



## CLOSED CASE SUMMARY

ISSUED DATE: JANUARY 31, 2025

FROM: DEPUTY DIRECTOR BONNIE GLENN ON BEHALF OF DIRECTOR GINO BETTS, JR.  
OFFICE OF POLICE ACCOUNTABILITY

CASE NUMBER: 2024OPA-0280

### Allegations of Misconduct & Director’s Findings

Named Employee #1

Allegation(s):		Director’s Findings
# 1	7.030 – Firearms, Ammunition, and Shell Casings, 7.030-POL-1. Employees Will Safely Handle Firearms	Sustained
<b>Proposed Discipline</b>		
9 (1 Day) to 27 (3 Days) Hours Suspension		
<b>Imposed Discipline</b>		
27 Hours (3 Days) Suspension		

***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.***

#### **ADMINISTRATIVE NOTE ON PROPOSED FINDINGS:**

*When the OPA Director recommends a sustained finding for one or more allegations, a discipline committee, including the named employee’s chain of command and the department’s human resources representative, convenes and may propose a range of disciplinary to the Chief of Police. While OPA is part of the discipline committee, the Chief of Police decides the imposed discipline, if any. See OPA Internal Operations and Training Manual section 7.3 – Sustained Findings.*

#### **EXECUTIVE SUMMARY:**

Named Employee #1 (NE#1) manipulated Community Member #1’s (CM#1) revolver at a shelter to render it safe. During that process, the revolver discharged one round. It was alleged that NE#1 unsafely handled that revolver.

#### **ADMINISTRATIVE NOTE:**

On November 8, 2024, the Office of Inspector General certified OPA’s investigation as thorough, timely, and objective.

#### **SUMMARY OF INVESTIGATION:**

##### **A. OPA Complaint**

On June 28, 2024, OPA responded to a Force Investigation Team (FIT) callout for an unintentional discharge incident. OPA learned that community service officers brought CM#1 to a shelter. Shelter staff learned that CM#1 had a revolver, acquired it, and requested police assistance in rendering it safe. NE#1 responded, manipulated the revolver, and discharged one round during his attempt to unload it. No injuries were reported, and the revolver and discharged round were recovered. FIT and OPA investigated the incident. OPA reviewed the computer-aided dispatch (CAD) call



report, body-worn video (BWV), incident report, shelter video, photographs, and FIT interview records. OPA also interviewed NE#1.

## B. Revolver Features<sup>1</sup> and Firearm Safety Rules



The revolver has a swing out-type cylinder, turning around a central axis. When the cylinder is locked in position, the revolver is ready for firing. The shots may be fired by single action (cocking<sup>2</sup> the hammer and, thereafter, pulling the trigger) or by double action (merely pulling the trigger). Unloading the revolver requires pushing the thumb piece forward (figure 1) and then pressing against the cylinder to swing it left (figure 2):



The following are the four cardinal rules for safely handling firearms:<sup>3</sup>

- (1) Assume firearms are always loaded.
- (2) Point the muzzle in a safe direction.
- (3) Keep fingers off the trigger until ready to fire.
- (4) Be certain of the target and what is beyond it.

<sup>1</sup> The images of the revolver that follow are for informational purposes. They do not depict the revolver at issue in this investigation.

<sup>2</sup> Cocking means to fully lower the hammer.

<sup>3</sup> The aforementioned rules for safely handling firearms are used as part of SPD training.



### C. Computer-Aided Dispatch (CAD) Call Report and Body-Worn Video (BWV)<sup>4</sup>

On June 28, 2024, at 5:19 PM, CAD call remarks noted, “[COMMUNITY SERVICE OFFICER SUPERVISOR REQUESTS] WE RESPOND TO ASSIST IN INTAKE FOR FEMALE SUBJ[ECT], [COMMUNITY SERVICE OFFICERS] BROUGHT HER HERE [AND] SHE HAD A FIREARM THAT HAS SINCE BEEN TAKEN BY STAFF, STAFF WON’T CHECK HER IN UNTIL UNITS RESPOND.”

NE#1 responded to a shelter and activated his BWV, capturing the following:

NE#1 spoke with the shelter’s manager outside. She said CM#1 entered the shelter and alerted staff that she had a revolver in her backpack. The manager said the revolver was “loaded” and “had bullets in it.” The manager said she set it in a locked office. The manager, CM#1, and NE#1 went to the office.

NE#1 retrieved the revolver from the backpack, lowered it into a paper bag, aimed the barrel at the ground, and manipulated it. NE#1 was unable to release the cylinder.



NE#1 cocked the hammer, which produced clicking sounds. NE#1 was unable to release the cylinder. About 30 seconds elapsed since the start of NE#1’s attempt at unloading the revolver in the office.

NE#1 exited the office with the paper bag and revolver, closed the office door, and stood in a hallway facing a storage shelf. NE#1 set the paper bag on top of an instant noodles box, lowered the revolver into the paper bag, and again attempted to release the cylinder with the barrel aimed at the ground. The hammer was cocked (red arrow), and the trigger was positioned near the handle (green arrow):<sup>5</sup>

<sup>4</sup> OPA applied a brightness filter to BWV to enhance visibility for the images that follow.

<sup>5</sup> Here, the revolver was in the single-action position, meaning less pressure applied to the trigger would discharge a bullet.



NE#1 pressed against the cylinder, but it remained locked in place. While the revolver was still cocked, NE#1 pressed his left thumb against the thumb piece (purple arrow):

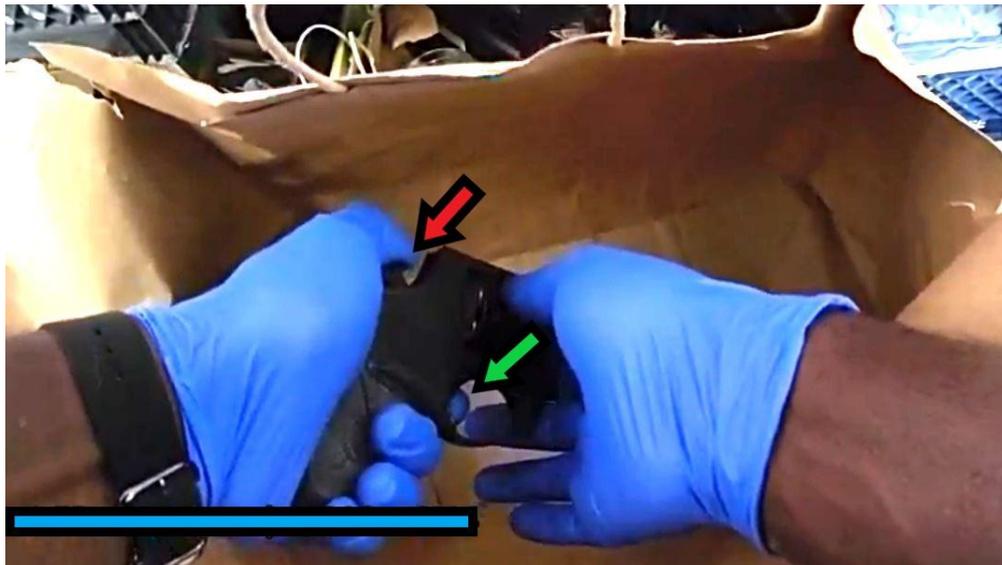


*The image above depicts the thumb piece before NE#1's left thumb covered it*

NE#1 wiggled the cylinder, but it remained locked in place. At one point, NE#1 briefly inserted his right ring finger into the trigger guard near the trigger while his right thumb pressed against the cylinder:



NE#1 removed his right ring finger from the trigger guard. NE#1 pressed his left thumb against the hammer (red arrow) and his left index finger against the trigger (green arrow), causing the hammer to move upward and the trigger to move toward the center of the trigger guard.<sup>6</sup>



<sup>6</sup> This maneuver decocked the revolver. Decocking returned the revolver to the double-action position, meaning more pressure applied to the trigger would discharge a bullet.



*The image above depicts the revolver after it was decocked*

NE#1 pressed against the cylinder, causing it to spin, but it remained locked in place. NE#1 recocked the hammer, causing the trigger to move back toward the handle (now in the single-action position):



NE#1's right thumb was pressed against the cylinder. NE#1's left index finger appeared to contact the trigger:



*The image above depicts the moment immediately preceding the discharge*

The revolver discharged when it was angled at the ground:



About 1 minute and 40 seconds elapsed since the start of NE#1's attempt at unloading the revolver in the hallway. The bullet pierced a Clorox bleach bottle, causing a spill:



NE#1 placed the revolver in a shoebox. FIT responded and investigated the incident.

#### **D. FIT and OPA Interviews**

On June 28, 2024, FIT interviewed NE#1. NE#1 said his goal was to render the revolver safe so he could transport it for safekeeping. NE#1 said CM#1 told him her revolver was 10 years old, and she never used it before.<sup>7</sup> NE#1 said the revolver “appeared old.” NE#1 said he did not ask CM#1 about the revolver’s mechanics. NE#1 believed the three-walled corner was the best location to render the revolver safe. NE#1 said he aimed the revolver at the ground, knowing it was loaded. NE#1 said he was unable to unload the revolver when he manipulated it. NE#1 said he tried to break the revolver forward (see image below for illustrative purposes), but it did not break.



*The revolver depicted above is not the same revolver at issue in this investigation*

NE#1 said the thumb piece was too stiff, so he focused on the hammer. NE#1 recalled that when the hammer was cocked and the trigger was near the handle, he tried to break the revolver forward (see image above), but the revolver suddenly discharged. NE#1 stated, “What I do remember is my finger was not on the trigger at the time the firearm went off.” NE#1 elaborated, “I will say that my finger was on the side of the firearm.”

<sup>7</sup> CM#1 told FIT she “never had any kind of issue with” her revolver, and “it’s never done what it did.” CM#1’s son—the purchaser of the revolver who reportedly showed CM#1 how to fire it—told FIT he was unaware of any issues with the revolver.



NE#1 said the first time he received firearm training was when he joined SPD. NE#1 said he was a rifle officer and received no training on revolvers. NE#1 said this incident was the second time he handled a revolver. NE#1 said the first time he handled a revolver was one year ago, which involved an empty and broken-down revolver that he did not have to clear. NE#1 said he did not consider declining to clear this revolver because he wanted to render it safe in a controlled environment before transport, given the risk it could inadvertently discharge. NE#1 said he did not consider asking someone else to assist him.

On August 23, 2024, OPA interviewed NE#1. NE#1's statements were consistent with his statements to FIT. NE#1 insisted his finger was not on the trigger when the revolver discharged. NE#1 denied knowing what caused it to discharge. NE#1 said he did not request another officer because he believed he could render it safe but acknowledged he should have requested one. NE#1 recognized the importance of requesting assistance in the future if he were to encounter a firearm beyond the scope of his training and experience.

### **ANALYSIS AND CONCLUSIONS:**

#### **Named Employee #1 – Allegation #1**

#### ***7.030 – Firearms, Ammunition, and Shell Casings, 7.030-POL-1. Employees Will Safely Handle Firearms***

It was alleged that NE#1 unsafely handled a revolver.

Employees will safely handle firearms. SPD Policy 7.030-POL-1. Employees will handle a firearm as if it were loaded and keep the muzzle pointed in a safe direction. *Id.* Employees will request assistance if they are unfamiliar with safely handling a firearm. *Id.*

A preponderance of the evidence established NE#1's violation of SPD Policy 7.030-POL-1. Several moments during NE#1's manipulations were particularly concerning. First, NE#1 inserted his right ring finger into the trigger guard and nearly contacted the trigger when the revolver was in the single-action position. Minimal pressure applied to the trigger could have discharged it. Second, immediately preceding the discharge, NE#1's left index finger appeared to contact the trigger when the revolver was in the single-action position. This contact, rather than a mechanical defect, likely caused the discharge. Third, NE#1 appeared to occasionally point the barrel toward the office, where CM#1 and the manager were located, while he manipulated the revolver on its side. An unintentional discharge during those moments could have pierced the office wall, depending on the angle at which NE#1 held the revolver.

Moreover, NE#1 violated policy by failing to request assistance in handling the revolver, given his unfamiliarity with it. NE#1 acknowledged receiving no training on revolvers and noted his only experience involved handling an already-cleared revolver a year ago. NE#1's inexperience was demonstrated by his unsuccessful attempt at unloading the revolver for about two minutes and 10 seconds and by his mistaken attempt at breaking the revolver forward, instead of swinging out the cylinder. These circumstances warranted the assistance of another officer. Instead, NE#1 exercised poor judgment by manipulating the revolver without understanding its basic mechanics.

OPA appreciates NE#1's cognizance in stepping away from the others, positioning himself in a three-walled corner, and trying to unload the revolver for transport, given his concern that it could inadvertently discharge if not rendered safe. The evidence did not suggest NE#1 intended to discharge it. Nevertheless, OPA could not overlook several objectively unsafe manipulations, combined with NE#1's ignorance about revolvers and declining to request assistance. The totality of these issues ultimately caused an unintentional discharge.



Accordingly, OPA recommends this allegation be Sustained.

Recommended Finding: **Sustained**