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

UNINTENTIONAL DISCHARGE – 116-11

Division	**Date**	**Duty-On (X) Off ( ) Uniform-Yes (X) No ( )**
Southeast	12/28/11	

Officer(s) Involved in Use of Force	**Length of Service**
Officer A	24 years, 11 months

Reason for Police Contact

Officer A manipulated his pistol, resulting in an unintentional discharge.

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 suspect 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 October 9, 2012.

Incident Summary

While at the police station, Officer A donned his uniform and put on his duty belt, after which he removed his pistol from his backpack. As was his habit, he checked the de-cocker lever and discovered it would not rotate to the de-cocked position. Officer A decided he would recheck the weapon when he was able to safely unload his weapon at the loading barrel, which was located outside the rear door of the station. Officer A met with his partner, Officer B, and they began to place their equipment in their police vehicle. As they were doing so, a radio call was broadcast of a man with a gun in the area that Officer A was responsible for. An airship over the location broadcast that a suspect was observed removing a gun from his pocket. Officer A told Officer B that they needed to respond to the location, which they did.

With Officer B driving, Officers A and B responded to the location of the radio call. While en route, Officer A remembered that he had neglected to check his pistol prior to leaving the station. Knowing that they were responding to a situation where he might need his weapon, he made the decision to examine the gun as they were driving to the location.

Officer A removed his handgun from his holster, examined it, and observed that there was a small unknown object stuck in it, which prevented the lever from functioning. Officer A removed the obstruction and noted that the lever was working properly. Officer A believed the de-cocking lever of his weapon was still in the downward position. Officer A, holding the gun in his right hand, pulled the trigger of his weapon causing it to discharge. The vehicle immediately filled with smoke. Once the smoke cleared from the vehicle, he looked down at the floorboard, saw blood, and informed his partner that he had shot himself in the foot. Officer A holstered his weapon.

Officer B began to pull the police vehicle to the curb and Officer A told him to not stop but to take him straight to the hospital. Officer B began to drive to the hospital. While en route to the hospital, Officer B contacted Sergeant A and made him aware of what had occurred.

After arriving at the hospital and parking his vehicle in the emergency ambulance parking area, Officer B advised Communications Division that he was at the hospital. Officer B ran inside the emergency room and approached the first nurse he saw. Officer B informed her that there was an officer with a gunshot wound in his police vehicle. Medical personnel rendered aid.

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/Holstering of a weapon 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 unanimously made the following findings.

A. Tactics

Does not apply.

B. Drawing/Exhibiting

Does not apply.

C. Unintentional Discharge

The BOPC found Officer A's unintentional discharge to be negligent.

Basis for Findings

In this instance, immediately after clearing the obstruction from the decocking lever and reloading the handgun to capacity, Officer A held his service pistol in his right hand. Officer A believed the decocking lever was in the downward position and inadvertently placed his finger on the trigger and pressed it, causing one round to be fired. The BOPC evaluated the circumstances relevant to Officer A's unintentional discharge and determined that the unintentional discharge of the firearm resulted from operator error and a violation of the firearms safety rule.

In conclusion, the BOPC found Officer A's unintentional discharge to be negligent.