

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

IN-CUSTODY DEATH – 088-08

Division	Date	Duty-On(X) Off()	Uniform-Yes(X) No()
Central	10/10/2008		

Involved Officer(s)	Length of Service
Not applicable.	

Reason for Police Contact

Subject 1 was in custody in a Department jail facility when he was found hanged in his cell.

Subject(s)	Deceased (X)	Wounded ()	Non-Hit ()
Subject 1: Male, 61 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 Los Angeles Police Department Command Staff presented the matter to the Commission and made itself available for any inquiries by the Commission.

The following incident was adjudicated by the BOPC on 9/1/09.

Incident Summary

In 1981, Subject 1 and his wife were in Los Angeles visiting from Japan. Subject 1 reported to the Los Angeles Police Department that he and his wife were shot during a robbery. Subject 1 sustained a gunshot wound to the left thigh, and his wife sustained a gunshot wound to the head. Subject 1's wife lapsed into a coma as a result of her injury. During the subsequent investigation, Subject 1 became a person of interest.

In January 1982, Subject 1 and his wife returned to Japan. In November, 1982, Subject 1's wife, having never regained consciousness, died as a result of the gunshot wound to her head and the crime against her was reclassified as murder.

In 1988, a warrant was issued for the arrest of Subject 1 in connection with his wife's murder.

In February, 2008, Subject 1 was taken into custody in Saipan and was housed at a jail facility there pending extradition proceedings.

On October 10, 2008, officers travelled to Saipan to extradite Subject 1. Subject 1 was transported without incident to a Los Angeles Police Department jail facility.

At 7:28 a.m. on October 10, 2008, Subject 1 was presented to Sergeant A for booking. During a pre-booking interview, Subject 1 (through a translator) advised Sergeant A that he understood why he had been arrested and indicated that he was suffering from back pain and insomnia and that he had food allergies. Sergeant A advised Subject 1 that he would be taken to the jail dispensary and seen by a doctor. Subject 1 asked Sergeant A questions related to jail procedures and calling his attorney, and inquired about the reading material and denture cream he had brought with him from Saipan.

At 8:04 a.m., officers escorted Subject 1 to the jail dispensary, where he was seen by Nurse A and Doctor A for a pre-booking medical examination. Nurse A took Subject 1's vital signs, which were within normal range. Subject 1 informed Doctor A that he was taking medications for lower back pain, anxiety and insomnia. Doctor A prescribed medication for these complaints. Doctor A provided medical approval for Subject 1 to be booked at the jail facility. At 8:42 a.m., Subject 1 was discharged from the dispensary.

Note: According to Nurse A, Subject 1 showed no signs of emotional distress and was calm and cooperative during his assessment. The only concerns Subject 1 raised were related to his back pain and need for dental powder for his dentures.

According to Doctor A, Subject 1 made no mention of being suicidal.

At 8:49 a.m., Detention Officer (DO) A booked Subject 1 into the jail facility. The booking process was completed at 9:01 a.m. Subject 1 was placed alone in Cell No. B-4 in the facility's B Block.

Note: B Block has a hallway that runs in an east/west direction and consists of three large cells (Cell Nos. B-6, B-7 and B-8) that are positioned on the north side of the hallway and five smaller cells (Cell Nos. B-1 through B-5) that are positioned on the south side of the hallway. Each end of the hallway is secured by a door.

At 9:30 a.m., DO B conducted the first mandatory 30-minute visual cell inspection of Cell No. B-4. The inspection was documented on the Jail Inspection Record affixed to the cell window.

Note: Between 9:30 a.m. and 9:31 p.m., a total of 25 jail cell inspections of Cell No. B-4 were conducted by Detention Officers (DOs) B, C, D, E and Senior Detention Officer (SDO) A. The inspections were completed without incident and were documented on the Jail Inspection Record.

At 10:49 a.m. and 11:00 a.m., Subject 1 made telephone calls to the Japanese Consulate in Los Angeles. At 11:15 a.m., Subject 1 was notified that he had visitors from the Japanese Consulate and was escorted by DO C to the Visitor's Booth. Subject 1 met with members of the consular staff for approximately 15 minutes and was then escorted back to Cell No. B-4.

At 3:20 p.m., Subject 1 received a visit from an attorney.

At 4:11 p.m., Sergeant B conducted a Watch Commander Inspection of Cell No. B-4 without incident and documented it on the Jail Inspection Record.

Between 5:00 p.m. to 6:00 p.m., dispensary personnel conducted their sick call rounds during which the inmates who had medical issues were provided medication prescribed by the doctor. Nurse B had contact with Subject 1 at Cell No. B-4 for approximately five minutes and gave him his prescribed medicine.

Note: According to Nurse B, Subject 1 showed him his dentures and inquired about his dental powder. Nurse B advised Subject 1 to request a nurse whenever he needed the dental powder. Nurse B noted that Subject 1 was calm and showed no signs of emotional distress.

Note: Inmate A was housed in Cell No. B-6, which was positioned across the hallway from Subject 1's cell. Cell Nos. B-4 and B-6 had large windows which allowed Inmate A and Subject 1 to look into each other's cells. Inmate A indicated that he and Subject 1 had several conversations; however, since Subject 1 spoke limited English Inmate A could not understand him very well. According to Inmate A, Subject 1 asked him questions about County jail. Inmate A indicated that Subject 1 was "stressing out" and would start crying.

At 9:01 p.m., Senior Detention Officer (SDO) A conducted an inspection of B Block. Upon reaching Cell No. B-4, Subject 1 asked SDO A what time it was. SDO A advised Subject 1 that it was nine o'clock and Subject 1 returned to the lower left bunk.

At 9:31 p.m., SDO A conducted another inspection of Cell No. B-4 and observed Subject 1 sleeping on the left lower bunk with his feet facing toward the cell door.

Meanwhile, DO E conducted inspections of cells elsewhere in the facility. Upon completing his last inspection at 9:33 p.m., DO E walked through B Block.

DO E was aware that SDO A had already conducted the mandatory inspections of B Block, but as he walked through the hallway he looked into the cells, checking for

unusual activity. When DO E looked inside Cell No. B-4, he observed Subject 1 facing the wall at the foot of the bed, "in a seated position like hanging from the neck to the top bunk." DO E used his flashlight to confirm his observation and then ran to look for backup. According to DO E, he activated his radio as he ran and broadcast, "Man down, man down. Bring the doctor. Man down. Man down. Possible suicide. B-4. B-4."

Note: According to Inmate A, he told Subject 1 that he was going to sleep. Approximately 15 minutes later, he heard a noise which sounded to him like a body bouncing against something. Inmate A looked through his cell window into Subject 1's cell and observed Subject 1 hanging at the foot of the bunk bed with a shirt around his neck. At the same time, Inmate A observed a DO coming down the hallway yelling, "Man down, man down." Inmate A then observed several DOs enter Subject 1's cell.

Note: For safety reasons, jail protocol requires that personnel not enter an occupied cell alone.

DOs E and F returned to Cell No. B-4 and were followed shortly thereafter by DOs G, H and SDO A, who had responded to the broadcast. The cell door was opened, and DOs G, H, E, F and SDO A entered the cell and observed Subject 1 unconscious and hanging by a shirt that was tied around his neck.

DO E approached Subject 1 and touched his (Subject 1's) right arm. DO E felt that Subject 1's arm was limp. DO E immediately grabbed Subject 1 by his armpits and lifted him up to relieve the tension on Subject 1's neck. DO F assisted DO E by grabbing Subject 1's legs and lifting Subject 1 up. DOs G and H unsuccessfully attempted to untie the makeshift ligature around Subject 1's neck. DO H yelled out for a "suicide knife." SDO A left the cell and returned with a knife which he handed DO H. DO H unsuccessfully attempted to cut the ligature from Subject 1's neck and handed the knife back to SDO A. DOs G and H were subsequently able to free Subject 1 by pulling the ligature away from his neck and then over his head.

Note: The "suicide knife" is a cutting instrument used by jail personnel to remove makeshift ligatures from inmates who attempt suicide.

DOs E, F and H carried Subject 1 out of the cell to the B Block hallway and placed him on the floor. DO E began cardiopulmonary resuscitation (CPR) by administering chest compressions and was subsequently relieved by DO F to avoid fatigue. Dispensary Nurses C and D and Doctor B arrived shortly thereafter with medical equipment. Doctor B assessed Subject 1 and noted that he had no pulse, no respiration and that his pupils were fixed and dilated. Doctor B and Nurse D continued CPR.

At 9:41 p.m., SDO A telephoned Communications Division and requested a rescue ambulance (RA) to respond.

At 9:48 p.m., the RA arrived at the scene and emergency medical treatment was administered to Subject 1. Subject 1 remained unconscious and unresponsive. At 10:11 p.m., Subject 1 was transported to a hospital, arriving at 10:18 p.m.

Upon arriving at the hospital, Subject 1 was transferred to Emergency Room. Resuscitative efforts by emergency room personnel were unsuccessful. At 10:24 p.m., Subject 1 was pronounced dead.

A subsequent Autopsy examination by the County of Los Angeles Department of Coroner determined the cause of Subject 1's death to be hanging and the manner of his death to be suicide.

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/Holstering of a weapon by any involved officer(s); and the Use of Force by any involved officer(s). All incidents are evaluated to identify areas where involved officers can benefit from a tactical debriefing to improve their response to future tactical situations. This is an effort to ensure that all officers benefit from the critical analysis that is applied to each incident as it is reviewed by various levels within the Department and by the BOPC. Based on the BOPC's review of the instant case, the BOPC unanimously made the following findings.

A. Tactics

The BOPC found tactics not to apply.

B. Drawing/Exhibiting/Holstering

The BOPC found drawing/exhibiting/holstering not to apply.

C. Use of Force

The BOPC found use of force not to apply.

Basis for Findings

A. Tactics

The BOPC found that there were no tactical actions associated with this incident.

B. Drawing/Exhibiting/Holstering

The BOPC found that no firearms were drawn or exhibited during this incident.

C. Use of Force

The BOPC found that no force was used on Subject 1 while he was in the Department's custody.

Additional

The BOPC noted that there was a delay in the issuance of required notifications regarding this incident. This delay was the result of instructions issued by Assistant Chief A and Deputy Chief A.

Subject 1 was discovered hanged at approximately 9:35 p.m. and was pronounced dead at 10:24 p.m.

At 12:50 a.m., Deputy Chief A instructed Real Time Analysis and Critical Response Division (RACR) Sergeant D to notify Force Investigation Division (FID) of the in-custody death (ICD).

At 5:25 a.m., Deputy Chief A instructed Sergeant D to notify concerned Department personnel of the ICD. At 5:26 a.m., RACR notified the Office of the Inspector General (OIG) of the ICD.

Note: Department policy requires that RACR be notified when an ICD occurs. RACR is required to promptly disseminate the notification to several Department entities, including the Chief of Police, FID and the OIG.

The BOPC noted that the Chief of Police has discussed the above issue with all Command Staff to ensure timely notifications are made subsequent to categorical use of force incidents.