

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

NON-TACTICAL UNINTENTIONAL DISCHARGE – 021-23

Division **Date** **Duty-On () Off (X)** **Uniform-Yes () No (X)**

Outside City 5/13/23

Officer(s) Involved in Use of Force **Length of Service**

Officer A 5 years, 1 month

Reason for Police Contact

On May 13, 2023, Officer A was off duty at his/her parents' residence, where he/she cleaned and reassembled his/her personally owned pistol and placed in into his/her duty holster. Officer A realized that he/she had not conducted a function test. Officer A placed his/her right index finger on the trigger and pressed, resulting in a Non-Tactical Unintentional Discharge (NTUD) of one round.

Subject **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 recommendations, including any Minority Opinions; the report and recommendations of the Chief of Police; and the report and recommendations of the Inspector General. The Department Command staff presented the matter to the BOPC and made itself available for any inquiries by the BOPC.

In accordance with state law, divulging the identity of police officers in public reports is prohibited, so the masculine pronouns (he/she, his/her, and him) will be used in this report in situations where the referent could in actuality be either male or female.

The following incident was adjudicated by the BOPC on January 9, 2024.

Incident Summary

On May 13, 2023, at approximately 1710 hours, Officer A was off duty inside his/her parent's residence.

According to Officer A, while in the northwest bedroom of the residence, he/she cleaned and reassembled his/her personally owned duty pistol. After loading it to capacity with 17 rounds in the magazine and one round in the chamber, Officer A placed it into his/her duty holster, which was attached to his/her Sam Browne equipment belt. He/she then donned the belt to verify that it fit properly. While wearing the belt, Officer A realized he/she had not yet completed a function test of his/her pistol and decided to practice acquiring his/her red dot sight as part of his/her unholstering. He/she believed he/she had removed the magazine and conducted chamber checks prior to conducting the function test of his/her pistol.

According to Officer A, he/she became distracted, and approximately two to three minutes later, he/she unholstered his/her pistol and while acquiring the red dot sight, presented his/her pistol toward the west wall of the bedroom. He/she then placed his/her right index finger on the trigger and pressed, resulting in a Non-Tactical Unintentional Discharge (NTUD) of one round. The bullet lodged within the west wall directly in front of him/her.

According to Officer A, immediately after the NTUD, he/she ensured his/her pistol was unloaded and placed it in his/her holster. He/she then removed his/her equipment belt from his/her waist and laid it on a chair located south of a bed that was positioned against the west wall.

Officer A verified that his/her relatives, who were located in other parts of the residence at the time of the NTUD, were uninjured. Officer A then exited the residence and verified the round had not exited the bedroom wall. Upon returning to his/her room, Officer A located the discharged cartridge case (DCC), which had ejected onto a dog bed located along the north wall. Officer A was concerned his/her dog would grab or swallow the DCC, so he/she placed it on the south portion of his bed next to the pistol's magazine.

According to Officer A's sibling, he/she passed by the northwest bedroom and observed Officer A with cleaning products laid out. Officer A's sibling realized that Officer A was going to clean his/her pistols and went to his/her adjacent bedroom.

According to Officer A's sibling, approximately an hour to an hour and a half later, he/she heard a gunshot and went into the northwest bedroom to see what occurred. He/she observed Officer A staring at the wall and wearing his/her Sam Browne. From his/her vantage point, Officer A's sibling could not see if Officer A was holding his/her pistol at the time. He/she accompanied Officer A outside to see if the round had exited.

According to Officer A, approximately five minutes after the NTUD, he/she contacted Sergeant A and notified him/her of the NTUD. Sergeant A was then dispatched to the incident. Additionally, Captain A also responded to the scene. While enroute, Captain A directed Officer A to contact the local police department and notify them of the NTUD.

Captain A followed up with the local police department Watch Commander, Sergeant B, who advised they would respond with a delay and that Force Investigation Division (FID) could begin their investigation.

At approximately 1928 hours, Sergeant A arrived and obtained a Public Safety Statement (PSS) from Officer A.

On May 13, 2023, FID investigators, processed the scene for evidence. Officer A's holstered pistol and equipment belt were resting on a chair along the west side of the bedroom. On an adjacent bed, which was also located on the west side of the bedroom, investigators located a magazine loaded with 17 rounds of duty ammunition. Next to the magazine was a discharged cartridge case (DCC).

According to Officer A, after cleaning and reassembling his/her pistol, he/she loaded his/her pistol to capacity with 18 rounds of ammunition. One round was in the firing chamber and seventeen rounds were in the magazine.

On May 13, 2023, at approximately 2130 hours, FID investigators conducted a post-incident examination of Officer A's pistol. The pistol, which was retrieved from the holster of his/her equipment belt, did not contain a magazine and the firing chamber was empty. The magazine that Officer A had reported may have been in the pistol at the time of the NTUD was loaded with 17 rounds of Department-approved ammunition. This information was consistent with Officer A having discharged one round.

On May 22, 2023, the Forensic Science Division Firearms Analysis Unit finalized a Laboratory Report documenting the test firing of Officer A's pistol. The pistol was found to be functional, and the trigger pull value was within the Department's established range.

Body-Worn Video (BWV) and Digital In-Car Video (DICV) Policy Compliance

| NAME | TIMELY BWV ACTIVATION | FULL 2-MINUTE BUFFER | BWV RECORDING OF ENTIRE INCIDENT | TIMELY DICV ACTIVATION | DICV RECORDING OF ENTIRE INCIDENT |
|-----------|-----------------------|----------------------|----------------------------------|------------------------|-----------------------------------|
| Officer A | N/A | N/A | N/A | N/A | N/A |

Los Angeles Board of Police Commissioners' Findings

The BOPC reviews each Categorical Use of Force (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 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. Non-Tactical Unintentional Discharge

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

Basis for Findings

A. Tactics

Officer A was not engaged in a tactical operation in this incident; therefore, his/her tactics were not reviewed or evaluated. However, Department guidelines require personnel substantially involved in a Categorical Use of Force incident to attend a Tactical Debrief. The Chief determined that it would be appropriate to recommend a Tactics finding of Tactical Debrief.

Tactical De-Escalation

Officer A was off duty at his parents' residence and not engaged in a tactical operation; therefore, Officer A was not evaluated for tactical de-escalation.

Command and Control

- Officer A contacted Sergeant C and informed him/her of the NTUD and Sergeant A was dispatched to respond to the incident. Additionally, Captain A was notified and responded to the scene. Captain A contacted the Department Operations Center and notified them of the incident at approximately 1748 hours.

While enroute to the residence, Captain A directed Officer A to contact the local police department and notify them of the NTUD. Captain A followed-up with the local police department Watch Commander, Sergeant B, who advised they would respond with a delay and that Force Investigation Division could begin their investigation.

At approximately 1928 hours, Sergeant A arrived at the scene and obtained a public safety statement (PSS) from Officer A inside the bedroom where the NTUD occurred. Immediately after the PSS, Sergeant A and Officer A exited the front of the residence and met with Captain A. Sergeant A and Captain A then monitored Officer A until approximately 1958 hours, when FID personnel arrived at scene and assumed investigative responsibility.

The BOPC determined the overall actions of Captain A, as well as Sergeants A and C, were consistent with Department supervisory training.

B. Drawing and Exhibiting

- Does not apply.

C. Unintentional Discharge

Officer A – (pistol, one round)

The NTUD occurred in a bedroom inside Officer A's parents' residence during early evening hours. The home is a one-story, single-family residence located within a residential neighborhood. The round traveled through the interior west wall of the northwest bedroom of the residence. According to the investigation, the bullet came to rest in the interior portion of the wall and did not penetrate the exterior wall. Members of Officer A's family were also inside the residence at the time of the incident.

According to Officer A, after cleaning and reassembling the pistol, he/she loaded it to capacity with a 17-round magazine and one round in the chamber. Approximately two to three minutes later, Officer A realized he/she did not perform a function test of the trigger. Believing the magazine had been removed from the pistol and the round removed from the chamber, leaving the pistol empty, Officer A drew his/her pistol from his/her Sam Browne duty belt, pointed it at the west wall of the bedroom and pulled the trigger, resulting in an NTUD.

The Chair of the UOFRB evaluated the circumstances and evidence related to the NTUD. The Chair noted Officer A's belief that the weapon was not loaded based on the weight of the pistol when he/she removed it from the holster to perform a function test of the trigger. Officer A could not specifically recall removing the magazine from the pistol or performing a chamber check prior to conducting the function test. After the NTUD occurred, Officer A indicated that he/she removed the magazine, then the round from the chamber, which indicated that the weapon was in fact loaded at the time the NTUD occurred. The Chair opined that, contrary to Officer A's belief that the pistol was unloaded, an inspection of his/her service pistol, including a chamber check, was not performed by Officer A before he/she pulled the trigger. As such, the Chair determined that the 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, requiring a finding of Administrative Disapproval, Negligent Discharge.