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

NON-TACTICAL UNINTENTIONAL DISCHARGE – 025-24

Division	Date	Duty-On (X) Off ()	Uniform-Yes (X) No ()
Wilshire	5/10/24		

Officer(s) Involved in Use of Force	Length of Service
Officer A	1 year, 4 months

Reason for Police Contact

On May 10, 2024, Officer A responded to a burglar alarm call with his/her partner. On approach to the business, Officer A deployed the shotgun. After clearing the business, Officer A went back to the police vehicle to download the shotgun. As Officer A attempted to remove the shotgun, which was slung on his/her back, one round was discharged, resulting in a Non-Tactical Unintentional Discharge (NTUD).

Subject	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 (LAPD or Department) or the deliberations by the Board of Police Commissioners (BOPC or Commission). 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 recommendations, including any Miniority Opinions; the report and recommendations of the Chief of Police; and the report and recommendations 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 April 15, 2025.

Incident Summary

On Friday, May 10, 2024, at 0615 hours, Officers A and B were assigned to Watch 2. The officers attended roll call at Wilshire Station. Upon completion of roll call, the officers responded to the kit room, where they checked out a Remington 870 shotgun, which was pre-equipped with a sling.

> **Note**: According to Officer A, as a probationary officer, he/she was primarily responsible for loading and unloading the shotgun at the beginning and end of his/her shift and had conducted this procedure approximately 90 times at this point of his/her probationary period.

According to Officer A, after he/she obtained the shotgun, he/she conducted an inspection and placed a butt cuff, equipped with six additional rounds of live shotgun ammunition, on the left side of the shotgun's wood stock. Upon verifying there were no signs of malfunction, deformity, or other abnormality, Officer A loaded the shotgun to "patrol ready" before he/she locked and secured it in the vehicle's shotgun rack.

> **Note**: Officer B was present while Officer A conducted the inspection of the shotgun. According to Officer B, Officer A appeared to be comfortable when manipulating the shotgun and there was no indication he/she had issues with his/her handling of it.

According to Officer B, he/she regularly discussed tactics and roles with Officer A prior to any of their radio calls. On the day of the incident, Officer B assigned Officer A as the contact officer on all their radio calls. Officer B assumed the cover officer position and was responsible for radio communications.

Officers A and B responded to a radio call for an alarm and arrived at the call at 1332 hours.

> **Note**: According to Officer B, he/she forgot to place Officer A and him/her Code Six when they arrived. The investigation determined the officers updated their Code Six location at 1401 hours, approximately 28 minutes after arriving.

As the officers drove into the east-west alley to the rear, they observed an open door on the 2nd floor of the location. Officer A ultimately parked the police vehicle behind the building. According to Officer B, due to the nature of the radio call and the open door, he/she directed Officer A to deploy the shotgun.

> **Note**: According to Officer A, this was the first time he/she had deployed the shotgun in a field situation as a probationary officer.

After deploying the shotgun, Officer A's BWV showed him/her walking east in the alley toward the rear of the location with the shotgun in his/her left hand. While holding the shotgun by the receiver, Officer A can be observed momentarily placing his/her left ring

finger in the trigger guard just above the trigger. During this time, the shotgun's safety was engaged.

Officers A and B entered the rear parking lot of the location. According to Officer B, Officer A was carrying the shotgun with a one-handed grip, grasped around the barrel of the shotgun. Officer B stated he/she did not like the way Officer A was holding the shotgun (with only one hand), so he/she took it from him/her and demonstrated a two-handed, port arms position. Officer B then handed the shotgun back to Officer A who then slung it over his/her left shoulder.

The officers observed three vehicles in the parking lot. Officer A slung the shotgun over his/her left shoulder before both officers unholstered their pistols and proceeded to check the vehicles to determine if they were occupied with possible burglary suspects based on the nature of the radio call. After completing a search of one of the vehicles, Officer A holstered his/her duty pistol.

As Officer B checked the final vehicle in the lot, he/she directed Officer A to cover the open door at the top of the stairs. Officer A unholstered his/her pistol a second time and pointed it in the direction of the open door.

> **Note**: Officer B explained their plan was to walk to the top of the stairs and obtain a better line of sight to determine if they could hear any activity inside. Officer B felt this was a better tactical position, rather than waiting at the bottom of the stairs and calling out anyone inside. If it was determined a building search was necessary, they would hold their positions and request an additional unit to respond.

While Officers A and B stood at the base of the stairs that led to a second-floor landing with a single open door, Officer A holstered his/her pistol. At this point, Officer B can be heard on BWV telling Officer A to come out with the shotgun.

Officer A then removed the shotgun he/she had slung on his/her left shoulder and took a left-handed grip on the shotgun before holding it at a low-ready position.

According to Officer A, he/she immediately re-engaged the safety and transitioned the shotgun to a port arms position. He/she in turn, manipulated the slide handle of the shotgun, resulting in a live round being fed into the chamber. Officer A then transitioned back to a low ready position and began ascending the stairs once again. Body Worn Video depicted the safety was engaged after Officer A chambered the round.

> **Note**: During his/her interview with FID, Officer A stated after he/she loaded one live round into the chamber, he/she did not "top off" the magazine by adding an additional round from his/her butt cuff because he/she was already at the door. Additionally, Officer A mistakenly believed proper procedure was to disengage the safety when he/she had the shotgun at a low ready position.

According to Officer A, he/she believed he/she disengaged the safety before chambering a round and left the safety in this condition for the duration of the radio call. When asked why he/she disengaged the safety, Officer A told investigators he/she did so because they were at the front door, and he/she wasn't sure what they "were going to walk into."

Officer A continued walking to the top of the stairs with the shotgun at the low ready and announced their presence. An employee who was inside the building, walked to the foyer and spoke to the officers. Officer B did not observe the employee to be armed with any weapons and heard what he/she believed to be regular business taking place inside the location. Officer B holstered his/her pistol and directed Officer A to sling the shotgun.

The investigation determined the safety was engaged as Officer A made his/her announcements at the 2nd floor landing and just before he/she slung the shotgun on his/her left shoulder and entered the business.

After speaking with the occupants inside the building, Officers A and B determined no crime had been committed. Upon completion of their investigation, Officers A and B walked back to their police vehicle.

As the officers approached their police vehicle, Officer A walked to the driver side and opened the door while Officer B walked to the passenger side. According to Officer A, as he/she moved the shotgun around to the front of his/her body the shotgun sling got stuck on his/her holstered handheld radio. As Officer A managed to maneuver the sling over his/her radio, he/she checked the safety to make sure it was engaged. As he/she did so, a round was discharged from the shotgun, resulting in a NTUD of one round.

Officer A was unaware if his/her finger had been inside the trigger guard while this occurred. He/she did not observe anything near the trigger guard and indicated he/she was attempting to manipulate the safety with his/her left thumb right before the shotgun discharged.

According to Officer B, while he/she remained on the passenger side of the police vehicle, he/she directed Officer A to put the shotgun away. Officer B then told Officer A to make sure that he/she did not "let any rounds off."

Officer B further explained as he/she leaned into their vehicle's passenger compartment to turn on its engine, he could see Officer A in his/her peripheral. Officer B stated he/she was looking at the console area and believed Officer A was putting the shotgun back to patrol ready when he/she heard a round discharged.

Immediately after the discharge, Officer B told investigators he/she asked Officer A what happened and if he/she fired a round. According to Officer B, Officer A was staring at the shotgun as he/she held it and initially remained quiet. In response, Officer B walked around the rear of the vehicle to check on Officer A.

Note: Officer B told FID investigators when he/she obtained the shotgun from Officer A, he/she observed the action to be closed and did not verify the position of the safety.

When FID investigators asked Officer B about his decision to have Officer A remove the remaining rounds in the shotgun immediately after the NTUD, Officer B stated that he/she wanted to render the shotgun safe to prevent anyone from getting hurt.

According to Officer A, he/she downloaded the remaining live rounds from the shotgun and placed both the discharged hull and live rounds in the vehicle next to the shotgun. Approximately 70 seconds after the discharge, Officer B broadcast a supervisor request to the rear of the location.

At 1342 hours, Sergeant A broadcast he/she was responding to the scene.

According to Officer B, while waiting for Sergeant A to arrive, Officer A made a comment to Officer B that his/her sling got caught up in his/her gear. Officer B said Officer A was not really making sense when he/she commented on how the NTUD occurred. Officer B mentioned he/she was not entirely paying attention to everything Officer A said because he/she was focusing on trying to figure out what he/she needed to do next.

At approximately 1351 hours, Sergeant A arrived on scene and declared himself/herself the Incident Commander (IC). Officers A and B were separated, and a Public Safety Statement (PSS) was obtained from each of them.

Moments after Sergeant A arrived on scene, Sergeant B arrived and requested two additional units to respond to assist with the investigation.

Sergeant B tasked the responding officers with canvassing for surveillance video, potential witnesses, damaged property, and possible victims struck by the shotgun discharge.

Prior to FID arriving, the officers canvassed the area surrounding the NTUD. The officers did not locate any bullet impacts in any neighboring properties or victims struck by the round fired by Officer A. Sergeant B remained with Officer A and monitored him/her.

At 1421 hours, Lieutenant A arrived at the scene and took over as IC. Lieutenant A directed Sergeant B to remove the shotgun, live ammunition, and the discharged hull from the primary vehicle and place it in Sergeant A's trunk.

According to Sergeant B, when he/she went to retrieve the shotgun from Officer A's police vehicle, he/she found it to be locked and secured in the vehicle's shotgun rack. Upon removing it, he/she observed the action was closed and the safety was engaged. Sergeant B also located the three live rounds and one discharged hull inside the center console near the shotgun rack. Sergeant B indicated after he/she removed the shotgun

from the rack, he/she conducted a chamber check to ensure there were no rounds inside before he/she transferred the shotgun, live ammunition, and the discharged hull to the trunk of Sergeant A's police vehicle. Lieutenant A took over the temporary monitoring of Officer A until Sergeant B returned from Sergeant A's vehicle and resumed monitoring.

Sergeant B ultimately transported Officers A and B to Wilshire Station, where they were separated and monitored until FID personnel arrived.

On May 10, 2024, Witness A was interviewed by FID investigators. According to Witness A, he/she noticed there was a police vehicle parked in the rear alley. Shortly thereafter, he/she was advised by his/her co-worker that officers had responded next door. Witness A initially saw the officers as they were returning to their vehicle.

Witness A indicated he/she ultimately went outside and was facing south toward the alleyway while another co-worker was beside him/her but facing north.

> **Note**: Although Witness A believed the shotgun recoiled and struck Officer A in the head, security footage, provided by Witness A depicting the NTUD, was inconclusive as to whether Officer A was struck due to the shotgun's recoil. Additionally, when interviewed, Officer A indicated he/she had a secure grip on the shotgun at the time of the NTUD and was not struck. Furthermore, the investigation determined Officer A did not sustain any injuries, nor did he/she complain of any pain as a result of the NTUD.

Witness A believed the discharge of the shotgun was unintentional because the muzzle was pointed upward and only a single shot was fired.

Body-Worn Video (BWV) and Digital In-Car Video (DICV) Policy Compliance

NAME	TIMELY BWV ACTIVATION	FULL 2-MINUTE BUFFER	BWV RECORDING OF ENTIRE INCIDENT	TIMELY DICV ACTIVATION	DICV RECORDING OF ENTIRE INCIDENT
Officer A	N/A	N/A	N/A	N/A	N/A

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 instant case, the BOPC made the following findings:

A. Tactics

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

B. Drawing and Exhibiting

Does Not Apply.

C. Non-Tactical Unintentional Discharge

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 reviewed nor evaluated. However, Department guidelines require personnel substantially involved in a CUOF incident attend a Tactical Debrief. The BOPC determined Officer A's actions warranted a finding of Tactical Debrief.

Tactical De-Escalation

- Officer A returned to his/her police vehicle after completing a radio call. Officer A was in the process of downloading the shotgun when the NTUD occurred and was not engaged in a tactical operation; therefore, he/she was not evaluated for tactical de-escalation.

During the review of the incident, the following Additional Tactical Debrief Topic was identified.

- **Shotgun Protocols –** During his/her interview with FID, Officer A described having difficulty with the shotgun sling during the radio call due to it not being properly adjusted. Officer A told FID investigators he/she did not think to adjust the sling.

  After deploying the shotgun, Officer A's BWV showed him/her holding the shotgun by the receiver and placing his/her left ring finger in the trigger guard just above the

trigger. During this time, the shotgun's safety was engaged. Officer A told FID investigators he/she did not recall placing his/her left ring finger in the trigger guard.

Officer A did not load a round into the chamber of the shotgun prior to ascending the stairs to the open door. Officer B asked Officer A if he/she had a round in the chamber, and Officer A loaded one into the chamber. During his/her interview with FID, Officer A stated after he/she loaded one live round into the chamber, he/she did not "top off" the magazine by adding an additional round from his/her butt cuff because he/she was already at the door. Additionally, Officer A mistakenly believed proper procedure was to disengage the safety when he/she had the shotgun at a low ready position.

Alternatively, Officer A could have adjusted the length of the sling attached to the shotgun after retrieving it from the kitroom and been mindful of the placement of his/her left ring finger to ensure it did not enter the trigger guard. Officer A could also have loaded a round into the chamber of the shotgun prior to ascending the stairs and "topped off" the magazine immediately after chambering the round. To enhance future performance, the Chief directed this to be a topic of discussion during the Tactical Debrief.

Command and Control

- At 1342 hours, Sergeant A broadcast he/she was responding to the scene and declared himself/herself the IC upon arrival. Officers A and B were separated and a PSS was obtained from each of them. Sergeant A ensured an inner and outer perimeter was established and formed a Command Post (CP). Moments after Sergeant A arrived on scene, Sergeant B arrived at scene and requested two additional units respond to assist with the investigation. Sergeant B tasked the responding officers with canvassing for surveillance video, potential witnesses, damaged property, and possible victims struck by the shotgun discharge, and the results were negative. Sergeant A directed one of the responding officers to complete a crime scene log.

  At 1421 hours, Lieutenant A arrived at scene and took over as IC. Lieutenant A directed Sergeant B to remove the shotgun, live ammunition, and discharged hull from the primary vehicle and place it in the trunk of Sergeant A's police vehicle, as well as Officers A and B's BWV cameras. Sergeant B transferred the shotgun, live ammunition, and discharged hull to the trunk of Sergeant A's police vehicle, along with both officers' BWV cameras, and ultimately transported Officers A and B to Wilshire CPS, where they were separated and monitored until FID personnel arrived. At 1452 hours, Sergeant C notified the DOC of the NTUD.

  Although there were some areas identified for improvement, the overall actions of Sergeants A, B, and C and Lieutenant A were consistent with Department supervisory training and met the BOPC's expectations of a department supervisor during a critical incident.

B. Drawing and Exhibiting

- Does not apply.

C. Unintentional Discharge

- **Officer A –** Shotgun, one round.

  Scene Description – The NTUD occurred in broad daylight in the east-west alley located south of a business.

  According to Officer A, he/she walked to the driver's side of their police vehicle and opened the door while Officer B walked to the passenger side. As Officer A moved the shotgun around to the front of his/her body, the shotgun sling got stuck on his/her holstered handheld radio, which he/she managed to maneuver around. Officer A checked the safety to make sure it was engaged, and as he/she did so, one round was discharged from the shotgun, resulting in the NTUD. Officer A was unaware if his/her finger was inside the trigger guard while this occurred. He/she did not observe anything near the trigger guard and indicated he/she was trying to manipulate the safety with his/her left thumb just before the shotgun discharged.

  On May 10, 2024, FID investigators conducted a post-incident examination of the shotgun. The action was in a closed position, and the safety was engaged. Three loose Department-approved Federal 12-gauge buckshot rounds and one discharged hull were also located in the trunk near the shotgun. Additionally, six Department-approved Federal 12-gauge buckshot rounds were in an elastic butt cuff affixed to the stock of the shotgun. Force Investigation Division investigators determined the shotgun did not contain any live rounds in the magazine nor firing chamber.

  The Chair of the UOFRB evaluated the circumstances and evidence related to the NTUD. The Chair noted Officer A failed to properly manipulate the shotgun throughout the incident, noting Officer A struggled with the shotgun sling, fumbled with the safety and placed his/her left ring finger in the trigger guard just above the trigger. The Chair opined it was apparent Officer A was struggling with shotgun manipulations when viewing the BWV footage and opined it appeared Officer A was picking up a shotgun for the first time. The Chair noted Officer A stated he/she was manipulating the safety with his/her left thumb when the round was discharged from the shotgun and noted the Firearms Analysis Unit (FAU) determined the shotgun only fired when the cross-bolt safety was in the "off" position and the trigger was pulled. Based on the available evidence, the Chair opined the unintentional discharge was a result of operator error.

  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, thus requiring a finding of Administrative Disapproval, Negligent Discharge.