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

NON-TACTICAL UNINTENTIONAL DISCHARGE – 004-24

Division	Date	Duty-On (X) Off ( ) Uniform-Yes (X) No ( )
Outside City	2/14/24	

Officer(s) Involved in Use of Force	Length of Service
Officer A	2 years, 3 months

Subject(s)	Deceased ( )	Wounded ( )	Non-Hit ( )

Does not apply.

Board of Police Commissioners' Review

This is a brief 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 of the transcribed statements of witnesses, pertinent subject criminal history, and addenda items); the relevant Training Evaluation and Management System materials of the involved officers; the Use of Force Review Board (UOFRB) recommendations, including any Minority Opinions; the report and recommendations of the Chief of Police (Chief); 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 17, 2024.

Incident Summary

On Wednesday, February 14, 2024, at approximately 2200 hours, Northeast Patrol Division, Police Officer A was off duty at his/her residence located in the city of Garden Grove. Officer A shares a condominium with his/her mother and his/her father. Both were home at the time of the incident and were in their respective bedrooms.

According to Officer A, he/she was scheduled to attend a Pistol Mounted Optic (PMO) red dot transition course. In preparation for the training, Officer A brought home his/her gear, which included his/her department-issued Sam Browne belt and 9mm Glock pistol, Model 17. While in his/her second floor bedroom, Officer A decided to unload his/her pistol.

After downloading his/her pistol Officer A secured it in his/her bedroom before having dinner. Following dinner, at approximately 2255 hours, Officer A gathered the tools he/she needed to install his/her red dot optic.

Officer A mounted the red dot optic onto his/her duty pistol, stating that the installation took approximately 15 minutes. He also mentioned that he/she was on his/her phone intermittently during the process.

Officer A, having just mounted his/her red dot optic, stood in the hallway adjacent to his/her bedroom. He removed two loaded magazines from his/her Sam Browne belt and unloaded the rounds. He also unloaded the rounds from the original magazine that was inserted in his/her pistol. Officer A unloaded the rounds into his/her hands dropping them onto his/her backpack in the hallway.

Officer A completed unloading all of his/her rounds, picked up his/her pistol and reinserted a magazine into it. As Officer A stood in the hallway, he/she put on his/her Sam Brown belt and decided to do a “short practice” and a “dry fire.”

Dry fire practice is a marksmanship training tool used to develop a shooter’s marksmanship abilities without using live ammunition. During dry fire training, shooters will manipulate their unloaded firearm in a manner that is consistent with how they would handle the gun when shooting live rounds. Dry fire training will consist of drills designed to refine the basic marksmanship principles such as grip, sight picture, and trigger control.

Officer A faced in the direction of the unoccupied bathroom and unholstered his/her pistol. Officer A pointed his/her pistol toward the bathroom and “dry fired once,” by pressing the trigger.

When asked by Force Investigation Division (FID) investigators if he/she had conducted a chamber check before conducting his/her first dry fire practice, Officer A could not recall.

Officer A reset the trigger intending to conduct a second dry fire and discharged a round into the bathroom shower wall.

When asked by FID investigators if he/she conducted a chamber check after he/she had "reset the gun," Officer A stated, "No chamber check."

Following the Non-Tactical Unintentional Discharge (NTUD), Officer A checked the condition of the gun, removed the magazine and rendered the gun safe.

Officer A stepped out of his/her residence and walked to the exterior wall adjacent to the bathroom.

Officer A did not observe anyone outside, so he/she returned to his/her residence and spoke to his/her mother again for approximately five minutes, explaining in further detail what had occurred.

At approximately 2355 hours, Officer A contacted the Garden Grove Police Department (GGPD) to report the NTUD. A radio call was generated at Officer A's residence and it was assigned Incident Report No. 24009012-1.

At 2355 hours, Officer A telephonically notified on duty Northeast Patrol Division Watch Commander, Lieutenant A of the NTUD. At 0020 hours, Lieutenant A notified the on-call FID Lieutenant of the NTUD.

At approximately 0003 hours, a GGPD Police Officer contacted Officer A at his/her door and entered the residence.

Officer A escorted the GGPD Officer to the second floor where his/her pistol was located. Officer A retrieved the pistol, locked the slide back and the GGPD Officer took possession of it while he/she conducted his/her investigation. Officer A spoke with the GGPD Officer, explaining the circumstances of the NTUD.

At approximately 0006 hours, a second Garden Grove Police Officer arrived and assisted the first GGPD Officer with the investigation. They conducted their investigation and completed Incident Report No. 24009012.

The GGPD Officers were both equipped with Body Worn Video (BWV). Their investigation was captured on BWV and later provided to FID investigators. Their BWV's were tagged in Evidence.com under Incident No. 24021500000189 and remain available for review.

According to Lieutenant A, at approximately 0125 hours, he/she arrived at Officer A's residence. Lieutenant A obtained a Public Safety Statement (PSS) from Officer A and began to monitor him/her.

Body-Worn Video Policy Compliance

Does not apply.

Los Angeles Board of Police Commissioners' Findings

The BOPC reviews each CUOF incident based upon the totality of the circumstances, namely all of the facts, evidence, statements and all other pertinent material relating to the particular 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 by any involved officer(s). Based on the BOPC's review of the incident, 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. Non-Tactical Unintentional Discharge (NTUD)

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. Therefore, Officer A was not evaluated for tactical de-escalation. 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 that it would be appropriate to make a Tactics finding of Tactical Debrief.

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

- **Preservation of Evidence –** After the NTUD, Officer A removed the magazine from his/her service pistol and locked the slide back. The Chief would have preferred Officer A had not unloaded his/her service pistol after the NTUD. To enhance future performance, the Chief directed this be a topic of discussion during the Tactical Debrief.

Command and Control

- At approximately 2355 hours, Officer A contacted the Garden Grove Police Department to report the NTUD. Officer A telephonically notified Lieutenant A of the NTUD and at approximately 0020 hours, Lieutenant A notified the on-call FID Lieutenant of the NTUD.

  Lieutenant A arrived at Officer A's residence at approximately 0125 hours before he/she obtained a Public Safety Statement (PSS) from Officer A and began to monitor him.

  At 0045 hours, FID notified the Department Operations Center (DOC) of the NTUD. The overall actions of Lieutenant A were consistent with Department supervisory training and the Chief's expectations of a field supervisor during a critical incident.

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.

  Therefore, the Chief directed Officer A to attend a Tactical Debrief and the specific identified topics be discussed.

General Training Update (GTU)

- On February 22, 2024, Officer A attended a GTU. All mandatory topics were covered, including the Basic Firearm Safety Rules.

B. Drawing and Exhibiting

Does Not Apply

C. Unintentional Discharge

Scene Description: The NTUD occurred at Officer A's residence in Garden Grove, during nighttime hours. The location is in a residential town home neighborhood.

Officer A – Glock, Model 17 Gen 5, 9 mm, one round, which traveled in an east trajectory through a shower bathroom wall and impacted a metal weather flashing on an adjacent rooftop.

The Chair of the UOFRB (Use of Force Review Board) evaluated the circumstances and evidence related to the NTUD. The Chair noted Officer A stated he/she had inadvertently inserted a loaded magazine into his/her service pistol and, while

conducting dry fire practice, pressed the trigger resulting in the NTUD. The Chair noted Officer A failed to conduct a chamber check to verify the condition of his/her weapon before pressing the trigger. The Chair noted there was no indication the NTUD was a result of a mechanical malfunction of the service pistol. As such, the Chair opined the NTUD was a result of operator error and Officer A's actions violated the Department's Basic Firearm Safety Rules.

Based on the totality of the circumstances, the Chair of the UOFRB determined, and the BOPC concurred, the NTUD was the result of operator error. Officer A's actions violated the Department's Basic Firearm Safety Rules, requiring a finding of Administrative Disapproval, Negligent Discharge.

Medical Treatment/Rendering Aid

- No officers or community members were injured during this incident.

Requirement to Intercede

- Based on a review of this incident, the UOFRB Chair determined that the NTUD would not have required an officer to intercede.

Audio/Video Recordings

- **Body Worn Video/ Digital In-Car Video System –** None.

- **Outside Video –** None.