

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

**NON-TACTICAL UNINTENTIONAL DISCHARGE – 022-21**

**Division**                      **Date**                      **Duty-On (X) Off ( )**   **Uniform-Yes (X) No ( )**

Pacific                      4/10/21

**Officer(s) Involved in Use of Force**      **Length of Service**

Officer A                      22 years, 8 months

**Reason for Police Contact**

Officer A was exiting a police vehicle when a Non-Tactical Unintentional Discharge (NTUD) occurred.

**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 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, including any Minority Opinions; the report and recommendations of the Chief of Police; and the report and recommendations of the Office of the Inspector General. The Department Command staff presented the matter to the BOPC and made itself available for any inquiries by the BOPC.

The following incident was adjudicated by the BOPC on February 1, 2022.

## **Incident Summary**

On April 10, 2021, at approximately 1200 hours, SWAT Police Officer A responded to a barricaded suspect incident in Pacific Division. Officer A was wearing a dark blue utility uniform with his/her Department-approved rifle carried in a two-point sling on his/her person and his/her Department-approved handgun on his/her belt. Officer A wore a tactical vest, gas mask, ballistic helmet and was equipped with a Body Worn Video (BWV). Officer A's BWV was not activated during the NTUD.

Officer A arrived at scene, was briefed, and received his/her assignment at the Command Post (CP). Officer A was assigned to a containment position, along with Police Officers B and C. Additionally, according to Officer A, he/she was tasked to drive an armed vehicle, the Ballistic Engineered Armored Response Counter Assault Tool (BEARCAT), to the containment position and deploy less-lethal munitions should the situation present itself.

Officer A stated that he/she never deployed his/her rifle during the incident and it remained slung in front of his/her body with the safety on. Officer A stated that from the time the rifle went from his/her trunk to the time that it was placed back in the BEARCAT, the safety mechanism was always on.

According to Officer A, at the conclusion of the incident, he/she deactivated his/her BWV and entered the BEARCAT to drive it back to the CP. Officer A entered the driver's side door, while Officers B and C entered the rear area of the BEARCAT. Officer A removed his/her rifle that was slung over the front of his/her body and placed it in between the driver's seat and center compartment area. The BEARCAT is not equipped with a rifle rack.

According to Officer A, the rifle was pointed in a safe direction, with the safety on and immediately accessible to him/her in case something happened. Officer A drove back to the CP and parked the BEARCAT along the west curbside.

According to Officer A, he/she stood up on the running board of the BEARCAT and retrieved his/her rifle. Officer A slung his/her rifle over his/her shoulder, with the rifle positioned in front of his/her body with the muzzle in a downward direction. Officer A reached across the driver's seat with his/her rifle slung in front of him/her and retrieved his/her helmet and gas mask. These items were just beyond the center console and he/she placed them on the driver's seat. Officer A stood on the running board and simultaneously placed his/her right hand on the top rail affixed to the exterior of the BEARCAT while placing his/her left hand on top of the driver's door. Officer A stated that he/she jumped backward off the running board, landed on the grass parkway, and felt the back of his/her tactical vest make contact with a metal cable coming out of the grass. According to Officer A, when he/she landed on the grass, a round discharged from his/her rifle.

Officer A stated his/her hands were not on the rifle when it discharged. According to Officer A, as he/she landed on the grass, his/her rifle went off and his/her hands were never near the rifle. When the rifle went off, Officer A at first did not realize what occurred. According to Officer A, after the rifle discharged, he/she observed his/her rifle was stuck on left side of his/her vest and the rifle was not hanging freely in front of him/her. According to Officer A, as he/she landed onto his/her feet, onto the grass, he/she realized that his/her rifle had kind of swung around more to the left-hand side of his/her vest. Additionally, Officer A stated that his/her rifle was pointing downward in a westerly direction with the butt stock of the rifle toward his/her left side.

Officer A did not recall if the safety was on or off after the rifle discharged. Officer A stated the safety is on the left side of the rifle, which rests against his/her vest. Officer A stated he/she could tell that the rifle was not hanging freely in front of him/her. The rifle looked like it was almost stuck towards the top portion of his/her vest. Officer A carefully removed the rifle and believed he/she would probably have swept the safety, just because it's a habit that he/she has, but he/she does not remember looking to see if the safety was on or off. Officer A stated that when he/she pulled the rifle from the vest, he/she could have put the safety back on, or it could have been that the safety was on the entire time. Officer A stated, "I don't know."

According to Officer A, he/she could not see the trigger guard, but could tell that it was stuck on the higher portion of his/her vest because it was higher than it normally was. After Officer A realized his/her rifle discharged, he/she observed there was a section of the grass where he/she could see into the dirt. Officer A also observed one shell casing between the curb line and the grass line by the BEARCAT driver's door.

Officer A stated that Officers B and C walked over to him/her, at which time he/she advised them his/her rifle discharged. Officer B walked to the target location and notified Sergeant A of the NTUD. According to Sergeant A, he/she was standing in front of the target location, prior to Officer B advising him/her of the NTUD, when he/she heard something loud but did not know what that sound was.

Sergeant A responded to Officer A's location at the BEARCAT. According to Sergeant A, Officer A advised him/her of the NTUD and observed Officer A's rifle lying inside the BEARCAT. Sergeant A verified the rifle was on safe and took possession of it. Sergeant A secured the rifle inside his/her police vehicle.

Sergeant A obtained a Public Safety Statement from Officer A and ordered him/her not to discuss the incident. In addition, Sergeant A identified Officers B and C as witnesses to the NTUD and ordered them not to discuss the incident. Sergeant A separated and began monitoring the officers at the scene until Force Investigation (FID) detectives arrived.

While at scene, during the NTUD with FID detectives, Officer A requested to conduct a walk-through and record a reenactment of his/her actions, leading up to the NTUD. The

reenactment was recorded via BWV to clarify Officer A's body position and movement just prior to the NTUD.

The reenactment videos depicted Officer A stand on the BEARCAT skid and sling his/her rifle over his/her shoulder. Officer A reached across the BEARCAT driver's seat with his/her rifle slung in front of his/her body. Officer A's rifle momentarily swept against the driver's seat while he/she retrieved his/her gear from the center console area. Officer A stood on the BEARCAT skid and jumped backward onto a grass parkway located next to the curbside. As Officer A landed on the grass, his/her rifle was pointed downward and appeared to be positioned to the left side of his/her body.

### **Witness Statements**

There were no officers or civilians who witnessed the NTUD. FID Detectives identified and interviewed two sworn "heard-only" witnesses. Officers B and C were near the BEARCAT and each heard one shot fired. According to Officer B, he/she just walked past the front passenger corner of the BEARCAT and heard a distinctive sound that sounded possibly like gunfire. Officer B turned around to see what occurred and observed Officer A walking in front of the driver's side grill without his/her rifle slung on his/her person. Officer A advised Officer B that he/she had an accidental discharge. Officer B located Sergeant A to advise him/her of the NTUD.

According to Officer C, as he/she exited the rear of the BEARCAT, he/she heard a single shot fired. Officer C looked around the corner of the BEARCAT and observed Officer A with his/her rifle slung across his/her chest, with the barrel pointed in a downward position. Officer C stated Officer A told him/her that he/she had a negligent discharge. Officer C observed a casing on the grass area just outside the BEARCAT driver's side door. Officers B and C's BWV's were deactivated after the Subject was taken into custody and did not capture the NTUD.

### **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. Accordingly, consistent with Department policy, the BOPC made a finding of Tactical Debrief for Officer A's tactics.

- During its review of this incident, The BOPC noted the following tactical considerations:
  - **Transportation of Firearms** – As rifle mounts were not an available accessory in 2007 when the vehicle was purchased, the BEARCAT driven by Officer A was not equipped with a rifle mount. Due to the vehicle not being equipped with a rifle rack, Officer A placed his/her loaded rifle between the BEARCAT's driver's seat and center console as he/she prepared to drive to the CP. According to Lieutenant A, Officer A was not required to remove the round from his/her rifle's chamber before securing the rifle between the BEARCAT's seat and center console. Per Lieutenant A, Officer A would remove the round prior to securing his/her rifle in his/her City-issued police vehicle's trunk. To enhance future performance, the BOPC directed this to be a topic of discussion during the Tactical Debrief.

#### **B. Drawing and Exhibiting**

- Does not apply

#### **C. Unintentional Discharge**

- **Officer A** – (rifle, one round)

**Background** – Officer A’s rifle was slung in front of his/her body/tactical vest. The muzzle of Officer A’s rifle was pointed down to the left, toward the grass parkway. The trajectory of the round traveled downward into the grass parkway.

Because the vehicle was not equipped with a rifle rack, Officer A placed his/her rifle between the driver’s seat and center console prior to driving the BEARCAT back to the CP. Officer A’s rifle was pointed towards the floorboard/engine compartment, with the selector switch set to safe, and was immediately accessible to him/her.

Arriving at the CP, Officer A parked the BEARCAT along the curb. Exiting the BEARCAT, Officer A stood up on the driver’s side running board, retrieved his/her rifle from between the driver’s seat and center console, and slung it in front of his/her body with the muzzle pointed in a downward direction. Based on his/her training, and because it was his/her “common practice,” Officer A believed that he/she “swept the safety up” as he/she “grabbed” his/her rifle from between the seat and center console. With his/her rifle slung in front of his/her body, Officer A reached across the driver’s seat, beyond the center console, retrieved his/her helmet and gas mask, and placed them on the driver’s seat. Officer A placed his/her right hand on the BEARCAT’s exterior top rail and his/her left hand on top of the driver’s door. Officer A then jumped backward off the running board, landing on his/her feet, on the elevated grass parkway; the back of his/her tactical vest contacting a metal utility pole guide wire.

According to Officer A, as he/she landed on the grass parkway, one round discharged from his/her rifle. According to Officer A, his/her hands were not on the rifle when it discharged. After it discharged, Officer A noticed that his/her rifle was not hanging freely in front of him/her but was “stuck” towards the “top portion” of his/her tactical vest, pointed downward, with the butt stock toward his/her left side. While Officer A did not recall “looking” at the selector switch following the NTUD, the safety was engaged when Officer A unslung his/her rifle. Officer A opined that as he/she unslung his/her rifle, he/she would have “swept” the safety, “just because it’s a habit.”

The BOPC conducted a thorough review in evaluating the circumstances and evidence related to the NTUD. The BOPC also considered Lieutenant A’s testimony as a SME.

The BOPC noted that during the tactical incident, BWV depicted Officer A applying upward pressure to his/her rifle’s selector switch, ensuring that the safety was engaged. The BOPC also noted that according to Officer A, prior to placing his/her rifle between the BEARCAT’s driver’s seat and center console, he/she verified that the rifle’s selector switch was set to safe. The BOPC further noted that while a rifle rack has subsequently been installed in the BEARCAT for the driver, Officer A’s decision to place his/her rifle between the seat and center console was consistent with SWAT’s practices and procedures at that time.

The BOPC noted that according to Lieutenant A, at its widest point, Officer A's rifle measured approximately 2.5 inches, while the gap between the BEARCAT's center console and driver's seat cushion measured three inches. Given the dimension of Officer A's rifle, in relation to the gap, combined with the results of the BWV demonstrations, the BOPC opined that Officer A's safety was inadvertently disengaged as he/she retrieved his/her rifle from between the driver's seat and center console. The BOPC noted that per Lieutenant A's testimony, at the time of the NTUD, SWAT personnel were unaware of the seat cushion's ability to accidentally disengage the rifle's safety as it had never been reported prior to this incident.

The BOPC noted that according to Officer A, when the NTUD occurred, his/her hands were not on the rifle or near the trigger guard. Based on the positioning of Officer A's equipment, combined with Lieutenant A's testimony, the BOPC opined that as Officer A jumped from the BEARCAT, one of the chemical sticks affixed to Officer A's tactical vest entered the trigger guard as the rifle rose and fell, contacting the trigger, discharging a round. However, as testified to by Lieutenant A, the BOPC noted that the positioning of Officer A's chemical sticks was not a deviation from past practices or training. While the BOPC believed that Officer A's jump from the BEARCAT created enough upward swing to raise the rifle's trigger above the chemical sticks affixed to his/her tactical vest, the BOPC noted Lieutenant A's testimony that Officer A's movement did not deviate from SWAT training. The BOPC further considered Lieutenant A's testimony that other than holding the rifle close to the chest with one hand, which is not taught nor required, there was no method to prevent the upward swing of the rifle.

The BOPC concluded that while Officer A's unintentional discharge was not the result of a mechanical malfunction of the firearm, it was also not the result of a violation of the Department's Basic Firearm Safety Rules. However, it is the responsibility of each officer to verify the condition of his/her firearm. As the facts indicate, Officer A's safety was most likely disengaged when he/she removed it from between the seat and center console. Although Officer A believed he/she "swept" the safety up, the facts indicate he/she did not verify that his/her rifle's safety was engaged. During the active stages of SWAT's response to this incident, Officer A repeatedly applied upward pressure to his/her rifle's selector switch, which demonstrated that Officer A knows the importance of verifying the condition of his/her firearm. Officer A's failure to verify the condition of his/her firearm after removing it from between the seat and center console was a significant factor in the unintentional discharge. Had Officer A verified that his/her safety was engaged, it is unlikely that the NTUD would have occurred.

Based on the totality of the circumstances the BOPC determined that the NTUD was the result of operator error, requiring a finding of Administrative Disapproval, Negligent Discharge.