# OFFICE OF THE INSPECTOR GENERAL
# REVIEW OF QUARTERLY DISCIPLINE REPORT
# THIRD QUARTER 2005
# JANUARY 19, 2006

## I. Introduction

The Consent Decree requires that the Department prepare a quarterly summary report (Department's Report) regarding discipline imposed, including Categorical Uses of Force (CUOFs) found to be out of policy. Pursuant to Consent Decree Paragraph 88, this report must be submitted to the Board of Police Commissioners (Commission), with a copy to the Office of the Inspector General (OIG), no later than 45 days following the end of each calendar quarter.

The Department has completed its report for the Third Quarter of 2005. The Commission received its copy of the report on November 10, 2005, within 45 days after the end of the quarter. As required under Paragraph 89 of the Consent Decree, the OIG has reviewed the Department's Report and submits this Report to the Commission.

The purpose of the Department's Report is to summarize the imposition of discipline during a particular quarter. Moreover, the OIG is charged with reviewing the Department's Report so as to assist the Commission in assessing the appropriateness of the actions of the Chief of Police (COP) in imposing discipline during that quarter, which assessment shall be considered by the Commission in conducting the COP's annual evaluation (Consent Decree, Paragraph 89).

This Quarter, the OIG decided to review cases closed during the quarter in which at least one initial or final allegation from the list designated in Consent Decree Paragraph 93 (Paragraph 93) was raised, regardless of disposition.[1] According to Paragraph 93, all complaints with allegations on the designated list are required to be investigated by Internal Affairs Group (IAG), and not by chain-of-command supervisors. Although the focus of this Report is on the appropriateness of the entity assigned to investigate cases with allegations denoted in Paragraph 93, selected other concerns that were noted during our review of some of those cases are also identified in this Report.

The OIG is pleased to find that the Department is, overall, doing a good job in its task of assigning Paragraph 93 allegations of misconduct to IAG for investigation. Moreover, as it concerns the imposition of discipline by the COP in officer-involved shooting (OIS) cases, the OIG is again pleased to report that overall, the COP appears to be imposing discipline in an appropriate manner.

---

[1] Paragraph 93 lists the following allegations: unauthorized uses of force, other than administrative Categorical Use of Force investigations (which shall be investigated by the OHB Unit as part of its investigation of such Categorical Uses of Force); invidious discrimination (*e.g.*, on the basis of race, ethnicity, gender, religion, national origin, sexual orientation, or disability), including improper ethnic remarks and gender bias; unlawful search; unlawful seizure (including false imprisonment and false arrest); dishonesty; domestic violence; improper behavior involving narcotics or drugs; sexual misconduct; theft; and any act of retaliation or retribution against an officer or civilian.

## II. Review of Cases -- Methodology

In an effort to review the appropriateness of the entity assigned to investigate Paragraph 93 cases during this Third Quarter of 2005, the population of cases from which those to be reviewed were selected was comprised of all complaints closed during the Third Quarter of 2005 that were determined at any point to contain at least one allegation listed in Paragraph 93. We obtained this list from IAG. This resulted in a total of 430 complaint investigations available for selection for the time period specified. Applying a one-tail test to this population, and in order to achieve a 95% confidence level, an expected error rate of 6%, and a "plus" precision of 7%, it was determined that a sample size of 30 cases was needed for our review. A unique number from 1 to 430 was assigned to each of the 430 cases in the order they appeared on the list of Paragraph 93 cases closed during the Third Quarter of 2005 that was generated for us by IAG. In order to determine which of the 430 cases would be selected for review, a random number generator was used to select a set of 30 unique numbers in the range of 1 to 430. The cases on the list from IAG that had been assigned to the corresponding 30 numbers were the ones initially selected.

However, during our preliminary review, 10 cases were disqualified from the selected group of 30 for various reasons. Seven of the cases were unavailable from IAG, and were therefore unavailable for review. One case was determined to have already been reviewed by the OIG's Audit Section for a Complaint Audit, and it was decided that the value to the Department of reviewing this case a second time was sufficiently outweighed by the value of replacing it with a new case (that had not yet been reviewed by the OIG) in the present report. Another case was deselected to avoid any appearance of partiality. Finally, one complaint was determined to be initiated as a part of one of the Department's internal Ethics Enforcement Section audits, meaning the complaint of misconduct in that case was entirely fabricated.

In order to replace the 10 deselected cases with 10 new ones, a second set of numbers was selected using a random number generator. Twenty-one numbers in all were generated this time, with the extra 11 selections being made in case any of the first 10 also had to be deselected. The numbers were produced unsorted to avoid any selection bias resulting from the fact that not every number in this set would likely be used. The first seven numbers selected, as well as the ninth through eleventh numbers, were then matched up to the corresponding numbers assigned to the cases on the list from IAG.[2] Together with the 20 cases selected initially, these 10 new cases formed the entire selection of thirty.[3]

---

[2] The eighth number randomly selected was the same as one of the numbers chosen during the initial selection, and it therefore corresponded to a complaint investigation that was already going to be reviewed for this report. The eighth number was therefore skipped during the second selection process.

[3] The 20 random numbers kept from the initial selection were as follows: No. 8, No. 19, No. 47, No. 69, No. 86, No. 94, No. 123, No. 137, No. 214, No. 227, No. 232, No. 236, No. 294, No. 306, No. 308, No. 343, No. 366, No. 374, No. 398, and No. 413. These numbers corresponded with the following CF Nos.: No. 02-3765, No. 03-4318, No. 04-2605, No. 04-3092, No. 04-3413, No. 04-3552, No. 04-3930, No. 04-4163, No. 04-5372, No. 04-5555, No. 04-5611, No. 04-5713, No. 05-0362, No. 05-0539, No. 05-0604, No. 05-1080, No. 05-1369, No. 05-1489, No. 05-2051, and No. 05-2504.

The 10 random numbers kept from the second selection of cases, in the unsorted order in which they were generated, were as follows: No. 277, No. 304, No. 14, No. 181, No. 11, No. 278, No. 29, No. 213, No. 363, and No. 233. These numbers corresponded with the following CF Nos.: No. 04-6457, No. 05-0537, No. 03-3160, No. 04-4750, No. 03-0815, No. 05-0015, No. 04-1000, No. 04-5365, No. 05-1347, and No. 04-5613.

In reviewing these 30 cases, a Matrix was utilized by the first and second level reviewers. This Matrix contains 19 questions designed to evaluate the quality, completeness, and findings of the completed investigation, including whether the discipline imposed was justified and appropriate in light of the surrounding circumstances, the officer's disciplinary history, and the standards enunciated in the Department's "Management Guide to Discipline" (January 2002) for sworn employees (Penalty Guidelines). In addition, a Crib Sheet was also used to assist in answering the questions on the Matrix. No interview tapes were reviewed.

## III. Results of the Review

### A. Summary of Findings

During the OIG's review of Paragraph 93 cases, two cases were discovered that contained an allegation listed in Paragraph 93 wherein the complaint investigation was assigned to the accused officers' chain-of-command instead of IAG. Of the remaining 28 cases, any concerns noted during our review did not directly impact the question of whether those cases were assigned to the appropriate entity for investigation pursuant to Paragraph 93 and therefore are not reported upon herein. A more detailed assessment of the OIG's findings is below.

### B. Discussion

**CF No. 04-5555**

This complaint arose after the accused officer conducted a traffic stop of the complainant, an African-American female, for failing to obey a posted sign. The complainant alleged that both she and the male Caucasian driver of the vehicle in front of her maneuvered from the number-two lane into the number-one lane of the street they were on. They were located close to an intersection at the time of their lane change. The accused officer was standing at one corner of the intersection when this occurred, and she was speaking with Witness No. 1, who had been in a traffic collision near that intersection moments before. The officer motioned for the complainant to pull her vehicle over to the side of the street, and the complainant complied. The complainant also stated that the driver of the vehicle in front of her was directed to pull over, which he did.

The complainant alleged that the accused officer spoke to the male Caucasian driver of the vehicle that had been in front of the complainant, and released him after a momentary conversation. The officer then approached the complainant in her vehicle and issued a citation for failing to obey a posted sign.[4] The complainant alleged that the officer was rude to her during the traffic stop. Specifically, she claimed that the officer yelled at her and used an unprofessional tone of voice.

The complainant next claimed that the accused officer asked for her driver's license and registration. As the complainant produced these documents, the officer allegedly "snatched" them from her hand, with "a real bad attitude." The complainant stated that she believed the accused officer was discourteous when she grabbed the license.

[4] The investigation indicated that the complainant's citation was issued specifically because she drove straight through an intersection from a "right-turn-only" lane.

A few moments later, the complainant exited her vehicle and approached the accused officer in order to speak with her about the traffic violation. At one point during the conversation, the complainant turned her back to the officer. The complainant alleged that the officer then pushed her in the back without any justification for doing so, and yelled, "[b]ack away from me, back away from me."

The complainant stated that Witness No. 1 was only two to three feet away from her when this activity occurred, and that he would have been in a position to see the officer push her. She claimed that immediately after the alleged push occurred, she made eye contact with Witness No. 1, who had a very surprised and/or confused look on his face indicating that he had indeed observed what happened.

The complainant's claims of misconduct were taken by a supervisor from IAG on the same day they were alleged to have occurred. On the Complaint Form (Form 1.28) for CF No. 04-5555, the Initial Classification Codes box indicates that only one type of misconduct was alleged by the complainant – "J" (Discourtesy). In the course of the investigation, however, the Department framed one allegation of Unauthorized Force in addition to two allegations of Discourtesy against the accused officer. Each of the three allegations was eventually adjudicated as "Unfounded" by the Department.

Pursuant to Paragraph 93, IAG is required to investigate the allegation of Unauthorized Force against the accused officer. In this case, however, the investigation was completed by chain-of-command supervisors.[5]

It is assumed that the investigation was assigned to the chain-of-command based on the initial classification of the complaint as only Discourtesy—a classification that does not require, on its own, an IAG investigation. Even if this is the case, however, once the Investigating Officer (I/O) realized that a Paragraph 93 allegation had in fact been made, the investigation should have been reassigned from chain-of-command to IAG in order to comply with the Consent Decree.

In addition to the Department's failure to reassign this case to IAG, the OIG's review of this case also revealed that the Department failed to frame an additional, serious allegation of misconduct made by the complainant. According to Investigator's Note No. 8, the complainant alleged that the accused officer issued her a citation, but allowed the driver in front of her to go without one, because she is African-American and the other driver, like the accused officer, is Caucasian. This is a clear Paragraph 93 allegation of Discrimination and/or Racial Profiling against the accused officer, yet the allegation was not framed or investigated by the Department.

[5] Even though a supervisor from IAG initially reported the complaint of misconduct and interviewed the complainant in doing so, the overall complaint investigation was conducted by chain-of-command personnel. A chain-of-command supervisor re-interviewed the complainant, interviewed two identified witnesses and the accused officer, canvassed the area of the incident for additional witnesses, gathered physical evidence, and signed the investigation before submitting it to a superior officer at the chain-of-command level (who also signed it). It does not appear that personnel from IAG had any role in conducting the investigation other than receiving the initial complaint.

Investigator's Note No. 8 also indicates that an acting Commanding Officer of Professional Standards Bureau apparently advised the I/O that the actions of the accused employee related to the potential allegation of Discrimination "did not rise to the level of misconduct." This conclusion, however, was made without any specific investigation of the claim, and is therefore unsupported by any evidence or justified rationale. The Department should have framed and investigated the allegation of Discrimination and/or Racial Profiling raised by the complainant.

The Department adjudicated the Unauthorized Force allegation as "Unfounded." The primary rationale for the conclusion that the officer did not push the complainant as she alleged was that Witness No. 1 unequivocally denied observing any such activity, even though the complainant appeared certain that Witness No. 1 had plainly seen what she claimed occurred. The adjudication of this allegation was also supported somewhat by the statements of Witness No. 2 who did not see any physical contact between the officer and the complainant, though she was watching only intermittently and from a significant distance.

With regard to the two allegations of Discourtesy against the accused officer, the adjudicator's primary rationale for concluding that they too were "Unfounded" was that the complainant could not be considered credible once it was determined by the investigation that her claim of being pushed by the officer was false. The OIG is concerned as to the rationale used by the adjudicator in this case. Although the OIG cannot say that the "Unfounded" adjudication of the Unauthorized Force allegation is improper given that the preponderance of the evidence weighs in favor of the accused officer, the notion that the complainant has therefore been proven to be not credible for all other purposes is not supported by the evidence. The OIG believes that a preponderance alone is insufficient to discredit the complainant for all purposes. As such, even though the complainant may not have been pushed by the officer as she alleged, it is still entirely possible that the officer was discourteous to her at other times during the encounter.

There was little evidence to either prove or disprove whether the accused officer rudely yelled at the complainant or discourteously "snatched" her driver's license from her. Without a preponderance of evidence to show that the complainant's allegations of Discourtesy were relatively likely (or relatively not likely) to have happened, the OIG believes that a more appropriate adjudication for these allegations would have been "Not Resolved" instead of "Unfounded."

**CF No. 05-0015**

The complainant in this case claimed that she was standing on the street when she was approached by Officer No. 1. The officer asked her what she was doing in the area, after which she and the officer engaged in an argument. Officer No. 1 then decided to leave the place where he and the complainant were standing, and he walked across the street. The complainant followed him, and admits to jaywalking across the street as she and the officer continued to exchange words.

The complainant alleged that at this point Officer No. 1 called her over to him and, as she was walking toward him, he pulled her by her arm and squeezed her arm hard. She further alleged that Officer No. 1 handcuffed her and placed her in the back of his police vehicle. After

completing a warrant check, the officer let the complainant out of his vehicle, again squeezing her arm tightly. Officer No. 1 took the handcuffs off of the complainant, at which time she allegedly "swung around and began to cuss at [him]." Officer No. 1 told the complainant he planned to give her a ticket for jaywalking, but that after she swung around at him, he was placing her under arrest for battery on a police officer. Officer No. 1 and his partner, Officer No. 2, transported the complainant to a police facility.

The complainant denied committing a battery against Officer No. 1, claiming that she never touched him. Ultimately, she was released from custody after receiving a citation for jaywalking. Battery charges against her were not pursued.

The complainant's claims of misconduct were taken by an Area supervisor, one day after the alleged incident occurred. On the Complaint Form for CF No. 05-0015, the Initial Classification Codes box indicates that only one type of misconduct was alleged by the complainant – "L" (Unauthorized Tactics). In the course of the investigation, the Department framed one allegation of misconduct against Officer No. 1. Despite the initial classification of Unauthorized Tactics, the Department alleged Unauthorized Force against the accused officer.[6]

Pursuant to Paragraph 93, IAG is required to investigate the allegation of Unauthorized Force against Officer No. 1. In this case, however, the investigation was completed by chain-of-command supervisors.

It is assumed that the investigation was assigned to chain-of-command based on the initial classification of the complaint as Unauthorized Tactics—a classification that does not require, on its own, an IAG investigation. Even if this is the case, however, once the I/O realized that the proper way to frame the allegation would be to classify it as "Unauthorized Force," the investigation should have been reassigned from Central Area to IAG in order to comply with the Consent Decree.

In addition to the Department's failure to reassign this case to IAG, the OIG's review of this case also revealed that the Department failed to frame additional allegations of misconduct made by the complainant. First, the complainant claimed that after she jaywalked across the street in front of Officer No. 1, he called her over to him. He then proceeded to handcuff her and place her in the back of his police vehicle as he conducted a warrant check. Soon after, the officer indicated his intention to issue her a citation for jaywalking.

As described by the complainant in her interview with the Department, the complainant alleged that this series of events led to her improper detention. According to the complainant, Officer No. 1 placed her in handcuffs and then into his police vehicle for no other reason than committing the infraction of jaywalking. This restriction of freedom, absent other justification, seems disproportionate and inappropriate as a response to a jaywalking infraction. The OIG

[6] In cases where an allegation of misconduct may be classified either as a Paragraph 93 allegation, such as Unauthorized Force, or a non-Paragraph 93 allegation, such as Unauthorized Tactics, the OIG believes that the Department should err on the side of caution and classify the allegation under Paragraph 93. In so doing, compliance with the Consent Decree is ensured in borderline cases and allegations of serious misconduct are assured to be investigated by IAG, which is the most trained and experienced entity in the Department in investigating these types of allegations.

believes that the complainant's description of precisely this series of events in her interview should have prompted the Department to frame and investigate an allegation of False Imprisonment[7] in this case.

Furthermore, the complainant stated in her interview that after Officer No. 1 took the handcuffs off, she "swung around and began to cuss at [him]." Officer No. 1 then arrested her for battery on a police officer. The complainant claimed that she "never touched [Officer No. 1] and never committed a battery." Although the accused officer stated that the complainant struck him in the face when she "swung around" at him, the complainant clearly denied making any physical contact with the officer, even during her "swing" toward him. Therefore, as described by the complainant, Officer No. 1 arrested her without proper justification. This claim should have prompted the Department to frame and investigate another allegation of False Imprisonment in this case.

Notably, both of these allegations of False Imprisonment would have to be investigated by IAG pursuant to the requirements of Paragraph 93. As such, the failure by the chain-of-command to recognize and frame these additional allegations may have contributed to the ultimate failure to reassign the case to IAG for investigation.

## IV. Review of Categorical Uses of Force

During this Third Quarter, five CUOF investigations were closed in which the Commission adopted a finding of "Out of Policy" or "Administrative Disapproval." All five of the incidents were officer-involved shootings. In all five cases, the Commission concurred with and adopted the findings of the COP. The five cases are described below, including the penalties imposed by the COP following the Out of Policy or Administrative Disapproval findings by the Commission.

### OIS No. 023-04

At 4:30 a.m., the suspect robbed a gas station in Agoura Hills, threatening the cashier with a knife and tying his hands behind his back with a plastic cable. The suspect left the scene in a 1991 white Ford Tempo, taking U.S. Highway 101 eastbound. The cashier called 911 and reported the crime.

Los Angeles County Sheriff's deputies observed the suspect traveling eastbound on Highway 101 and initiated a pursuit when the suspect failed to yield. The pursuit continued eastbound, and when the suspect reached the junction of Highway 101 and State Route 134, the California Highway Patrol (CHP) took over the pursuit and the deputies disengaged.

As the pursuit approached downtown Los Angeles, the CHP requested the assistance of LAPD Air Support. An LAPD Air Unit joined the pursuit as the suspect was driving eastbound on Interstate 10. The suspect then turned his vehicle around and began to drive westbound in the eastbound lanes of Interstate 10.

---

[7] The Department typically classifies allegations of unjustified detentions, such as the one raised in this case, as False Imprisonment.

At approximately 5:05 a.m., the CHP discontinued the pursuit and the Air Unit continued to monitor the suspect's progress. The suspect continued to flee by driving south in the northbound lanes of Highway 101. The suspect then reversed direction and began driving northbound on Highway 101. The CHP re-engaged in the pursuit.

Officers No. 1 and No. 2 were traveling north on Highway 101 and heard the Air Unit broadcasting the pursuit. Officer No. 1 was the driver and Officer No. 2 was the passenger. The pursuit passed these officers, who noted that a single CHP unit was involved in the pursuit. Officers No. 1 and No. 2 began to follow the pursuit, but did not activate their emergency lights or siren.

The suspect exited Highway 101 at Santa Monica Boulevard. The Air Unit requested two Hollywood units to assist with the pursuit. Officers No. 3 and No. 4 responded to this request and, at the direction of the Air Unit, assumed the role of primary unit in the pursuit. Noting that only one Hollywood unit had responded to the Air Unit's request, Officers No. 1 and No. 2 assumed the role of secondary unit at 5:17 a.m. The CHP then discontinued its involvement in the pursuit.

The pursuit continued westbound through the City of Los Angeles and into the City of Beverly Hills. As this happened, Officers No. 5, No. 6, No. 7, No. 8, No. 9, and No. 10, and Supervisor No. 1 joined in or began tracking the pursuit. The pursuit continued into the City of Santa Monica. At 5:53 a.m. the suspect stopped his vehicle in the entrance to a driveway that led to a parking lot.

Officers No. 3 and No. 4 stopped their vehicle approximately twenty-one feet behind the suspect's vehicle. Officers No. 3 and No. 4 exited their vehicle, took positions behind their vehicle doors, and drew their handguns. According to Officers No. 3 and No. 4, they gave verbal commands to the suspect to "[g]et out of the car," "[s]top the car," and "[s]how me your hands."

The white reverse lights of the suspect's vehicle illuminated, and the suspect's vehicle began to slowly reverse. Officer No. 4 fired two rounds through the rear windshield of the vehicle. The suspect applied the vehicle's brakes, and the vehicle stopped for a moment before starting to roll backwards at a low speed. Officer No. 4 then fired seven more rounds.

Meanwhile, Officer No. 3 fired at least one round as the vehicle moved backwards. Officers No. 1 and No. 2 pulled their patrol car to the right of the patrol car occupied by Officers No. 3 and No. 4. Officer No. 2 exited his patrol vehicle and took a position behind the vehicle door. As the suspect's vehicle was about to collide with the patrol car containing Officers No. 3 and No. 4, Officer No. 2 fired five rounds at the suspect's vehicle. The involved officers all later reported that they believed the suspect's vehicle moved towards the police vehicle at a high rate of speed.

The suspect's vehicle collided with a police vehicle. This was a low speed collision that did not appear to cause any damage. As the vehicles made contact, the suspect's vehicle stopped. The suspect then opened his vehicle door. Officer No. 3 again fired at the suspect. As Officer No. 3 continued to fire, the suspect fell out of his vehicle and went face-first to the ground.

Officer No. 3 indicated that he observed the suspect's body "torque," causing the officer to believe that the suspect was about to shoot him. Officer No. 3 also reported that he believed that other officers' gunfire was actually coming from the suspect.

The suspect was handcuffed without further incident. An ambulance was requested for the suspect at 5:55 a.m. The suspect was transported to an area hospital and was pronounced dead at 7:00 a.m.

Officers No. 2 and No. 4 stated that they fired at the suspect's vehicle because of the danger posed by its rearward movement. Officer No. 4 additionally stated that he fired in the hope that the suspect "would begin to somehow communicate with us."

Officer No. 3 stated that he heard gunfire, saw the suspect open the vehicle door with his right hand in front of his body, and start to "torque" his upper body. Officer No. 3 guessed that the gunfire he heard was coming from inside the suspect's vehicle, and he took the suspect's movement as an indication that he was going to turn around and shoot at him.

In sum, the evidence indicates that the use of deadly force by Officer No. 3 was unreasonable.

The suspect sustained eight gunshot wounds, one of which was fatal. The fatal round was fired by Officer No. 3.

The COP was critical of the involved officers' decision to use lethal force, noting that it was apparent that the suspect was performing a maneuver to continue evading officers. The COP further noted that Officer No. 3 did not see any muzzle flashes or movements from within the suspect's vehicle indicative of the suspect shooting at officers, and that the suspect was not seen holding a firearm when the door opened. The COP found the use of force by Officers No. 2, No. 3, and No. 4 to be out of policy, Administrative Disapproval.

The COP recommended that the tactics displayed by Officers No. 2, No. 3, and No. 4 warranted additional training. Specifically, the COP would have preferred the officers to consider other alternatives to remaining outside their vehicles when the suspect's vehicle began to drive in reverse, such as re-entering their patrol vehicles or deploying behind or away from the police vehicles.

The COP found that all officers' drawing of a firearm was In Policy.

The Commission adopted the COP's recommendations.

As a result of the Administrative Disapproval findings as to the tactics and use of force by Officers No. 2, No. 3, and No. 4, a Complaint Form was generated. The adjudicator notes in the Letter of Transmittal (LOT) that although Officers No. 2, No. 3, and No. 4 indeed were fearful of the actions of the suspect, the officers' tactics were nevertheless deficient, and their judgment in the use of lethal force was flawed. The LOT notes that a review of the TEAMS records of the

involved officers revealed no prior sustained complaints akin to the allegations in the instant case.

Indeed, Officer No. 2 has no prior sustained complaints and no prior OIS's. Officer No. 3 has three prior sustained complaints that were dissimilar in nature to the instant case. Officer No. 3 received an Admonishment in each of those three cases and has never been suspended. Moreover, the TEAMS record of Officer No. 3 indicates that the officer has never been involved in a prior OIS.

Officer No. 4 had two prior sustained complaints that were dissimilar in nature to the instant case. Officer No. 4 received a total of three suspension days for the prior sustained complaints. Moreover, the TEAMS record of Officer No. 4 indicates that the officer was involved in two other OIS's in 1998. In both of those incidents, the use of force was found to be In Policy. In one of the two cases, the officer was directed to training for tactics used during the incident.

The Commanding Officer that authored the LOT recommended a penalty of 10 suspension days each for Officers No. 2, No. 3, and No. 4, as well as training at Continuing Education Division. The COP, however, increased the penalty from the recommended 10 suspension days for each officer to 20 suspension days for each officer. In light of the grave consequences of the use of force by these officers, the OIG concurs with the decision of the COP to increase the penalty to 20 days.

The TEAMS record of Officer No. 2 indicates that approximately two months after the COP issued discipline in this matter, he received a total of four hours of training in the areas of tactics and use of force. However, the TEAMS records of Officers No. 3 and No. 4 do not indicate that any similar training was given to them at or around the same time as Officer No. 2's training. Notably, Officer No. 2 was assigned to a different Area than Officers No. 3 and No. 4 at the time of the incident. As such, it appears that the Area to which Officer No. 2 was assigned was diligent in performing the training imposed by the COP. It is unknown whether the Area to which Officers No. 3 and No. 4 are assigned failed to impose the training as required or simply failed to indicate on the officers' TEAMS records that the training was performed.

**<u>OIS No. 056-04</u>**

In this case, Officers No. 1 and No. 2 observed the suspect walking down a street. The suspect appeared to be looking into the vehicles parked on the street. The officers communicated to each other that the suspect appeared to be looking to break into parked vehicles. The officers followed the suspect for a short while. The suspect looked over his shoulder and appeared to notice the officers' police vehicle. Officer No. 1 put the police vehicle in park. Officer No. 1 then opened his vehicle door and slammed it shut to see what the suspect's reaction would be.

The suspect turned around and began to walk in the officers' direction. When the suspect reached the sidewalk next to the police vehicle, Officer No. 2 asked the suspect where he was going through his open car door window. The suspect replied that he was going home. Officer No. 2 asked the suspect where he lived. At that time, the suspect ran from the scene. The officers followed the suspect by driving the police vehicle in reverse on the street.

The suspect continued to run and jumped over a wrought iron/slump stone fence in front of a residence. Officer No. 1 reversed the patrol vehicle to a position near the suspect. Officer No. 2 got out of the vehicle and drew his weapon. The suspect got caught on the fence and fell, landing in a sitting position on the side of the fence opposite the officers. As the suspect fell, Officer No. 2 heard something metallic hit the ground. When the suspect got to his feet, he produced what looked to the officers to be a blue steel handgun. He began to raise the handgun in the officers' direction, and Officer No. 2 fired three rounds at him. The suspect then turned and ran between the houses.

Officer No. 1 exited and moved to the rear of the patrol vehicle and drew his weapon. Upon hearing Officer No. 2's first three gunshots, Officer No. 1 broadcast an officer needs help/shots fired call on the radio. Officer No. 1 was unaware at the time that the shots had been fired by Officer No. 2.

While running away, the suspect looked back toward the officers with the handgun in his right hand at chest level. Officer No. 2 then fired one more round at the suspect. The suspect ran north behind a residence and out of the officers' view.

In an effort to contain the suspect, Officer No. 1 ran to the alley behind the houses through which the suspect fled. Before doing so, however, Officer No. 1 states that he communicated to his partner his intent to go around the corner and up to the alley behind the residences.

Officer No. 2 ran around the back of the police vehicle, got in the driver's seat, and backed the vehicle down the street, tracking Officer No. 1.

Meanwhile, Officers No. 3 and No. 4, who had also been deployed in the same general area working crime suppression, turned onto the street and could see the taillights on Officer No. 2's police vehicle. They saw the reverse lights on the police vehicle illuminate and heard gunshots. Officers No. 3 and No. 4 exited their police vehicle and ran one block towards Officer No. 2's vehicle.

Officers No. 3 and No. 4 identified themselves to Officers No. 1 and No. 2. Officers No. 3 and No. 4 then took positions to help secure the perimeter.

Supervisor No. 1 arrived on scene, and K-9 officers were called to track the suspect. The K-9 officers located the suspect inside a parked vehicle in the area. The suspect was not hit by any of the rounds fired by Officer No. 2.

Approximately five hours after the initial encounter, a citizen notified Critical Incident Investigation Division Supervisor No. 2 that he had found a handgun in the area. The handgun was located approximately 60 feet west and 8 feet south of where the suspect climbed over the fence.

The COP was critical of Officer No. 2 for engaging the suspect in conversation while Officer No. 2 was seated in his police vehicle. The COP was also concerned with Officer No. 1's decision to

open and slam his vehicle door as a ploy to get the suspect's attention and was critical of him for following the suspect by driving in reverse and then stopping the police vehicle parallel to the suspect. The COP was critical of both Officers No. 1 and No. 2 for not properly notifying Communications Division of their location and activities, especially when they knew they were in a high crime/gang area. The COP was also critical of both officers for separating after the OIS. The COP determined that the tactics employed by Officers No. 1 and No. 2 were seriously deficient, requiring a recommendation of Administrative Disapproval. The COP directed the officers to formal tactical training at Training Division.

The COP found that when Officers No. 1 and No. 2 drew their weapons they had sufficient information to believe the incident might escalate to the point where deadly force was necessary. He found their drawing to be In Policy, no action.

The COP found that when Officer No. 2 fired his weapon at the suspect, Officer No. 2 reasonably believed he was under the immediate threat of serious bodily injury or death. He found Officer No. 2's use of force In Policy, no action.

In connection with the subsequent complaint investigation, Officers No. 1 and No. 2 eventually received an Official Reprimand (OR).[8] The LOT provided no rationale for this penalty whatsoever, beyond that which was addressed by the COP when recommending Administrative Disapproval to the Commission. Despite this, the OIG concurs with the COP's concerns about the way in which Officers No. 1 and No. 2 initially engaged the suspect, and further agrees that an OR for deficient tactics was a reasonable penalty for each officer.

Finally, the OIG is concerned that a review of the involved officers' TEAMS reports reveals that neither Officer No. 1 nor Officer No. 2 is shown to have received formal tactical training after this incident, as directed by the COP.[9]

**OIS No. 078-04**

At the request of Gang Enforcement Detail (GED) Supervisor No. 1, at approximately 8:45 p.m., GED Officers No. 1, No. 2, No. 3, and No. 4 responded to a residence known to GED Officers No. 1 and No. 2 for gang activity. Outside the location was a group of 12-13 people, some of which the officers recognized as gang members. Among the group was Suspect No. 1, whom GED Officer No. 1 recognized and knew to be on parole.

GED Officers No. 1, No. 2, No. 3, and No. 4 proceeded to detain the group. They were joined less than two minutes later by GED Supervisor No. 2.

---

[8] Both Officers No. 1 and No. 2 indicated on their respective Complaint Adjudication Forms the intent to submit a response to the proposed disciplinary action against them. However, the investigation file did not include any such responses from either officer and therefore no such responses were taken into account during the review of the investigation.

[9] Also, the TEAMS reports for Officers No. 1 and No. 2 each appear to incorrectly list the allegation sustained against them as a "Shooting Violation." The allegation that should be listed under this complaint in each officer's TEAMS report is "Unauthorized Tactics."

According to GED Officer No. 1, the group was detained for investigation due to a strong odor of burnt marijuana. GED Officer No. 2 added that the officers stopped the group because they observed Suspect No. 1 in apparent violation of his parole conditions.

GED Officer No. 1 used his cellular telephone to contact the California Youth Authority (CYA) and confirmed that Suspect No. 1 was in violation of his parole conditions by associating with gang members. GED Officer No. 1 was informed by a CYA supervisor that a parole search could be conducted of Suspect No. 1's residence if consent was given by the person in charge of the residence.

Suspect No. 1 was arrested for the parole violation. The remainder of the group was released.

GED Officers No. 1, No. 2, No. 3, No. 4, and GED Supervisor No. 2 drove to Suspect No. 1's residence, taking Suspect No. 1 with them. They arrived at the residence at approximately 9:40 p.m., accompanied by GED Officers No. 5, No. 6, No. 7, No. 8, No. 9, No. 10, No. 11, and No. 12.

As the officers approached the residence, they observed Suspect No. 2 in the area of the residence's porch. GED Officer No. 1 knew Suspect No. 2 from previous contacts. When the officers attempted to detain Suspect No. 2 after the suspect appeared to throw an object into the house and attempted to lock the door, Suspect No. 2 resisted, and a Non-Categorical Use of Force occurred, which was found to be In Policy.[10]

The officers were informed by Suspect No. 1 that his grandmother, Witness No. 1, was in the residence. GED Officer No. 11 knocked on the open front door to the residence, and GED Officer No. 1 called Witness No. 1's name. There was no response from inside the house. According to GED Officer No. 1, a neighbor also told him that Witness No. 1 was inside the residence.

GED Officers No. 1, No. 2, No. 6, and No. 10 entered the residence to conduct a search. Officers No. 2 and No. 6 drew their weapons. The search revealed that the residence was unoccupied.

In the course of conducting the search, GED Officers No. 6 and No. 10 located a 9mm pistol and a bag containing a substance that resembled crack cocaine next to one another, in plain view in a bedroom.

According to GED Officer No. 1, it was subsequently determined that Suspects No. 1 and No. 2 both resided in the bedroom where the weapon and substance were found.

GED Officer No. 6 picked up the pistol and removed its loaded magazine. GED Officer No. 6 then attempted to retract the pistol's slide in order to eject any round that might have been in the weapon's chamber. The slide did not move, however, and GED Officer No. 6 determined that it

---

[10] The details of the use of force against Suspect No. 2 have no bearing on this discussion and are therefore omitted.

was jammed. GED Officer No. 6 placed the pistol down and requested the assistance of GED Officer No. 12, who has extensive experience with firearms.

GED Officer No. 12 entered the residence and examined the pistol. He saw that the safety was not engaged, and that the slide appeared to be very slightly retracted. He held the pistol and attempted to retract the slide. However, the slide remained jammed and he was unable to retract it. GED Officer No. 12 then pulled back the hammer of the pistol with his thumb, believing that the slide would retract if the hammer was placed into the cocked position. He then removed his thumb from the hammer, expecting that it would remain in the cocked position. However, the hammer fell forward and the pistol discharged.

At the time of the discharge, GED Officer No. 12 was pointing the pistol at a downward angle, towards a bed and away from GED Officers No. 2 and No. 6, who were present in the bedroom. The round struck the bed and did not cause any injuries.

GED Officer No. 12 then retracted the slide, which was now operable, checked that the weapon's chamber was empty, and placed the pistol down. GED Officer No. 12 asked the other officers present if they were okay, then exited the residence and informed Supervisor No. 2 that a negligent discharge had occurred.

Upon reviewing the facts of this case, the COP noted that Suspect No. 1 was transported to his residence when officers went there to conduct a follow-up investigation. The COP would have preferred that Suspect No. 1 be transported to the station instead. The COP therefore determined that GED Supervisor No. 2 and GED Officers No. 1, No. 2, No. 3, and No. 4 would benefit from additional training in this area. The COP noted that a determination will be made whether a change in policy is needed that would require officers to transport arrestees to the station in a more timely manner.

The COP determined that the tactics of GED Officers No. 5, No. 6, No. 7, No. 8, No. 9, No. 10, No. 11, and No. 12 were appropriate and required no action.

The COP further determined that GED Officers No. 2 and No. 6 had sufficient information to believe the situation might escalate to the point where deadly force may have become necessary when they entered the residence with their guns drawn to conduct a search. As such, the COP found the drawing/exhibition/holstering of a firearm by GED Officers No. 2 and No. 6 to be In Policy, requiring no action.

The COP was concerned that when GED Officers No. 6 and No. 12 experienced difficulty rendering the pistol safe, they did not seek the assistance of Scientific Investigation Division, Firearms Analysis Unit. The COP found GED Officer No. 12's use of force in discharging the firearm to be accidental, requiring Administrative Disapproval. The COP determined that GED Officers No. 6 and No. 12 would benefit from additional firearms training at Training Division.

The Commission adopted the COP's recommendations.

In connection with the Administrative Disapproval finding of the use of force by GED Officer No. 12, a Complaint Form was generated. In the LOT, the Commanding Officer of the Area determined that GED Officer No. 12 believed he could render the firearm found in the residence safe based upon his extensive experience in handling weapons. According to the LOT, GED Officer No. 12 knew that weapons have a feature that holds the hammer of the weapon back if it is cocked even halfway. Nevertheless, the Commanding Officer noted that despite the experience of GED Officer No. 12, and despite that officer's belief that he could make the weapon safe, he still bears some responsibility for its discharge. Specifically, GED Officer No. 12 could have kept his thumb on the hammer of the weapon and guided it back, preventing the weapon from discharging, instead of simply releasing the hammer.

The Commanding Officer recommended that no penalty be imposed for this misconduct other than to provide training to GED Officer No. 12. The Commanding Officer noted that the incident was not the result of horseplay and that GED Officer No. 12 took caution in pointing the weapon downward and away from other individuals when attempting to render it safe.

The COP adopted the recommendation of the Area Commanding Officer and issued no penalty to GED Officer No. 12 despite the fact that the complaint of misconduct was "Sustained."

A review of the TEAMS record for GED Officer No. 12 revealed only one prior "Sustained" complaint for a Preventable Traffic Collision. The TEAMS record of GED Officer No. 12 also reveals that the officer has extensive training in firearms and, as noted in the LOT, serves as an instructor for both the Handgun Instructor Training School and the Shotgun Instructor Training School. Thus, it cannot be disputed that GED Officer No. 12 had extensive knowledge of firearms.

Nevertheless, the fact remains that an accidental discharge did occur and could have resulted in the injury and/or death of either the involved officer or the bystander officers. In this regard, Department Manual Section 4/540.30 requires field officers to contact Scientific Investigation Division, Firearms Unit, to examine and clear hazardous weapons prior to booking:

> An officer booking a firearm into Department custody shall ensure that the firearm is unloaded and safe for handling. Employees unfamiliar with the unloading or securing of a firearm shall contact the Firearms Unit, Scientific Investigation Division (SID), for advice.
>
> ***
>
> **In all cases**, the Firearms Unit **shall** be contacted to examine and clear the following types of hazardous weapons prior to booking… **Jammed or inoperative weapons, including weapons with rounds that cannot be extracted**.

(Emphasis added.) Given that it was clear the weapon was jammed, Department policy seems to require that officers contact the Firearms Unit to examine the weapon instead of taking it upon themselves to clear the weapon. Thus, although GED Officer No. 12 undoubtedly has vast experience in the handling of firearms, he nevertheless violated a Department policy by attempting to clear the weapon without the assistance of the Firearms Unit.

Because of the extensive training and experience of GED Officer No. 12 in the handling of firearms, including the fact that the officer is a firearms instructor, the officer arguably knew or should have known that Department policy required him to contact the Firearms Unit prior to clearing the jammed weapon. Given that GED Officer No. 12 failed to follow Department procedures when handling the firearm in this case, the OIG would have preferred that the COP impose some form of penalty in this matter, such as an Admonishment or an OR. Instead, no penalty was issued, despite a "Sustained" finding of misconduct. Because GED Officer No. 12 has no prior history of suspension days, a suspension for this incident does not appear to be warranted. However, a written penalty would have been appropriate.

As it relates to the training issue, there is no indication in the TEAMS record of GED Officer No. 12 that he in fact received training in the area of firearms handling as required by the COP. The LOT in the complaint investigation indicates under the "Actions Taken" portion: "Training provided." Nevertheless, the TEAMS record of the individual officer should reflect such training if it was indeed provided to him.

Finally, as to the tactics of GED Officers No. 1, No. 2, No. 3, and No. 4, and Supervisor No. 2 regarding the transporting of Suspect No. 1 to his residence for the search of that residence, a review of the TEAMS records for each officer and supervisor does not reveal that any such training was provided as required by the COP.

**OIS No. 064-04**

In this case, Gang Impact Team (GIT) Narcotics Enforcement Detail (NED) Officers No. 1 and No. 2 arrested Suspect No. 1 for sales of a controlled substance. Suspect No. 1 was transported to a police facility, where it was determined that he was on parole. The officers identified several addresses as possible residences used by Suspect No. 1. NED Supervisor No. 1 consulted with Officers No. 1 and No. 2, and it was determined that follow-up investigations would be conducted at the addresses to determine if Suspect No. 1 resided at any of them. If his place of residence was confirmed, it was agreed that a parole search would be performed.

Supervisor No. 1 briefed GIT/NED Officers No. 1, No. 2, No. 3, No. 4, No. 5, and No. 6 regarding the planned follow-up investigations. According to Supervisor No. 1, the other officers were "stepping in and out" during the briefing.

Approximately three and one-half hours after the initial arrest, the team of officers arrived at one of the possible addresses—a house with a gated, narrow walkway that ran north-south along the western side of the building. At the rear of the house was a camper trailer. The officers were dressed in plain clothes with raid jackets.

Officers No. 2, No. 3, and No. 6 deployed to the front (south) of the house. Meanwhile, Officer No. 4 deployed to the east of the house. Officers No. 1 and No. 5 and Supervisor No. 1 deployed to the west side of the house. Officer No. 5 drew his pistol.

Before the gate that led to the walkway along the west side of the house was opened, Supervisor No. 1 told Officer No. 1 to "be careful for dogs." Officer No. 1 whistled, called for a dog and

rattled the gate, but did not hear any response to indicate that a dog was present. He also illuminated the walkway with his flashlight, and did not see a dog. Officer No. 1 then opened the gate and walked north along the walkway. Officer No. 5 followed Officer No. 1, while Supervisor No. 1 remained at the gate.

Meanwhile, Officer No. 2 repeatedly knocked at the front door of the house and rang the doorbell. Seeing that nobody had opened the door in response to Officer No. 2's actions, Supervisor No. 1 began to follow Officers No. 1 and No. 5 along the walkway.

As they walked along the west side of the house, Officers No. 1 and No. 5 and Supervisor No. 1 saw a child's legs inside the house through a window. Supervisor No. 1 knocked on the window and, when nine-year-old Witness No. 1 responded to the knock, asked the child to tell his mother that officers were at the front door.

As Supervisor No. 1 talked to Witness No. 1, Officer No. 1 continued walking north to the end of the walkway and the backyard of the house. Standing at the end of the walkway, Officer No. 1 saw the camper trailer in the backyard and saw that a light was on inside the trailer. The lower half of the trailer was obscured from Officer No. 1's view by plants. At first Officer No. 1 did not see anyone in the trailer, but he then saw a male (subsequently identified as Witness No. 2) at its window. Officer No. 1 held up his badge, verbally identified himself as a police officer, and asked the male to come out.

Officer No. 1 heard the door of the trailer open and the sound of a dog barking. Officer No. 1 assumed that the dog was coming out of the trailer. He drew his pistol and flashlight and used a Harries flashlight technique to illuminate the dog.[11] When Officer No. 1 first saw the dog (subsequently identified as a medium-sized mixed Chow) it was standing approximately 25 feet away to his northeast, growling and baring its teeth. The officer repeatedly told the occupant of the trailer to take the dog back inside.

Officer No. 1 told Officer No. 5 and Supervisor No. 1 that there was a dog and that they should retreat. All three began moving backwards, southbound along the walkway. As they retreated, Officer No. 1 continued to tell the male in the trailer to take the dog back inside.

The still-growling dog continued to move towards the officers as they continued to back away. Officer No. 5 placed his hand on Officer No. 1's back to assist him as the group moved backwards. The dog then charged towards the officers. As the animal reached a distance of approximately 12 feet from him, Officer No. 1 fired one round at the dog. The dog continued to move forwards, and Officer No. 1 fired a second and then a third round. The dog then yelped and ran eastbound, out of Officer No. 1's view.

Officers No. 1 and No. 5 and Supervisor No. 1 came back through the gate, which they secured. They advised the remaining officers that the shots were fired at a dog. All officers then reholstered their weapons and regrouped.

---

[11] The Harries technique is a method of holding a flashlight and a pistol together, using the flashlight hand to support the hand holding the weapon.

Witness No. 3, a resident of the address, told the officers that Suspect No. 1 did not reside at the address.

The COP was concerned that Supervisor No. 1 did not ensure that all officers were aware of the objective of the follow-up investigation, did not advise the Area Watch Commander of his follow-up investigation, and did not include uniformed officers in his plan. The COP was also concerned that the officers did not notify Communications Division of their locations.

The COP determined that the tactics of Supervisor No. 1 were seriously deficient and required Administrative Disapproval. He also determined that Officers No. 1, No. 2, No. 3, No. 4, No. 5, and No. 6, and Supervisor No. 1 required formal training in tactics.

The COP determined that Officers No. 1, No. 2, No. 3, No. 4, No. 5, and No. 6 had sufficient grounds to believe that the situation may escalate to one where deadly force may become necessary when they drew their pistols, and found their drawing In Policy, requiring no action.

The COP determined that Officer No. 1 reasonably believed that the dog presented an immediate threat of serious injury or death when he fired his weapon, and found the officer's use of force In Policy, requiring no action.

The Commission adopted the COP's recommendations.

In connection with the subsequent complaint investigation, Supervisor No. 1 eventually received an Admonishment.[12] The rationale behind this penalty was largely based on the fact that even if Supervisor No. 1 had utilized better tactics in planning the follow-up investigation and had done a better job of notifying the proper Department personnel of his plans and of his unit's location, the dog that was present at the scene would have still charged the officers who got close to it, and an OIS would have still resulted.

Although the OIG agrees that an OIS may have occurred despite the tactical deficiencies, this fact should not, alone, reduce the penalty for the tactics used given that the flawed tactics may very well have posed additional unknown dangers to the involved officers. That is, the tactics should be evaluated on their own merit without regard to the Department's determination that, even if proper tactics were used, the end result would have nevertheless have been the same.

It seems that a few basic tactical efforts to improve planning and communication would have done a great deal to minimize some of the risks created by Supervisor No. 1's tactics, irrespective of whether the dog would have still been shot. One risk brought about by the lack of communication in Supervisor No. 1's tactical plan involves the failure to notify Communications Division of the investigative unit's location. Although the officers present at the scene fortunately avoided any serious injury during their investigative activities, it is not impossible that one or more of them could have unexpectedly encountered a dangerous individual at the residence. Indeed, several of the involved officers believed that the potential danger in this situation was high enough that it caused them to draw their firearms. Thus, it is apparent that the

[12] The TEAMS report of Supervisor No. 1 appears to incorrectly list the allegation sustained against him in this case as a "Shooting Violation." The allegation that should be listed under this complaint is "Unauthorized Tactics."

search of the residence, which was the possible home of a parolee, was an inherently dangerous activity, and it is clear that a sound tactical plan should have been implemented to ensure as much as possible the safety of all involved.

A review of the TEAMS record for Supervisor No. 1 shows that he has served a total of four suspension days for six sustained complaints in his 31-year service with the LAPD. In 1976, Supervisor No. 1 was suspended for two days for utilizing Unauthorized Tactics.[13] In 1984, Supervisor No. 1 was suspended for two days for a Shooting Violation. The other four sustained complaints in 1982, 1988, 1994, and 2001 were for Neglect of Duty, Failure to Appear, Failure to Qualify, and Neglect of Duty, respectively. Supervisor No. 1 received an Admonishment for each of these complaints.

The Department's Penalty Guidelines indicate that an officer's second sustained allegation of Unauthorized Tactics should result in a minimum of a five-day suspension. Although the decision to admonish Supervisor No. 1 is outside of the recommended penalty, the OIG understands that the Penalty Guidelines are simply a guide as opposed to a required penalty continuum. Other factors must be taken into consideration when imposing a penalty, such as, in this case, the length of time that passed between the last Sustained allegation of Unauthorized Tactics against Supervisor No. 1. The only Unauthorized Tactics complaint involving Supervisor No. 1 was adjudicated 29 years ago. Based upon this length of time, in addition to the overall complaint history of Supervisor No. 1, the OIG agrees with the COP's decision to impose an Admonishment in this case.

Finally, the OIG is concerned that a review of the involved officers' TEAMS reports reveals that only Officers No. 1 and No. 3 appear to have received formal tactical training as directed by the COP, whereas training was ordered for all officers involved.

**<u>OIS No. 060-03</u>**

In this case, Officer No. 1 checked out equipment from the Kit Room for his tour of duty. The officer was assigned a Remington 12-gauge shotgun. Officer No. 1 stated that prior to starting his shift, he conducted a six-point safety check of the shotgun,[14] then loaded four rounds into the magazine and placed a butt-cuff on the stalk with six additional rounds. At the end of his shift, Officer No. 1 unloaded the shotgun, but only unloaded three rounds. Officer No. 1 stated he looked inside the magazine for the fourth round but could not see it. He also stuck his finger into the magazine but could not feel the round. Officer No. 1 searched the inside of the police car, found a shotgun round on the raised floorboard between the front seats, and assumed it was the missing round from the shotgun. Officer No. 1 then removed the butt-cuff, without counting the rounds, and gave it to Officer No. 2. The equipment was then returned to the Kit Room, where it was apparently received and stored by Officer No. 3.

---

[13] In its analysis of Supervisor No. 1's complaint history, the Department stated that he received a two-day suspension for "discourtesy, unbecoming conduct and unauthorized tactics." Supervisor No. 1's TEAMS report, however, indicates that the suspension resulted solely from the allegation of Unauthorized Tactics, as the other allegations raised in that complaint were either "Not Resolved" or "Unfounded."

[14] A six-point safety check consists of inspection of the barrel, ejector, extractor, firing pin, safety, and shell carrier.

The following day, Officer No. 4 checked out equipment from the Kit Room to start his tour of duty. Officer No. 5, assigned to the Kit Room, issued the same Remington shotgun to Officer No. 4. Officer No. 5 stated that prior to giving Officer No. 4 the gun, he conducted a visual check of the shotgun's chamber and ensured that the safety was on and the action was open. Officer No. 4 stated that while standing at the rear of his assigned police car, in the lower level parking area of the station, he conducted the six-point shotgun safety check before he loaded the shotgun. Officer No. 4 stated the shotgun action was in the "open" position and the safety was in the "on" position. He then inspected the barrel, ejector, and firing pin for malfunctions and obstructions and noted none. Officer No. 4 stated he inspected the ejector ports and the extractor and they operated properly. As Officer No. 4 checked the firing pin, he unlocked the safety mechanism and depressed the trigger. A round discharged from the shotgun, striking the cement ceiling of the parking lot. Officer No. 4 then opened the action, ejected the expended shot shell into the trunk, and placed the shotgun in the trunk.

Supervisor No. 1, after hearing a muffled sound in the lower garage level, along with Supervisor No. 2, exited from the station into the parking lot. They were then told that there had been an accidental discharge. Officer No. 4 informed them that he had accidentally fired one round from the shotgun.

The COP was concerned that Officer No. 4 failed to follow the basic firearms safety rules and directed Officer No. 4 to training.

The COP was also critical that Officer No. 1 did not ensure that the shotgun was empty prior to returning it to the kit room; Officer No. 3 did not ensure that the shotgun was unloaded prior to placing it into the storage cabinet; and Officer No. 5 did not ensure the shotgun was unloaded prior to issuing it to Officer No. 4. All of these officers were ordered to additional firearms training at Continuing Education Division.

In connection with the subsequent complaint investigation, Officer No. 1 received one suspension day;[15] Officer No. 3 received 10 suspension days;[16] Officer No. 4 received 10 suspension days; and Officer No. 5 received an Admonishment.[17]

With respect to Officer No. 1, the OIG believes that a one-day suspension is an adequate penalty given that the officer has no prior sustained complaints in his three years of service with the Department. While the conduct of Officer No. 1 was extremely hazardous, the Penalty Guidelines justify the penalty of a one-day suspension. Indeed, the Guidelines allow for a written penalty through four suspension days.

---

[15] Officer No. 1 indicated on his Complaint Adjudication Form the intent to submit a response to the proposed disciplinary action against him. The investigation file did not include any such response from Officer No. 1, however, and therefore no such response was taken into account during the review of the investigation.

[16] Officer No. 3 was initially going to receive an Admonishment. Due to his unfavorable complaint history, however, the COP decided to raise his penalty to 10 suspension days. Officer No. 3 resigned from his position with the Department before any penalty was imposed against him. Therefore, his TEAMS report shows only "Resign/Retire" under the Penalty section. Officer No. 3's resignation is discussed further below.

[17] Officer No. 5 indicated on his Complaint Adjudication Form the intent to submit a response to the proposed disciplinary action against him. The investigation file did not include any such response from Officer No. 5, however, and therefore no such response was taken into account during the review of the investigation.

With respect to Officer No. 4, the Department based its decision to impose a 10-day suspension largely on the fact that this officer had one previously-sustained allegation of Accidental Discharge in 1999, which drew a four-day suspension. Additionally, Officer No. 4 has had a long history of misconduct with a total of 36 suspension days for 8 prior sustained complaints since 1991. Given the prior complaint history of Officer No. 4 including the prior Accidental Discharge, the OIG believes that the issuance of the 10-day penalty by the COP was appropriate under the circumstances.

With respect to Officer No. 5, the OIG believes that the Admonishment penalty is justified for his neglect of duty. In issuing a weapon from the Kit Room to Officer No. 4, Officer No. 5 has a critical responsibility to ensure that the weapon is unloaded. The failure to do so could easily have dire consequences, and this responsibility must therefore be taken extremely seriously. It was fortunate in this case that no injuries resulted from the accidental discharge. Still, the importance of Officer No. 5's responsibility to confirm that weapons issued from the Kit Room are unloaded should not be trivialized. A review of the TEAMS record for Officer No. 5 reveals only one prior sustained complaint in seven years of service with the Department for Neglect of Duty in 2000, for which the officer received an Admonishment.

With regard to Officer No. 3, the COP increased the recommended penalty from Admonishment to 10-days for the failure of Officer No. 3 to properly check the weapon prior to accepting it in its loaded condition from Officer No. 1 at the end of shift. As a Kit Room officer, Officer No. 3 inspected shotguns being returned from service on a routine basis. In fact, this function is likely one of the most important assignments of a Kit Room officer, in order to ensure the safety of all personnel at the station. In addition to the neglect of duty displayed by Officer No. 3 in this case, the officer has a lengthy complaint history, including eight other Sustained complaints with allegations of Unbecoming Conduct, False Statements, Neglect of Duty, and Failure to Report Misconduct. Officer No. 3 served a total of 33 suspension days for five of these eight Sustained complaints. The remaining three complaints, which were Sustained, did not go through the penalty phase because Officer No. 3 resigned prior to the imposition of discipline.

Given the extensive complaint history of Officer No. 3, the OIG concurs with the decision of the COP to increase the recommended penalty from a mere Admonishment to a 10-day suspension. This is Officer No. 3's fifth Sustained complaint for Neglect of Duty in less than five years. The Penalty Guidelines contemplate a severe penalty for a third Neglect of Duty violation, up to and including sending the officer to a Board of Rights.

One final concern of the OIG is that a review of the involved officers' TEAMS reports reveals that Officers No. 1, No. 3, No. 4, and No. 5, and Supervisor No. 1 do not appear to have received formal tactical training after this incident, as directed by the COP.[18]

[18] Supervisor No. 1 was directed to receive training regarding the monitoring of Officer No. 4 subsequent to the incident. The COP was concerned that Supervisor No. 1 left Officer No. 4 unmonitored after he advised the officer to go into the police facility and contact the Los Angeles Police Protective League following the accidental discharge.

## V. Conclusion

The OIG is pleased to find that the Department is, overall, doing a good job in its task of assigning Paragraph 93 allegations of misconduct to IAG for investigation. Our review of Paragraph 93 cases resulted in a finding of two cases wherein the Department did not properly assign or reassign the investigation of complaints to the appropriate entity. Although this number is low, it is nevertheless incumbent on the Department to ensure that the most serious allegations of misconduct, most of which are contained in Paragraph 93 of the Consent Decree, are assigned to the most appropriate investigative entity—IAG.

Additionally, several investigative issues were noted in the two Paragraph 93 investigations cited in this Report, which have been reported on by the OIG in the past. In both cases, serious allegations of misconduct were never framed, investigated, and/or adjudicated by the Department. These allegations were for False Imprisonment and Discrimination/Racial Profiling, all of which are listed in Paragraph 93 as requiring an investigation by IAG due to their severity.

As it concerns the COP's imposition of discipline in OIS cases, the OIG is again pleased to report that overall, the COP appears to be imposing discipline in an appropriate manner. However, in reviewing CUOF investigations, it was noted on multiple occasions that directed training is not being reflected on the involved officers' TEAMS reports. This issue has arisen in past reports by the OIG, including the OIG's Review of the Quarterly Discipline Report for the Second Quarter 2005. This problem continues to be an issue of concern.

## VI. Additional Comment

During the OIG Complaint Investigation Audit, the OIG Audit Section requested IAG to run a query of the Personnel Complaints Statistical System (PCSS) to determine whether there were any complaint investigations closed in August and September 2005 that had a Paragraph 93 allegation that was indicated as having been investigated by chains-of-command. The query indicated that a small number of these types of complaints were investigated by various chains-of-command rather than by IAG. This information was provided to IAG, and IAG staff performed research into the matter. The IAG informed the OIG that some of the allegations were misclassified, non-disciplinary in nature, and/or were incorrectly listed in the PCSS as having been investigated by chains-of-command instead of IAG. Unfortunately, due to time constraints, the OIG was not able to further research this matter. However, the next OIG Complaint Investigations Audit will include detailed testing of this audit area.