

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

**IN-CUSTODY DEATH – 031-19**

**Division                      Date                                      Duty-On (X) Off ( )    Uniform-Yes (X) No ( )**

Central                      7/14/19

**Officer(s) Involved in Use of Force      Length of Service**

Does not apply.

**Reason for Police Contact**

On July 12, 2019, officers were monitoring locations for narcotics activity. The officers observed Subject 1 involved in a narcotics transaction. This information was broadcast to uniformed officers who detained and searched Subject 1, locating heroin in his shoe. Subject 1 was placed under arrest for California Health and Safety Code section 11350(a), Possession of Narcotics and was booked at the Los Angeles Police Department (LAPD) Metropolitan Jail Section (MJS) later that evening.

On July 14, 2019, in the late afternoon, Subject 1 was found unconscious inside of his cell. Jail personnel performed Cardiopulmonary Resuscitation (CPR) until the Los Angeles Fire Department (LAFD) arrived. Paramedics attempted lifesaving measures before determining that Subject 1 was deceased a short time later.

**Subject(s)                                      Deceased (X)                                      Wounded ( )                                      Non-Hit ( )**

Subject 1: Male, 57 years of age.

**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 (Department) or the deliberations by the Board of Police Commissioners (BOPC). In evaluating this matter, the BOPC considered the following: the complete Force Investigation Division 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 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 June 9, 2020.

### **Incident Summary**

On July 12, 2019, in the afternoon, plainclothes Police Officers A and B were conducting narcotics enforcement activities.

Officers A and B observed Subject 2, a person they believed to be a narcotics dealer. The officers established an observation post and began watching Subject 2. Moments later, Officer A observed a male, identified as Subject 1, walk up to Subject 2 and converse with him. During the conversation, Subject 1 handed Subject 2 an unknown amount of U.S. Currency. Subject 2 accepted the currency before leaning down, manipulating his left shoe and handing Subject 1 a small dark substance. Subject 1 accepted the substance and wrapped it in a piece of white plastic before leaning down to tie his right shoe. Seconds later, Subject 1 stood up and walked away.

After watching the interaction between the two men, Officer A formed the belief that Subject 1 purchased heroin from Subject 2 and broadcast this information to uniformed Police Officers C and D, who were waiting nearby.

After receiving Officer A's radio broadcast, Officers C and D observed Subject 1 walking down the street. Officers C and D approached Subject 1 and verbally directed him to the corner of the intersection. Subject 1 complied and was handcuffed without incident. Officer C searched Subject 1 and located a brown, tar-like substance resembling heroin in his right shoe; the substance was wrapped in a piece of white plastic. Officer C recovered the item and placed Subject 1 under arrest. Officers C and D placed Subject 1 in the right rear passenger seat of their police vehicle and transported him to the Central Community Police Station, hereafter referred to as Central Station, for processing.

At Central Station, Subject 1 was brought before Sergeant A for an intake interview. Sergeant A completed the Adult Detention Log and pre-booking inspection. When asked, Subject 1 denied having any complaints of injury or illness. Immediately thereafter, Subject 1 was seated on the arrestee detention bench inside the Central Station report writing room.

Officer B completed an Arrestee Medical Screening Form. When questioned, Subject 1 advised he did not have any injuries or require medical attention. Force Investigation Division (FID) investigators reviewed the Arrestee Medical Screening Form and observed a notation indicating that Subject 1 had open wounds on his right leg. When interviewed, Officer B stated that he/she did not observe any injuries on Subject 1. The source of the notation is unknown.

Detectives A and B transported Subject 1 to MJS for booking. Detectives A and B entered MJS with Subject 1 and began the booking process. Detective A completed a strip search of Subject 1. Detective A did not locate any additional contraband or observe any signs of injury or medical distress. After the search, Detective B walked Subject 1 to a cell, where he was temporarily housed while jail personnel finalized his booking paperwork. Detectives A and B then left MJS and returned to Central Station to complete reports.

On July 13, 2019, in the early morning hours, Subject 1 met with Medical Services Division (MSD) Registered Nurse (RN) A and Physician Assistant (PA) A in regard to the pre-existing wounds on his right leg. Subject 1 told the medical staff he was a heroin user and was experiencing withdrawal symptoms. PA A advised FID investigators that he/she initially gave Subject 1 medications to lower his blood pressure, and to ease his muscle cramps. After assessing Subject 1, PA A prescribed additional medications and placed him on the "Q4 Protocol." The Q4 Protocol is an opiate withdrawal protocol that requires nurses to check on inmates every four hours and to provide them with prescribed medication as needed. Nurses check for overall alertness and symptoms such as diarrhea, vomiting, and dehydration.

Subject 1 was placed in the South-D housing module, where he was housed with other inmates over the course of the next 26 hours. During that time period, the South-D module was the subject of 53 Title 15 safety checks. The California Code of Regulations, Title 15, Section 1027, requires hourly safety checks of inmates. A safety check is a direct, visual observation performed at random intervals to provide for the health and welfare of inmates. Safety checks shall be done in person. Audio/video monitoring may supplement but not substitute for direct visual observation. In addition to the hourly safety checks mandated by the State of California, the LAPD Jail Operations Manual mandates an additional check every hour, for a total of two checks per hour. Detention personnel conducting safety checks shall look at an inmate for signs of life (e.g. breathing, talking, movement) and obvious signs of distress (e.g. bleeding, trauma, visible injury, choking, or difficulty breathing).

On July 13, 2019, RN B was assigned to perform the Q4 checks on the South-D housing module. According to RN B, Subject 1 did not come to the module's door when he/she called for Subject 1 during the morning and early afternoon Q4 checks. On his/her third check, RN B asked Custody Services Division (CSD) Police Officer E to enter the module and bring Subject 1 to the module door. According to RN B, when Officer E entered the module, he/she located Subject 1 in a bunk and told him that the nurse wanted to see him; however, Subject 1 declined. Nurse B left the module since Subject 1 refused to meet with him/her. Medical staff must always be escorted throughout the jail facility and are not authorized to enter housing modules.

When interviewed, Officer E advised that upon entering the module, he/she located Subject 1 and observed him to be "okay." Subject 1 told Officer E he did not need to see a doctor or need any other services. Officer E conveyed this information to RN B, who advised Officer E that Subject 1 could remain in the module.

On July 14, 2019, in the early morning, Officer E and CSD Detention Officers (DOs) A and B conducted a start of watch inspection of the South-D housing module to account for each inmate. According to DO A, during the inspection he/she found Subject 1 lying on the floor and asked him if he was okay. Subject 1 told him/her that he was having trouble breathing. Upon contacting Subject 1, DOs A, B and Officer E each observed a small amount of blood on Subject 1's lips and mouth. The officers left the module to obtain a wheelchair. When they returned approximately four minutes later, they assisted Subject 1 into the chair and wheeled him to the dispensary.

RN C examined Subject 1 at the dispensary. According to RN C, Subject 1 advised that he was experiencing abdominal pain and nausea, but that he had not vomited. Nurse C was aware that Subject 1 was withdrawing from opiates and attributed his symptoms to the withdrawal process. Nurse C administered medicines to treat Subject 1's stomach cramps and nausea, in addition to a muscle relaxer. After administering the medication, RN C cleared Subject 1 to return to the South-D housing module.

DO B directed Officer E and DO A to place Subject 1 into cell South-B-102. Later in the afternoon, RN D performed Q4 checks in the South-B housing module. According to RN D, he/she stopped in front of Subject 1's cell door, observed him lying in his bunk and noticed he had not eaten his lunch. After being encouraged by RN D to eat, Subject 1 stood up, walked to the door, and picked up his lunch from the cell port. Nurse D asked Subject 1 if he was okay. Subject 1 responded "yeah" before taking his food and returning to the bed. According to RN D, Subject 1 appeared to be tired, which was a side-effect consistent with the medications he had received earlier in the day.

DO C later entered the South-B housing module to perform Title 15 safety checks. Prior to entering the module, DO C documented the check by signing a CSD Observation Record. Detention Officer C stopped in front of Subject 1's door, looked through the window, and observed Subject 1 sitting on the toilet. According to DO C, Subject 1's head was tilted to the right and his chest was moving; he/she believed Subject 1 was sleeping. DO C stated he/she did not bang on the window or enter the cell, because it was common for arrestees to fall asleep while on the toilet. After completing the Title 15 safety check of Subject 1's cell, DO C completed additional Title 15 safety checks before leaving the module.

Approximately thirty minutes later, DO C entered the South-B housing module to perform Title 15 safety checks. Prior to entering the module, DO C again signed the CSD Observation Record. According to DO C, before he/she started the checks, DO B contacted him/her via intercom and asked him/her to go to the second level and escort an inmate, (Subject 3), out of the module so that he could be transferred to Twin Towers. Detention Officer C suspended his/her Title 15 safety checks, went to the second level, located Subject 3 and escorted him down the stairs, passing Subject 1's cell. According to DO C, as he/she passed cell South-B-102, he/she could see Subject 1 in his/her peripheral vision and could tell he was still seated on the toilet, but he/she did not stop and look directly into the cell, because his/her focus was on escorting

Subject 3. Detention Officer C left the South-B housing module without performing any additional Title 15 safety checks or notifying other staff members that the checks were not completed.

FID investigators reviewed CSD Observation Records documenting the Title 15 safety checks done in the South-B housing module on July 14, 2019. These records were compared to the MJS security video, and it was determined that all prior checks were completed in accordance with Department policy.

Approximately thirty minutes later, Officer E was conducting Title 15 safety checks in the South-B housing module. When Officer E looked into cell 102, he/she observed Subject 1 sitting on the toilet with the right side of his body leaning against the west wall. Officer E attempted to get Subject 1's attention by knocking on the window with his/her hand. Officer E noticed Subject 1 was drooling and believed he was unconscious or deceased. Officer E used his/her radio to request that DO B, who was working in the control tower, open Subject 1's cell door.

Once the door was open, Officer E stepped into the cell alone and attempted to rouse Subject 1 by tapping Subject 1's chest and left elbow with his/her left hand. When he/she did not receive a response, Officer E gripped Subject 1's left forearm and gently shook it. Over the intercom, DO B asked Officer E if Subject 1 was okay. Using first his/her police radio and then the cell's intercom, he/she advised DO B that he/she did not think Subject 1 was breathing. Officer E then checked Subject 1's left wrist for a pulse. After failing to locate a pulse, Officer E moved Subject 1 to the floor of the cell and placed him in a supine position.

Upon hearing Officer E's request to open the cell door, DO B began monitoring the cell's security camera; DO B also activated the intercom so he/she could monitor the audio inside the cell and communicate with Officer E. According to DO B, he/she observed Officer E enter the cell and attempt to wake Subject 1. DO B asked Officer E if Subject 1 was okay, and Officer E advised that Subject 1 was unresponsive and did not have a pulse. DO B alerted DO's A and C to the situation before leaving the control tower to assist Officer E. DO A left with DO B, while DO C remained behind to staff the control tower. After leaving the tower, DO's A and B encountered RN D, who was conducting Q4 checks in the area with CSD Police Officer F. The group joined Officer E.

Nurse D assisted Officer E with moving Subject 1 outside of the cell, where they immediately initiated CPR. Officer E performed chest compressions, while RN D held Subject 1's head and maintained an open airway. According to DO B, he/she simultaneously used his/her police radio to broadcast, "We have a man down in South Boy 102. The arrestee is unresponsive. We're starting CPR. I need additional personnel and medical staff."

In response to DO B's broadcast, MJS staff contacted the LAFD Metropolitan Fire Communications. The LAFD dispatched a fire engine and Rescue Ambulance.

After issuing a “man down” broadcast, DO B obtained an Automated External Defibrillator (AED) and placed the defibrillator pads on Subject 1’s chest and torso. Although the defibrillator pads were applied to Subject 1 and the AED was powered on, a shock was not administered, because the AED did not detect a shockable heart rhythm.

MSD Doctor A arrived with RN’s B and C; all three were in the dispensary at the time the “man down” broadcast was initiated. Prior to leaving the dispensary, RN B obtained a bag of emergency medical supplies and brought it with him/her to the South-B housing module. Doctor A oversaw the lifesaving efforts, while RN B began ventilating Subject 1 with a bag valve mask and RN C prepared to administer an intravenous line.

During this incident, CPR was provided continuously until the arrival of LAFD. Officer E, RN D, DO’s A and D, provided chest compressions, while RN’s B, C, and D provided ventilations.

The LAFD personnel assigned to the engine company entered the South-B housing module and assumed care of Subject 1. Firefighter/Paramedics (FFP’s) A and B joined the engine company personnel. After attempting life saving measures, FFPs A and B determined Subject 1 to be deceased.

### **Los Angeles Board of Police Commissioners’ Findings**

The BOPC reviews each Categorical Use of Force 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:

- There was no Use of Force related to Subject 1’s detention or arrest. The BOPC determined that the actions of the involved Central Patrol Division and Custody Services Division personnel did not contribute to Subject 1’s death and that no findings were warranted.

During its review of the incident, the BOPC noted the following issues:

- **Incomplete Arrestee Medical Screening Form** – The investigation revealed that Officer B did not complete the Arrestee Medical Screening Form in its entirety. Officer B’s actions resulted in unknown personnel completing the Arrestee Medical Screening Form inaccurately with a notation that Subject 1 had an open wound on his leg.
- **Administrative Segregation** – The FID investigation revealed that on July 14, 2019, Detention Officer B directed Officer E and Detention Officer A to place Subject 1 into South-B-102, a single occupant segregation cell. Detention Officer B was

assigned as a Lead Detention Officer (LDO) for the South housing modules. LDO's are non-supervisory team leaders, who are tasked with overseeing the completion of jail logs and delegating assignments to other staff members. Detention Officer B's status as an LDO did not authorize him/her to place Subject 1 in a segregation cell, which must be approved by a supervisor.

- **Unescorted Medical Staff** – The FID investigation identified that Registered Nurse D was not escorted by jail staff for the July 14, 2019, morning Q4 check. Department policy requires that medical staff be escorted by jail personnel. Medical staff assigned to the jail were to be reminded of the requirement to have a jail staff escort, and the prohibition to conduct sick or pill call without such escort.
- **CSD Observation Logs – Inmate Tracking** – The FID investigation revealed that on July 14, 2019, CSD staff did not properly document the relocation of Subject 1 from the South-D housing module into the South-B-102 single occupant segregation module. CSD Observation Logs are used to document the inmate population in housing blocks to ensure inmate accountability and that overcrowding does not occur.
- **Documentation of Title 15 Safety Check** – Detention Officer C signed the CSD Observation Log on two occasions prior to completing the Title 15 safety checks.
- **Missed Title 15 Safety Checks** – Detention Officer C missed a mandated Title 15 safety check for July 14, in the afternoon as a result of being re-directed to retrieve another inmate.
- **Improper Inmate Escort** – When Detention Officer C was diverted from the July 14, 2016 Title 15 safety check to escort another inmate for reasons unrelated to the ICD, Detention Officer C did not handcuff that felony suspect and conducted the escort alone.
- **Improper Radio Broadcast** – Officer E did not broadcast, "Officer Needs Help," prior to entering Subject 1's cell alone and broadcast the incorrect verbiage after entering Subject 1's cell. The Jail Operations Manual provides an exemption to entering an occupied cell, "In an exigent, life threatening circumstance or the need to render medical aid to a lone occupant in a cell, a lone employee may enter the cell prior to the arrival of sufficient personnel." Officer E did broadcast, "Man Down," but not until after he/she had already requested the opening of the cell door, entered the cell, and performed an initial assessment of Subject 1.

The BOPC noted that the Department has taken remedial action regarding the above-described issues, and that the Department is currently developing a Categorical Use of Force In-Custody Death Adjudication Process Order for consideration by the Board of Police Commissioners.