

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

IN-CUSTODY DEATH – 103-08

<u>Division</u>	<u>Date</u>	<u>Duty-On(X) Off()</u>	<u>Uniform-Yes(X) No()</u>
Central	12/03/2008		

Officer(s) Involved in Use of Force **Length of Service**
Not applicable.

Reason for Police Contact

A subject was arrested for a narcotics violation and booked at Department Jail facility.

<u>Subject(s)</u>	<u>Deceased (X)</u>	<u>Wounded ()</u>	<u>Non-Hit ()</u>
Subject: Male, 33 years old			

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 suspect 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.

Because state law prohibits divulging the identity of police officers in public reports, for ease of reference, the masculine pronouns (he, his, and him) will be used in this report to refer to male or female employees.

The following incident was adjudicated by the BOPC on November 10, 2009.

Incident Summary

Detective A and Officers A and B were conducting a plainclothes narcotics investigation when Officer A observed the subject involved in a narcotics transaction. After the subject walked away from the transaction, Detective A and Officers A and B detained the subject and placed him under arrest for a narcotics violation.

Subsequent to the arrest, Officer C and his partner transported the subject to the station for booking. After arriving at the station, Officer C presented the subject to Watch Commander Lieutenant A, who interviewed the subject.

Lieutenant A documented on the Adult Detention Log that the subject understood why he was arrested, that the subject was sick, and that the subject was referred to the Metropolitan Jail Section (MJS) Dispensary. No response was documented to the third standard pre-booking question regarding whether the arrestee had any questions or concerns. When later questioned regarding the lack of notation, Lieutenant A stated, "I'm sure I asked it. It's just an oversight."

Upon completion of Lieutenant A's pre-booking questions, Officer C sat the subject on a bench and completed the medical screening form. The subject told Officer C that he was not a mental patient, nor did he have a mental disorder. Officer C asked the subject if he was suicidal and he replied that he was not. Officer C did not observe any behavior to indicate that the subject was suicidal.

Doctor A and Nurse A next interviewed the subject. The subject was also asked whether he had thoughts regarding suicide, or whether he had made any attempts at suicide. As recounted by Nurse A, "The doctor, you know, does the eval. We – we ask them, you know, how they're feeling. If they have any, you know, history of suicide attempts, are they feeling suicidal now, and basically – and he was – the officers were real friendly with him. And he was basically in a good spirits in that he was thanking the officers for their help and cooperation."

Upon completion of the interview by Doctor A, Detective D escorted the subject to the booking area and released him to the custody of the detention officers. During the booking process, the subject did not give any indication that he was suicidal.

When the booking process was completed, the subject was placed into a cell. Also present inside the cell were two other arrestees (Witnesses 1 and 2). Witness 1 said that Witness 2 was released approximately four hours prior to breakfast.

After breakfast was served, the subject spoke to Witness 1 about committing suicide. As recounted by Witness 1, "He says, 'have you ever seen anybody commit suicide?' And I said, 'no.' I said, 'I don't want to.' And he said, 'Well, would it freak you out if – if you woke up and I was, like, struggling or I hung myself?' And I told him I said, 'Yeah, that would seriously freak me out.' I said, 'Don't - I said, don't do it. You know, if - if you're thinking that way, please, tell - tell the jailer. Tell the jail people.' And he - and he goes, 'oh no.' He says, 'I just – you know, I'm just thinking. You know, just – you know, just random questions.'"

Detention Officer A removed Witness 1 out of his cell in order to release him from custody. According to Detention Officer A, he observed the subject standing up inside the cell. According to Witness 1, the subject appeared to be in a good mood. Following Witness 1's removal from the cell, the subject was the only arrestee inside the cell. Witness 1 never informed jail staff of the subject's comments regarding suicide.

Detention Officer B subsequently conducted a check of the cell and the subject asked Detention Officer B if his arrest would be a third strike. Detention Officer B explained that the subject's narcotics possession charge would not be considered a strike. As

Detention Officer B was walking away, the subject said to Detention Officer B, "Well thank you very much You just saved me."

Detention Officer B thought about the subject's statement, considered it "weird," and returned to his cell. Detention Officer B then engaged the subject in a conversation regarding his arrest, a third strike and a drug diversion program that he might be eligible for. As described by Detention Officer B, "So he said, "Thanks for talking to me and letting me know that there's other alternatives.' So he didn't use those words, but that was like the conversation. So he seemed okay."

The Jail Inspection Record had an entry indicating that Detention Officer B conducted a check of the cell at "1301." However, the "0" was written over another number and it appeared that the original time documented was "1331." When interviewed, Detention Officer B indicated the actual time of the cell check for the isolation cell was "1301." When asked about the overwriting, Detention Officer B that that he "made a mistake." The Jail Inspection Record for the isolation cell did not indicate that any additional inspections occurred after the 1:01 p.m. check.

At 1:40 p.m., as Detention Officer A passed by the cell, he observed the subject with a blue sheet around his neck, hanging from the top rail of a bunk bed.

Detention Officer A immediately shouted for Detention Officer C. As Detention Officer C ran to assist, Detention Officer A opened the cell door, then used his radio to broadcast that there was a "man down." Detention Officer C called to the subject, but received no response. The subject's head was slumped forward and his knees were bent and almost touched the floor.

According to Detention Officer C, "I was trying to remove the sheet that he had around his neck, and that's what I was doing. And my partner had both hands on – his armpits." Detention Officer A "grabbed [the subject] from his pants and his right arm." Detention Officer C could not remove the bed sheet from the subject's neck due to the weight of his body. According to Detention Officer C, "he was too heavy. And all I could do was - I held him with one arm, my right arm. And then with my left arm, I was trying to pull the sheet. It seemed like he had a knot around his neck." Detention Officer C continued, "Eventually, I told my partner just lift, you know, to basically concentrate and I told him just pick him up, pick him up. And I – with both hands, I pulled the sheet and it came off."

Detention Officers A and C then laid the subject down on his back on the floor of the cell. Sergeant A arrived and directed Detention Officers A and C to remove the subject from the cell and lay him down in the hallway where there was more space to treat him.

The dispensary received a phone call alerting them to a "man down," and Doctors B and C, along with Nurses B and C, immediately responded with emergency medical equipment. According to Doctor B, upon arrival, Doctor B observed that the subject was not breathing and that his eyes were open and dilated. Cardio Pulmonary Resuscitation

(CPR) was then initiated. Sergeant B next requested that a Los Angeles Fire Department (LAFD) Rescue Ambulance (RA) respond to the jail.

The doctors and nurses performed CPR until the arrival of the RA; however, the subject did not respond. As described by Paramedic A, “[the subject] had no pulse, no spontaneous respirations and he was on a cardiac monitor. He was in a pulse-less electrical activity and without pulses being able to be felt.” Subsequent contact by LAFD personnel with personnel from an area medical center resulted in the subject being telephonically pronounced 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/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.

Findings

The Use of Force Review Board determined, and the BOPC concurred, that the subject’s detention and arrest was consistent with Department standards. It was established that there was no use of force involved in the arrest, transportation and detention of the subject. Furthermore, the Coroner’s report noted the cause of death was a result of suicide by hanging. A thorough review of these facts indicated that there was no correlation established between the actions of Department personnel and the death of the subject. Therefore, no specific findings pertaining to this incident are necessary.

Additional

The investigation revealed that the subject was found by Jail Division personnel hanging from a bunk inside the isolation cell at approximately 1:40 p.m. The final documented cell inspection for the isolation cell was completed at 1:01 p.m. The subsequent inspection, scheduled for approximately 1:30 p.m., was not completed. The BOPC has noted reoccurring inaccuracies or omissions pertaining to these mandatory inspections in similar cases. The BOPC noted that the Commanding Officer, Jail Division, has been directed to establish additional protocols and procedures and to provide the necessary training and audits to ensure that proper cell inspections are completed and accurately documented.