

**ABRIDGED SUMMARY OF CATEGORICAL USE OF FORCE INCIDENT AND
FINDINGS BY THE LOS ANGELES BOARD OF POLICE COMMISSIONERS**

NON-TACTICAL UNINTENTIONAL DISCHARGE – 002-25

<u>Division</u>	<u>Date</u>	<u>Duty-On () Off (X)</u>	<u>Uniform-Yes () No(X)</u>
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Outside City	1/11/25		
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<u>Officer(s) Involved in Use of Force</u>	<u>Length of Service</u>
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Officer A	13 years, 4 months
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<u>Subject</u>	<u>Deceased ()</u>	<u>Wounded ()</u>	<u>Non-Hit ()</u>
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Does not apply.

Board of Police Commissioners' Review

This is a summary designed only to enumerate salient points regarding this Categorical Use of Force (CUOF) incident and does not reflect the entirety of the extensive investigation by the Los Angeles Police Department (Department) or the deliberations by the Board of Police Commissioners (BOPC). In evaluating this matter, the BOPC considered the following: the complete Force Investigation Division (FID) investigation (including all the transcribed statements of witnesses and addenda items); the relevant Training Evaluation and Management System materials of the involved officer; the Use of Force Review Board (UOFRB) recommendations; the report and recommendations of the Chief of Police; and the report and recommendations of the Office of the Inspector General. The Department Command staff presented the matter to the BOPC and made itself available for any inquiries by the BOPC.

The following incident was adjudicated by the BOPC on December 16, 2025.

Incident Summary

On January 11, 2025, Officer A was outside of the City of Los Angeles on an approved assignment. At approximately 1500 hours, Officer A left his/her location and drove home. Officer A was armed with a Department-approved Glock 9mm semiautomatic pistol, which was secured in an inner waistband holster on the right side of his/her hip with a clip that fastened over his/her belt. At approximately 1620 hours, Officer A arrived home, parked inside the garage, and closed the garage door.

Officer A stood to the right of his/her vehicle. While attempting to remove the pistol along with its holster, he/she partially pulled the pistol from the holster, pressed the trigger accidentally, and shot him/herself in the thigh/buttock area.

Following the Non-Tactical Unintentional Discharge (NTUD), Officer A removed the holster and the weapon from his/her waistband and placed it on top of a black safe directly next to his/her vehicle.

After placing the holstered pistol on top of the safe, Officer A looked down and noticed a Discharged Cartridge Case (DCC) and a fired bullet approximately three feet away from where he/she was standing.

According to Officer A, he/she reached down and picked up the bullet. After inspecting the fired bullet, Officer A placed it in approximately the same location where he/she first noticed it.

Immediately after the incident, Officer A notified the Los Angeles Police Department Operations Center (DOC) of the NTUD and that he/she would be self-transporting to the hospital. After notifying the DOC, Officer A notified West Traffic Division (WTD) Watch Commander Sergeant A of the NTUD.

Following the notifications, Officer A drove him/herself to the local emergency room. Officer A did not notify the local law enforcement agency about the NTUD.

At approximately 1647 hours, Officer A arrived at the emergency room, identified him/herself as an off-duty Los Angeles Police Department officer and informed medical staff of his/her injury.

At approximately 1700 hours, Sergeant A contacted off-duty Sergeant B. Sergeant B responded to the hospital to check on Officer A's condition. He/she later responded to Officer A's residence and waited for FID investigators to arrive.

On January 21, 2025, FID investigators discovered that the local county sheriff's department had not been notified by Officer A or the local hospital of the incident. FID investigators then notified the local sheriff's department.

BWV and DICVS Policy Compliance

Does not apply.

Los Angeles Board of Police Commissioners' Findings

The BOPC reviews each Categorical Use of Force incident based upon the totality of the circumstances, namely all the facts, evidence, statements and all other pertinent material relating to the incident. In every case, the BOPC makes specific findings in three areas: Tactics of the involved officer(s); Drawing/Exhibiting of a firearm by any involved officer(s); and the Use of Force and/or Unintentional Discharge by any involved officer(s). Based on the BOPC's review of the instant case, the BOPC made the following findings:

A. Tactics

The BOPC found Officer A's tactics to warrant a Tactical Debrief.

B. Drawing and Exhibiting

Does not apply.

C. Unintentional Discharge

The BOPC found Officer A's NTUD to warrant a finding of Administrative Disapproval, Negligent Discharge.

Basis for Findings

A. Tactics

In this case, Officer A was not engaged in a tactical operation. Officer A's tactics were not reviewed or evaluated as they were not a factor in this incident. However, as Department guidelines require personnel who are substantially involved in a CUOF incident to attend a Tactical Debrief, the BOPC determined it would be appropriate to make a finding of Tactical Debrief.

During its review of this incident, the BOPC noted the following tactical considerations:

- **Notification to Local Law Enforcement** – Officer A stated that after the NTUD, he/she did not call 911 and did not notify local law enforcement because he/she was focused on Department notifications and thought that the hospital would notify the local law enforcement. Officer A stated that he/she informed hospital personnel he/she was an off-duty officer and told them how his/her injury occurred. This topic was to be discussed at the Tactical Debrief.

- **Preservation of Evidence** – According to Officer A, following the NTUD, he/she reached down and picked up the expended bullet from the garage floor, inspected it, and then put it back down in approximately the same location. Because the preservation of evidence is important in maintaining the integrity of every investigative scene, this topic was to be discussed at the Tactical Debrief.

Tactical Debrief

- Each tactical incident merits a comprehensive debriefing. In this case, there were identified areas where improvements could be made. A Tactical Debrief is the appropriate forum for involved personnel to discuss individual actions that took place during this incident.

The BOPC found Officer A's tactics to warrant a Tactical Debrief.

B. Drawing and Exhibiting

Does not apply.

C. Unintentional Discharge

Scene Description: The NTUD occurred in the garage at Officer A's single-family residence outside the City of Los Angeles, in a residential neighborhood. The garage was illuminated by interior lights.

Officer A: Pistol, one round.

The BOPC evaluated the circumstances and evidence related to the NTUD. The BOPC noted that according to Officer A, while attempting to remove the pistol along with its holster, he/she partially pulled the pistol from the holster and inadvertently pressed the trigger. The BOPC also noted no indication that the NTUD was a result of a mechanical malfunction of the pistol. Based on the preponderance of the evidence, the BOPC determined that the NTUD was a result of operator error, and Officer A's actions violated the Department's Basic Firearm Safety Rules, requiring a finding of Administrative Disapproval, Negligent Discharge.

Accordingly, the BOPC found Officer A's NTUD to warrant a finding of Administrative Disapproval, Negligent Discharge.

Medical Treatment / Rendering Aid

- Officer A sustained an entry and exit gunshot wound to his/her right thigh/buttock area. According to Officer A, he/she did not feel the injury was life threatening, he/she was not in severe pain and was not bleeding profusely. As such, he/she made the decision to self-transport to a local hospital, which was approximately 6.3 miles from his/her residence. Officer A was not admitted and was released at approximately 1900 hours.