what information should be contained in follow-up investigation paperwork.

During its investigation, OPA also determined that the investigator conducted a video recorded interview of the victim, but that the fact that this interview occurred was not documented in the investigative file. The policy governing such documentation – SPD Policy 7.110-POL-6, only referenced documenting audio recorded interviews and was silent on video recorded interviews.

OPA believes that the Department should encourage investigators to take video statements and believes that the Department must ensure their documentation.

Similarly, in reviewing SPD Policy 7.110-POL-5, which governs the uploading of audio recorded statements to the Department's evidence management system (DEMS), OPA discovered that the policy is silent as to where and how video recorded statements are to be stored. It is OPA's understanding, based on its investigation, that DEMS does not accept the uploading of video recorded statements, as only audio files or .jpg files can be uploaded into that system. In this case, the Named Employee stated that she saved the video recorded statement in the Sexual Assault Unit's "vault" and "drive." OPA recommends that the Department provide more formal guidance in policy concerning the expectation for how and where video recorded statements should be stored.

Consistent with the above, OPA further recommends that the Department amend SPD Policy 7.110 to account for the practice of video recording interviews. Specifically, SPD Policy 7.110-POL-6 should be updated to require Department employees to document in an appropriate report when they have conducted and created a video recorded interview.

Thank you very much for your prompt attention to these matters. Please inform me of your responses to these recommendations and, should you decide to take action as a result, the progress of these actions.

Please also feel free to contact me with any questions or concerns.

Sincerely,

Andrew Myerberg

Andrew Myerberg
Director, Office of Police Accountability

cc: Deputy Chief Chris Fowler, Seattle Police Department
Assistant Chief Lesley Cordner, Standards and Compliance, Seattle Police Department
Rebecca Boatright, Senior Police Counsel, Seattle Police Department
Fe Lopez, Executive Director, Community Police Commission
Tito Rodriquez, OPA Auditor
Josh Johnson, Assistant City Attorney, Seattle City Attorney's Office
Anne Bettesworth, Senior Policy Advisor, Office of Police Accountability