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

OFFICER-INVOLVED SHOOTING – NEGLIGENT DISCHARGE 048-05

Division	Date	Duty-On(x) Off( )	Uniform-Yes(x) No()
Rampart	06/22/2005		

Involved Officer(s)	Length of Service
Officer A	9 years

Reason for Police Contact

Officer was on duty and handled a Department issued shotgun, which resulted in the discharge of the weapon.

Subject(s)	Deceased ( )	Wounded ( )	Non-Hit ( )
N/A			

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.

Because state law prohibits divulging the identity of police officers in public reports, 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 June 20, 2006.

Incident Summary

Officers A and B were in the lower level parking structure preparing for their start of watch. The Officers had checked out a Remington, Model 870 12-gauge shotgun from the Kit Room at the Rampart Station. During the preparation for their patrol watch, Officer B undertook the standard safety check of the shotgun. Upon confirmation that the weapon was loaded and ready to be placed in the patrol unit, Officer B placed the shotgun in the trunk and returned to the station to retrieve other items.

Officer B did not communicate to Officer A that the shotgun was loaded and ready for placement in the patrol unit. Officer A walked to the rear of the patrol unit where he observed the shotgun in the trunk with the barrel pointed down and the slide handle not completely closed.

The interview with Officer B did not confirm that he left the slide handle of the shotgun open when he placed it in the trunk of the patrol unit. Officer B believed that he had loaded the shotgun with four rounds, placed the safety mechanism on, then placed the shotgun back in the trunk in a "patrol ready" mode.

Officer A, believing the shotgun had not been prepared for patrol, picked up the shotgun and began again to do the standard safety check. In so doing, Officer A, with barrel of the shotgun pointed upwards, checked the barrel and firing pin for obstructions or damage and found none. Next Officer A inspected the injector ports and extractor to assure they were in working order. Officer A felt inside to chamber for a round, however, he did not visually check the chamber to see if the weapon was loaded. Officer A moved the weapon safety from "on" to "off" and pulled the trigger in order to test the firing pin. The weapon discharged into the ceiling of the parking structure. Immediately after the discharge Officer B returned to the rear of the patrol unit. Officer A downloaded the shotgun of the remaining rounds and placed the empty shotgun into the trunk of the patrol unit.

The Watch Commander, Sergeant A, was walking from the parking structure to the station when he heard the round discharged. Sergeant A returned to the parking structure to find Officer A holding the shotgun. Officer A provided Sergeant A with a Public Safety Statement and Sergeant A immediately secured the area, separated Officer A and Officer B, and admonished them not to speak of the incident. The Department Command Post was subsequently notified of the accidental discharge and Force Investigation Division detectives responded and conducted the investigation.

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

The BOPC found that tactics did not apply to this incident.

B. Drawing/Exhibiting/Holstering

The BOPC found that drawing/exhibiting/holstering did not apply to this incident.

C. Use of Force

The BOPC found that Officer A's weapon discharge was a negligent discharge, requiring Administrative Disapproval.

Basis for Findings

A. Tactics

The BOPC found that tactics did not apply to this incident.

B. Drawing/Exhibiting/Holstering

The BOPC found that drawing/exhibiting/holstering did not apply to this incident.

C. Use of Force

The BOPC found that Officer A's weapon discharge was a negligent discharge, requiring Administrative Disapproval. The BOPC was concerned that Officer A did not follow proper firearm safety procedures, specifically, that he did not properly examine the shotgun to assure it was not loaded prior to depressing the trigger. The BOPC determined that the negligent discharge was a serious incident that could not be mitigated.