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

## NON-TACTICAL UNINTENTIONAL DISCHARGE - 014-23

<u>Division</u>	Date	Duty-On () Off (X)	Uniform-Yes () No (X)
Rampart	4/16/23		
Officer(s) Involved i	n Use of Force	Length of Service	
Officer A		4 years, 1 months	
Reason for Police C	ontact		

## Reason for Police Contact

On April 16, 2023, at approximately 1815 hours, Officer A was in the locker room and decided to inspect his/her backup pistol (a revolver). Officer A placed his/her right hand around the revolver's grip and removed it from the holster.

Erroneously believing the revolver was unloaded, Officer A pointed the revolver's muzzle downward and toward the base of his/her locker. Believing it was safe to perform a function check to ensure the revolver was operational, Officer A placed his/her finger on the trigger and pressed it, resulting in a non-tactical unintentional discharge (NTUD).

#### **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 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; 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 12, 2023.

# **Incident Summary**

On Sunday, April 16, 2023, at approximately 0530 hours, Police Officer A began his/her patrol shift. Before starting his/her shift, Officer A placed his/her Department-approved .38 caliber revolver in his/her left rear pants pocket. This revolver, a backup pistol to his/her semi-automatic service pistol, was carried in a synthetic rubber holster. The revolver's cylinder can hold five rounds of ammunition.

At approximately 1730 hours, Officer A completed his/her 12-hour shift. At around 1800 hours, Officer A went to the locker room, opened his/her locker, and removed his/her equipment from his/her person. Officer A hung his/her Sam Browne equipment belt, containing his/her semi-automatic service pistol, on the locker door and removed his/her uniform shirt.

Officer A stood in front of his/her locker, facing in a northerly direction, while now wearing his/her white undershirt, uniform pants, and boots. According to Officer A, he/she had not inspected or discharged his/her backup revolver in two years and wanted to inspect it to see if it was still functioning. Officer A placed his/her left arm behind his/her back and removed his/her backup revolver from the left rear pocket of his/her uniform pants. Officer A stated that he/she routinely carried his/her backup revolver in the left rear pants pocket of his/her uniform pants and had not oiled it since he/she purchased it in 2019.

Officer A placed his/her right hand around the revolver's grip and removed it from the holster. Officer A then placed the holster at the base of his/her open locker while holding his/her revolver in his/her right hand.

According to Officer A, he/she pressed the cylinder release, opened the revolver's cylinder, and noted that the cylinder was fully loaded with five live rounds. Officer A pointed the muzzle upward and let the force of gravity extract the rounds into the palm of his/her left hand. Officer A placed the rounds on a bench in front of his/her open locker and then closed the revolver's cylinder. Officer A stated that he/she visually inspected the closed cylinder by looking at the exposed chambers and did not see any rounds in the chambers. Officer A did not open the cylinder again to perform a safety check of the revolver's cylinder.

During his/her interview with Force Investigation Division (FID) detectives, Officer A stated that when the cylinder was open, he/she inspected the cylinder and then closed the cylinder. The investigation determined that Officer A placed four live rounds on the bench and left one round in the chamber.

Believing that the revolver was unloaded and while standing in front of his/her locker holding it in a single right-handed low-ready position, Officer A pointed the revolver's muzzle downward and in a northerly direction toward the base of his/her locker. Believing it was safe to perform a function check to ensure the revolver was operational, Officer A placed his/her finger on the trigger and pressed it, causing a bullet to be

discharged from the revolver. The discharged bullet struck his/her Department-issued cellphone, which was inside and at the base of his/her locker, went through the phone, and impacted the bottom surface of his/her locker. The discharged bullet came to rest inside the locker between a Field Officer's Notebook and some miscellaneous papers. The discharged bullet did not fragment or penetrate the bottom of the locker. According to Officer A, the momentum of the discharged bullet caused his/her cellphone to move onto a bench just outside of his/her locker.

According to Officer A, immediately after discharging the round, he/she pressed the cylinder release and opened the cylinder to render the revolver safe. Officer A removed the discharged cartridge case (DCC) from the revolver's cylinder and placed the DCC inside and at the base of his/her locker. Officer A then placed the revolver on a bench outside of his/her open locker.

In the interim, Sergeant A was in the restroom, preparing for his/her shift. Sergeant A did not have his/her body-worn video (BWV) camera or uniform on during this incident. Sergeant A heard a loud noise, which he/she recognized as a possible gunshot. Sergeant A exited the restroom area, entered the locker room, and observed Officer A standing in front of his/her locker as if in disbelief. Sergeant A approached Officer A and asked if he/she had a negligent discharge. Sergeant A stated that Officer A replied, "Yeah, I shot my phone." Sergeant A observed a revolver on a bench in front of Officer A's locker.

After determining that Officer A was not injured during this incident, Sergeant A instructed off-duty Police Officer B to advise the Watch Commander of the NTUD. Officer B did not have his/her BWV camera or uniform on at the time of this incident.

Officer B responded to the Watch Commander's office and informed Sergeant B of the NTUD. According to Sergeant B, he/she was notified of the NTUD at 1816 hours.

Sergeant B responded to the locker room, assumed the role of the Incident Commander (IC), and obtained a Public Safety Statement from Officer A. Sergeant B checked the locker room aisles to the north and south to ensure the round did not penetrate the locker and that no one was injured. After verifying there was no one injured, Sergeant B instructed Police Officer C to secure the locker room aisle, which he/she did.

Technical Investigation Division Photographer A responded and photographed the scene and evidence.

At approximately 2200 hours, FID Detective A conducted a post-incident examination of Officer A's revolver. Detective A determined that the revolver cylinder was empty. However, four live rounds of Department-approved ammunition were recovered from a bench in front of Officer A's open locker. A discharged cartridge case was recovered from inside Officer A's locker.

The investigation determined that Officer A discharged one round, which traveled downward and in a northerly direction. The bullet struck and penetrated a Department-

issued cellphone, grazing the base of his/her locker. A deformed bullet was recovered inside Officer A's locker near a Field Officer's Notebook. The bullet did not fragment or penetrate the locker. There were no injuries as a result of the NTUD.

On April 18, 2023, LAPD Training Division Ordinance Unit completed a report documenting the test-firing of Officer A's revolver. The revolver was found to be in good mechanical condition.

# BWV and Digital In-Car Video (DICV) 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 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 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 non-tactical unintentional discharge (NTUD) to be negligent, warranting a finding of Administrative Disapproval.

#### **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 Categorical Use of Force (CUOF) incident to attend a Tactical Debrief. Accordingly, consistent with Department policy, the BOPC adopted a finding of Tactical Debrief for Officer A's tactics.

# B. Drawing and Exhibiting

Does not apply.

## C. Unintentional Discharge

• Officer A – revolver, one round in a downward, northerly direction.

**Scene Description:** The NTUD occurred in the locker room of Rampart Division Community Police Station (CPS) at approximately 1815 hours.

Officer A – According to Officer A, he/she had not inspected or discharged his/her back-up revolver in two years and wanted to inspect it to see if it was still functioning. Officer A stated that he/she opened the revolver's cylinder, noted that it was fully loaded with five live rounds, and pointed the muzzle upward to let gravity extract the rounds into the palm of his/her left hand. Officer A placed the rounds on the bench in front of his/her open locker, closed the cylinder, and visually inspected the cylinder by looking at the exposed chambers and not seeing any rounds in the chambers. Officer A did not open the cylinder again to perform a safety check. Officer A believed that the revolver was unloaded and, while standing in front of his/her locker, held the revolver in a single, right-handed, low-ready position and pointed the muzzle downward in a northerly direction toward the base of his/her locker. Officer A believed that it was safe to perform a function check to ensure the revolver was operational. Officer A placed his/her finger on the trigger and pressed it, resulting in an NTUD.

The FID investigation determined that Officer A discharged one round, which traveled downward in a northerly direction, struck and penetrated a Department-issued cellphone and grazed the base of his/her locker. A deformed bullet was recovered inside Officer A's locker near a Field Officer's Notebook, and it did not fragment nor penetrate the locker. Four live rounds, an expended bullet and a cartridge casing of Department-approved ammunition were recovered by FID investigators

The BOPC noted that the Chair of the Use of Force Review Board (UOFRB) evaluated the circumstances and the evidence related to the NTUD. The Chair noted that according to Officer A, he/she extracted the live rounds and closed the cylinder; however, Officer A did not reopen the cylinder to conduct a safety check and only viewed the exposed chambers of the closed cylinder along the sides of the revolver. The Chair also noted that nothing indicated the NTUD was a result of a mechanical malfunction of the revolver. As such, the Chair opined that NTUD was a result of operator error and that Officer A's actions violated the Department's Basic Firearm Safety Rules.

Based on the totality of the circumstances, the BOPC determined that the NTUD was the result of operator error. Officer A's actions violated the Department's Basic

Firearm Safety Rules, thus requiring a finding of Administrative Disapproval, Negligent Discharge.