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

NON-TACTICAL UNINTENTIONAL DISCHARGE – 058-23

Division	Date	Duty-On (X) Off ( ) Uniform-Yes (X) No ( )
North Hollywood	10/9/23	

Officer(s) Involved in Use of Force	Length of Service
Officer A	8 years, 6 months

Brief Summary

Officer A was on duty at the Los Angeles Police Department (LAPD) North Hollywood Patrol Division. While preparing for the patrol shift Officer A inspected the patrol shotgun and attempted to prepare the shotgun for patrol use when a Non-Tactical Unintentional Discharge (NTUD) occurred.

Subject(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 (Chief); 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 17, 2024.

On October 9, 2023, at 1000 hours, Police Officers A and B were assigned to North Hollywood Patrol Division and attended roll call in the Watch Commander's office.

According to Officer B, an officer was not assigned to the kitroom, and after roll call, he/she obtained the kitroom key from the front desk. Officer B logged on to the Kitroom

Inventory Tracking System (KITS) to sign their equipment out. According to Officer A, Officer B selected a Remington 870 shotgun from the rack of available shotguns, scanned the barcode affixed to the shotgun, and handed the shotgun to him/her. Officer A stated that upon receiving the shotgun from Officer B, he/she did not conduct a chamber check; however, the action was open, and he/she ensured the safety was on. Additionally, he/she pressed on the "ejector" to ensure there were no rounds in the magazine. The officers then exited the kitroom with Officer A possessing the 870 shotgun. Officer B provided the kitroom key to another Watch 4 officer before exiting to the parking lot.

Officer A referred to the shell stop as the "ejector" throughout his interview. The ejector is a separate part of the 870 shotgun that is not utilized for releasing rounds from the tubular magazine during the unloading process.

Once in the parking lot, Officer A placed the 870 shotgun in the trunk of their assigned police vehicle. The officers then drove to the storage room at the rear of the station, where their equipment bags were stored. After fueling their vehicle, they drove to the station's underground parking lot, where they acquired additional items from their personal vehicles.

A review of Officer A's Body Worn Video (BWV) determined that after Officer A returned to the police vehicle, he/she placed his/her coffee in the passenger compartment before moving to the trunk of the vehicle. He/she then removed a butt cuff containing six rounds of shotgun ammunition from his/her medical bag, along with four loose shotgun rounds. As Officer A placed the butt cuff on the stock of the shotgun, a live round can be seen in the magazine tube of the shotgun. Additionally, the safety was on, and the action was open; however, the slide handle was not fully retracted.

After Officer A lifted the shotgun out of the trunk of the police vehicle, his/her specific manipulations occurred above the view of his/her camera; however, it was determined that the muzzle of the shotgun remained oriented toward the ceiling. Approximately eight seconds later, Officer A discharged a round into the ceiling of the parking lot.

According to Officer A, after removing the shotgun from the trunk of the police vehicle, he/she began his/her check of the shotgun, which he/she described as checking parts of the barrel, ensuring the safety was on, and opening the action.

A review of Officer A's BWV determined that when he/she retrieved the shotgun from the trunk of the vehicle, the action was already open, but the slide handle was not fully retracted.

Officer A added that after no rounds were released, he/she did a chamber check, placing his/her thumb in the chamber and ensuring it did not contain a round.

On Officer B's BWV, Officer A can briefly be seen manipulating the shotgun in a manner consistent with checking the chamber with his/her thumb and pressing on the shell stop;

however, the slide handle remained short of being fully retracted. If the slide handle is fully retracted with a round in the magazine, the first round from the magazine will be released onto the shell carrier or out of the shotgun, depending on the position of the shell carrier. All subsequent rounds can be released from the magazine tube by pressing on the shell stop located at the base of the magazine. This can only occur if the slide handle remains fully retracted. This is the process that occurs when unloading a shotgun from patrol ready, before returning it to the kitroom.

According to Officer A, he/she continued his/her inspection by closing the action halfway and checking the extractor for tension. He/she then opened the action again, ensuring the firing pin was present and the proper shape. Officer A closed the action and pressed the trigger with the safety engaged, ensuring the function of the safety. He/she then took the safety off and "racked the shotgun" [this caused the round formerly in the magazine to be released onto the shell carrier and cycled into the firing chamber].

Without conducting an additional chamber check, Officer A pressed the trigger and discharged the round into the ceiling, resulting in a Non-Tactical Unintentional Discharge (NTUD).

Officer A indicated that upon pressing the trigger, the shotgun recoiled out of his/her hands onto the floor. He/she observed that Officer B, who was positioned to the left of him/her, had a look of surprise. After ensuring they were not injured, Officer A observed that the pellets struck the concrete ceiling above him/her, creating a shallow impact.

Officer A added that after the discharge, he/she felt "debris or multiple objects" hit his/her uniform; however, he/she did not see any pellets on the floor. Approximately 16 seconds after the discharge, Officers B and A activated their BWV cameras. Officer A stated he/she believed doing so may be beneficial to the investigation.

The NTUD occurred at 10:23:13 hours. A review of BWV determined that immediately after the discharge, Officer A picked the shotgun up from the floor and ejected the spent hull from the firing chamber. He/she then placed the shotgun in the back of their police vehicle.

According to Officer A, he/she initially searched for his/her phone to notify the watch commander telephonically but believed he/she might not have cell reception.

Approximately one minute and 14 seconds after the NTUD, Officer A requested a supervisor to respond to the underground parking area over North Hollywood Base frequency. Sergeant A arrived at 1025:50 hours, approximately two and half minutes after the NTUD. At that point, the officers shut off their BWV, and Sergeant A separated them and obtained a Public Safety Statement (PSS) from Officer A.

Officer B's account of the NTUD

According to Officer B, while Officer A was handling the 870 shotgun, he/she was

focused on inspecting and loading their beanbag shotgun to patrol ready. As Officer B placed the beanbag shotgun in the trunk of their vehicle the NTUD occurred.

Police Officers C and D had previously checked out the shotgun possessed by Officer A for their shift, which started on October 8, 2023, at 1830 hours. According to Officer C, at the start of their shift, he/she checked the shotgun and ensured it functioned properly before loading it to patrol ready. At the end of his/her shift on October 9, 2023, at 0630 hours, Officer C believed he/she downloaded all four rounds from the magazine tube by opening the action [retracting the slide handle] and "clicking the ejector" [pushing on the magazine's shell stop] until all the rounds came out.

Officer C also referred to the shell stop as the "ejector" in his/her interview.

When Officer C conducted the unloading process, a single round remained in the magazine tube. Officer C stated he/she became aware of this after learning of Officer A's NTUD and that he/she and Officer D were the last officers assigned the 870 shotgun. According to Officer C, he/she typically carried ten rounds of Department-issued shotgun ammunition. Six of the rounds were held in a butt cuff (which he/she placed on the stock of the shotgun as spare ammunition), and the other four rounds were used to load the shotgun to patrol ready. When Officer C inspected his/her equipment bag, he/she realized he/she only had nine of his/her ten shotgun rounds and that one was unaccounted for.

According to Officer C, at the end of his/her shift, the kitroom was open, and Watch 2 officers were acquiring their equipment. A kitroom officer was not assigned, so he/she and the other Watch 3 officers placed their equipment on the metal kitroom table [counter] to be checked in by whoever assumed the role. When Officer C returned the shotgun to the kitroom, the action was open [slide handle retracted], and the safety was on. Officer C could not recall which Watch 2 officers were present and described it as a "group effort" to organize the equipment. Officer D stated that when a kitroom officer is not present at the end of a shift, equipment is just placed inside the kitroom and is generally checked in and out by a probationary police officer.

FID detectives reviewed all documents and circumstances surrounding the separation, monitoring, and the admonition not to discuss the incident prior to their interviews.

Los Angeles Board of Police Commissioners' Findings

The BOPC reviews each 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 incident, 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. Non-Tactical Unintentional Discharge (NTUD)

The BOPC found Officer A's NTUD to warrant a finding of Administrative Disapproval, Negligent Discharge.

Basis for Findings

A. Tactics

- Officer A was not engaged in a tactical operation in this incident; therefore, his/her tactics were not evaluated. However, as Department guidelines require personnel who are substantially involved in a Categorical Use of Force incident to attend a Tactical Debrief, the Chief determined that it would be appropriate to recommend a Tactics finding of Tactical Debrief.

  Tactical De-Escalation

  Officer A was not engaged in a tactical operation; therefore, Officer A was not evaluated for tactical de-escalation.

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

Additional Tactical Debrief Topics

- **Shotgun Safety Check –** The investigation revealed Officer A failed to perform a proper seven-point safety check of the shotgun. During Officer A's inspection of the weapon, he/she failed to identify a live round in the magazine tube when the action was open. Additionally, Officer A failed to fully retract the slide handle of the shotgun, which prevented the round from ejecting from the magazine tube when the action was open. Furthermore, Officer A failed to perform a chamber check after disengaging the safety and prior to pressing the trigger, resulting in the NTUD. To enhance future performance, the Chief directed this be a topic of discussion during the Tactical Debrief.

- **Preservation of Evidence –** After the NTUD occurred, Officer A retrieved the shotgun from the ground. Officer A opened the action of the shotgun, ejecting the spent shell hull from the firing chamber onto the ground before he/she placed the shotgun in the trunk of the police vehicle. For the purpose of maintaining the

integrity of evidence following a critical incident, the Chief would have preferred Officer A leave the shotgun on the ground. To enhance future performance, the Chief directed this be a topic of discussion during the Tactical Debrief.

Command and Control

- Sergeant A responded to Officer A's supervisor request at approximately 1025 hours. After determining an NTUD had occurred and checking on the status of Officers A and B, Sergeant A assumed the role of Incident Commander (IC) and immediately separated both officers. Sergeant A checked the surrounding area to ensure no one was injured. Sergeant A obtained the PSS from Officer A while Officer B set-up crime scene tape to cordon off the area.

  Sergeant A contacted Sergeant B, the North Hollywood Patrol Division Watch Commander, and notified him/her of the NTUD. At approximately 1055 hours, Sergeant B contacted the Department Operations Center and notified them of the incident.

  While Sergeant A obtained the PSS from Officer A, Detective A, North Hollywood Area, arrived and assumed monitoring responsibilities of Officer B. Subsequently, Detective B, North Hollywood Area, relieved Detective A and assumed responsibility for monitoring Officer B. Detective B and Sergeant A monitored their respective personnel until FID investigators arrived and assumed investigative responsibility.

  The overall actions of Detectives A and B, as well as Sergeants A and B, were consistent with Department supervisory training and the Chief's expectations of field supervisors during a critical incident.

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, the Chief directed Officer A to attend a Tactical Debrief and that the specific identified topics be discussed.

General Training Update (GTU)

- On May 20, 2024, Officer A attended a GTU. All mandatory topics were covered, including the Basic Firearm Safety Rules.

Unintentional Discharge

- **Scene Description –** The NTUD occurred in the North Hollywood Area underground

parking structure at approximately 1023 hours. At the time of the NTUD, the underground parking structure, including the immediate area of the incident, was illuminated by artificial lighting.

- **Officer A –** shotgun; one round in an upward direction.

  According to Officer A, he/she believed the shotgun was unloaded after pressing the shell stop several times and not recovering any ammunition. As Officer A conducted the safety check of the shotgun, he/she closed the action of the weapon, disengaged the safety and racked the slide handle. Officer A pressed the trigger without conducting a chamber check, which resulted in one round being discharged from the shotgun.

  At the time of the NTUD, Officer A was facing the open trunk of his/her assigned police vehicle in an easterly direction while holding the shotgun with the muzzle pointed toward the ceiling of the parking structure.

  On October 10, 2023, an LAPD armorer completed a Weapon Discharge Inspection Report documenting the inspection of the shotgun. The shotgun was found to be in good working order with an operable magazine tube spring. The armorer noted that with the action slightly closed, the shotgun would not release the round from the magazine tube. The armorer noted this is the normal function of the shotgun's mechanical design.

  The investigation revealed Officer A discharged a single shotgun round containing nine pellets, all of which traveled in an upward trajectory, resulting in a one inch by one-and-a-half-inch impact on the overhead concrete ceiling. The pellets deflected into a concrete support beam immediately adjacent to the impact. An expended 12-gauge shotshell, five pellet fragments, and a shotshell wad were recovered from the floor of the underground parking structure in the area surrounding the NTUD.

  The Chair of the UOFRB evaluated the circumstances and the evidence related to the NTUD. The Chair noted that according to Officer A, he/she believed the magazine tube was empty of ammunition after he/she pressed on the shell stop several times after he/she acquired the shotgun. However, Officer A failed to adequately verify the condition of the shotgun, performed the seven-point safety check out of sequence and failed to perform a chamber check during a check of the shotgun's safety mechanism.

  The Chair noted during Officer A's initial verification of the condition of the shotgun, he/she failed to identify the round in the magazine tube. Furthermore, Officer A failed to fully retract the slide handle to the rear of the weapon, which prevented the round from ejecting from the magazine tube when he/she pressed on the shell stop.

  Officer A performed the seven-point safety check out of sequence by closing the action, taking the safety off and racking the shotgun before pressing the trigger.

Additionally, Officer A failed perform a chamber check while in the process of inspecting the weapon's safety mechanism and trigger, which resulted in the NTUD. The Chair also noted there was no indication the NTUD was a result of a mechanical malfunction of the shotgun.

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