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

NON-TACTICAL UNINTENTIONAL DISCHARGE – 061-21

Division	Date	Duty-On (X) Off ()	Uniform-Yes (X) No()
West LA	11/1/21		

Officer(s) Involved in Use of Force	Length of Service
Officer A	22 years, 7 months

Reason for Police Contact

Officer A was showing his/her partner, Officer B, the functionality of his/her personal shotgun prior to starting their watch together when a Non-Tactical Unintentional Discharge (NTUD) occurred.

Suspect(s)	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 (CUOF) 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 (FID) 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 (UOFRB) 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 September 27, 2022.

Incident Summary

On Monday, November 1, 2021, at approximately 1745 hours, Police Officer A and his/her partner, Police Officer B, attended roll call.

Prior to roll call, Officer A obtained his/her Department-authorized, privately purchased Benelli shotgun from his/her station locker.

Note: Officer A attended the appropriate shotgun training on October 24, 2012 and has been authorized to deploy the weapon system for the last 9 years.

According to Officer A, the day of the NTUD was the first time he/she and Officer B worked together.

At the conclusion of roll call, Officers A and B met at the kit room and obtained their equipment for the day, including the keys to their police vehicle. Officers A and B walked together to their vehicle, which was parked in the northwest corner of the West Los Angeles station parking lot.

According to Officer A, as he/she and Officer B loaded their equipment into the back of their vehicle, he/she learned that Officer B was in Phase Three (the final phase) of his/her probationary training.

During their pre-deployment discussion, Officer B advised Officer A that he/she was unfamiliar with the Benelli shotgun weapon system. According to Officer A, he/she wanted to familiarize Officer B with the shotgun in the event of a tactical situation where Officer A was unable to deploy the shotgun him/herself.

According to Officer A, he/she and Officer B were standing to the rear of their vehicle, facing east, approximately 4 to 5 feet away from each other as Officer A demonstrated the functionality of the Benelli shotgun.

Officer A later advised FID investigators that he/she was holding the shotgun with his/her right hand on the pistol grip and his/her left hand on the handguard as he/she demonstrated the functionality of the shotgun. During the demonstration, Officer A unintentionally discharged the shotgun.

Note: Officer B advised FID investigators that he/she was standing approximately 2 feet away from Officer A as he/she held the shotgun pointed upward at a 45-degree angle when the NTUD occurred.

Officer A advised FID investigators that he/she wanted Officer B to “be a part of this. And I kind of skipped what you call the -- like the BEEFS, what you have with the thing. So it's a process we go through. You check the chamber. You check the -- you do a function check to make everything works and all that. And I kind of I skipped that process and kind of wanting to show him how [he/she'd] be involved in a situation with the shotgun.”

Officer A advised FID investigators that at the end of each work shift, his/her normal practice is to completely unload his/her shotgun and remove all ammunition from the magazine well. Officer A then normally places the shotgun in a soft carrying case and stores it in his/her station locker until his/her next work shift. According to Officer A, “I think what might have happened was when I downloaded the weapon, there was a hull

left in the chamber, in the magazine well." Officer A advised that immediately prior to the NTUD, he/she had not handled any ammunition as he/she demonstrated the functionality of the Benelli shotgun.

After the shotgun discharged, Officer A immediately checked on Officer B and made sure he/she was not injured. Officer A verified there were no additional cartridges in the chamber and secured the shotgun in the back of the police vehicle.

After placing the shotgun in the back of the vehicle, Officer A used his/her cellular telephone and contacted the Watch Commander, Lieutenant A, and informed him/her that an accidental discharge occurred with his/her shotgun.

While Officer A made the telephonic notification to the Watch Commander, he/she and Officer B were approached by Officers C and D.

According to Officer D, he/she and Officer C were standing in the West Los Angeles station parking lot. He/she and Officer C were standing in the center parking stalls, approximately 25 feet away from Officers A and B. Officer D noticed Officer A conducting a safety inspection of a shotgun. Officer D recalled seeing Officer A with the shotgun stock resting against his/her thigh, with the barrel pointed at a 45-degree angle, moments before he/she heard the shotgun discharge.

> **Note:** Force Investigation Division detectives determined Officers C and D stood approximately 65 feet east of Officer A at the time of the NTUD.

BWV and DICVS Policy Compliance

- Not applicable

Los Angeles Board of Police Commissioners' Findings

The BOPC reviews each Categorical Use of Force (CUOF) 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

BOPC found Officer A's actions to warrant a finding of Tactical Debrief.

B. Unintentional Discharge

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

Basis for Findings

A. Tactics

Tactical De-Escalation

During the review of this incident, no Debriefing Points were noted.

Additional Tactical Debrief Topics

- **Shotgun Safety Check –** According to Officer A, he/she inspected the chamber and ensured no live ammunition was present; however, he/she did not conduct a six-point safety check. Additionally, according to Officers C and D, Officer A had the shotgun's buttstock on his/her thigh and was holding the muzzle at a low angle while showing it to Officer B.

Tactical Debrief

- Each tactical incident merits a comprehensive debriefing. In this case, there were identified areas where improvements could be made. A Tactical Debrief is the appropriate forum for involved personnel to discuss individual actions that took place during this incident.

  Therefore, Officer A was directed to attend a Tactical Debrief.

B. Unintentional Discharge

Officer A –12-gauge, semi-automatic shotgun, one round in an easterly direction.

According to Officer A, he/she and Officer B were standing at the rear of their police vehicle, facing east, approximately four to five feet away from each other as he/she demonstrated the shotgun's functionality. Officer A held the shotgun with his/her right hand on the pistol grip, his/her left hand on the handguard, and the barrel pointed up at a 45-degree angle toward a vacant parking lot to the east. Officer A inspected the chamber and ensured that no live ammunition was present. At approximately 1808 hours, as he/she went through the functions of the shotgun, Officer A racked the chamber, demonstrated how to disengage the safety, and pressed the trigger, resulting in the NTUD. According to Officer A, he/she did not handle any ammunition during the demonstration. Officer A opined that when he/she last downloaded the weapon, a shotgun cartridge was inadvertently left in the magazine tube.

The BOPC noted that the Chair of the UOFRB had evaluated the circumstances and evidence related to the NTUD. The Chair noted that according to Officer A, he/she inspected the chamber and ensured no live ammunition was present; however, he/she did not conduct a six-point safety check. The Chair also noted that Officer A opined that he/she had inadvertently left a live round in the magazine tube, which

was loaded into the chamber when he/she cycled the action. Officer A then disengaged the safety and pressed the trigger, resulting in the NTUD.

The Chair noted that Officer A did not verify the condition of his/her shotgun after he/she cycled the action, nor did he/she know the condition of his/her shotgun when he/she pulled the trigger. The Chair opined that had Officer A conducted a six-point safety check, he/she may have discovered the live round in the shotgun. Additionally, nothing indicated that the unintentional discharge was a result of a mechanical malfunction of the firearm.

In terms of Officer A's decision to press the trigger, the Chair understood why he/she demonstrated the shotgun's functionality to Officer B; however, the Chair noted that for this demonstration, pressing the trigger was unnecessary. Had Officer A omitted this portion of the demonstration, it is unlikely the NTUD would have occurred.

Based on the totality of the circumstances, the Chair of the UOFRB determined, and the BOPC concurred, that the NTUD was the result of operator error. Officer A's actions violated the Department's Basic Firearm Safety Rules, requiring a finding of Administrative Disapproval, Negligent Discharge.

Therefore, the BOPC found Officer A's unintentional discharge to be Negligent.