Seattle
Office of Police
Accountability

CLOSED CASE SUMMARY

ISSUED DATE: OCTOBER 19, 2018

CASE NUMBER: 2018OPA-0318

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	6.010 - Arrests 5. Sergeants Must Screen All Arrests Prior to Booking or Release	Sustained
# 2	6.010 - Arrests 6. Screening Sergeant Will Approve Report	Not Sustained (Training Referral)
# 3	6.010 - Arrests 7. Reports Must Be Completed by End of Shift	Not Sustained (Lawful and Proper)
# 4	5.001 - Standards and Duties 11. Employees Shall Be Truthful and Complete in All Communication	Not Sustained (Inconclusive)
# 5	8.400 - Use of Force Reporting and Investigation 3. The Sergeant Will Review the Incident and Do One of the Following:	Sustained
# 6	8.400-POL-3 Use of Force – TYPE II INVESTIGATIONS 1. In Conducting a Type II Investigation, a Sergeant Will Respond to the Scene and Thoroughly Investigate [...]	Not Sustained (Unfounded)
# 7	8.400-TSK-2 Use of Force –RESPONSIBILITIES OF THE SERGEANT DURING A TYPE I INVESTIGATION	Not Sustained (Unfounded)
# 8	8.400-TSK-6 Use of Force –RESPONSIBILITIES OF THE SERGEANT DURING A TYPE II INVESTIGATION	Not Sustained (Unfounded)
# 9	8.400-TSK-9 Use of Force – RESPONSIBILITIES OF THE SERGEANT DURING A TYPE III INVESTIGATION (NOT A FIREARMS DISCHARGE)	Not Sustained (Lawful and Proper)
# 10	16.110–PRO–2 Referring a Subject for an Involuntary Mental Health Evaluation 5. Reviews the incident and advises the officer whether to order the evaluation	Sustained

Imposed Discipline

Demotion

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:

It was alleged that the Named Employee failed to fulfill his supervisory responsibilities concerning the screening, review, and investigation of an arrest, involuntary detention, and use force.

ADMINISTRATIVE NOTE:

At the discipline meeting in this matter, the Named Employee's chain of command identified that his assertion that he asked the officers to screen this incident at the precinct due to an impending shift change was inconsistent with the evidence. Specifically, the CAD Call Report indicated that the Named Employee was first dispatched to this incident at 08:00 hours, almost four hours prior to the shift change. The discussions in the context of Allegations #1 and #4 have been updated to reflect this. In addition, OPA further added additional content concerning the Named Employee's repeated failure to act consistent with the Department's expectations for its supervisors.

STATEMENT OF FACTS:

OPA received a complaint from the Captain of the Department's Force Investigation Team (FIT). The Complainant reported that, during a FIT investigation of a possible Type III incident, it was determined that officers supervised by Named Employee #1 (NE#1) were involved in a use of force and asked that he respond to the scene. NE#1 failed to do so. While he screened the arrest and force at the West Precinct, he failed to personally interview the arrestee or take photographs of the arrestee's person as is required of sergeants investigating force. It was reported that NE#1 was later ordered by the FIT Lieutenant to go Harborview Medical Center (HMC) to take photographs of the arrestee. The Complainant further contended that NE#1 failed to approve the General Offense Report or complete an arrest screening report before concluding his shift as required. Lastly, the Complainant alleged that the use of force witness statement provided by NE#1 was vague and potentially intentionally inaccurate.

OPA accordingly initiated this complaint. During its investigation, OPA reviewed the FIT file for this incident, including both the FIT Captain and FIT Lieutenant reviews. OPA additionally reviewed the Force Review Board's findings on this case. OPA also reviewed the underlying documentation concerning the use of force, including a use of force witness statement generated by NE#1, as well as the documentation generated concerning the arrest, un-arrest, and involuntary detention. OPA reviewed the Department video that captured the incident. Lastly, OPA interviewed both NE#1 and a Witness Officer, who was one of the individuals involved in the use of force.

Body Worn Video

The Witness Officer's Body Worn Video (BWV) captured the Witness Officer requesting a supervisor over the radio and that he asked for NE#1 to come to the scene. The video reflected that, at that time, the arrestee kicked out at another officer. The Witness Officer then again went over the radio to ask a supervisor to come to the scene. During these calls the arrestee continued to scream.

The officers tried to maintain custody of the arrestee and the Witness Officer asked another officer to again call for a supervisor. NE#1 then called the Witness Officer. The Witness Officer informed NE#1 that this was a crisis situation (a 220) and that the arrestee had a knife. The Witness Officer further told NE#1 that there was an open warrant for the arrestee and that she was being taken into custody for that warrant. Lastly, the Witness Officer told NE#1 that the arrestee was uncooperative and was "fighting" them. The Witness Officer got off the phone and told the other officers that there was a "change of plan." He stated that they were now going to put the arrestee into an ambulance and transport her to the precinct per NE#1's request.

While at the precinct, the Witness Officer informed NE#1 that, even though he had been informed by radio of a warrant, the Witness Officer determined that no warrant existed. He told NE#1 that they were now involuntarily committing the arrestee. At that time, the Witness Officer told NE#1 that the officers had used de minimis force at the scene. The Witness Officer further stated that he had been "poked" and another officer was "bleeding."

Witness Officer's OPA Interview

The Witness Officer detailed that the arrestee was taken into custody and, at that time, force was used on her. He stated that he determined that the arrestee had an open warrant. He told OPA that he requested radio to send a supervisor to the scene, as well as to send a female officer. The Witness Officer explained that he also asked for an ambulance to come to the scene. The Witness Officer's plan was to load the arrestee into the ambulance, have NE#1 come to the scene and screen the arrest, and then transport her directly to the jail. He recalled that he then spoke to NE#1 on the phone and updated him as to what had occurred. The Witness Officer stated that NE#1 told him to bring the arrestee to the West Precinct so that he could screen the incident there. The Witness Officer complied with that request and had the arrestee transported to the precinct.

The Witness Officer indicated that he told NE#1 during their phone call that the arrestee was "fighting" the officers; however, NE#1 did not make any inquiries as to this statement. The Witness Officer additionally disclosed to NE#1 that the arrestee was being uncooperative. NE#1 also did not make any inquiries as to this statement. The Witness Officer told OPA that there was significant yelling and other noises consistent with an ongoing struggle. The Witness Officer stated that, in his experience, such sounds would indicate to him that he needed to go to the scene and assist. However, NE#1 did not do so here. The Witness Officer did not know why NE#1 directed him to come to the precinct. He stated the following: "I'm not sure what he was working on or what he was doing, but it was clear from our conversation, he just couldn't, at the time, couldn't drop whatever he was doing to come to the scene."

The Witness Officer, other officers, and the ambulance containing the arrestee arrived at the precinct and NE#1 came outside. The Witness Officer recalled that he told NE#1 that all of the officers used de minimis force. The Witness Officer stated that NE#1 did not ask any specific questions about what the nature of that force was. During the screening, the Witness Officer reported that he had a cut on his finger; however, NE#1 did not further inquire into that injury.

NE#1's OPA Interview

NE#1 told OPA that, when screening an arrest, he either responds to the scene or has the officers bring the subject to the precinct. He provided the following description regarding the steps he takes during such an in-person screening: "I speak with the person, I advise them what they're under arrest for, I ask them if they have any injuries, or medical conditions I should be aware of, or any other questions that they might have for me."

NE#1 recalled that he received a phone call from the Witness Officer asking him to respond to the scene to screen an arrest. He asked that the Witness Officer bring the arrestee to the precinct. He was aware that the arrestee was struggling against the officers and that de minimis force had been used. He believed that he got this information from listening to the radio – it did not come from the Witness Officer. NE#1 stated that he believed that this was likely going to be an involuntary commitment and told OPA that this belief came both from his conversations with the Witness Officer and radio transmissions. He acknowledged, however, that he heard the arrestee screaming over the radio and,

presumably, during his calls with the Witness Officer. When asked why he told the Witness Officer to bring the arrestee to the precinct, he stated that it was due to the fact that it was near shift change. He said that it was common in such situations to do the screening at the precinct.

With regard to the screening conversation he had with the Witness Officer, NE#1 stated that he trusted the Witness Officer's decision that the arrestee should be involuntarily committed. He did not inquire into the specifics of the force that was used by the involved officers and, instead, trusted their assertion that it was de minimis. During this screening conversation with the officers and while still at the precinct, NE#1 was informed that the arrestee, who was in the ambulance, may have suffered a broken pinky finger on her left hand. He then ordered that she be transported to HMC and notified FIT of a possible Type III use of force. FIT assumed investigatory responsibility over the incident.

NE#1 told OPA that, where a subject is being involuntarily committed, he generally does not speak to that person until the person has calmed down and is being treated. He said that this happens all the time. When asked whether he would have been required to screen the arrestee's "un-arrest," he stated that he probably would have done that at the hospital and that he wanted to get her to HMC immediately due to the possible broken pinky finger.

ANALYSIS AND CONCLUSIONS:

Named Employee #1 - Allegation #1
6.010 - Arrests 5. Sergeants Must Screen All Arrests Prior to Booking or Release

SPD Policy 6.010-POL-5 requires sergeants to screen all arrests prior to booking or release. The policy explains that: "The sergeant shall screen the arrest in-person if the person detained has been handcuffed by SPD, is injured or claiming injury, or has been the subject of a reportable use-of-force." (SPD Policy 6.010-POL-5.) SPD Policy 6.010-TSK-1 concerns what steps the sergeants must take to screen and approve arrests, and includes the following: (1) review the circumstances surrounding the incident and the physical condition of the person arrested or detained; (2) determine the appropriateness of the offense charged and the disposition of the person arrested or detained; (3) complete an arrest screening supplemental form; and (4) review the reports for completeness.

Based on my review of the record, including the BWV and the interviews of NE#1 and the Witness Officer, I find that NE#1 failed to comply with Department policy during this incident. First, I find that he should have gone to the scene to screen the arrest. This was particularly the case given that he knew it was a potential crisis call, the officers told him that the arrestee had been fighting with them – which strongly suggested that some level of force was used to stop that assaultive behavior, and given that he was requested multiple times to do so. That he did not go to the scene because of an impending shift change is not an acceptable explanation. Moreover, his failure to go to the scene later negatively impacted FIT's investigation insofar as the location of the scene was not actually identified, the scene was not secured, and witnesses and other evidence was not identified.

I further find that NE#1 violated policy and the expectations placed on him as a sergeant when he failed to interview the arrestee. When the officers (and NE#1) determined that there was not actually a warrant for the arrestee's arrest, they decided to involuntarily commit her. This was a functional un-arrest. As such, it was required that NE#1 speak to the arrestee in person.

NE#1 also did not conduct a thorough review of the circumstances of the incident. This includes not asking any follow up or probative questions as to what occurred at the scene and concerning the basis for the decision to involuntarily commit the arrestee. Indeed, NE#1 did not perform virtually any of the screening steps that he stated were his practice to do.

Lastly, NE#1 failed to evaluate the physical condition of the arrestee. This was the case even though she was secured in an ambulance just steps away from him at the precinct. While it is certainly possible that this conversation would not have been productive, he still could have examined her person, spoken to Medics, evaluated whether she had any injuries, and, if so, photographed those injuries at that time. In explaining why he did not do so, NE#1 suggested that he would have later had this screening conversation at HMC. However, this explanation is undercut by NE#1's statement that the primary reason that he asked that the arrestee be brought to the precinct in the first place was because of an impending shift change. If he was not willing to go to the scene to screen the arrest in-person due to this shift change, I cannot imagine that he would have extended his shift by later going to HMC to interview the arrestee.

Moreover, as discussed above, NE#1's assertion that he asked the officers to screen the arrest at the precinct based on an impending shift change is simply inaccurate based on the objective evidence. Most notably, NE#1 was initially dispatched to this incident at around 08:00 hours. This was nearly four hours prior to the end of his shift. As such, this assertion was false.

Ultimately, I find that NE#1's supervision of this matter and particularly his screening of the arrest and un-arrest of the arrestee was inadequate and fell short of the very clear expectations set by the Department. I further note that failing to properly conduct his supervisory responsibilities is an ongoing concern for NE#1. Notably, this is his third recommended Sustained finding for failing to carry out his supervisory responsibilities – whether that be failing to properly screen incidents or failing to attend work. Despite this, NE#1 continues to fail to meet the expectations of the Department for his supervision. His repeated conduct not only reflects poorly on NE#1, but also negatively impacts the officers under his command, many of whom are new to the Department and in need of close and competent supervision. This is simply unacceptable and, as such, I recommend that this allegation be Sustained.

Recommended Finding: **Sustained**

Named Employee #1 - Allegation #2
6.010 - Arrests 6. Screening Sergeant Will Approve Report

SPD Policy 6.010-POL-6 sets forth the responsibility of the sergeant to approve the General Offense Report. The policy states that: "The same sergeant that screened the arrest will be the one to review all documentation related to the incident." (SPD Policy 6.010-POL-6.) The policy provides for an exception from this general rule when "it is impractical for the initial sergeant to" review the documentation. (*Id*.) However, the policy instructs that: "The screening sergeant will locate an alternate to perform the review and will inform the reporting officer of the change." (*Id.*)

It is undisputed that NE#1 failed to approve the General Offense Report for this incident. This was the case even though he was the screening sergeant and was required to do so pursuant to policy. NE#1 explained that he did not approve the report because the FIT investigation extended the involved officers' shifts well beyond his. I find that

explanation to be reasonable. However, as discussed above, the policy requires that, in this exact situation, the screening sergeant locate an alternate sergeant to perform the review. NE#1 did not do so here and this failure represented a violation of policy. That being said, given that multiple other Sustained findings issued in this case, I recommend that NE#1 receive a Training Referral.

- **Training Referral**: NE#1 should receive retraining on SPD Policy 6.010-POL-6 and, specifically, the requirement that where it is impractical for him to review and approve a report he locates another sergeant to do so. NE#1 should be counseled by his chain of command concerning his failure to do so in this case and should be instructed to more closely comply with this policy moving forward. This retraining and associated counseling should be documented and this documentation should be maintained in an appropriate database.

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

Named Employee #1 - Allegation #3
6.010 - Arrests 7. Reports Must Be Completed by End of Shift

SPD Policy 6.010-POL-7 requires officers to complete the General Offense Report prior to the end of their shifts. Officers are required to notify the screening sergeant once the report is set and the "sergeant will review the arrest report immediately for approval."

As discussed above, NE#1's shift ended well before the report for this incident was completed. This was due to the multiple-hour FIT investigation that occurred after it was determined that the subject had a broken pinky finger. For this reason, I find NE#1's failure to approve the report prior to the end of his shift to be excused and, as such, I recommend that this allegation be Not Sustained – Lawful and Proper.

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

Named Employee #1 - Allegation #4
5.001 - Standards and Duties 11. Employees Shall Be Truthful and Complete in All Communication

SPD Policy 5.001-POL-11 requires Department employees to be truthful and complete in all communications.

The Complainant alleged that NE#1's use of force witness report was vague and potentially deliberately inaccurate and misleading.

OPA identified two primary areas in which this was potentially the case. First, in the opening paragraph of the report, NE#1 wrote that he received a call from the Witness Officer "informing [him] that they had one in custody and that the subject was being transported via [an ambulance] due to her violent nature." This language suggested that it was the involved officers' decision to bring the subject to the precinct. NE#1 did not disclose in his report that he, in fact, told the officers to bring her there.

Second, NE#1 wrote in his report that the subject was under arrest for a SMC warrant. He did not disclose that he knew the warrant was invalid at the time and, instead, that the subject was being involuntarily detained.

While I find the above portions of NE#1's report to have been both vague and incomplete, there is insufficient evidence to determine that this report was purposefully written in this manner for some nefarious reason. Arguably, this language could have been included to provide cover for NE#1's potential violations of policy; however, it also could have simply been a drafting error or poor report writing.

Moreover, as discussed above, I am also concerned by NE#1's statement to OPA that he asked the involved officers to transport the arrestee to the precinct rather than going to the scene and screening the incident in person due to an impending shift change. This assertion was conclusively disproved by the evidence, as the CAD Call Report indicated that he was first dispatched to the scene at 08:00 hours. This could also constitute dishonesty, it could also simply be reflective of a lack of recollection. The evidence in this regard is insufficient to meet the burden necessary to provide deliberate and material dishonesty.

As I cannot reach a definitively conclusion on this allegation, I recommend that it be Not Sustained – Inconclusive.

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

Named Employee #1 - Allegation #5
8.400-POL-1 Use of Force Reporting and Investigation 3. The Sergeant Will Review the Incident and Do One of the Following:

SPD Policy 8.400-POL-1(3) provides that, upon responding to a use of force, the Sergeant reviews the incident and classifies the force by type and ensures that it is documented. There are three types of reportable force: Type I – which includes force that "causes transient pain or disorientation, but does not cause, and would not reasonably cause, injury or otherwise require a Type II investigation"; Type II – which includes force that "causes injury greater than temporary pain" or that "could be reasonably be expected to cause such an injury," and force that results in the complaint of an injury that does not rise to the level of Type III; and Type III – force "that results in, or could reasonably be expected to result in, great bodily harm…or substantial bodily harm…to include broken bones and an admission to the hospital for treatment." De minimis force, the lowest level, need not be reported.

Here, NE#1 stated that he was initially informed by the involved officers that only de minimis force had been used. He stated that, while outside of the West Precinct, he was informed by one of the officers that the subject may have suffered a broken pinky finger. NE#1 then notified FIT and FIT initiated a Type III investigation into this matter.

As indicated above, at no point during his screening of the incident did NE#1 interview the arrestee or observe her person for any injuries. This was the case even though the officers stated that they used force on her, the Witness Officer informed NE#1 that he and another officer were injured, and NE#1 heard the subject continuously yelling. Based on OPA's review of the policy, as well as OPA's understanding of Department training, this fell below the expectation for a sergeant screening of a potential force incident. Indeed, aside from engaging in a cursory conversation with the involved officers, in which he asked virtually no probing or follow up questions, NE#1 did nothing else to facilitate the appropriate classification of the force that was used. While NE#1 was certainly entitled to place weight on the accounts of the force provided by the involved officers, his responsibility as a sergeant was to more fully explore the incident to ensure that those accounts accurately described the force. When NE#1 did not do that here, he violated this policy.

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

Recommended Finding: **Sustained**

Named Employee #1 - Allegation #6
8.400-POL-3 Use of Force – TYPE II INVESTIGATIONS 1. In Conducting a Type II Investigation, a Sergeant Will Respond to the Scene and Thoroughly Investigate [...]

SPD Policy 8.400-POL-3(1) states that, when conducting a Type II investigation, a sergeant will respond to the scene and thoroughly investigate the event." The policy further indicates that: "The sergeant retains the discretion to refer any use of force to FIT for their determination of whether to take investigatory responsibility over the matter." (SPD Policy 8.400-POL-3(1).)

When NE#1 learned about the potential broken pinky, he notified FIT. NE#1 stated that, at this point, he believed that FIT took investigatory responsibility over the matter and investigated it as a Type III. Accordingly, NE#1 told OPA that this was not a Type II investigation and, as such, this policy was inapplicable to his actions.

Based on my review of the record, I agree. I find that this was a Type III investigation that was conducted by FIT. As such, I recommend that this allegation be Not Sustained – Unfounded.

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

Named Employee #1 - Allegation #7
8.400-TSK-2 Use of Force –RESPONSIBILITIES OF THE SERGEANT DURING A TYPE I INVESTIGATION

SPD Policies 8.400-TSK-2 and 8.400-TSK-6 govern the responsibilities of sergeants during Type I and Type II investigations, respectively.

As discussed above, the initial report to NE#1 by the involved officers was that they had used de minimis, non-reportable force. When NE#1 learned of the potential broken pinky, the incident became a possible Type III situation and, in fact, FIT took over the investigation. Accordingly, the policies concerning NE#1's responsibilities during a Type I or Type II investigation are inapplicable to this case and, as such, I recommend that this allegation be Not Sustained – Unfounded.

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

Named Employee #1 - Allegation #8
8.400-TSK-6 Use of Force –RESPONSIBILITIES OF THE SERGEANT DURING A TYPE II INVESTIGATION

For the same reasons as stated above (*see* Named Employee #1, Allegation #7), I recommend that this allegation be Not Sustained – Unfounded

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

Named Employee #1 - Allegation #9
8.400-TSK-9 Use of Force – RESPONSIBILITIES OF THE SERGEANT DURING A TYPE III INVESTIGATION (NOT A FIREARMS DISCHARGE)

The main tasks that NE#1 did not perform were going to the scene where the force occurred and securing it, as well as identifying any witnesses to the incident. NE#1 explained that he did not know where the exact scene was and, for that reason, he could not secure it or go there and identify witnesses. He further stated that, once FIT took over the investigation, he was ordered not to speak with the involved officers. As such, he asserted that he could not talk to them to learn specific details about the scene. I note that, had he gone to the scene in the first place as he should have, this would not have been an issue. However, that failure is addressed above. NE#1 also did not ensure that the involved officers upload ICV by the end of their shifts, but that responsibility was obviated by the order from FIT that the officers bring their ICV hard drives to the FIT office.

Otherwise, I find that NE#1 substantially complied with the elements of this policy. Notably, he did the following: ensured that the subject was transported to the hospital; sent an officer to HMC to act as a hospital guard, notified an on-duty watch commander; identified sufficient information (the potentially broken pinky) to determine that a FIT notification was appropriate; identified all of the involved officers, separated them, and ordered them not to discuss the incident; complied with FIT's directions; and evaluated the incident for potential misconduct or other concerns.

For these reasons, I recommend that this allegation be Not Sustained – Lawful and Proper.

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

Named Employee #1 - Allegation #10
16.110–PRO–2 Referring a Subject for an Involuntary Mental Health Evaluation 5. Reviews the incident and advises the officer whether to order the evaluation

SPD Policy 16.110-PRO-2 sets forth the responsibilities of the sergeant where a subject is referred for an involuntary mental health evaluation. The policy specifies that the sergeant must review the incident and advise the officers whether to order the evaluation. (SPD Policy 16.110-PRO-2.) The policy does not provide any guidance as to what is required of a sergeant when reviewing the incident. (*See id*.)

NE#1 contended that he discussed the decision to involuntarily detain the subject with the Witness Officer and, after that conversation, approved this course of action. The BWV indicated that this conversation consisted solely of the Witness Officer telling NE#1 that there was more than enough for an involuntary detention. NE#1 did not ask for any additional information or ask any follow up questions to explore the Witness Officer's reasoning.

NE#1 asserted his belief that the Witness Officer's statement that the involuntary detention was appropriate was sufficient. However, the Department's policies and expectations certainly require and expect more than what NE#1 did. At a minimum, NE#1 should have asked at least one probing question to determine why the subject was being involuntarily detained prior to giving his approval. In addition – or even in the alternative – he could have tried to speak with the subject, who was still at the scene, to independently determine whether the detention was appropriate. He did not do so. NE#1 contended that face to face screenings for involuntary detentions were not his

usual practice and were not necessarily required. While that may be the case, if such a screening is not going to be completed, at least a modicum of investigation should be performed. Here, that simply was not done.

For these reasons, I find that NE#1's screening of the involuntary detention was inconsistent with policy. As such, I recommend that this allegation be Sustained.

Recommended Finding: **Sustained**