SPOKANE POLICE DIVISION

CRAIG N. MEIDL
CHIEF OF POLICE

Closed Case Summary

Complaint Number:	C17-050	OPO Number:	17-23
Date of Complaint:	9/6/2017		
Allegation:	Inadequate Response		
Chain of Command Finding:	Training Failure		
Final Discipline:	Not Applicable		

INCIDENT SYNOPSIS

The complainant was involved in a domestic dispute. Officers placed the complainant in protective custody and transported him to the hospital. At the hospital, the complainant became assaultive. Police officers used a Lateral Neck Restraint control hold on the complainant during the incident so hospital staff could place him in restraints. After he was restrained, staff continued to evaluate him and drew blood.

COMPLAINT

The complaint alleged a nurse grabbed his testicles during the struggle with officers and that officers failed to respond.

INVESTIGATION

The use of force in the incident was reviewed by the chain of command and was found to be in compliance with policy. At the time, when the officers' supervisor had interviewed the complainant about the use of force, he said he had no concerns about the officers' actions. Hospital management also confirmed that the ER doctor deemed the blood draw medically necessary, which could override a patient's refusal for a blood draw. The officers' actions to assist medical staff with a combative patient were reasonable.

The Internal Affairs investigation focused on the officers' actions during the overall incident, rather than the use of force. The investigation included a review of all available documentation, including police reports and BWC (body worn camera) video, and interviews with the complainant and involved officers.

The investigation showed that a nurse made an unsolicited statement to a Reserve Officer regarding her actions controlling the complainant while officers were trying to detain him. Her statement was significant and was recorded on BWC. Neither officer reported actually seeing the nurse's action and the complainant did not make any statements to officers. The Reserve Officer did not remember doing so, but he passed along the information provided by the nurse to another officer. Neither officer took further action in regards to the nurse's statement. Neither officer documented the information.

The Internal Affairs Lieutenant spoke with hospital management. She told him that the complainant had filed a complaint with the hospital as well and there was an open investigation into the nurse's actions.

ANALYSIS AND CONCLUSION

The chain of command review determined that the incident was a Training Failure. The officers were preoccupied with their procedure related to the use of force and failed to recognize the significance of the nurse's statement. The chain of command noted that officers should have documented the statement in their reports. Officers would have been prudent to contact a supervisor to determine proper course of action. The situation was unusual and warranted further training for all department members on notification and documentation.

Assistant Chief Justin Lundgren directed the SPD Training Unit to deliver training outlining officers' responsibilities to record pertinent information in their police reports and conduct further investigation when necessary. The training outlined when a supervisor should be notified, if the suspect involved is another professional or partner agency such as medical staff, fire, law enforcement, CPS caseworkers, etc. Training took place during Spring 2018 In-Service.