



## **Incident Summary**

Police Officer A checked out a shotgun from the equipment room at the station, while his partner Officer B checked out a beanbag shotgun. Officer A did not recall if the action on the shotgun was open or closed; however, he recalled he placed his right thumb through the shell carrier area by pushing it upward to ensure it did not contain a round.

After receiving their equipment, Officers A and B walked to their assigned police vehicle that was parked in the Wilshire Station parking lot. According to Officer A, he walked to the front of their police vehicle, while Officer B walked to the rear of the vehicle.

Officer A initiated a safety check on the shotgun. Officer A checked the shotgun's barrel, ejector, extractor, shell carrier, then firing pin. Although Officer A did not recall if the action of the shotgun had been open or closed at the start of the safety check, he acknowledged the action was open when he conducted the check of the ejector, extractor, and firing pin. As he proceeded with the safety check, he noticed the safety was set to the "on" position. He conducted a chamber check, then pressed the trigger.

**Note:** Officer A described his chamber check procedure as partially opening the action to view into the ejection port and determine if a round was present. To assist in viewing into the ejection port, he slightly lowered and canted his shotgun to his eye level, while his right hand was on the slide handle and his left hand was on the shotgun's pistol grip.

The safety was functional and there was no trigger pull. Officer A conducted an additional chamber check, then put the safety in the "off" position. Officer A did not identify a round in the shotgun during the chamber checks. Officer A advised he pulled the trigger with the shotgun pointed upward, and an unintentional discharge occurred.

## **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 and Exhibiting of a firearm by any involved officer(s); and the Use of Force by any involved officer(s). All incidents are evaluated to identify areas where involved officers can benefit from a tactical debriefing to improve their response to future tactical situations. This is an effort to ensure that all officers benefit from the critical analysis that is applied to each incident as it is reviewed by various levels within the Department and by the BOPC. 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/Exhibiting** – Does Not Apply.

**C. Unintentional Discharge**

- The BOPC found Officer A's unintentional discharge to be negligent, warranting Administrative Disapproval.

**Basis for Findings**

**A. Tactics**

- Officer A's tactics were not a factor in this incident. Therefore, they were not reviewed or evaluated. However, Department guidelines require personnel who are substantially involved in a Categorical Use of Force incident to attend a Tactical Debrief. Therefore, the BOPC determined that it would be appropriate to recommend a Tactics finding.

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

- Firearms Manipulations – Four Basic Firearms Safety Rules/Weapon Inspections

**B. Drawing/Exhibiting** – Does Not Apply

**C. Unintentional Discharge**

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

According to Officer A, as part of his shotgun safety check, he made sure the safety was in the "on" position, partially opened the action, and conducted a visual chamber check. After verifying the chamber was empty, he closed the action, pressed the trigger, and determined the safety was functional. He conducted another chamber check and placed the safety to the "off" position. He then pressed the trigger, resulting in one round being fired from the shotgun.

Upon reviewing the evidence, the BOPC determined that the Unintentional Discharge was the result of operator error after Officer A pressed the trigger of his shotgun while attempting to conduct a pre-watch weapon inspection. Officer A's action violated the Department's Basic Firearm Safety Rules.

Accordingly, the BOPC found that Officer A's unintentional discharge to be negligent.