

**Semi-Annual Report of the Independent Auditor  
For the City of Seattle  
Office of Professional Accountability**

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**January - June, 2014**

**Judge Anne Levinson (Ret.)**

**OPA Auditor**

**August 12, 2014**

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## Introduction

The City of Seattle's Office of Professional Accountability (OPA) has the responsibility for overseeing the accountability system for employees of the Seattle Police Department ("SPD" or "Department"). While housed within SPD, OPA is intended to be completely functionally independent, so as to be able to conduct internal investigations free from influence or interference by either Department or City officials. To increase trust in the fairness and integrity of the accountability system, OPA was established with a civilian as its Director and another civilian as an "OPA Auditor", an individual with legal or judicial experience who is not a City employee and with whom the City independently contracts to provide outside oversight of the accountability system.

The OPA Auditor's primary role is to provide additional review of every complaint made to OPA and the ensuing actions taken. After OPA staff completes the initial intake for a complaint, they make a recommendation to the Director and the Auditor as to whether the complaint should be investigated by OPA or referred to the employee's supervisor for follow up. This is called the 'classification' of complaints. The intent of having the Auditor review the proposed classification and provide input to the Director is to ensure that all complaints receive the level of attention that is warranted. Then, for each investigation conducted, the Auditor reviews it once the OPA Lieutenant and the Director believe it to be complete. If she concurs that the investigation was thorough and objective, the Auditor will certify it and the Director can proceed to issue recommended findings (i.e., whether the allegations were sustained or not, based on a preponderance of the evidence). If the Auditor finds that additional evidence should be obtained, additional witnesses interviewed or other investigative steps taken, she can order it to be done at that point, while the case is still active, before the Director issues his proposed findings.

The Auditor is required by City ordinance to issue a public report twice each year, detailing such things as the number of complaints and investigations reviewed; those investigations where she requested additional investigatory work be conducted; issues or trends noted as a result of her

reviews; recommendations for changes to training, policy or practice in the Department; or any findings from audits of OPA records for other purposes.<sup>1</sup>

## **Policy, Procedure and Training Recommendations**

As of the end of this reporting period, I had not received any information from the Department about the status of recommendations made in either my last semi-annual report (issued in January) or my April 2014 special report on issues regarding the Department's and the City's handling of the disciplinary aspects of police misconduct cases.<sup>2</sup>

During the intervening months, the systemic policy and operational recommendations from these reports and past reports have been reviewed and discussed by the Community Police Commission (CPC) and the consultant hired by the new Mayor to assist him with assessing police practices. All concerned worked in a collaborative fashion to move these and other recommendations forward by synthesizing and integrating the work. This resulted in a comprehensive set of recommendations, with only a few areas of disagreement, to expedite implementation of the needed reforms, whether through the bargaining process or directly by the new Chief and other City officials. A significant number of the recommended reforms are not mandatory subjects of bargaining. They should improve the system for employees, management, the City and the public alike, and implementation could have been initiated at any point.

The new Chief reviewed the recommendations, directed her leadership team to provide an accurate assessment of the progress of implementation, and has initiated action in several areas.

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<sup>1</sup> See SMC 3.28.850 et seq.

<sup>2</sup> See: [OPA Auditor Semi-Annual Report July-December 2013](#);

[OPA Auditor Special Review-SPD Disciplinary Procedures April 2014](#)

## Complaint Review

On average, OPA receives between 550 – 600 complaints annually alleging misconduct involving SPD employees. The complaints can be made by members of the public, other employees or by referral from others internally or externally. One improvement in the accountability process related to referrals that I had recommended some time ago has now largely been implemented, under the leadership of the new OPA Director and with the mandated deliverables of the consent decree.

In the past there had been a philosophy in the Department that OPA's role was to be a relatively passive recipient of complaints, rather than playing a leadership role in helping ensure that all SPD interactions reflect best practices. This meant that regardless of the issue that might be raised in a use of force, an incident, or a lawsuit, OPA would not be engaged unless someone had filed a complaint. In my view, this internally-imposed limitation on OPA's jurisdiction undercut OPA's value to the organization and resulted in an undermining of public trust as significant incidents were not reviewed by OPA, contrary to public expectations. In 2014, OPA has moved forward to establish clear protocols for involvement in incidents where use of force is being reviewed, and for referrals from City claims and the City Attorney's Office for incidents involving SPD employees for which those offices are involved. Direct referrals from the Use of Force Review Board and call-outs to the scene alongside force investigation teams have now become operational practice. The OPA Director, supervisors and investigators should be commended for taking on this additional responsibility without additional staff. Since the beginning of the year they have devoted a significant amount of time to these call-outs, regardless of the hour or the day of the week, shadowing the force investigation to its completion and then reviewing the completed investigative file for each incident.

An important jurisdictional improvement that has not yet been fully implemented is OPA's involvement in the officer-involved shooting review process. Several of those reviews were unnecessarily delayed by SPD in 2013 and 2014 rather than simply allowing full participation by OPA. As a result, those officers who had been placed on administrative leave during the shooting review processes were left in limbo for months, and the public lost the value of both their active

work and a timely review of the incidents. After needless months of delay, interim agreements were drafted to allow those reviews to proceed.

During the first six months of 2014, the OPA Director and I reviewed 292 new complaints alleging misconduct<sup>3</sup>. We agreed with the initial classifications recommended by OPA staff for all but eight complaints. Of the 292 complaints, 130 were ultimately classified for OPA Investigation and 155 classified for "Supervisor Action" (referral to the employee's supervisor for reaching out to the complainant and then taking specific follow-up steps with the employee). Three were referred for an EEO investigation and four reclassified to "Contact Log". We also reviewed the other 361 inquiries to OPA during the six-month period that had been entered by staff into the OPA "Contact Log." As a best practice, OPA protocol is to ensure that every contact with OPA is logged, even those that are requests for information or assistance, or are messages left, walk-in visits or letters from individuals who may have significant mental illness, or are concerns involving employees from other agencies. This protocol helps ensure that all contacts have been appropriately handled. By also having the OPA Director and Auditor review the log monthly, OPA adds an additional transparency step so that the public and employees know that no inquiry or complaint involving possible misconduct by SPD employees made to OPA is ignored or swept under the rug regardless of the type of issue raised, the background of the complainant, or any other factor.

During this reporting period, because the changes recommended for the mediation program have not yet been implemented, and the recommended addition of a 'problem-solving alternative' has also not yet been established, only two cases were recommended for mediation. Neither was ultimately mediated, based on the preference of the complainants. During this reporting period I also reviewed the quarterly reports of alleged misconduct cases being prosecuted criminally or considered for prosecution that are being monitored by OPA.

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<sup>3</sup> The total of 292 complaints compares to 303 in the previous reporting period, but it should be noted that 40 of the 292 all stemmed from a single complaint that alleged that a number of employees failed to meet their annual firearms training requirements. This was separated into a complaint for each employee named. So a perhaps more helpful comparable number for complaints filed during the first six months of 2014 is 253.

As part of the classification review, the Auditor and Director also determine whether additional or different allegations are warranted, if additional employees should be named for a particular incident, or if an allegation should be investigated criminally initially rather than administratively. During this reporting period, we added 16 allegations, related to possible bias, use of force, courtesy, discretion, professionalism, service quality, failure to self-identify, misuse of authority, property handling, thoroughness of DUI processing, and detainee management (length of time in a holding cell and request for medical attention). We also added three additional named or unknown employees.

The Director and I each reviewed the 120 Supervisor Action referrals completed during this time period to ensure that the supervisor had followed through with the requested actions, including steps such as contacting the complainant to hear directly what his or her concerns were, counseling the employee and documenting it in the performance appraisal system, conducting a roll call training, referring a problem for further engagement by a community police team, and writing or emailing the complainant to let him or her know what actions were taken.

These referrals to supervisors are supposed to be quickly made by OPA and then completed by the supervisor within 30 days, in order to respond to the public as soon after the interaction as possible. During this reporting period there were unnecessary delays in the initial transmittals by OPA out to the line, failure to complete the requested actions in a timely manner by some supervisors, and failure both by the SPD chain of command and OPA to address the delays. In fact, several of the more than 20 significantly overdue referrals at the end of the reporting period were those cases that had been referred to SPD Assistant Chiefs or Captains for handling. As of the writing of this report, there were still nine referrals with due dates ranging from January to May that had yet to be completed. While one might argue that these are 'lesser' matters because they did not warrant further investigation, this lack of concern about quality and timeliness in responsiveness to the public is what stands in the way of having a less-centralized accountability system where more responsibility rests directly with the supervisors. One cannot in good faith argue that the direct line should be given more authority and responsibility and then not have an organizational expectation of excellence by those to whom the authority and responsibility have been delegated.

## Investigation Review

During this reporting period I reviewed 141 investigations<sup>4</sup>. The investigations were for the most part very well done, intake was thorough, and investigative deadlines were met. Those cases that were exceptions to this are noted below. OPA staff should be commended for the thoroughness of OPA intake (where preliminary information must be quickly gathered in order to notify the employee of the allegations and move the case to classification within 30 days), particularly in light of the fact that the Department command staff transferred out the assigned OPA intake Sergeant and did not replace him. That meant that for the past several months all investigators have had to pitch-in to do intake in addition to their assigned investigations (and the newly added responsibility for the FIT call-outs mentioned above). On some days or weekends there can be a significant number of intakes to which they need to respond, which can be very disruptive to their investigative obligations.

I explained in my previous report how the command staff had transferred out the OPA Captain and Lieutenant during the first quarter, which also undercut OPA's management capacity and delayed several cases. These actions provide concrete examples of the Department's need to move forward with my past recommendations that the Director should be in charge of selecting his or her personnel, that they should serve at least two years in OPA before being transferred, that past service in OPA should be considered a preferred assignment when promotional decisions are made, that there should be overlap when personnel are transitioned so that adequate training and sharing of information will minimize disruption and loss of institutional knowledge, and that there should be a mix of civilian and sworn personnel in intake, investigative and supervisory roles so that civilians with investigative expertise are constant as sworn personnel rotate through OPA to get helpful experience.

An investigative challenge of a different sort also arose during this reporting period because many Departmental policies are being, or had been changed, as part of the ongoing consent decree process. I asked OPA to institutionalize a practice to ensure that the SPD policy being

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<sup>4</sup> This compares to 97 in the last reporting period, but as noted above, 40 of the cases derived from a single issue of failure to complete required firearms training, so a better comparison is 102 investigations for this reporting period.

cited for each allegation was the version in effect at the time of the incident, rather than the version one finds when referring to the manual at the time of the investigative process. Employees' conduct must be viewed in light of the policy in effect when their actions occurred.

The other operational problem during this reporting period was the delay in closing OPA cases. While the investigators by and large did an excellent job of meeting timelines, the actual closure of the cases is handled by other staff. The closing process that has been in place is quite manually intensive, with closing letters being drafted by administrative staff who must review the file in order to include the relevant information in these letters. As a result, any data analysis of length of time to close OPA cases would seem to suggest that the investigations are taking much longer than they actually are. More importantly, the other negative consequence of this process is that complainants and named employees do not receive final communications about the results of their respective cases until months after they should have. This process should be simplified by either having the sworn personnel who have already investigated or reviewed the investigation draft the letters or changing the content of the letters so they are not as labor-intensive.

The delay in closing cases is also tied in with the Department's failure to keep basic integrated electronic records for cases once the OPA Director has made his recommended findings to the Chief. As I discussed in my special report on disciplinary practices earlier this year, another way in which the Department was able to constrain OPA's role as OPA was first established was to end OPA's involvement once the OPA Director makes his recommended findings. Although as far as the public and policymakers are concerned these are "OPA cases", the cases are in fact from that point forward not managed by OPA. This has implications with regard to deadlines (see below), responsiveness, accurate record-keeping, information sharing, effective representation by the City Attorney's Office (who have not been routinely informed when an appeal has been filed) and basic organizational management practices. In terms of closing cases, the administrative staff do not even have ready access to know which cases have been appealed, so that notification to the complainant can be timely and accurate. The process of managing appeals must be improved, and is not onerous to do so. OPA should be given authority and staff capacity to manage the processing of OPA cases from start to finish, rather than have these cases handed over to SPD human resources or others in the command staff structure. Ensuring accurate data entry, tracking



of cases, meeting required timelines, sharing of information, comprehensive discipline records and other process improvements noted in my April report can then quickly be implemented, with appropriate collaborative roles with human resources personnel maintained, and streamlining the case closing process can happen at the same time.

### **180-day deadline**

It is often stated that the Collective Bargaining Agreement (CBA) between the City and the Seattle Police Officers' Guild (SPOG) requires that investigations be completed within 180 days or no discipline may be imposed. But, the actual CBA requirement is *not* that the *investigation* must be complete within 180 days. The 180-day period runs from the time notice of the complaint is received by a sworn supervisor or by OPA *until the Department issues the proposed Disciplinary Action Report (DAR) to the named employee*. The DAR is the document that describes for the employee what findings and discipline the Chief is considering and affords the employee the opportunity to then request a due process or "Loudermill" hearing with the Chief, at which time the employee and his or her bargaining representative state his or her case. After that hearing the Chief makes her final decision as to findings and discipline, and the employee is notified. The case is then closed unless the employee or respective union appeals.

As I discussed above, one of the challenges inherent in meeting the 180-day timeline is that the Department has chosen to not have OPA be responsible for the steps that follow once the Auditor certifies the case as complete and the OPA Director sends his recommended findings (the Director's Certification Memo or "DCM") to the Chief. It is the Chief's office and the human resources and legal staff who take responsibility for holding the meeting where the investigation is reviewed by the chain of command and then their input is provided to the Chief. It is at this point that the proposed DAR is delivered to the employee. If that DAR is not issued within 180 days, then no discipline may be imposed, even if OPA's investigation was done in a timely manner.

That is exactly what occurred due to delay by the former Chief and his staff in a case where a finding of dishonesty could otherwise have resulted in discipline up to and including termination of the employee. On December 30, OPA sent the DCM to the chain of command and their

review meeting was scheduled for January 16. The employee's bureau chief stated at the conclusion of the meeting that he intended to advise the Chief that he disagreed with the recommended Sustained finding. The Chief and his staff were reminded that the 180-day deadline was January 21. Nonetheless, no DAR was issued by that date and the Chief held onto the case until April, all the while not providing the employee with the required DAR. It was not until May that the Chief's office issued the DAR, advising the employee that the Chief intended to sustain the allegation, and to impose a 30-day suspension. The Loudermill hearing was held and the employee received a final DAR with the Sustained finding and what was at this point only a theoretical 30-day suspension because the 180-day deadline had long since passed.

It should be noted as well that during the OPA investigation, the named employee was to be interviewed in late September; OPA was notified one day before his scheduled interview that he would be unavailable. He did not make himself available for his interview until October 31. Then, based on his responses, additional investigative work was required, thus pushing OPA's completion of the case much closer to the 180-day deadline, a period which also included the holidays. In my view, the OPA Captain or Lieutenant should have requested an extension of the 180 days due to the employee's unavailability, as is permitted by the SPOG contract, so as not to create the need for a rush review by the chain of command or the Chief. Obviously, given the several months delay by the Chief's office, that would not have cured the missed deadline, but OPA also has a responsibility to manage case timelines as effectively as possible.

During this reporting period, OPA missed the 180-day deadline in one other case, but in that case the finding was Lawful & Proper, so there would not have been any discipline imposed and thus there was no impact. OPA also forwarded several cases for discipline too close to the 180-day deadline, resulting in unnecessary compression of the time allowed for the discipline meeting and Chief's initial consideration. These delays were for the most part due to the failure of OPA command staff to take responsibility for monitoring timeliness in case flow and to the continued practice that only the OPA Captain prepares and distributes the Director's Certification Memo (DCM). For many cases during this reporting period, there was a gap of a month or more from the time I certified a case as complete to OPA's issuance of the DCM to the chain of command.

## **Policy, management and contractual issues**

Several policy, contractual or management issues arose from investigations completed during this reporting period. For example, an investigation into the actions of a recently hired officer still on probationary status highlighted the importance of the Department taking appropriate action when significant performance issues are identified for a new officer before that officer's probationary status ends, as well as the need for the Department to then review the hiring process to ascertain how a candidate made it through the screening process with what appeared to be readily discernable ethical deficiencies. In the case in point that was referred to OPA (and should instead have been handled directly by SPD human resources given the probationary status of the employee), concerns were raised regarding the named employee's honesty when he was confronted regarding work-related performance problems. While still at the Academy, his instructors noted that he had made a number of inconsistent statements regarding a mock scene search. His field-training officers then noted that his statements in response to questions regarding his on-duty accidents also raised honesty concerns. He made additional false statements about reporting damage to his precinct locker in order to avoid getting into trouble, as well as other remarks made to those supervisors which gave them cause for concern regarding his trustworthiness. Finally, his taking another officer's food without consent, preparing to leave his shift before his scheduled end time, and his possible mishandling of an arrestee's property were also problematic.

Because he was not terminated, but instead a complaint was made to OPA, the student officer continued to be deployed. He was dispatched to investigate a hit & run accident involving a parked vehicle. A review of the Police Traffic Collision Report narrative written by him listed several inaccurate statements. The inaccuracies were that the incident was recorded on In-Car Video (ICV) when it was not, that another officer also responded to the call when he did not, and that photos showing damage to the victim vehicle were taken and uploaded into SPD's photo retention system (DEMS) when they were not. This then resulted in another referral to OPA. OPA completed both investigations and the probationary employee was ultimately terminated just prior to the conclusion of his probationary status.

Another OPA case once again resulted in no accountability for unprofessional conduct because the Department has not implemented a recommendation I made in the past to revise the policy manual so that there is over-arching language making expectations clear, instead of needing specific sections that address every possible type of misconduct that might arise.<sup>5</sup> In this case, the allegation was that an officer was involved in a relationship with someone he met while on duty working an emphasis patrol at a club (thus establishing the nexus for this investigation), borrowed money from her, and did not pay her back in the amount she felt she was owed.

She learned the officer was married (there was some dispute as to when she learned this), ended the relationship, and filed an OPA complaint alleging the named employee should have paid her interest on the loan to cover her early withdrawal penalty. While the facts bore out that the employee did pay her back, during her interview she also stated that she lives within his assigned precinct and that on several occasions he went to her house during breaks in his shift and they had sex. While it might appear obvious that having sexual relations during working hours should be prohibited, and it is clearly inconsistent with public expectations, there is not an express prohibition in policy, so OPA did not add an allegation to address this aspect of the employee's behavior.

In my view, if employees do not want hundreds of pages of policies by which they must abide, the manual should clearly articulate the Department's overall values and expectations, explain that not every possible action is expressly delineated, and make crystal clear that any behavior that is inconsistent with those values and standards will not be tolerated.

Another behavior which would appear neither to have any justification nor to comport with public expectations yet seems to be expressly *permitted* by Departmental policy arose in a case where members of the Vice Unit were seen consuming alcohol at a tavern on several occasions while on duty. The Sergeant and the Detectives - all of the named employees - confirmed that they did

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<sup>5</sup> My specific recommendation was this language: "A police officer's ability to perform his or her duties is dependent upon the respect and confidence communities have for the officer, other officers and the Department in general. Whether or not delineated in a specific sub-section below, officers must conduct themselves in a manner consistent with the professionalism, fairness, integrity and trustworthiness expected of them by the public. Officers shall not, whether on or off duty, exhibit any conduct which discredits themselves or their Department or otherwise impairs their ability or that of other officers or the Department to provide effective law enforcement services to the community."

consume alcohol at the tavern "so that they would have the smell of alcohol on their breath when they went to contact prostitutes or high risk juveniles". The relevant Captain and Lieutenant were asked in written questions whether this was appropriate and within policy. Both stated it was an accepted and appropriate practice, and done pursuant to policy.

Indeed, SPD's policy manual states that consumption of alcohol to maintain undercover status, as long it is approved and monitored by a supervisor is permissible. If impaired, employees may not then drive or take official action, but other than that, how much they drink and for what purpose, is controlled only by Vice Unit protocols, which, based on the OPA interviews, are neither complete nor well understood by those working in Vice.

It is hard to find any legitimate justification for this policy and practice or for the lack of clear protocols by those assigned to this Unit. Surely officers could use other means to have alcohol on their breath where doing so is actually warranted, without the need to consume it. And certainly gathering at a pub to drink as preparation for interacting with "prostitutes and high risk juveniles" would not qualify as a best practice.

A case involving domestic violence (DV) stalking, identity theft, perjury, honesty and other allegations highlighted the lack of public accountability in the limitation on the Chief under the CBA allowing her to put an employee on leave without pay prior to the completion of the administrative investigation only if the employee has been charged with a felony, but not if charged with a misdemeanor, regardless of the nature of the offense. Despite the egregious nature of the employee's behavior in this case, the crimes charged by the prosecutor were only misdemeanors. Thus the public continued to pay the named employee's salary from the moment the allegations were first raised in July of 2013 until the conclusion of the criminal process. The Department, in my view, also has the clear authority to terminate an employee once he or she is incarcerated, because the employee cannot then report to work as required under the contract. In this case the former chief elected not to do that, but the Department maintains and should use its authority in this way whenever appropriate. SPD and OPA did an excellent job with their investigations of this case, and there is no question that the employee's behavior did not meet public expectations. In an action that further disrespects the public, the employee and SPOG

have appealed his termination, asserting that the 180-day deadline used was not consistent with the contract.

### **Investigations with further action requested**

There were several cases during this reporting period that appeared to be a reflection of the particularly toxic atmosphere in the Department in the first half of 2014, where employees used the OPA process to address workplace issues that would have been better addressed by leadership setting a tone that reflected a healthy and professional organizational culture. Instead, fellow employees filed OPA complaints that used time and money that could have been better spent, not to mention the fact that once an investigation was concluded, the underlying dysfunction remained unaddressed. (To be clear, these are different sorts of complaints than those complaints employees and supervisors should and do make when there is the possibility of real misconduct having occurred.)

Regardless of the genesis of any complaint or its underlying merit, OPA must still ensure each investigation is thorough and objective. In one such case that stemmed from an EEO investigation, I felt the Lieutenant and investigating Sergeant had not established a clear investigative plan. The interview questions were often not relevant to the specific allegations at issue, some questions were leading or conclusory, and the case summary was not objective. Further, I felt that the Assistant Chief, who allegedly approved of the actions at issue, should have been interviewed. Additionally, other issues were raised during the witness interviews with regard to possible downloading of In-Car Video (ICV) onto a personal computer and irregularities in the process used by the Department for hiring contractors. These latter issues provide yet another example of the need for OPA and the Department to implement a recommendation I have made in the past that there should be a clear process by which the public can be assured that larger management, policy, or systemic issues which come to light as a result of an OPA complaint are addressed. An accountability process that only focuses on the named employee does not serve the public well when there are other concerns that also warrant attention.

Hospital employees felt an officer was intimidating and unprofessional to them in another OPA case. The officer had a warrant for a blood draw and was concerned about how long it was

taking hospital staff to take the draw. A nursing supervisor was listed in the case file as a witness, but she had not been interviewed. I asked that she be interviewed if she had witnessed the interaction, or, if not, that the summary be clarified to explain she had not. Additionally, there had not been follow up on the issue of whether the named employee announced that the complainant was being recorded, as is required. Because this was not the central issue and too much time had passed by the time the case was submitted for review, I did not require follow up on that aspect of the case but instead asked that the Lieutenant review it with the investigator.

I had several concerns about the quality of the interviews, the summary, and timeliness of an investigation involving an allegation of improper disposal of a small amount of narcotics. Because that case is still delayed as of the writing of this report, I will not go into specifics at this point. There were similar issues in another case involving the same investigator, but because the allegation was clearly unfounded, I did not require additional work but instead asked that additional training and coaching be provided.

I requested OPA obtain additional evidentiary documentation from the Court or City Attorney's Office (CAO) in an investigation that arose from an allegation that the named employee, who was on his way to work, should not have conducted a traffic stop and issued a citation to the complainant taxi driver for a red light violation and prohibited turns. The OPA investigator had done a thorough job in interviewing the complainant, employee and witness, had obtained maps of the area including the notice of infraction, satellite photos, screen shots of a video showing GPS tracking and private video. But the complainant had asserted that the prosecutor had watched the video and, based on that, decided to dismiss the ticket. If that were in fact true, that would be material. If, however, the ticket had been dismissed for reasons unrelated to the complainant's driving, it would not provide any additional weight to the complainant's allegation. The investigator followed up on my request and learned from the CAO that the traffic infraction had been dismissed due to a technical error.

Charges of reckless driving and malicious mischief had originally been filed in a case referred to OPA by another jurisdiction. On a summer evening, the named employee had allegedly driven his car, accelerating and spinning his tires, over his neighbor's lawn while yelling at his neighbor. The

named employee had done this based on his belief that his neighbor did something that warranted this response. Another neighbor heard the commotion and called 911. Upon completion of the criminal case, OPA conducted an administrative investigation. The investigator obtained the incident report, citations, court transcript, 911 call, photos and case disposition, and conducted an interview of the employee. Although the responding officers had interviewed the homeowner whose lawn had been damaged by the incident at issue, I requested that OPA also interview him to ask some additional questions.

Additional follow-up was needed in a case where a supervisor had alleged an employee had violated policy by the way in which he handled a 911 call with an individual for whom English is not his primary language. The named employee had raised some issues suggesting the policy violation was due to problems with the system SPD uses for this purpose. I requested that OPA either interview or submit written questions to the relevant Captain to get additional information on that point. OPA did obtain that information in writing, but took an additional seven weeks to do so, and then another week for OPA to issue the Director's Certification Memo, thereby leaving only a week in the 180-day timeline for the chain of command to review the case, hold the discipline meeting, and notify the employee of the Chief's proposed findings.

Allegations of unnecessary force, discourtesy, and exercise of discretion were at issue in a traffic stop conducted by a Sergeant who was off-duty and driving home with his fiancé. The named employee was driving behind the complainant, who was driving a pick-up truck that crossed over a double-yellow line into the oncoming traffic lane (although there was no oncoming traffic at the time), and then crossed back over to cut in front of the Sergeant's car. The named employee called 911 to request uniformed officers stop the complainant, whom the employee had by that point observed driving recklessly, speeding, making frequent lane changes, and nearly hitting a pedestrian. When the complainant pulled into a retail store parking lot, the named employee ran after him and instructed him to wait, ultimately directing the complainant to put his hands on a wall and then the employee placed his hands on the complainant's back. There was no available video from the store of the interaction. The investigator did thorough interviews of the complainant, the named employee and the officers who responded, but did not interview the named employee's passenger/fiancé. Although she would not be an independent witness, given



her relationship with the employee, she was nonetheless a witness both to the complainant's driving and to the interaction. I requested that the investigator interview her, and she corroborated the information provided by the named employee and witness officers.

The complainant in another OPA case had been arrested in Courthouse Park on two warrants. The named employee then transported her to the King County Jail; a distance of about three blocks. The transportation was captured on ICV and there was no indication the recording was stopped or interrupted. The subject could be seen yelling and kicking during the transportation and was clearly alone in the rear prisoner compartment of the vehicle. At the booking desk, the subject alleged to the booking officers that the named employee raped her en route to booking. The subject stated that the rape lasted for 2-3 minutes and that the named employee stopped his ICV before the alleged assault and started it back up after the alleged assault. The subject stated the named employee told her not to tell anyone what had happened.

The King County Jail declined the subject and she was taken to Harborview Medical Center for a rape examination. SPD's sexual assault unit investigated and found the subject not to be credible. (Once in custody, the subject had also stated multiple times that she did not want to go to jail and that she lied about her name and had no warrants.) The named employee had used his ICV system continuously during the transportation of the subject and there was no indication that the transportation stopped or was interrupted.

When the Director and I first reviewed the intake for this case, we noted a concern that the named employee also transported the complainant to Harborview Medical Center from the jail after she articulated her complaint of sexual assault to jail booking personnel. Although the employee's ICV was on, an additional officer followed behind in his vehicle, and HMC is only a few minutes from the jail, we asked the OPA Captain to make sure that the West Precinct Captain had noted this and to counsel employees that an employee accused of misconduct should never then continue to transport the subject.

With regard to the ICV evidence, the fact that the ICV was never paused or stopped could have been buttressed by the investigator requesting written documentation from information technology staff explaining that one of the features of the COBAN system (the ICV system) used

by SPD is that once a video has started, it cannot be stopped or paused without the system indicating that has occurred. Because this allegation was so clearly unfounded, I did not require this additional follow-up but simply asked that the Lieutenant note it for future cases.

In a case where the named employee had been alleged to have used a Department-owned "light bar" in his personal vehicle, the named employee made an assertion at the end of his interview that other employees also used "light bars" in their personal vehicles. I asked that the Lieutenant note for the investigator the importance of following up on this kind of assertion, as this is often the sort of defense that is later raised by an employee should an allegation be sustained. In this case, there was insufficient evidence to make a determination one way or the other, so the finding on this allegation was inconclusive. The employee was found to have violated the secondary employment policy.

A supervisor alleged the named employee was insubordinate, by abandoning his post, logging off duty before being relieved of duty, and ignoring his (the complainant's) order to get back in his patrol car and return to his patrol duties during the Seahawks celebration activities. The complainant further alleged the named employee then lied to a Sergeant about being relieved of duty by the complainant. Other allegations were that the employee added his name to the Event Summary without supervisor approval after the supervisor signed off (approved) the timesheet and was inaccurate with the time he listed as his end time worked for the event. During his OPA interview, the employee told the investigator he should interview some other officers who would back up his version of events and should look at their timesheets as well to see if they also reported their time the way he did. Because it appeared to me that there was much more than a preponderance of evidence already established to sustain the allegations and his actions should stand on their own merit, regardless of the actions of his co-workers, I did not require OPA follow-up on the named employee's assertions. I should have, particularly because there was an allegation of dishonesty, which by the terms of the Collective Bargaining Agreement carries with it a presumption of termination along with a concomitant standard of proof of clear and convincing evidence rather than the usual preponderance standard.

Finally, during this reporting period there were three cases where the complainant alleged someone in OPA might have been involved, necessitating the use of a process by which the OPA Director recuses himself until an independent investigator determines there is no conflict. These take additional time and can be cumbersome to manage in a way that ensures employee collective bargaining requirements are met while also ensuring the real or apparent conflict of interest are appropriately addressed. In each of these the OPA Director took all requisite steps to meet both of those objectives.