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

NON-TACTICAL UNINTENTIONAL DISCHARGE – 072-23

Division	Date	Duty-On (X) Off ( ) Uniform-Yes (X) No ( )
Foothill	12/17/23	

Officer(s) Involved in Use of Force	Length of Service
Officer A	6 years, 2 months

Brief Summary

A uniformed police officer was in the Foothill Division parking structure. As the officer loaded his equipment bag into the rear of a police vehicle, an 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 December 10, 2024.

On Sunday, December 17, 2023, at approximately 1845 hours, Foothill Patrol Division uniformed Police Officers A and B began their patrol shift within Foothill Division. Officer A carried his/her fully loaded Department-approved polymer, .45 caliber Smith and Wesson, Model M&P pistol, in a gun case when he arrived at the Foothill Division locker room.

Officer A changed into his/her police uniform, put on his/her Sam Browne equipment belt, and placed his/her pistol into his/her Safariland triple retention duty holster on the left side of his/her belt. According to Officer A, the gun was seated in the holster, and the holster's hood was engaged, which would provide greater protection against an attempted firearm takeaway.

At 1845 hours, Officer A attended Watch-Three roll-call training. After roll-call training, Officers A and B responded to the kitroom. They checked out equipment, including the keys to a marked black and white police Sport Utility Vehicle equipped with ballistic door panels, and a Digital In-Car Video System (DICVS).

Officers A and B located their assigned police vehicle in the Foothill Division parking structure. Officer B entered the vehicle's driver door while Officer A sat in the front passenger seat. Officer B drove the vehicle to the ground level to the equipment locker area. Officer B exited the vehicle, retrieved his/her equipment bag, and placed it in the rear cargo area of the police vehicle.

Officer B then re-entered the vehicle, drove to the fourth level of the parking structure, and parked adjacent to Officer A's vehicle. Officer B remained in the vehicle while Officer A exited, leaving the front passenger door open. He/she walked to the rear of the police vehicle, opened the rear cargo area, and turned on the interior light. Officer A then responded to his/her personally owned vehicle and retrieved his/her ballistic helmet, side-handle baton, and equipment bag.

Officer A carried his/her equipment bag by placing the long shoulder strap of the bag on his/her left shoulder. He/she held his/her ballistic helmet in his/her left hand and his/her side-handle baton in his/her right hand. Subsequently, he/she responded to the rear cargo area of his/her police vehicle, stood behind it, and faced the open cargo compartment. Officer A placed his/her side-handle baton and ballistic helmet into the rear cargo area while maintaining his/her equipment bag on his/her left shoulder. While behind the rear cargo area of his/her police vehicle, Officer A placed both hands on the shoulder strap and swung the bag away from his/her body and into the rear cargo area. Simultaneously, he/she felt a tug on the left side of his/her duty belt and heard the discharge of a firearm. Officer A felt the muzzle blast on his/her left thigh and experienced ringing in his/her ears. Officer A looked toward his/her holster and observed that his/her pistol was adequately seated, and the hood was engaged correctly. He/she then raised his/her arms, visually inspected himself, and verified that he/she had no injuries.

During his/her interview with FID investigators, Officer A indicated that one of the two shorter hand straps on his/her equipment bag may have been entangled with his/her pistol. When the NTUD occurred, Officer A looked toward his/her holster and did not see the straps entangled with his/her pistol. Officer A informed investigators that, while performing the same maneuver in the past, the bag straps had become entangled with his/her pistol.

After hearing a loud bang, Officer B exited the vehicle and responded to the rear cargo area. Officer A advised Officer B that his/her gun had discharged in his/her holster. Officer A then walked to the vehicle's front passenger seat while Officer B remained behind the rear cargo area.

Officer A was standing just outside the front passenger door, facing the open door, when he/she unholstered his/her service pistol with his/her left hand. He/she held his/her pistol in a one-hand low-ready position, with his/her left index finger on the slide and the muzzle pointed toward the front passenger seat of the police vehicle. Officer A stated he/she observed no visible malfunctions or defects on his/her pistol and noted the slide of the pistol was forward.

Officer A then removed the magazine from the pistol and placed it on the front passenger seat of his/her vehicle. He/she utilized his/her right hand to pull the pistol's slide to the rear, which caused the discharged cartridge casing (DCC) from the chamber to be ejected into his/her right hand. He/she then released the slide of the pistol and placed it and the DCC on the front passenger seat.

During his/her interview with FID investigators, Officer A stated he/she unholstered his/her pistol to identify the malfunction/defect. He/she proceeded to unload the pistol believing the weapon could discharge again.

Officer A then returned to the rear of the police vehicle and observed an impact, bullet fragments, and pieces of plastic on the cement. Officer A examined him/herself again for injuries and then notified Foothill Patrol Division uniformed Watch Commander (WC) Sergeant A via cellphone. Officer A did not sustain any injuries during this incident.

The investigation determined that the discharged bullet struck the cement parking structure roadway. The distance from Officer A's stated position at the time of the NTUD to the impact measured approximately 1 foot, 8 inches. The distance from Officer A's stated position at the time of the NTUD to the vehicle's rear bumper measured approximately 1 foot, 10 inches. Due to the rearward cant of Officer A's holster, the location of the impact in relation to Officer A's stated position was consistent with the direction of his/her barrel.

Force Investigation Division investigators asked Officer A if he/she had inspected his/her holster after the NTUD. Officer A indicated he/she observed pieces of plastic missing from the bottom portion of the holster, and the seams of the holster were wider. According to Officer A, the damage to the holster was a result of his/her pistol firing.

During his/her interview with FID investigators, Officer B stated he/she parked next to Officer A's vehicle so he/she could retrieve his/her equipment bag. Officer A then exited the police vehicle. While seated in the driver seat, he/she heard a loud bang, which he/she initially thought was a beanbag shotgun. Officer B promptly disembarked from the vehicle and responded to the cargo area. He/she approached Officer A and observed that his/her pistol was in his/her holster.

At approximately 1922 hours, Sergeant A was notified of the NTUD and commanded that Foothill Patrol Division uniformed Sergeant B respond to the station. Sergeant B was briefed by Sergeant A about the NTUD and instructed to respond to the parking structure. Sergeant B met Officers A and B in the parking structure and confirmed that no one was injured.

Foothill Patrol Division uniformed Sergeant C also responded to the scene. Sergeant B directed him/her to monitor Officer B. Sergeant B directed Officer A to the rear of his/her police vehicle and obtained a Public Safety Statement (PSS).

Sergeant A broadcast the incident over the Foothill Division radio frequency, responded to the scene, and assumed the role of Incident Commander (IC). After verifying that no one was injured, he/she returned to the WC's office to make notifications.

Force Investigation Division Detectives reviewed all documents and circumstances surrounding the separation, monitoring, and admonition not to discuss the incident prior to being interviewed by FID investigators.

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 Approval, Accidental Discharge.

Basis for Findings

A. Tactics

Officer 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 it would be appropriate to recommend a Tactics finding of Tactical Debrief.

Tactical De-Escalation

Officer A was in the station parking structure prior to beginning his/her shift 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; however, the following Additional Tactical Debrief Topic was identified.

Additional Tactical Debrief Topics

- **Preservation of Evidence –** After the NTUD, Officer A removed the magazine from the well and a spent casing from the firing chamber as he/she locked the slide to the rear. The Chief would have preferred Officer A had not unloaded the pistol after the NTUD. To enhance future performance, the Chief directed this to be a topic of discussion during the tactical debrief.

Command and Control

- Sergeant A was the Watch Commander when he/she was contacted by Officer A, who informed him an NTUD occurred. Sergeant A directed Sergeant B to respond to the scene. Sergeant B ensured there were no injuries and obtained a PSS from Officer A before securing the scene and monitoring Officer A.

  The overall actions of Sergeants A and B were consistent with Department supervisory training and met the Chief's expectations of a department supervisor 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 the specific identified topics be discussed.

General Training Update (GTU)

- On December 26, 2023, Officer 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

- **Officer A –** .45 caliber, one round discharged in a downward direction striking the cement parking structure roadway. The round struck the ground and fragmented.

  According to Officer A, while attempting to move his/her equipment bag from his/her shoulder into the rear cargo area of his/her police vehicle, he/she swung the bag from his/her body, felt a tug on his/her duty belt and heard the discharge of his/her firearm.

  FID Detectives conducted a post-incident examination of Officer A's service pistol. Detectives determined the pistol was unloaded and did not have a magazine inserted. The magazine recovered from the front passenger seat of the police vehicle, as well as the two additional magazines carried in Officer A's magazine pouch on his/her duty belt, were each loaded to capacity with ten rounds of Department authorized ammunition.

  On January 9, 2024, Officer A responded to Forensic Science Division (FSD) to perform a re-enactment of the events he/she described during the NTUD utilizing a Safariland 7360 holster and Officer A's equipment bag. Forensic Science Division, Firearm Analysis Unit (FAU), Supervising Criminalists A, B and C facilitated the re-enactment. During this and subsequent testing, Criminalist C determined Officer A's pistol could be fired while holstered. The trigger is covered by the holster walls, but there is a space between the pistol and the holster wall when the pistol is in the holster. While it cannot be accessed by a finger, a small space exists where a string or cord can fit in. Under the right conditions, the trigger can be snagged and pulled by a string or cord. This was verified by Criminalist C who was able to insert a tassel attached to Officer A's equipment bag into the space resulting in the pistol firing on two occasions while holstered and snapped into place. The investigation and subsequent laboratory testing determined the evidence was consistent with the pistol firing while holstered when a tassel from Officer A's bag snagged and pulled the trigger while he/she was hoisting his/her equipment bag into the cargo area of his/her police vehicle.

  On October 11, 2024, Criminalist C conducted a re-enactment of the events described during the NTUD and an analysis using the Safariland Model 6360 holster. The Safariland Model 6360 holster is leather/synthetic leather wrapped, rather than finished in, with the hard plastic exterior of the Safariland Model 7360. Criminalist C was not able to duplicate the event described in the NTUD; however, he/she did document the space between the trigger guard of Officer A's handgun and the sidewall of the holster appeared larger in the Department-approved

Safariland Model 6360 holster than it was in the Safariland 7360 holster used by Officer A.

The Chair of the UOFRB evaluated the circumstances and the evidence related to the NTUD. The Chair noted Officer A did not violate any one of the firearm safety rules. The Chair further noted Officer A carried an unauthorized holster and considered the FSD analysis of the unauthorized holster as compared the authorized version which showed the spacing between the trigger guard of a holstered handgun and the sidewall of the holster was larger in the authorized holster than the unauthorized one. The Chair further noted this issue of spacing had previously been addressed in a prior Department Notice and as such, the holster Officer A was carrying, while not approved, was not a contributing factor in the NTUD. The Chair found the incident occurred not as a result of a firearm safety violation but rather due to an extraordinary set of circumstances. As such, the Chair opined the unintentional discharge of the firearm resulted from an accident, not the result of operator error.

Based on the totality of the circumstances, the Chair of the UOFRB determined, and the Chief and the BOPC concurred, the NTUD resulted from an accident, not the result of operator error, thus requiring a finding of Administrative Approval, Accidental Discharge.