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

NON-TACTICAL UNINTENTIONAL DISCHARGE – 070-23

Division	Date	Duty-On (X) Off ( ) Uniform-Yes (X) No ( )
Topanga	12/5/23	

Officer(s) Involved in Use of Force	Length of Service
Sergeant A	15 years, 3 months

Brief Summary

Topanga Area Sergeant A was attempting to place a firearm in the slide lock position after assembling the red dot optic and a Non-Tactical Unintentional Discharge 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 November 19, 2024.

Sergeant A advised his/her start of watch on December 5, 2023, was 1200 hours. He/she arrived at work at approximately 1045 hours and intended to mount his/her red dot optic on his/her Glock 17 to prepare for firearm training on December 7, 2023. He/she advised that his/her pistol was unloaded and locked in his/her desk drawer when he came to work that day. His/her intention was to mount the optic and then carry his/her other pistol which he/she was issued in the academy during his/her regular work shift until he/she attended red dot school.

According to Sergeant A, he/she was seated at the head of the table located in the middle of the office with the red tablecloth and mounted the optic to his/her pistol. He/she advised this took approximately 20 minutes.

Once the optic was fastened to his/her pistol, his/her intention was to place the pistol in the slide lock position. Sergeant A stated that somewhere during this process he/she must have inadvertently inserted a loaded magazine into his/her pistol. He/she stood up and grabbed the slide with an overhand grip with his/her left hand and his/her right hand on the grip of the pistol. Sergeant A advised that his/her finger was along the frame.

Sergeant A noticed that his/her left hand was now on his/her optic and he/she did not want to break it because it was very expensive. He/she moved his/her left hand down the slide toward the middle of the pistol. He/she attempted to lock the slide to the rear but was having difficulty. He/she racked the slide numerous times to the rear but was unable to get the gun into the slide lock position. He/she believed that this is when a round was unknowingly inserted into the chamber. He/she brought the pistol closer to his/her body near his/her upper chest to gain leverage as he/she continued to try and lock the slide to the rear. He/she advised that his/her finger must have moved from the frame to the trigger and a round was fired.

After the round was fired, Sergeant A realized that a magazine was in the pistol and ejected the magazine. He/she grabbed the pistol with an overhand grip on the optic and removed the round from the chamber. Sergeant A placed the magazine and the round from the chamber on the table along with his/her pistol.

After Sergeant A placed his/her pistol on the table he/she exited the office to make sure no one was injured. He/she opened the door and did not observe anyone in the hallway. He/she listened for a second and did not hear anyone in distress.

At that time, Topanga Officers A and B entered the hallway.

According to Sergeant A, he/she told Officer A "that was me." After verifying that no one was injured, he/she advised Officer A that he/she was going to go tell the Watch Commander what occurred.

Sergeant A immediately walked to Topanga Patrol Division Lieutenant A's office and reported the incident. Lieutenant A advised Topanga Area Commanding Officer Captain A and Topanga Patrol Division Captain B of the NTUD (Non-Tactical Unintentional Discharge). All of them walked to the office and Sergeant A was monitored by a supervisor until his/her interview.

Topanga Patrol Division Sergeant B conducted a Public Safety Statement with Sergeant A. Captain A notified the Department Command Post of the NTUD. Force Investigation Division was notified of the NTUD.

Force Investigation Division investigators responded to the scene. A Technical Investigation Division (TID) Photographer responded and photographed the scene, evidence collected, and Sergeant A.

Force Investigation Division Detectives conducted a thorough crime scene investigation and determined the round fired by Sergeant A traveled east and struck the refrigerator located along the east wall. That round penetrated the door and came to rest near the back of the refrigerator. The round was recovered by FID detectives from the area near the back of the refrigerator. There were no injuries as a result of the NTUD.

The casing was located on Sergeant A's desk between the optic case and the black bag.

FID assisted with the post firearm discharge examination, took possession of Sergeant A's pistol and it was transported to the Firearms Analysis Unit, where it was tested. The pistol was fully functional, and the trigger pull was within Department specifications.

During a magazine count, it was determined that Sergeant A's pistol was loaded with 15 live rounds in the magazine and there was one live round, which he/she removed from the chamber after the NTUD.

Force Investigation Detectives identified and interviewed two sworn witnesses, Officer A and Detective A.

Detective A advised he/she did not hear a gunshot but did have an interaction with Sergeant A in the hallway near the narcotics and vice offices.

Detective A advised that he/she was unaware that a negligent discharge occurred until minutes later when officers came to his/her office to make sure he/she was alright. At that time, he/she was told a negligent discharge occurred in the vice office and saw that the office had been sealed off.

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 Sergeant A's tactics to warrant a Tactical Debrief.

B. Drawing and Exhibiting

Does Not Apply.

C. Non-Tactical Unintentional Discharge (NTUD)

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

Basis for Findings

A. Tactics

- Sergeant A was not engaged in a tactical operation in this incident; therefore, his/her tactics were not reviewed or evaluated. However, Department guidelines require personnel substantially involved in a Categorical Use of Force (CUOF) incident attend a Tactical Debrief. The Chief determined that it would be appropriate to recommend a Tactics finding of Tactical Debrief.

Additional Tactical Debrief Topics

- **Preservation of Evidence –** After the NTUD, Sergeant A unloaded the pistol, removing the magazine from the well and the live round from the firing chamber. The Chief would have preferred Sergeant A had not unloaded the pistol after the NTUD. To enhance future performance, the Chief directed this be a topic of discussion during the tactical debrief.

Tactical De-Escalation

- Sergeant A was at the station prior to his/her start of watch and was not engaged in a tactical operation; therefore, he/she was not evaluated for tactical de-escalation.

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

Command and Control

- Lieutenant A was the Watch Commander when he/she was approached by Sergeant A who informed him/her an NTUD had occurred inside of the Vice office. Lieutenant A notified Topanga Area Commanding Officer Captain A and Topanga Patrol Division Commanding Officer Captain B of the NTUD. Captains A and B walked with Sergeant A and conducted a safety check to ensure there were no injured persons or witnesses before securing the Vice office. Topanga Patrol Division

Sergeant B was assigned monitoring duties and obtained a Public Safety Statement (PSS) from Sergeant A. At 1200 hours, Captain A notified the Department Operations Center (DOC) of the NTUD.

The overall actions of Captains A and B, Lieutenant A and Sergeant B were consistent with Department supervisory training and met the Chief's expectations of Department 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 Sergeant A to attend a Tactical Debrief and the specific identified topics be discussed.

General Training Update (GTU)

- On December 12, 2023, Sergeant A attended a GTU. All mandatory topics were covered, including the Basic Firearm Safety Rules.

B. Drawing and Exhibiting

- Does Not Apply.

C. Unintentional Discharge

- **Sergeant A –** 9mm, one round fired in an easterly direction and struck the refrigerator located along the east wall. The round penetrated the door and came to rest near the back of the refrigerator.

  The Chair of the UOFRB (Use of Force Review Board) evaluated the circumstances and the evidence related to the NTUD. The Chair noted Sergeant A stated he/she had inadvertently inserted a loaded magazine into his/her service pistol and, while attempting to lock the slide to the rear, placed his/her index finger on the trigger, inadvertently pressing it, causing the NTUD. The Chair also noted there was no indication the NTUD was a result of a mechanical malfunction of the service pistol. As such, the Chair opined the NTUD was a result of operator error and Sergeant A's actions violated the Department's Basic Firearm Safety Rules.

  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 and Sergeant A's actions violated the Department's Basic Firearm Safety Rules, thus requiring a finding of Administrative Disapproval, Negligent Discharge.