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

NON-TACTICAL UNINTENTIONAL DISCHARGE 029-24

Division	Date	Duty-On () Off (X) Uniform-Yes () No (X)
Out of City	5/31/24	

Officer(s) Involved in Use of Force	Length of Service
Officer A	2 years, 10 months

Reason for Police Contact

Officer A was in his/her residence cleaning his/her pistol when he/she inserted a loaded magazine into the pistol, and in the process of attempting to "rack" the pistol, Officer A pressed the trigger resulting in a Non-Tactical Unintentional Discharge (NTUD).

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 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 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; 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 April 22, 2025.

Incident Summary

On Friday, May 31, 2024, Central Patrol Division Police Officer A was off duty and alone at his/her residence. According to Officer A, he/she was on a regularly scheduled day off and had attended a three-hour shooting training session at a gun range. Officer A utilized his/her Sam Browne utility belt and duty pistol as part of his/her training.

Officer A began cleaning his/her firearm in the spare bedroom in preparation for work the following day. After cleaning the pistol, Officer A loaded his/her magazines with his/her duty ammunition. He/she inserted a loaded magazine into the pistol and attempted to load a round into the firing chamber. According to Officer A, he/she is left-handed and held his/her pistol in his/her outstretched left hand while pointing the muzzle toward the floor. With his/her right hand, Officer A reached across his/her body to "rack" the pistol.

When investigators asked if he/she pressed the trigger, Officer A replied that he/she must have because the pistol fired. Asked if he/she remembered at what point the round was fired, Officer A replied, that it was right when he/she "racked the gun." Officer A removed the magazine from his/her pistol, locked the slide to the rear, and placed the items on the floor to his/her left.

Officer A's primary concern was the safety of his/her neighbors since the condominiums in the complex were close to one another. Officer A was focused on finding the impact and determining if anybody was injured. Officer A searched the spare bedroom and windows for an impact and exited his/her residence to listen for any signs of distress or commotion, with negative results. Officer A was unable to locate the impact or identify any possible victims or witnesses outside.

Officer A called the Central Patrol Division Watch Commander, Sergeant A, and notified him/her of the NTUD. Sergeant A obtained a synopsis of the incident and advised Officer A to call his/her local police department. Sergeant A called Central Patrol Division Acting Commanding Officer Lieutenant A and Central Patrol Division Sergeant B and advised them to respond to the scene.

Officer A then called the local police department and advised the operator that he/she had an "accidental discharge" in his/her residence. Officers B and C, and Sergeants C and D from the local police department responded to the scene. They checked for any potential victims or witnesses and searched for the bullet impact. They were unable to locate any victims or witnesses to the incident but were able to locate the bullet impact.

According to Lieutenant A, he/she arrived at the scene and met with Sergeant D. Sergeant D directed Lieutenant A to the bullet impact.

Sergeant B assumed monitoring responsibilities and obtained a Public Safety Statement (PSS) from Officer A. Sergeant B continued monitoring Officer A until he/she was released for an interview with investigators.

BWV and DICVS Policy Compliance

Does not apply.

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 tactics to warrant a finding of Tactical Debrief.

B. Drawing/Exhibiting

Does Not Apply.

C. Lethal Use of Force

The BOPC found Officer A's Non-Tactical Unintentional Discharge to be Negligent, warranting a finding of Administrative Disapproval.

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 to attend a Tactical Debrief. The BOPC determined it would be appropriate to recommend a Tactics finding of Tactical Debrief.

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

Additional Tactical Debrief Topics

Preservation of Evidence – After the NTUD, Officer A removed the magazine from his/her service pistol and placed the pistol into the slide lock position. The BOPC would have preferred that Officer A did not unload his/her service pistol after the NTUD.

Command and Control

Officer A called Sergeant A and notified him/her of the NTUD. Sergeant A obtained a synopsis of the incident and advised Officer A to call his/her local police department. Sergeant A then called Lieutenant A and Sergeant B and advised them to respond to the scene. Sergeant A then notified the Department Operations Center of the NTUD.

Lieutenant A arrived at scene and met with the local police department. Lieutenant A then monitored Officer A until the arrival of Sergeant B. Sergeant B then obtained a PSS from Officer A.

The overall actions of Sergeants A and B 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 –** Smith & Wesson, M&P, 9mm semi-automatic pistol. One round discharged in a southwest direction.

Officer A had cleaned his/her pistol, loaded his/her magazines with duty ammunition, and inserted a loaded magazine into the handgun. Subsequently, Officer A held his/her pistol with his/her outstretched left hand, while pointing the muzzle toward the floor. With his/her right hand, Officer A then reached across his/her body to "rack" the pistol and a NTUD occurred. The bullet was recovered in the lower portion of the baseboard of the spare bedroom in which he/she was in.

The Chair of the UOFRB evaluated the circumstances and evidence related to the NTUD. The Chair noted Officer A reported that he/she inserted a loaded magazine into his/her pistol, and in the process of attempting to "rack" the pistol, Officer A pressed the trigger resulting in a NTUD. The Chair noted Officer A failed to properly manipulate his/her pistol while chambering a round into his/her pistol. The Chair noted there was no indication the NTUD was the result of a mechanical malfunction of the service pistol. Based on the preponderance of the evidence, the Chair concluded the unintentional discharge was a result of operator error as Officer A inadvertently pressed the trigger of his/her service weapon.

Based on the totality of the circumstances, the Chair of the UOFRB determined, 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.