Seattle
Office of Police
Accountability

CLOSED CASE SUMMARY

ISSUED DATE: JUNE 4, 2026

FROM: INTERIM DEPUTY DIRECTOR NELSON R. LEESE (ON BEHALF OF INTERIM DIRECTOR BONNIE GLENN)
OFFICE OF POLICE ACCOUNTABILITY

CASE NUMBER: 2024OPA-0057

Allegations of Misconduct & Director's Findings

Named Employee #1

Allegation(s):		Director's Findings
# 1	15.180 – Primary Investigations, 15.180-POL-1. Officers Shall Conduct a Thorough and Complete Search for Evidence	Not Sustained - Training Referral

Named Employee #2

Allegation(s):		Director's Findings
# 1	15.180 – Primary Investigations, 15.180-POL-1. Officers Shall Conduct a Thorough and Complete Search for Evidence	Not Sustained - Training Referral
# 2	15.180 – Primary Investigations, 15.180-POL-5. Officers Shall Document all Primary Investigations on a Report	Not Sustained - Management Action

Named Employee #3

Allegation(s):		Director's Findings
# 1	5.001 – Standards and Duties, 5.001-POL-10. Employees Will Strive to be Professional	Not Sustained - Inconclusive

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:

SPD officers, including Named Employee #1 (NE#1) (a sergeant on the incident date) and Named Employee #2 (NE#2), responded to Community Member #1's (CM#1) death caused by a single gunshot wound. The Complainant—CM#1's mother—believed CM#1's death was improperly investigated as a suicide instead of a homicide. The Complainant alleged that NE#1 and NE#2 conducted an unthorough investigation. The Complainant also alleged that NE#2's incident report was inaccurate and improperly favored the accounts of Community Member #2 (CM#2)—CM#1's roommate—and CM#2's girlfriend (Girlfriend #1). Finally, the Complainant alleged that NE#3—a Homicide Unit sergeant—was unprofessional during a phone conversation by stating, "It's a suicide. The case is closed. Get over it."

ADMINISTRATIVE NOTE:

On May 15, 2025, the Office of Inspector General certified OPA's investigation as thorough, timely, and objective.

OPA originally recommended Sustained findings for all allegations against NE#1 and NE#2. On June 2, 2025, OPA attended a discipline meeting with the named employees' Chain of Command. The meeting participants had a robust discussion concerning the facts and allegations in this case. The Chain of Command offered insight of their review of

the facts as well as their expectations of patrol officers and the training provided by the Department specific to conducting death investigations. Considering this, OPA is now amending its recommendations for NE#1 and NE#2 to include two Training Referrals and a Management Action Recommendation (MAR).

SUMMARY OF INVESTIGATION:

A. OPA Complaint

On January 29, 2024, the Complainant left OPA a voicemail, stating that her deceased son, CM#1, had special needs. She said officers improperly investigated CM#1's death as a suicide instead of a homicide and based their conclusion on his roommates' accounts, which she claimed contained many discrepancies.

On February 14, 2024, OPA interviewed the Complainant. She believed CM#1 did not shoot himself and disapproved NE#1's and NE#2's inadequate investigation into the matter. She believed NE#1 and NE#2 failed to thoroughly question CM#1's roommates and accepted their accounts without scrutiny. She said CM#2 was unreliable and frequently bullied CM#1. She recounted an incident from October 2023, where CM#1 was assaulted by unknown individuals in a parking lot after visiting a bar with his roommates, which resulted in his hospitalization. She said his roommates abandoned CM#1 in the parking lot and did not visit him during his hospital stay. She said she provided her contact information to his roommates and noted that CM#1's license listed his family's address. She said no SPD officer visited the family's address or attempted to obtain contact information for CM#1's family, apart from asking his roommates. She said CM#1 had plans for New Year's Day and in the weeks that followed, which made it illogical for him to consider self-harm. She said CM#1 overcame his learning disability stemming from seizures during infancy and ran a successful business.

The Complainant said CM#1 had a large gun safe and believed the safe documented in the incident report as belonging to CM#2 actually belonged to CM#1. She said his roommates did not attend CM#1's funeral, despite the arrangements being widely disseminated. She believed an altercation led to CM#2 killing CM#1. She said CM#1 had no prior history of suicide attempts. While she acknowledged that CM#1 experienced depression following a difficult breakup and the death of a family member years earlier, she maintained that he overcame his depression. She alleged that during a phone conversation with NE#3 about the investigation into CM#1, NE#3 remarked, "It's a suicide. The case is closed. Get over it."

OPA investigated the complaint by reviewing the computer-aided dispatch (CAD) call report, body-worn video (BWV), and incident report. In addition to interviewing the Complainant, OPA also interviewed the named employees.

B. Computer-Aided Dispatch (CAD) Call Report

On December 30, 2023, at 11:15 PM, CAD call remarks noted, "HANDGUN[.] [REPORTING PARTY] SAYING ROOMMATE IS DEAD, JUST COMMITTED SUIC[IDE], SCREENING FIRE." CAD then noted, "SAYING ROOMMATE SHOT HIMSELF" and "[REPORTING PARTY] AND GIRLF[RIEND] HEARD AND WITN[ESS] THIS."

C. Body-Worn Video (BWV)

BWV captured the following:

NE#2 arrived at the home where CM#2 permitted entry and told him that CM#1 had taken his own life. Upon locating CM#1, NE#2 found him seated on the floor with his back against the wall, his head resting against a trash bin, and his legs positioned over three cases of water bottles. Blood was present on the wall, floor, and CM#1's face. CM#2 said (Girlfriend #1), and Community Member #3 (CM#3), another roommate, were present at the time. NE#2 radioed that the scene was under control and requested the Seattle Fire Department (SFD). NE#2 did not assess CM#1 for a pulse but retrieved a gun located near him and ensured it was cleared. NE#2 aimed a flashlight at CM#1 and asked CM#1 where he was hit. CM#1 appeared to be breathing based on movements of his head and chest. CM#2 told NE#2 that CM#1 had sustained a gunshot wound beneath his chin. NE#2 radioed, "Looks like a single [gunshot wound] under his chin. Not responsive." NE#2 moved the water bottles and trash bin aside. NE#2 again pointed his flashlight at CM#1 and said, "Hey, man. Hey." CM#1 still appeared to be breathing. After backing officers arrived, NE#2 described CM#1 as "agonal." The officers moved CM#1 to the recovery position. Witness Officer #1 (WO#1), an emergency medical technician (EMT), assessed CM#1, confirmed a pulse, and indicated the need to stop the bleeding. With NE#2's assistance, WO#1 applied first aid to CM#1 just as SFD personnel arrived. NE#2 then exited the home and secured the gun in the rear of his patrol vehicle.

NE#2 approached CM#2 and Girlfriend #1, who were together on the front lawn. CM#2 reported the following account.[1] CM#1, CM#2, and CM#3 cohabited, while Girlfriend #1 was visiting. Initially, CM#1, CM#2, and Girlfriend #1 were socializing at home, eating food, and drinking alcohol, but they later separated into different rooms. CM#2 returned to CM#1, who was eating, and jokingly asked, "You want some?"[2] CM#1 replied, "Yeah, I want some" and menacingly approached CM#2 with a fork. CM#1 then retreated to his room and charged his gun, prompting CM#2 to return to his own room to retrieve his gun, as he was aware of CM#1's gun ownership and had heard him charge it. CM#2 closed his door and locked it, but CM#1 knocked and invited a confrontation.

NE#2 interrupted CM#2 by requesting personal information from CM#2 and Girlfriend #1, which they provided. NE#2 asked about Girlfriend #1's whereabouts at that moment, to which she replied that she was cooking. CM#2 interjected, saying he had exited his room with his gun. Both CM#2 and Girlfriend #1 claimed that CM#1 had aimed his gun at his own chin, which they demonstrated by forming a fist beneath their chins. They both said they urged CM#1 to put the gun away. NE#2 asked whether CM#1 had made suicidal statements in the past, to which CM#2 confirmed and mentioned that CM#1 had been hospitalized years ago due to a breakup. NE#2 then recounted CM#2's narrative to both CM#2 and Girlfriend #1.

Upon reentering the home, NE#2 learned that CM#1 had succumbed to the gunshot wound. CM#3 told WO#1 that he knew CM#1 for most of his life and was unsure why CM#1 did this. NE#2 asked whether a specific room belonged to CM#1, which CM#3 affirmed. NE#2 asked whether CM#1 had any behavioral issues or previous suicide attempts, which CM#3 replied no. NE#2 began recounting CM#2's narrative to CM#3, who interrupted by saying he had been asleep downstairs. NE#2 then entered CM#2's room with NE#1 and recounted CM#2's narrative to NE#1, who asked

[1] As CM#2 provided his account, Girlfriend #1 appeared to be distressed. NE#1 also arrived during this interview and approached NE#2, CM#2, and Girlfriend #1, listening for a moment before entering the home. Inside, NE#1 interviewed CM#3, who reported that he was unaware of what happened, as he had been asleep downstairs. CM#3 also reported that CM#2 ran downstairs and alerted him that CM#1 had shot himself.

[2] The context seemed to indicate that CM#2 was proposing a fight, although NE#2 did not seek clarification from CM#2.

whether NE#2 had interviewed CM#2 and Girlfriend #1 separately. NE#2 replied no, prompting NE#1 to instruct him to do so and to assess discrepancies in their accounts. NE#1 asked whether NE#2 found the shell casing, to which NE#2 replied no, as he had been moving around. NE#1 then spoke with CM#3, who reported that he did not hear arguing, as he had been asleep. CM#3 said he was unaware of any dispute during the day and had not seen CM#1 for about two days. CM#3 said he was unaware if CM#1 had mental health or depression issues. NE#1 instructed CM#3 to wait outside, as the police would consider the home as a potential crime scene. CM#3 complied and exited the home.

NE#2 returned to CM#2 and Girlfriend #1, who were with a backing officer. CM#2 expressed reluctance to provide a recorded statement, as he had already provided his account on NE#2's BWV. The officers separated the parties, with CM#2 accompanying NE#2, and Girlfriend #1 accompanying the backing officer. NE#2 initiated the interview by repeating CM#2's earlier statements. CM#2 then took the lead and recounted his narrative to NE#2, which was generally consistent with his previous account, as NE#2 interjected with clarifying questions. CM#2 expanded upon his account, stating that he, along with Girlfriend #1, exited his room with his gun holstered in his waistband and approached CM#1, who had already put his gun away at that moment. CM#2 said he cautioned CM#1 against playing with a gun. CM#2 said CM#1 retrieved his gun from his room and stepped in front of CM#2 and Girlfriend #1. CM#2 said CM#1 charged his gun, aimed it at his own chin, and questioned whether they thought he was joking, as CM#1 was on the verge of pulling the trigger. CM#2 said after he and Girlfriend #1 heard this, they urged CM#1 to put the gun away and CM#1 pulled the trigger. CM#2 said CM#1 was his long-time friend but would act recklessly with a gun while intoxicated. CM#2 said CM#1 had previously threatened himself with a gun, but the police had not responded to such incidents.

During CM#2's interview, NE#1 joined the backing officer and Girlfriend #1, who was crying as she told her account. She said she had known CM#1 for about six months but did not live at the home, as she was merely visiting. She expressed uncertainty about why CM#1 shot himself. She said CM#1 and CM#2 were joking around, not arguing. She said she was in CM#2's room when CM#2 entered and shut the door, at which point CM#1 approached and proposed a fight—a proposal that CM#2 rejected. She said CM#2 exited the room with a gun concealed in his waistband, intending to de-escalate the situation by encouraging CM#1 to put the gun away. She said CM#2 never drew his gun. She said CM#1 accused them of trying to portray him as the bad guy, while CM#1 had his gun pointed at his chin. She said she then heard a gunshot sound and saw blood everywhere. She said she did not see any physical altercation between CM#1 or CM#2 but mentioned that CM#1 acted aggressively that day. When NE#1 asked whether Girlfriend #1 observed any unusual behavior or signs of depression from CM#1, she recalled an incident about two months ago when CM#1 overreacted by slamming objects in his room.

NE#1 joined NE#2 and asked CM#2 clarifying questions, including why CM#2 had exited his room knowing CM#1 was armed. CM#2 replied that he concealed a gun in his waistband for protection and tried to calm CM#1. NE#1 asked why CM#2 did not call the police after CM#1 armed himself, to which CM#2 replied that he calmed CM#1 in prior instances. NE#2 then allowed CM#2 to reunite with Girlfriend #1.

After NE#1 requested a call from the Homicide Unit, NE#3 called NE#1, who stated, "This is most likely a suicide." NE#1 said he was screening the incident with NE#3 due to reported "roughhousing" between CM#1 and CM#2. NE#1 recounted the witness narratives and mentioned that CM#1 reached a tipping point while intoxicated. NE#1 conveyed confidence in categorizing the incident as a suicide based on CM#1 being "super dark."[3] After their conversation

[3] Super dark in this context likely referred to CM#1's emotional state being negative and/or depressed.

ended, a backing officer approached NE#1 and told him that a 2018 crisis report documented CM#1 expressing suicidal ideation. NE#1 then screened the incident with a lieutenant, opining that this was a suicide.

NE#2 briefly interviewed CM#3 outside. NE#2 asked whether CM#1 had ever made suicidal statements or brandished a gun toward himself, to which CM#3 replied that he was unaware of CM#1's situation. CM#3 believed CM#1 had "snapped." CM#3 said he was unaware of the location of CM#1's family. NE#2 asked CM#3 if he knew whether CM#1 played with his gun while angry or intoxicated, to which CM#3 replied no. NE#2 then recounted the witness narratives to NE#1, who indicated that he screened the incident with the Homicide Unit and was confident that this was a suicide. NE#2 and WO#1 agreed, with WO#1 saying CM#1's injury was consistent with a suicide and that the gun was registered to CM#1. The backing officer who interviewed Girlfriend #1 said she expressed confusion as to why CM#1 had drawn his gun. The backing officer also said Girlfriend #1 felt as though the officers were implying she had done something wrong. NE#2 mentioned that he accounted for two loose rounds but did not account for the shell case of the fired round.

CM#2 told NE#2 that he would spend the night elsewhere and asked to retrieve his belongings. NE#2 agreed to accompany CM#2 inside the home. NE#2 and a backing officer escorted CM#2 and Girlfriend #1 inside, remaining present as they collected their items. NE#2 denied CM#2's request to take his gun but permitted him to return it to his safe.[4] After CM#2 opened the safe, NE#2 placed CM#2's gun inside and partially closed the door. CM#2 reopened the safe and asked about the gun's location. NE#2 replied that he placed it on the top shelf, after which CM#2 closed the safe. NE#2 permitted CM#2 to use the bathroom before NE#2 proceeded to the area where CM#1's body had been found.[5] NE#2 entered CM#1's room, which contained food on a plate and multiple beer bottles. After CM#2 finished in the bathroom, NE#2 escorted him out of the home, and CM#2 subsequently left.

NE#2 briefed an investigator with the King County Medical Examiner (KCME#1). KCME#1 asked whether NE#2 believed the roommates were responsible for the shooting. NE#2 replied that he did not believe so, as their accounts were consistent and aligned with the evidence at the scene. NE#2 also mentioned that they believed the discharge was unintentional. KCME#1 asked whether CM#1's family had been notified, to which NE#2 replied that CM#1's roommates lacked any information about CM#1's family. KCME#1 entered the home and photographed the scene, while NE#2 continued to brief her about his observations and the evidence collected.

CM#3, along with his brother, returned to the home to request a final farewell with CM#1. NE#2 and KCME#1 advised against this due to CM#1's condition. CM#3 insisted, expressing uncertainty about whether CM#1 would be cremated. KCME#1 granted CM#3's request and said she would prepare CM#1 for viewing. CM#3 and his brother bid their farewells to CM#1 before leaving. NE#2 and backing officers assisted KCME#1 in transporting CM#1's body to the KCME van. NE#2 later returned to his patrol vehicle and deactivated his BWV.

D. Incident Report

NE#2 prepared an incident report following his response to the scene. The incident report primarily summarized CM#2's, CM#3's, and Girlfriend #1's accounts and the physical evidence NE#2 observed at the scene.

[4] CM#2's gun had been set atop the safe.
[5] SFD personnel moved CM#1's body to the living room.

E. OPA Interviews

Named Employee #1

On April 29, 2025, OPA interviewed NE#1. He said he had been with SPD since 1999. He described his extensive experience in responding to incidents involving deaths and gun-related suicides. He said he approaches suicide calls with an open mind, as further investigation may change the initial call. He said officers had already secured the scene upon his arrival. He emphasized the importance of gathering statements from the relevant parties. He said he observed NE#2 interviewing CM#2 and Girlfriend #1 together, which he deemed appropriate given the "dynamic" nature of the scene, especially after they had witnessed something traumatic. He believed the circumstances did not warrant separating them at that moment, as there were other priorities. He said NE#2 would have had to proceed differently had there been clear indications of violence suggesting that CM#2 and Girlfriend #1 were suspects. He pointed out that NE#2 eventually separated them and obtained their accounts. He acknowledged the importance of separating witnesses before obtaining statements to detect inconsistencies. He also acknowledged the importance of the officers' role as investigators to investigate the scene, which included asking "weird" questions and "snooping around." He believed the totality of the evidence indicated suicide.

NE#1 said he first contacted CM#3, who appeared drowsy and shaken up, and then instructed CM#3 to exit for "scene preservation." He said he saw a gun atop CM#2's safe and recalled the caliber as .40, which differed from the .45-caliber gun used by CM#1. He said there were two ejected .45-caliber rounds, one spent shell case, and CM#1's gun at the scene. He believed everyone in the home was armed but doubted that the other guns were of the same caliber. He pointed out that the weapon used was found in the kitchen beside CM#1. He said the potential crime scene shifted to a suicide scene "fairly early on" when he did not see evidence of a struggle in the kitchen or injuries on CM#2. He believed a verbal dispute and posturing occurred between intoxicated individuals. He also noted that CM#1 had a history of suicidal threats. He said even though there were no indicators of criminality, the officers—as investigators—were obligated to conduct a thorough investigation until they could conclude that a suicide occurred. He posed a hypothetical scenario about witness statements. He said if one witness provided information that altered the course of an investigation, then "all of the work that you have done previously leading up to that point still has to stand up, and you still have to be able to articulate why you went in a certain direction." He noted that neither the SFD nor the roommates provided statements that would have altered the course of the investigation.

NE#1 stated that this incident marked NE#2's third or fourth death investigation and emphasized that NE#2 conducted each one with thoroughness and professionalism and wrote "incredible" reports, while also being prepared for subsequent calls. He advocated for NE#2's mental health, as NE#2 was required to repeatedly relive death investigations by responding to scenes and reviewing footage, only to face scrutiny on his commendable work.

Named Employee #3

On May 23, 2024, OPA interviewed NE#3, who reported having 20 years of law enforcement experience. He said he is currently assigned to the Homicide and Assault Unit. He said he was the standby sergeant on the incident date when he spoke with NE#1, who sought to assess whether a homicide detective should be dispatched. He said NE#1 did not find sufficient evidence to indicate criminality, so NE#1 called for notification purposes. He said NE#1 regularly screens death investigations with him.

NE#3 recalled speaking with the Complainant but did not consider his discussion unprofessional. He denied telling the Complainant to "get over it," insisting that he would never communicate insensitively to bereaved family members.

He insisted that he shows empathy by offering condolences, providing them an opportunity to express their feelings, and explaining the investigatory process. He recalled the Complainant voicing concerns about the investigation.

NE#3 expressed confidence in NE#2's incident report and investigation. He mentioned that a family friend—a homicide detective with the Kent Police Department—reviewed the report, opined that the investigation was conducted appropriately, and indicated that she would not have approached it differently. He said a suicide occurring in a home shared by multiple roommates and witnessed by two individuals was unusual but believed the death was likely unintentional, rather than a suicide. He believed CM#1 was teasing and "messing" with CM#2 and Girlfriend #1. He said he saw no evidence of criminality, whether the death was accidental or suicidal.

NE#3's union representative commented that she works near NE#3, often overhears his conversations with victims' family members, and had never heard him say, "Get over it."

Named Employee #2

On June 7, 2024, OPA interviewed NE#2. He said he became an SPD officer on March 15, 2018. He recounted being dispatched to a suicide call and arriving at the scene with the expectation of finding CM#2 outside, only to discover that he was inside the home. He said he did not consider this unusual, as he believed CM#2 was in a state of shock. He said there were no indications suggesting that CM#1 had died from anything other than suicide. He expressed confidence that CM#1's injury was a self-inflicted gunshot wound, drawing from his previous experiences with firearm-related suicide incidents. He said he did not render aid to CM#1 due to CM#1's injury and agonal breathing and to prevent further injury. He clarified that he believed CM#1 was likely deceased, as agonal breathing is indicative of the body expelling air. He said he did not apply a chest seal to the wound because he was focused on securing the scene. He said he was more at ease rendering aid alongside someone with greater experience. He said he did not request guidance via radio once he recognized CM#1's agonal breathing. He said he was not an EMT but received training in basic first aid.

NE#2 said he allowed CM#1's roommates to remain in the home after he secured CM#1's gun, as their presence did not make him feel unsafe. He recounted CM#2's and Girlfriend #1's accounts, which were consistent with the evidence summarized above. When OPA asked whether NE#2 found it unusual that playful fighting between roommates escalated to firearm presentment, NE#2 replied no, as CM#2 was unable to clarify why the situation escalated so significantly. When OPA asked whether NE#2 considered CM#2's account to be thorough, NE#2 replied yes, as the narrative was chronological and aligned with the physical evidence he observed at the scene. He described CM#2 as animated, upset, and speaking loudly and quickly, which he did not interpret as dishonesty, leading NE#2 to accept the veracity of CM#2's account. He did not express concern about CM#2's reluctance to provide a recorded statement, as witnesses occasionally decline. He said he investigated this incident similarly to two or three other incidents that involved witnesses observing the suicide, although he acknowledged that these incidents did not involve disturbances or armed occupants.

NE#2 said CM#2's account mirrored Girlfriend #1's account. When OPA asked whether NE#2 considered the possibility that CM#2 and Girlfriend #1 may have fabricated a story before the police arrived, NE#2 believed it did not appear that way. When OPA asked why NE#2 questioned CM#2 and Girlfriend #1 together, NE#2 said he aimed to gather an initial narrative due to the "fairly active scene." He acknowledged that the best practice would have been to separate them before questioning to identify inconsistencies and prevent collusion. However, he did not believe interviewing them together adversely affected their statements, as they were consistent with the physical evidence, which included a plate of food on the ground where the confrontation occurred, two unfired cartridge cases located where CM#1 was

reported to have manipulated his gun's slide, a fired cartridge case, and a dresser in CM#1's room that reportedly contained CM#1's gun. When OPA asked whether NE#2 examined CM#2's gun, NE#2 replied no, as CM#1 had a .45-caliber gun, which was in his hand and covered in blood, while CM#2 appeared to have a 9-mm gun. He said there were additional weapons inside CM#2's safe, but he neither checked the safe nor verified the caliber of the weapons. He said his decision not to verify other weapons at the scene was based on the evidence around CM#1 and the witness accounts. He believed CM#2's account but lacked other means to verify it since there were no other witnesses.

When OPA asked whether CM#3 owned any weapons, NE#2 said he was unsure and had no reason to ask CM#3. He also said he did not believe Girlfriend #1 had a gun since she was visiting. He believed he explored all possibilities during his investigation and thoroughly investigated the home, although he acknowledged that he did not inspect the basement where CM#3 resided. He said he did not ask CM#2 about past conflicts he had with CM#1.

ANALYSIS AND CONCLUSIONS:

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

As discussed below at Named Employee #2, Allegation #1, OPA originally recommended this allegation be Sustained. However, for the same reasons articulated in Named Employee #2 – Allegation #1, OPA now recommends that this allegation be Not Sustained – Training Referral.

- **Training Referral**: NE#1's chain of command should discuss OPA's findings with him. This discussion should include each of the six issues raised in OPA's Original Findings set forth below at Named Employee #2, Allegation #1. NE#1's chain of command should also review SPD Policies 15.055 and 15.180 with him and provide any further retraining and counseling that it deems appropriate. In addition to these policies as a whole, the retraining and counseling should place particular emphasis on the responsibilities of a patrol sergeant at a death investigation, 15.055-TSK-2. The retraining and counseling conducted should be documented in Blue Team.

Recommended Finding: **Not Sustained – Training Referral**

Named Employee #2 – Allegation #1
15.180 – Primary Investigations, 15.180-POL-1. Officers Shall Conduct a Thorough and Complete Search for Evidence

The Complainant alleged that NE#1 and NE#2 conducted an unthorough investigation.

In primary investigations, officers must conduct a thorough and complete search for evidence. SPD Policy 15.180-POL-1. All sworn personnel are responsible for knowing how to collect the most common physical evidence that might be encountered in a primary investigation. *Id.* Only evidence impractical to collect or submit to the Evidence Unit shall be retained by the owner. *Id.* Officers shall photograph all evidence retained by the owner. *Id.*

1. *OPA'S Original Findings*

For the reasons articulated below, OPA originally found that NE#1 and NE#2 did not conduct a thorough investigation. NE#1 was the on-scene sergeant who supervised the investigation, while NE#2 was the primary officer. As such, both

bore responsibility in ensuring the collection of physical evidence. OPA originally found that their investigation was deficient for the following reasons.

First, NE#2 questioned CM#2 and Girlfriend #1 together. BWV showed CM#2 dominating the conversation and interrupting Girlfriend #1 as she attempted to speak. Questioning them together contradicted best practices, invited potential collusion, tainted witness statements, and hindered the police's ability to identify inconsistencies. NE#1 and NE#2 justified this investigative approach by citing the "dynamic" or "active" nature of the scene. The dynamic or active nature of the scene should have prompted NE#1 and NE#2 to slow down and speak to each of them individually. Moreover, multiple backing officers were present, allowing for their separation and individual questioning. Although NE#1 was correct in instructing NE#2, as captured on BWV, to question them separately, NE#1 failed to intervene when he noticed NE#2 interviewing them together initially. By that time, the investigation had arguably been tainted, even though NE#2 later interviewed them separately. While showing compassion toward witnesses who experienced a traumatic event is important, it should not compromise the integrity of the investigation.

Second, the way NE#2 questioned CM#2 was problematic. Several of his questions were leading, rather than open-ended. For instance, during CM#2's second interview, NE#2 initiated the questioning by repeating CM#2's prior statements, such as the location of CM#2 and Girlfriend #1 within the home (leading), instead of asking about what happened (open-ended). Additionally, NE#2 questioned CM#2 about whether CM#1 had previously made suicidal statements (leading), instead of asking whether CM#1 had a history of mental health concerns (open-ended). NE#2 also failed to follow-up with obvious clarifying questions that were relevant to the investigation. For instance, CM#2 repeatedly claimed that he asked CM#1, "You want some?" However, NE#2 did not seek clarification on the meaning of that statement or the reasons behind CM#2 provoking a conflict with CM#1.[6] Another obvious question that NE#2 failed to ask was whether CM#2 had any past conflicts with CM#1. Finally, NE#2 interrupted CM#2 while he was attempting to provide his account by requesting information about CM#2 and Girlfriend #1. Overall, NE#2's questioning appeared passive, failing to elicit a comprehensive and thorough account of the incident.

Third, NE#1 and NE#2 failed to investigate or collect evidence regarding other guns in the home, especially CM#2's gun. NE#1 correctly stated on BWV that the home was a potential crime scene. Yet, it was not treated as such since NE#1 and NE#2 concluded "fairly early on" that CM#1's death was a suicide, contrary to NE#1's assertion that officers should act as investigators first and conduct a thorough investigation, even when criminal activity is not evident. Here, CM#2 reported a verbal altercation, leading both CM#1 and CM#2 to arm themselves. CM#2 also reported a need to barricade himself in his own room before approaching CM#1 with a concealed gun for protection. Given this information, further investigation was warranted, instead of unduly relying on CM#2's account that CM#1 committed suicide. This required approaching the incident with an "open mind"—as NE#1 stated—by further examining the guns inside the home to determine their possible involvement. Although the discovery of CM#1's gun near him might suggest it was the weapon responsible for his death, NE#1 and NE#2 would not have been able to prove or disprove whether other guns, including CM#2's, were involved in the incident without examining them. Due to the possibility that another gun could have caused CM#1's death, along with NE#1's and NE#2's awareness of multiple guns in the home and the significance of CM#2's gun in his narrative, they should have examined or seized them as evidence, at least until they could be definitively ruled out as causing CM#1's death. However, NE#1 and NE#2 overlooked the potential evidentiary value of CM#2's gun by leaving it atop his safe and failed to consider other guns in the home as potential evidence. Moreover, NE#1 and NE#2 could not even agree on the type of gun CM#2 owned, with NE#1

[6] OPA also notes that CM#2 described CM#1 as acting "weird." Although NE#2 did not seek clarification on the meaning of this statement, NE#1 followed up with a clarifying question, to which CM#2 provided an incoherent response.

believing it to be a .40 caliber and NE#2 believing it to be a 9 mm, calling into question their ability to correctly identify the gun that caused CM#1's death. Furthermore, CM#3 said he did not have a gun and CM#2 said everyone in the house had a gun.

NE#1 and NE#2 cited their experience and the physical evidence at the scene being consistent with a suicide, but neither could cite a previous instance involving similar circumstances—specifically, a reported suicide following a confrontation between armed individuals. NE#2 also could not explain how playful fighting, joking, or rough housing between roommates could escalate to a suicide. Even if OPA were to accept NE#1's and NE#2's premise that the totality of the evidence indicated suicide, they were still obligated to conduct a thorough investigation by gathering evidence. This meant, at the very least, documenting and photographing all guns inside the home, yet this was not done. NE#1 and NE#2 relied heavily on the physical evidence around CM#1, which was indeed important, but they should have investigated the scene thoroughly, especially considering that CM#2 and Girlfriend #1 were the last individuals to have been in that area before CM#2 called the police. NE#1 told OPA that if the police were to acquire information that altered the course of the investigation, then "all of the work that you have done previously leading up to that point still has to stand up." Considering NE#1's hypothetical scenario, if the police were to acquire information indicating, for example, that a different gun caused CM#1's death, then their investigation would certainly not "stand up" since they did not examine other guns or even document them. NE#1's assertion that he and NE#2 concluded "fairly early on" that CM#1's death was a suicide contradicts his assertion that officers, as investigators, are required to conduct a thorough investigation until they could conclude that a suicide occurred. Since NE#1 and NE#2 only had one account from CM#2—who refused to provide a recorded statement and had every motivation to deny criminal liability—along with the physical evidence at the scene, OPA finds, they should have explored other possibilities as well. At a minimum, other guns merited further examination.

Fourth, NE#1 and NE#2 failed to contact the people who would likely have the most knowledge about CM#1—his family. CM#1's roommates claiming that they had no information about CM#1's family did not absolve NE#1 or NE#2 from the responsibility of seeking alternative methods to obtain contact details, particularly given their access to law enforcement databases. They failed to make any attempts to contact CM#1's family members, who could have provided insight into CM#1's mental health. Instead, NE#1 and NE#2 quickly concluded that CM#1 was "super dark" based on a crisis report from five years ago and CM#2's account of CM#1 being hospitalized years prior due to a breakup. This conclusion was reached despite CM#3 being unaware if CM#1 had mental health or depression issues. CM#3 reported being unaware of any behavioral issues, prior suicide attempts, mental health concerns, or any dispute that may have occurred that day. Based on the evidence provided, OPA remains unconvinced that such a cursory review of CM#1's background could conclusively establish that CM#1 was "super dark." At a minimum, statements from CM#1's family would have been pertinent to the investigation, yet this information was not sought.

Fifth, NE#1 and NE#2 failed to conduct additional investigatory steps, such as checking CM#3's room or interviewing neighbors. CM#3, along with CM#2, reported that he was asleep in the basement. NE#1 and NE#2 could have quickly checked his room to corroborate that statement and to ascertain whether any relevant evidence, such as a gun, was present for the investigation. NE#1 and NE#2 could have also interviewed neighbors to seek corroboration of CM#2's account. Even if it may have been improbable, neighbors might have overheard something that could have been pertinent to the investigation. However, this information was not sought.

Sixth, NE#2 failed to secure the home as a potential crime scene by allowing CM#2 and Girlfriend #1 to reenter to collect their belongings. NE#2's decision was predicated on the belief that this incident was a suicide, not a crime. As OPA noted above, this conclusion was reached prematurely without a thorough investigation. Thus, allowing CM#2

and Girlfriend #1 to take their belongings may have compromised the scene, as they may have taken items of evidentiary value. In fact, BWV captured NE#2 leaving CM#2 unattended for a period while he was in his room and the bathroom, giving CM#2 the opportunity to, for instance, retrieve a gun from his safe. Allowing their reentry while the police did not account for all guns in the home also posed a serious safety concern for everyone inside. Ultimately, NE#2 allowed CM#2 and Girlfriend #1 to contaminate the scene before a thorough investigation could be completed.

Given the gravity of a death caused by a gunshot wound, NE#1 and NE#2 were obligated to conduct a thorough investigation.[7] OPA originally found that, based on the totality of the circumstances, NE#1 and NE#2 failed to do so.

2. OPA's Amended Findings

On June 2, 2025, OPA attended a discipline meeting with NE#1 and NE#2's Captain- and Assistant Chief-level Chain of Command. The participants had a detailed, robust conversation concerning the incident and OPA's recommended findings. At the meeting, the Chain of Command spoke persuasively about the challenges and needs for conducting a death investigation at a dynamic scene. Ultimately, NE#1 guided NE#2 to take separate statements from CM#2 and Girlfriend #1, and the physical evidence recovered appeared consistent with the manner of death as they described. Other concerns, such as using closed- versus open-ended questioning, detailed collection of all firearms in the home, contacting family members and neighbors, and securing the entire house as a crime scene—while perhaps better practices—were more in line with a follow-up investigation. Here, NE#1 screened this incident with NE#3, the Homicide sergeant. NE#1 provided the information he had about the altercation between CM#1 and CM#2 that occurred prior to the shooting, and Homicide did not respond. Finally, the chain of command raised at the discipline meeting that patrol officers have not received regular, updated, in-service training concerning how to conduct a Death Investigation or the importance of cognitive interviewing concepts—such as open-ended questioning—in these investigations.[8]

OPA is still concerned about the issues it raised in its original findings. But, considering the totality of the circumstances, finds that NE#1 and NE#2's conduct did not rise to willful misconduct. Instead, the potential shortcomings in their investigation are more appropriately addressed through additional training.

For these reasons, OPA recommends that this allegation be Not Sustained – Training Referral.

- **Training Referral**: NE#2's chain of command should discuss OPA's findings with him. This discussion should include each of the six issues raised in OPA's Original Findings for Named Employee #2, Allegation #1. NE#2's chain of command should also review SPD Policies 15.055 and 15.180 with him and provide any further retraining and counseling that it deems appropriate. In addition to these policies as a whole, the retraining and counseling should place particular emphasis on the responsibilities of a primary patrol officer at a death investigation, 15.055-TSK-1. The retraining and counseling conducted should be documented in Blue Team.

Recommended Finding: **Not Sustained – Training Referral**

[7] See also, SPD Policy 15.055 – TSK-1 and TSK-2.

[8] Following the discipline meeting, OPA confirmed with SPD's Education and Training Section (ETS) that such training has not been offered by ETS and that most of the training exposure for conducting death investigations comes during the "post-BLEA" training for student officers, or in specialized or outside training provided for detectives or supervisors.

Named Employee #2 – Allegation #2
15.180 – Primary Investigations, 15.180-POL-5. Officers Shall Document all Primary Investigations on a Report

The Complainant alleged that NE#2's incident report was inaccurate and improperly favored CM#2's and Girlfriend #1's accounts.

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

OPA originally recommended this allegation be Sustained. OPA reasoned that NE#2 accurately documented statements from CM#2, Girlfriend #1, and CM#3, along with the physical evidence found at the scene. This included two unfired .45-caliber cartridges in CM#1's room and the kitchen, a single fired .45 -caliber cartridge in CM#1's room, Asian food spilled on the floor near the couch, numerous empty alcohol bottles in CM#1's room, and a pipe and open containers in the living room where CM#1 had been eating. NE#2 then concluded, "This evidence was consistent with the narrative provided by [CM#2] and [Girlfriend #1]. This evidence and the narrative indicated a suicide by [CM#1]." OPA originally concluded that, based on the evidence provided, the suicide determination was made hastily without a thorough examination of the scene. Consequently, OPA originally found that NE#2's incident report could not be considered complete or thorough due to the deficiencies in his investigation.

The participants at the discipline meeting discussed the equity of including a Sustained finding for this allegation. Because the finding in this allegation is predicated entirely on the issues covered in Named Employee #2, Allegation #1, OPA would amend its recommended findings for this allegation to be Not Sustained for the same reasons.

However, OPA notes that a significant portion of the discussion at the discipline meeting concerned the importance of regularly training patrol officers on how to properly conduct a death investigation according to policy and best practice. *See* SPD Policy 15.055 – Death Investigation. This would include training on the importance of cognitive interviewing concepts for these investigations. At the meeting, it was noted that SPD has not provided such in-service training to patrol officers. OPA is issuing a Management Action Recommendation for the Department to provide this essential training.

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

- **Management Action:** SPD should develop a training module on SPD Policy 15.055 – Death Investigation and provide this training Department wide. The module should emphasize, (1) the respective responsibilities of primary patrol officers and primary patrol sergeants responding to a death investigation, (2) the appropriate categorization of the death as a natural death, death of a person under hospice care, natural death at a hospital, accidental death or suicide, and possible homicide or death with suspicious circumstances, and (3) the importance of using cognitive interviewing concepts, such as open-ended questions, in these investigations.

Recommended Finding: **Not Sustained – Management Action**

Named Employee #3 – Allegation #1
5.001 – Standards and Duties, 5.001-POL-10. Employees Will Strive to be Professional

The Complainant alleged that NE#3 was unprofessional during a phone conversation by stating, "It's a suicide. The case is closed. Get over it."

SPD employees must "strive to be professional." SPD Policy 5.001-POL-10. Further, "employees may not engage in behavior that undermines public trust in the Department, the officer, or other officers," whether on or off duty. *Id*. Employees will avoid unnecessary escalation of events, even if those events do not end in reportable uses of force. *Id.* Any time employees represent the Department or identify themselves as police officers or Department employees, they will not use profanity directed as an insult or any language that is derogatory, contemptuous, or disrespectful toward anyone. *Id.*

NE#3 denied this allegation, insisting that he shows empathy toward bereaved family members during telephone discussions. NE#3's union representative vouched for NE#3, stating that she frequently overhears his conversations and has never heard him saying such comments. Although this may support NE#3's account, the union representative was not present during the conversation between NE#3 and the Complainant. Consequently, OPA finds this allegation inconclusive, as one party alleged inappropriate comments, while the other party denied having made those comments.

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

Recommended Finding: **Not Sustained – Inconclusive**