



INDEPENDENT INVESTIGATIONS DIVISION

Report Concerning the Police-Involved
Death in Washington County on
October 26, 2024

August 12, 2025

Declination Report Concerning the Police-Involved Death of Kelvin Lashawn Baker on October 26, 2024

The Independent Investigations Division of the Maryland Office of the Attorney General (the “IID”) is charged with investigating “police-involved incidents that result in the death of individuals or injuries likely to result in death.”¹ If the Attorney General determines that the investigation provides sufficient grounds for prosecution, then the IID “shall have exclusive authority to prosecute the offense.”²

I. Introduction

On October 26, 2024, at approximately 10:06 p.m., Hagerstown Police Department (“HDP”) officers responded to the 100 block of E. Washington Street in Hagerstown, Maryland, to execute a search and seizure warrant. Mr. Kelvin Lashawn Baker was the subject of the investigation.³ Upon arrival, two officers observed Mr. Baker standing on the sidewalk in front of a home in the 100 block of E. Washington Street. Officers frisked Mr. Baker, handcuffed him, and placed him in the rear driver’s seat of a marked police cruiser. Mr. Baker remained seated in the cruiser for approximately 28 minutes under the guard of three officers. Thereafter, an officer noticed Mr. Baker was exhibiting symptoms of medical distress, and then another officer provided him with emergency medical aid. The officers also requested emergency medical services (“EMS”). Community Rescue Service (“CRS emergency services”) paramedics arrived, took over medical aid efforts, and transported Mr. Baker to an area hospital, where he was pronounced dead.

After completing its investigation and evaluating all available evidence, the Office of the Attorney General has determined that none of the subject officers committed a crime under Maryland law. Accordingly, the Attorney General has declined to prosecute the subject officers in this case.

The IID’s investigation focused exclusively on potential criminal culpability relating to the subject officers’ conduct. By statute, the IID only has jurisdiction to investigate the actions of police officers, not those of any other individuals involved in the incident. Moreover, the IID’s analysis does not consider issues of civil liability or the department’s administrative review of the subject officers’ conduct. Compelled statements by subject officers may be considered in civil or administrative proceedings but may not be considered in criminal investigations or prosecutions due to the subject officers’ Fifth Amendment rights. If any compelled statements exist in this case, they have not been considered in the IID’s investigation.

This report is composed of a factual narrative followed by a legal analysis. Every fact in the narrative is supported by evidence obtained in this investigation, including an autopsy report,

¹ Md. Code, State Gov’t § 6-602 (c)(1).

² Md. Code, State Gov’t § 6-604 (a)(1).

³ Due to the scope of the IID’s investigation, the IID has not examined the potential criminal culpability of Mr. Baker. The facts involving Mr. Baker’s alleged prior criminal activity were not considered and have no impact on the prosecutorial decision.

police radio transmissions, dispatch records, police and EMS reports, police body-worn camera footage, surveillance footage, photographs, department policy, and interviews with civilian and law enforcement witnesses. The subject officers in this case chose not to make statements to the IID, which had no impact on the prosecutorial decision.

The legal analysis explains why the IID will not bring charges under the relevant Maryland statutes.

This investigation involved one decedent and three subject officers:

- A. The decedent, Kelvin Lashawn Baker, was 46 years old at the time of the incident. He was a Black male who lived in Chambersburg, Pennsylvania.
- B. Captain Thomas Langston has been employed by HDP since December 1999. He was previously employed by the Baltimore Police Department for three years. He is a White male, and at the time of the incident, was 53 years old.
- C. Sergeant Steve Lucas has been employed by HDP since March 2013. He is a White male, and at the time of the incident was 37 years old.
- D. Officer Zach Rowe has been employed by HDP since January 2016. He is a White male, and at the time of the incident was 34 years old.

The IID reviewed all available departmental disciplinary records and criminal histories of these involved parties and where they existed, determined none were relevant to this investigation.

II. Factual Summary

On October 26, 2024, at approximately 10:06 p.m., Washington County Narcotics Task Force officers and HDP officers arrived at a two-level multi-unit residential building in the 100 block of E. Washington Street in Hagerstown, Maryland, to execute a court-ordered search and seizure warrant on an apartment within the building for two handguns. Two uniformed witness officers were the first to arrive on scene, where they observed Mr. Baker, who was a subject identified in the warrant, standing in front of the building. They confirmed Mr. Baker's identity based on his appearance. A woman⁴ was also in front of the building, seated on the front steps. Woman was known to a witness officer, as a primary resident of the subject residential location.

The two witness officers approached Mr. Baker, instructed him to take his hands out of his pockets, and place his hands behind his back. The two witness officers grabbed Mr. Baker's arms, placed him in handcuffs, and patted him down for weapons.⁵ Mr. Baker asked, 'What's going

⁴ For privacy purposes, the woman will be referred to as "Woman" throughout the report.

⁵ Mr. Baker's physical detention was reasonable, lawful, met with no resistance, and was attenuated from Mr. Baker's medical distress.

on?” One of the witness officers told Mr. Baker that police had a search warrant for his residence. For approximately three minutes, one of the witness officers and Mr. Baker had a verbal exchange. At all times during the verbal exchange, Mr. Baker spoke clearly as he attempted to gather information about the basis of his detention. Also, Mr. Baker clearly instructed Woman to call her mother multiple times.

At approximately 10:08 p.m., Mr. Baker was escorted to a police cruiser. The witness officer asked Mr. Baker if he had anything illegal on him and Mr. Baker responded, “No, I don’t have anything on me!” Mr. Baker showed no indication of being in medical distress. After placing Mr. Baker in the cruiser, the witness officer closed the back driver’s seat door for approximately 17 seconds and then opened it again. The witness officer remained outside of the back driver’s side door of the cruiser until Captain Thomas Langston relieved him from his post. At approximately 10:10 p.m., the witness officer entered the target location to assist with the execution of the search warrant, which subsequently yielded the handguns identified in the search warrant.

Captain Langston was introduced to Mr. Baker and stood posted near the rear door to ensure that Mr. Baker was secured. As Captain Langston stood outside of the cruiser, the rear driver’s side door was closed. At approximately 10:18 p.m., Officer Zach Rowe relieved Captain Langston, and he remained posted outside of the rear cruiser door. Mr. Baker remained in the rear driver’s seat. At approximately 10:33 p.m., Sergeant Steve Lucas relieved Officer Rowe. Sergeant Lucas posted outside of the rear driver’s side door of the cruiser and remained for approximately three minutes. None of the subject officers conversed with Mr. Baker.

At approximately 10:37 p.m., Sergeant Lucas shined his flashlight on the rear driver’s side window where Mr. Baker was seated. Seven seconds later, Sergeant Lucas opened the rear driver’s side door, and Mr. Baker was slouched forward, still handcuffed. Sergeant Lucas pulled the hood of Mr. Baker’s sweatshirt from his head and shined the flashlight onto Mr. Baker’s face. Mr. Baker was unresponsive. Sergeant Lucas lifted Mr. Baker’s left shoulder, which put Mr. Baker back into a seated position. He then performed several sternum rubs on Mr. Baker’s chest. This was the only physical contact that any subject officer had with Mr. Baker. At 10:38 p.m., emergency medical services were requested.

At approximately 10:39 p.m., a witness officer took over efforts to render medical aid from Sergeant Lucas by administering sternum rubs, checking his pulse, and confirming that Mr. Baker was breathing.⁶ Mr. Baker remained unresponsive. At approximately 10:44 p.m., as officers attempted to remove Mr. Baker from the cruiser, paramedics arrived and began rendering medical aid. Mr. Baker was subsequently transported to a local hospital and pronounced dead at 11:40 p.m.

⁶ On December 16, 2024, the IID interviewed the witness officer who advised that he performed sternum rubs on Mr. Baker’s chest because based on his training and experience, if someone is overdosing and not making any breath sounds, the sternum rubs could get a response and may cause them to take breaths. He did not observe any drugs in the back of the cruiser.

III. Supplemental Information

A. Autopsy

On October 28, 2024, the Office of the Chief Medical Examiner (the “OCME”) performed an autopsy of Mr. Baker. The medical examiner determined that Mr. Baker’s cause of death was “mixed drug intoxication”. The medical examiner concluded that Mr. Baker’s manner of death was an “Accident.”⁷

Toxicology testing revealed that Mr. Baker had multiple narcotics in his blood, including cocaine and fentanyl. The autopsy revealed Mr. Baker’s upper esophagus was obstructed with foreign material that consisted of “an approximately 2” x 3/4” collection of plastic bags and white gauze”, which contained 30 gel capsules. The medical examiner determined that there was “no evidence of trauma, injury.” However, the capsules were positive for multiple narcotics including substances that the medical examiner determined contributed to Mr. Baker’s cause of death.



***Image 1:** Photograph of foreign material that was removed from Mr. Baker’s esophagus during the autopsy.*

Further, the medical examiner determined that Mr. Baker had a clinical history of congestive heart failure, and that cardiovascular disease was a significant condition that was a contributing factor in his death.

⁷ Manner of death is a classification used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes. The Maryland Office of the Chief Medical Examiner uses five categories of manner of death: natural, accident, suicide, homicide, and undetermined. “Accident” applies when an injury or poisoning causes death and there is little or no evidence that the injury or poisoning occurred with intent to harm or cause death. These terms are not considered a legal determination; rather, they are largely used to assist in collecting public health statistics. *A Guide for Manner of Death Classification*, First Edition, National Association of Medical Examiners, February 2002.

B. Department Policy

HDP General Order Chapter 18 governs searches and seizures. Specifically, 18.2, paragraph 12 states, “Search of persons on the premises -- a search warrant for premises is not authority for searching persons found on the premises unless the search warrant so commands, or if officers develop probable cause independent of the search warrant. Officers may frisk persons on the premises if reasonable suspicion exists that the persons may be armed, however the suspicion must be articulable for each individual to be frisked.” 18.2, paragraph 13 states, “Detention of persons on the premises -- during the execution of a search warrant, persons found on the premises may be detained to ensure officer safety, prevent destruction of or tampering with evidence, or as is reasonably needed to determine the person’s involvement in the crime under investigation.”

On January 25, 2025, the IID interviewed HDP Lieutenant John Lehman, who was the leader of the training division at the time that this incident occurred. Lieutenant Lehman indicated that officers are trained to secure a detainee either outside or inside a police vehicle to ensure the individual is looked after, and if the detainee experiences a medical emergency, the detainee can get prompt assistance. While there is no equivalent General Order regarding observation of detainees at scenes, this is consistent with the General Order governing detainees that are secured in a holding facility. HDP General Order Chapter 27 governs the holding facility and detainee transport procedures, and in pertinent part states, “When detainees are secured in a cell, the Watch Commander, or his/her designee shall conduct a face-to-face visual observation every 30 minutes and more frequently if needed in the opinion of the Watch Commander (i.e., detainee is emotionally distressed or displays suicidal tendencies or is an escape threat).” Similarly, while there is no General Order regarding medical and health care of detainees on scene, HDP General Order 27 also states, “Any detainee found to be in need of medical attention by the arresting officer’s observations, information and/or experience will not be detained until he/she has received the necessary medical attention. Transportation will be made by ambulance whenever possible.”

HDP General Order 53.11 governs raids, and states, “Raids shall be conducted using the same procedures outlined in the Washington County Special Response Team Operations Manual.” Section 5 of the Washington County Special Response Team Operations Manual governs responsibilities at an incident scene. Within the manual, Paragraphs A7, A8, A9, and A11 indicate the Incident Commander Responsibilities are to: ensure the evacuation of any injured parties and ensure medical aid is provided as needed; designate a dedicated arrest team to take custody of the suspect(s) should he/she surrender or attempt to escape, and to react to exigent circumstances until the arrival of the Special Response Team; ensure the safe and orderly evacuation of bystanders and residents who may be in danger or direct them to shelter in place; gather available intelligence information, including information about suspect(s) and hostages, and prepare exterior or interior scene diagrams.

IV. Legal Analysis

After a criminal investigation, prosecutors must determine whether to bring criminal charges against a person. When making that determination, prosecutors have a legal and ethical duty to only charge a person with a crime when they can meet the State's burden of proof; that is, when the available evidence can prove each element of that crime beyond a reasonable doubt. Prosecutors must also determine whether the person accused of the crime could raise an affirmative defense. In those cases, prosecutors not only need to prove the crime, but they also must determine whether the evidence could disprove the defense beyond a reasonable doubt. Ultimately, the decision to bring any charges rests on whether the available evidence is sufficient for prosecutors to meet that standard.

Based on the evidence, two relevant offenses were considered in this case. First is the violation of Maryland's Use of Force Statute, which makes it a crime for police officers to intentionally use excessive force.⁸ The second offense is Involuntary Manslaughter, which occurs when an accused person's grossly negligent conduct causes the death of another person.⁹

The evidence in this case shows that the subject officers did not violate any of the aforementioned statutes. Accordingly, the IID will not pursue criminal charges against any of the subject officers. This report explains in further detail why, based on the evidence, a prosecutor could not prove beyond a reasonable doubt that any officer committed a crime.

A. Maryland Use of Force Statute

Proving a violation of the Use of Force Statute requires a prosecutor to establish beyond a reasonable doubt that a subject officer:

- (1) used force that was not necessary and proportional to prevent an imminent threat of physical injury to themselves or another person, or to accomplish a legitimate law enforcement objective;
- (2) intended to use force that was excessive, *i.e.*, not necessary and proportional under the circumstances; and
- (3) the use of excessive force resulted in serious bodily injury or death.¹⁰

First, prosecutors would need to establish that one or more of the subject officers used force that was not necessary and proportional under the circumstances. Second, prosecutors would need to establish that one or more of the subject officers intended to use force that was excessive. Finally, prosecutors would need to establish that the excessive force used by the subject officers resulted in Mr. Baker's death.

⁸ See Md Code, Public Safety §3-524(d)(1).

⁹ MPJI-Cr 4:17.9.

¹⁰ MPJI-Cr 4:36.

When a factfinder—either a judge or a jury—conducts this analysis, they must consider the totality of the circumstances, including, but not limited to, the nature of the call for service, what occurred in the moments before force was used, what the subject officers knew at the time force was used, and the time and distances involved.¹¹

Regarding whether the use of force was necessary, officers responded to execute a search and seizure warrant, where they were authorized to search for two handguns. When they arrived, they found Mr. Baker, the confirmed subject, standing outside the residence. Officers conducted a frisk for weapons and handcuffed Mr. Baker and placed him in the cruiser without incident. This detention was reasonable, and the force was not excessive. It was necessary and proportional to accomplish a legitimate law enforcement objective.

Furthermore, the post detention physical contact by any of the subject officers is limited to lifting Mr. Baker’s shoulder and sternum rubs. The physical contact with Mr. Baker was initiated for the purpose of administering aid.¹² Based on the totality of the circumstances, there is no evidence that the subject officers used force on Mr. Baker.¹³ Based on the evidence, the use of force statute is not applicable in this case.

Accordingly, the Office of the Attorney General will not charge the subject officers with a violation of the Use of Force Statute.

B. Involuntary Manslaughter

Proving involuntary manslaughter requires a prosecutor to establish beyond a reasonable doubt that one or more of the subject officers: 1) acted in a grossly negligent manner; 2) and that their gross negligence caused Mr. Baker’s death.¹⁴ Gross negligence is conduct that demonstrates a “wanton and reckless disregard for human life.”¹⁵ In order to determine whether the subject officers acted with gross negligence, prosecutors must examine the subject officers’ actions that could have had an impact on Mr. Baker’s death. To determine whether the subject officers acted with gross negligence, prosecutors must examine whether the subject officers were grossly negligent by failing to observe Mr. Baker’s medical stress as they stood outside of the cruiser.

Mr. Baker was lawfully detained in the cruiser during the execution of a court-ordered search warrant. When the subject officers initially encountered Mr. Baker, there was no reason for them to believe that he was in medical distress or was likely to be in medical distress while seated in the cruiser. Prior to being placed in the cruiser, Mr. Baker was alert and mobile. He

¹¹ *Id.*

¹² The subject officers in this case were not the officers who handcuffed, frisked, and placed Mr. Baker in the police cruiser.

¹³ Since there is insufficient evidence to establish that the subject officers intended to use force that was excessive, this report does not analyze whether the subject officers caused the death of Mr. Baker.

¹⁴ MPJI-Cr 4:17.9 Homicide—Involuntary Manslaughter (Grossly Negligent Act and Unlawful Act), MPJI-Cr 4:17.9 (2d Ed. 2021).

¹⁵ *Duren v. State*, 203 Md. 584, 588 (1954).

communicated clearly with officers and Woman. While there is no HDP General Order governing on scene detention, HDP General Order Chapter 27 provides some guidance for on scene observation, stating that while at a holding facility, face-to-face visual observation should be conducted every thirty minutes. Thirty minutes had not elapsed between visual observations of Mr. Baker by the subject officers. During the twenty-eight minutes that Mr. Baker was seated in the cruiser, the subject officers stood outside of the cruiser watching Mr. Baker and checked on him at various times. There was no indication that Mr. Baker was in medical distress until Sergeant Lucas opened the back driver's side door and observed Mr. Baker slouching forward in the rear of the cruiser. EMS was immediately called, and Sergeant Lucas rendered aid by administering sternum rubs (which were continued by another officer) until paramedics arrived. Sergeant Lucas's actions were well within the boundaries of expected and reasonable behavior.¹⁶

Given the totality of circumstances, there is no evidence to indicate that the subject officers' conduct demonstrated a wanton and reckless disregard for human life. Accordingly, the Office of the Attorney General will not charge the subject officers with involuntary manslaughter.

VI. Conclusion

This report has presented factual findings, legal analyses, and conclusions relevant to the October 26, 2024, police-involved death of Kelvin Lashawn Baker in Washington County, Maryland. The Office of the Attorney General has declined to pursue charges in this case because, based on the evidence obtained in its investigation, the subject officers did not commit a crime.

¹⁶ Because there is insufficient evidence to establish that the subject officers acted with gross negligence, this report does not analyze whether the subject officers caused the death of Mr. Baker.