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

NON-TACTICAL UNINTENTIONAL DISCHARGE – 058-19

Division	Date	Duty-On (X) Off ()	Uniform-Yes (X) No ()
Pacific	12/31/19		

Officer(s) Involved in Use of Force	Length of Service
Officer A	8 years 11 months

Reason for Police Contact

While conducting a check of his/her shotgun Officer A disengaged the safety, pressed the trigger, and a Non-Tactical Unintentional Discharge (NTUD) occurred.

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 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 recommendations; 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, his, 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 November 10, 2020.

Incident Summary

On Tuesday, December 31, 2019, Police Officers A and B, attended Day Watch roll call. After roll call, both officers walked to the kit room, checked out their Department-issued equipment from the Pacific Division kit room officer, Police Officer C, which included a shotgun.

After obtaining their equipment, both officers walked to the station parking lot and located their police vehicle. According to Officer A, he/she opened the trunk, placed paperwork in the vehicle, and began to conduct his/her pre-watch shotgun inspection. Officer A described holding the shotgun at a "port arms" position with the muzzle pointed toward the air with his/her back towards the trunk of his/her police vehicle. Officer A checked the barrel, the sights, and the ejection port. According to Officer A, he/she pushed up on the magazine tube with his/her left thumb and did not believe anything was amiss. Officer A opened the action and conducted a chamber check with his/her left pinky, checked the ejector, and checked what Officer A referred to as the "shell."

Officer A closed the action of the shotgun and believed the shotgun was empty. Officer A squeezed the trigger with the safety on and nothing happened. He/she disengaged the safety, squeezed the trigger, obtained a surprise break and heard a loud bang. The shock of the incident caught Officer A off guard and he/she kneeled down because he/she did not know where the round came from. Officer A stated he/she was not expecting the shotgun to go off. Officer A could not recall if he/she conducted a second chamber check prior to disengaging the safety and squeezing the trigger. Officer A was surprised that the shotgun went off because he/she did not handle any shotgun shells prior to obtaining the shotgun from the kit room.

After the round went off, Officer A noticed that his/her partner, Officer B ran to him/her and asked if he/she was injured. Officer A was in a daze and briefly experienced ringing to his/her left ear.

Officer D ran over to Officer A, took the shotgun from Officer A, located and picked up the expended shotgun shell, and made sure that Officer A was not injured. After ensuring that Officer A was not injured, Officer D handed Officer A the shotgun and the expended shotgun shell.

Officer A walked inside the station and notified Officer C, who was assigned to the kit room of the incident. Officer C instructed Officer A to notify a supervisor. Officer A walked to the Watch Commander's Office and notified Sergeants A and B. According to Officer A, Sergeant B asked Officer A to provide a public safety statement, ordered him/her not to discuss the incident, and monitored him/her until relieved by FID personnel.

Officer C checked the records and established that Police Officer E and his/her partner, Police Officer F, checked the shotgun into the kit room immediately before the shotgun was checked out to Officers A and B. Officer C recalled visually inspecting the shotgun

when it was checked in by Officers E and F and noted the action was open and that there was no round in the chamber.

BWV and DICVS Policy Compliance

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

Los Angeles Board of Police Commissioners' 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 Non-Tactical Unintentional Discharge to be Negligent.

Basis for Findings

A. Tactics

- Officer A was on-duty, at the time of this incident, but was not engaged in a tactical operation; therefore, Officer A was not evaluated on tactics. However, as Department guidelines require personnel who are substantially involved in a Categorical Use of Force incident to attend a Tactical Debrief. Accordingly, consistent with Department policy, the BOPC made a finding of Tactical Debrief for Officer A's tactics.

  During the review of this incident, the following Debriefing Point was noted:

  - Firearms Manipulations – Four Basic Firearm Safety Rules

Tactical De-Escalation

- Tactical de-escalation involves the use of techniques to reduce the intensity of an encounter with a suspect and enable an officer to have additional options to gain voluntary compliance or mitigate the need to use a higher level of force while maintaining control of the situation.

Tactical De-Escalation Techniques

- **P**lanning
- **A**ssessment
- **T**ime
- **R**edeployment and/or Containment
- **O**ther Resources
- **L**ines of Communication (Use of Force - Tactics Directive No. 16, October 2016, Tactical De-Escalation Techniques)

Tactical de-escalation does not require that an officer compromise his/her or her safety or increase the risk of physical harm to the public. De-escalation techniques should only be used when it is safe and prudent to do so.

In this case, Officer A was conducting the administrative function of verifying the condition and performing a function check on the shotgun. Officer A was not engaged in a tactical operation and was preparing his/her equipment for patrol functions; therefore, Officer A was not evaluated for Tactical de-escalation.

- The BOPC also considered:

Background – As Officer A was verifying the condition and performing a function check of his/her shotgun, he/she held it in a port arms position with the barrel pointed upward towards the air, in the police station parking lot. Officer A stood behind his/her police vehicle, which was located between the police station and the gas pumps. Officer A disengaged the shotgun's safety, pressed the trigger, and discharged a single round into the air in an upward direction. The incident occurred at approximately 0700 hours. The police station parking lot did not have any nearby public or residential properties, and there was minimal pedestrian or vehicle traffic within the parking lot. Officer A was reminded that an officer's background is an important consideration while handling any firearm and there is always a potential for injury to other officers and community members in the area.

Preservation of Evidence - The FID investigation revealed that following the NTUD, Officer A moved the shotgun and the expended shotgun shell away from the scene of the NTUD incident. Officer A carried the shotgun to the kit room, gave it to Officer C, and proceeded to the Watch Commander's Office where he/she gave the expended shotgun shell to Sergeant A. Officer A was reminded of the importance of maintaining the integrity of the scene following a Categorical Use of Force (CUOF) incident for FID investigators.

The FID investigation revealed that following the NTUD, Officer D looked in Officer A's direction and observed him/her holding a shotgun at port arms with his/her right hand and covering his/her ear with his/her left hand. Officer D ran to Officer A and took the shotgun from him/her. Officer D checked to make sure Officer A was not injured. Officer D observed a shotgun shell casing on the ground under a black and

white police vehicle parked next to Officer A's police vehicle. Officer D picked up the shotgun shell casing and gave Officer A back the shotgun and the expended shell casing. Officers A and D were reminded of the importance of crime scene preservation.

Downloading Shotgun – The investigation revealed the shotgun involved in the NTUD had not been properly downloaded by Officer E prior to returning it to the kit room at the end of his/her shift. Officer E was reminded of the need to ensure that firearms are downloaded when they are returned to the kit room.

Kit room Officer's Responsibilities – The FID investigation revealed that Officer C did not properly check the condition of the shotgun when it was returned to the kit room by Officer E. Officer C should have ensured the shotgun was unloaded, the action was open, and that the safety was on, once accepting the shotgun into the kit room. Officer C was reminded of his/her responsibilities when receiving firearms back into the kit room.

B. Drawing and Exhibiting

Does not apply.

C. Non-Tactical Unintentional Discharge

- **Officer A** – (shotgun, one round)

Officer A held the shotgun in his/her right hand in a port arms position with the muzzle pointed upward into the air. Officer A had his/her back towards the trunk of the police vehicle as he/she checked the shotgun's barrel, sights, and ejection port. Officer A pushed up on the magazine tube with his/her left thumb and then conducted a physical chamber check of the shotgun with his/her left pinkie finger. Officer A continued to check the ejector and shell carrier before closing the action of the shotgun, believing that the shotgun was empty and there were no shotgun rounds inside the shotgun. Officer A began the safety check of the shotgun and with the shotgun safety engaged, pressed down on the trigger, resulting in nothing happening. Officer A disengaged the safety, pressed the trigger, which resulted in a surprise break, and discharged a round into the air, causing him/her, out of shock, to kneel down behind the police vehicle.

The BOPC conducted a review in evaluating the circumstances and evidence related to the NTUD. The BOPC determined that the Unintentional Discharge was the result of operator error and a violation of the Department's Basic Firearm Safety Rules. All officers are taught in the academy and at every shotgun qualification that they are required to ensure the shotgun's action is open and the safety is on. Officers are then required to visually and physically check the magazine well, loading area, and chamber of the shotgun prior to completing a Six-Point Safety Check, which includes a visual and physical inspection of the shotgun's barrel,

ejector, extractor, firing pin, safety, and shell carrier. Prior to testing the shotgun's safety, officers are required to close the action and then conduct a chamber check before disengaging the safety and pressing the trigger. Therefore, Officer A failed to properly check the shotgun's chamber to verify its condition.

Based on the totality of the circumstances, the BOPC determined that the NTUD was the result of operator error as Officer A's actions violated the Department's Basic Firearm Safety Rules. The BOPC found Officer A's Unintentional Discharge to be Negligent.