

Incident Summary

On April 2, 2021, off-duty Police Officer A flew to Arizona for personal business. According to Officer A, he/she declared and checked in three pistols in a travel case along with his/her luggage. The pistols included a 9mm semiautomatic pistol that he/she carries on-duty.

According to Officer A, at approximately 1500 hours, he/she checked into a hotel. Present in the room with him/her were his/her two sons.

At approximately 2000 hours, Officer A, and his/her sons left the hotel room for dinner. Prior to leaving the hotel, Officer A loaded his/her pistol and carried it on his/her person.

At approximately 2315 hours, Officer A and his/her sons returned from dinner to their hotel room, and Officer A removed his/her holstered pistol from his/her person with the intent of securing it in the travel case with his/her other pistols. He/she then unholstered the pistol and began explaining to his/her sons the differences in how the front sights are secured on various pistols.

The hotel room that Officer A rented contained two beds. At the head and in between the beds, against a wall, was a nightstand with an alarm clock and a hotel telephone placed on the top. According to Officer A, he/she sat down with the loaded pistol on the inside edge of one of the beds. The nightstand was to his/her left within arm's reach. One son was standing to his/her right and behind him/her near a table on the opposite side of the room. The second son was lying on the bed in front and across from Officer A.

According to Officer A, he/she unloaded and disassembled his/her pistol to show his/her sons how the bottom of the front sight was secured. While unloading his/her pistol, Officer A held it in his/her right hand while leaning forward. Officer A then removed the loaded magazine and set it down before racking the slide and catching the chambered round in his/her left hand. He/she then racked the slide three additional times to ensure the pistol was unloaded.

To begin the disassembly process, Officer A pulled the trigger, retracted the slide and slide lock, allowing the slide to be removed from the frame of the pistol. Officer A then removed the barrel and guide rod from the slide and examined the underside of the sight. Throughout the unloading and disassembly procedure, Officer A kept the pistol pointed to his/her left, toward the nightstand. Officer A considered this to be the safest direction, based on his/her sons' positions in the room.

According to Officer A, while still seated on the bed, he/she began reassembling the pistol by placing the barrel and guide rod back on the slide. While pointing the pistol to his/her left toward the nightstand, Officer A held the slide with his/her left hand and placed it onto the frame of the pistol, which he/she maintained in his/her right hand. Officer A believed that he/she was distracted by the discussion of the front sight during

the reassembly procedure. Although he/she did not recall doing so, Officer A believed that before or after replacing the slide on the frame, he/she inadvertently placed a loaded magazine into the pistol.

According to Officer A, the slide did not feel properly secured onto the frame. When he/she retracted the slide farther to the rear, a live round was ejected from the ejection port into his/her left hand. Officer A believed that he/she placed the live round onto the nightstand.

Officer A believed the pistol was unloaded and he/she decided to disassemble the pistol to determine why the slide did not seat properly onto the frame. Without additionally manipulating the pistol, Officer A pulled the trigger with the intent of starting the disassembly procedure. In doing so, one round was discharged toward the nightstand. The round passed through the alarm clock on the top of the nightstand, before striking a metal wire guard and becoming lodged in the drywall.

According to Officer A, after the pistol discharged, he/she ensured that his/her sons were not injured and set the pistol down on the table.

After the discharge occurred, Officer A heard somebody in an adjacent room inquiring if he/she was okay. Officer A opened his/her hotel room door and advised that he/she was fine.

According to Officer A, he/she then observed a uniformed security guard in the hallway. He/she requested the guard to come into his/her room to verify that everything was okay. The guard refused to approach Officer A and advised him/her to call 911.

Force Investigation Division (FID) investigators interviewed the guard, who advised he was checking on the vacancy status of an adjacent room at the time of the incident.

According to the guard, he knocked on the door of the adjacent room and announced himself as security for the hotel. Upon receiving no response, he attempted to open the door, but found the door secured by the top safety latch. As the guard was attempting to determine if the room was occupied, he heard a gunshot and believed he was being shot at from someone inside.

After hearing the gunshot, the guard walked down the hall before observing Officer A exiting his room and calmly wave for him to come back. The guard refused to return to meet with Officer A. He did not know if Officer A was associated with the adjacent room, where he believed the gunshot emanated from. At approximately 2324 hours, the guard responded to the front desk and had an employee call 911.

At approximately 2326 hours, Officer A called 911 and notified the dispatcher that he/she was an off-duty police officer and that he/she, "...was getting ready to do something with my weapon and I accidently discharged a round." Officer A stated that he/she observed a hole in the wall and requested the responding officers to check the

adjoining room to ensure nobody was injured. Officer A advised that he/she had placed the pistol on the table and that he/she had his/her badge and identification with him/her. He/she added that he/she would be fully cooperative with whatever the responding officers wanted him/her to do. While conversing with the dispatcher, Officer A advised that he/she had to notify the Los Angeles Police Department of the incident but would wait until the local police officers arrived.

Multiple officers responded to the 911 dispatch call. While en route to the call, Officer B spoke with Officer A via cellphone and described Officer A as cooperative. When officers arrived at the hotel room, they advised Officer A and his/her sons to exit their room.

Officer C interviewed the two sons. According to Officer C, "They both said that they heard a loud bang which they associated to be a gunshot. [At] which point in time they looked around and saw their dad, standing there." Officer C said that Officer A asked his/her sons if they were okay. "They both said that they were. And then they both said that they saw him/her with a firearm, and they assumed that he/she had an accidental discharge."

The on-scene investigation by the local police department determined that Officer A's round passed through a digital alarm clock on the nightstand before coming to rest within the wall.

Based on the review of BWV of the responding officers, it appeared they cleared the scene at approximately 0100 hours. Officer A contacted the Department Operations Center (DOC) to report the incident approximately 10 minutes later, on April 3, 2021, at 0010 hours.

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 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 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, 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 consideration:
 - **Firearms Manipulations** – Four Basic Firearms Safety Rules.

B. Drawing and Exhibiting

- Does Not Apply

C. Unintentional Discharge

- **Officer A** – (pistol, 1 round)

To show his/her sons how the bottom of the front sight was secured to the slide of his/her pistol, Officer A disassembled his/her pistol. To begin the disassembly process, Officer A aimed his/her pistol towards the nightstand against west wall. Based on his/her sons' position in the room, other than the floor, Officer A considered the nightstand to be the safest direction. Keeping the pistol pointed towards the nightstand, Officer A leaned forward, removed the loaded magazine from the pistol, and ejected the round from the pistol's firing chamber. Officer A then "racked" the slide three times to ensure the pistol was unloaded. As part of the disassembly process, Officer A pressed the trigger in order to allow the slide to be removed from the pistol's frame. While still seated on the bed, Officer A reassembled his/her pistol while pointing the pistol towards the west wall. Because the slide did not feel properly secured to the frame, Officer A began the disassembly

process again. Retracting the slide to the rear, Officer A ejected a round from the firing chamber. Believing the pistol was unloaded, Officer A pulled the trigger without further manipulation of the pistol, unintentionally discharging one round towards the west wall. Officer A opined that during the reassembly process, he/she was “distracted” by the front sight discussion, and while he/she did not recall doing so, inadvertently placed a loaded magazine into the pistol. Because the magazine was still seated in the frame when he/she retracted the slide during the second disassembly process, Officer A ejected one round while loading another into the firing chamber.

The BOPC conducted a thorough review in evaluating the circumstances and evidence related to the NTUD. The BOPC determined that the NTUD was the result of operator error. The BOPC noted that Officer A failed to verify the condition of his/her pistol during the second disassembly process. Leaving a magazine inserted in the pistol, Officer A unloaded one round while loading another round into the chamber. Instead of “racking” the slide again to verify if his/her pistol was in fact unloaded, Officer A pressed the trigger, while covering objects he/she did not intend to shoot, unintentionally discharging a round. While Officer A identified the nightstand/west wall as the safest direction to aim his/her pistol, the BOPC noted that as Officer A was in a hotel room; it was possible that there were occupied rooms on all sides, as well as above and below Officer A. The BOPC would have preferred that Officer A had waited until he/she arrived at the pistol range before unloading, disassembling, and inspecting his/her pistol.

The BOPC noted that Officer A acted with exemplary professionalism and calm demeanor immediately following a critical incident. Officer A was cooperative with responding personnel, made notification to the DOC, and preserved evidence from the scene for FID investigators.

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, and therefore require a finding of Administrative Disapproval (AD), Negligent Discharge.