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

IN-CUSTODY DEATH – 006-22

Division	**Date**	**Duty-On (X) Off ( ) Uniform-Yes (X) No ( )**
Pacific	2/15/22	

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

Not Applicable.

Reason for Police Contact

On Tuesday, February 15, 2022, officers observed the Subject walking in the roadway. The officers made contact with the Subject and learned he had an outstanding felony warrant for vandalism. The Subject was arrested for his warrant and booked into Pacific Jail for housing. On Wednesday, February 16, 2022, the Subject was found nonresponsive inside of his lone jail cell. Officers performed Cardiopulmonary Resuscitation (CPR) and summoned the Los Angeles Fire Department (LAFD) for medical assistance. Despite lifesaving efforts, The Subject was pronounced dead by LAFD paramedics.

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

Subject: Male, 31 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 (UOFRB) recommendations; the report and recommendations of the Chief of Police; and the report and recommendations of the Office of the Inspector General. The Department Command staff presented the matter to the BOPC and made itself available for any inquiries by the BOPC.

The following incident was adjudicated by the BOPC on January 24, 2023.

Incident Summary

On February 15, 2022, at approximately 1445 hours, Police Officers A and B were conducting patrol when they observed the Subject walking in the roadway and decided to conduct a consensual encounter. They drove alongside the Subject and requested to speak with him. According to Officer A, he/she remembered the Subject from a contact approximately two years earlier.

According to Officer B, Officer A told him/her that he/she possibly knew the Subject and wanted to speak with him. Officers A and B remained seated in their police vehicle as the Subject stood on the sidewalk on the passenger side.

Officers A and B engaged in a conversation with the Subject and requested his name and date of birth. Officer B conducted a want and warrant check via their Mobile Data Computer (MDC) system. According to Officer A, after the Subject provided his information to them, he was pacing back and forth on the sidewalk. Officer A repositioned the police vehicle in response to where the Subject had moved on the sidewalk.

The MDC inquiry returned with a felony vandalism warrant in the Subject's name and matching date of birth.

Officer B's body-worn video (BWV) captured him/her handcuff the Subject and conduct a search incident to arrest. During the search, Officer B asked the Subject if he had anything sharp on his person. The Subject stated he had a "rig" (syringe) in his rear pants pocket.

Officer B located and removed the syringe from the Subject's rear pocket and placed it on top of the police vehicle. The Subject also told the officers he had marijuana in his bag, which was then located by Officer A. According to Officer B, he/she used the technique taught at the Los Angeles Police Academy to search the Subject's pockets, waistband, pant legs, and groin area during a search "incident to arrest." Officer B did not locate any weapons or additional narcotics during the search of the Subject's person.

After verifying that the felony warrant was active and descriptors matched the Subject's, Officers A and B placed the Subject in the rear passenger seat of their vehicle.

At 1500:50 hours, Officers A and B transported the Subject to Pacific Station for his felony warrant. At approximately 1510 hours, the officers arrived at Pacific Police Station. The Subject was brought before Sergeant A for an intake interview. During the intake questioning, the Subject did not complain of any illness or injuries and understood the cause for his arrest. Sergeant A documented the Subject's responses to the questions on the Adult Detention Log.

Immediately thereafter, the Subject was seated on the arrestee detention bench outside of the report writing room. Officer B completed a Los Angeles County Unified Arrestee Medical Screening Form with the Subject. The Subject indicated on the screening form that he did not have any medical problems or regularly use alcohol or drugs.

Officer A searched the Subject's shoes and removed the laces as he sat on the bench. Nothing was recovered from the shoes. He/she did not search the Subject's socks or clothing while at the scene or station. Officer A advised he/she would not be expected to search an arrestee's socks for this type of arrest.

Officer A conducted a criminal history inquiry on the Subject via the Consolidated Criminal History Reporting System (CCHRS).

Officer A completed an LAPD Booking Approval Form and presented it to Sergeant A for approval. According to Officer A, he/she did not advise Sergeant A about the syringe or marijuana.

Sergeant A reviewed and approved the booking form and checked the boxes which indicated he/she reviewed the criminal rap sheet and did not approve a strip search.

At approximately 1658 hours, Officers A and B escorted the Subject into the Custody Services Division (CSD) Pacific Jail booking area and began the booking process. Officers A and B did not conduct any further search of the Subject.

CSD Senior Detention Officer (SDO) A completed the computer data entry of the arrest while his/her partner, Detention Officer (DO) A, performed the Live Scan process, including photographs and fingerprints. As observed on jail video surveillance, DO A used a metal detection wand to conduct a search of the Subject's clothing before escorting him to Cell No. J-1.

The Subject remained in Cell No. J-1 for the entire time spent at Pacific Jail and did not share his cell with another inmate. Cell No. J-1 is under 24-hour video surveillance. The camera is affixed to the ceiling of the cell in the southeast corner. The video footage is in color and there is no audio.

Pacific Jail is equipped with a digital surveillance system with cameras affixed at various positions throughout the facility. Facilities Management Division Security Services is responsible for the surveillance system. The Force Investigation Division (FID) Video Technology Unit examined the surveillance system and noted the time was slow by 5 minutes and 52 seconds compared to the time reported by the DOs' digital scanners, which were found to have the correct time. Investigators obtained the video surveillance which depicted all of the Subject's movements while in the facility. The times throughout the remainder of this report are based on the video surveillance time stamp, which is 5 minutes 52 seconds behind time.

DOs are required to conduct safety checks of the inmates housed in the jail facility. DOs documented each inspection on a handwritten log kept only for that current watch. In addition to the handwritten log, DOs utilize the Guardian Management System, which is a Radio Frequency Identification System (RFID) that digitally records each safety check.

Pacific Jail has magnetic tags affixed to the walls throughout the jail facility wherever inmates are housed. During safety checks, the DOs are required to scan the tag with a handheld electromagnetic reader, which records the date and time the safety check was completed. FID investigators reviewed the Pacific Jail surveillance video and associated FID Compliance Monitor Report and verified the Title-15 safety checks were conducted on the Subject twice an hour during the entire time he/she was housed at Pacific Jail.

At 1723 hours, video captured the Subject using the toilet in his cell with his pants pushed down to his ankles. As he sat on the toilet, he reached inside his pants with both hands. He appeared to be looking for something on the interior of the pants near the groin area. Shortly after, his hands reappeared; however, his right hand was clenched in a fist. After several minutes, the Subject fidgeted with an item in his right hand and appeared to transition the item to his left hand. As that occurred, the Subject looked up toward the jail cell surveillance camera. At 1726 hours, the Subject briefly opened his left hand which revealed him holding an off-white-colored object. The Subject continued to sit on the toilet for several more minutes until he stood up and eventually placed the item in his front-right sweater pocket.

DO A conducted three safety checks on the Subject at 1730, 1757, and 1821 hours before his/her shift ended. According to jail security footage, the Subject was sitting on the toilet during DO A's check at 1730 hours.

At 1830 hours, CSD SDO B and DO B began their shift at Pacific Jail and were responsible for all the inmates. Over the course of their 12-hour shift, SDO B and DO B properly conducted the required safety checks of the Subject and other inmates at twice hourly intervals.

According to SDO B, he/she was responsible for all the inmates' overall well-being; providing meals, showers and addressing anything an inmate may need. SDO B said that during every mandated wellness inspection, he/she checks to make sure the inmate is alive and doing well. If the inmate is asleep, he/she will check for the chest to rise or any body movement.

According to SDO B, once he/she sees movement, he/she will then move on to check the next cell. SDO B advised that during his/her shift, the Subject did not complain or indicate he was in any kind of medical distress. If there had been any issues with the Subject, SDO B advised that he/she would have notified the watch commander and have the Subject transported for medical treatment.

According to Cell No. J-1 video surveillance, at 0154 hours, the Subject was awake in his cell and seemed to be looking at items in his hand. The camera captured him drop an object on the floor and it appeared to land near his feet.

At 0611 hours, the Subject was awake and appeared to be looking for something in his cell. The footage captured the Subject checking his clothing, shoes, and the mattress on his bed. The Subject appeared to bend down and pick up an off-white object from the floor where he had been standing earlier that morning.

At 0618 hours, the Subject was observed huddled at the edge of his bed with his back turned to the jail cell security camera in his room. As that occurred, DO B conducted his/her final inspection of the Subject's cell before the end of his/her shift. The Subject kept his back turned to the camera for approximately eight minutes.

The Subject was never observed on video surveillance, or by any of the DOs, ingesting a foreign substance. For the next 20 minutes, the Subject was observed lying down and sitting up in various positions and appeared to display symptoms of being under the influence of an unknown substance.

On February 16, 2022, at 0630 hours, SDO A and DO A reported for duty. They assumed responsibility of the inmates housed at Pacific Jail as SDO B and DO B ended their shift. The Subject was still housed alone in Cell No. J-1.

According to Cell No. J-1 video surveillance, at approximately 0634 hours, the Subject placed both of his hands inside the front of his pants. He then leaned against his cell wall and remained in this position.

According to DO A, during his/her safety check of the inmates, he/she is "making sure they have some kind of movement or chest rise, or engage in some type of conversation with them, make sure they're well."

At 0700 hours, jail security video depicted DO A conduct a safety check of the Subject's cell. DO A was seen looking through the Plexiglas while the Subject was sitting on his bed, leaning against the cell wall with both hands inside the front of his pants.

As observed on Cell No. J-1 video surveillance at 0702:23 hours, slight secretions exit from the Subject's nose. This was approximately two minutes after DO A conducted his/her first wellness inspection of his/her shift. The Subject's nose continued to slowly secrete fluid until approximately 0817 hours.

At 0719 hours, jail security video depicted SDO A look through the Plexiglas of the Subject's cell and conduct a safety check.

At 0752 hours, jail security video depicted DO A conduct a safety check of the Subject's cell. DO A was seen looking through the Plexiglas while holding a set of plyers in his hand. The Subject's body position continued to remain the same.

FID investigators examined jail cell video and, based on a limited video angle, could not observe the Subject move during the time DO A conducted his 0752 hours wellness check. FID investigators determined that the Subject's last visible body movement took place at approximately 0805:20 hours. The Subject's nose continued to secrete fluids for another twelve minutes.

At 0822 hours, jail video surveillance depicted DO A return to conduct a safety check of the Subject's cell. According to DO A, as he/she looked through the Plexiglas, he/she observed foam near the side of the Subject's mouth.

DO A called out for SDO A to bring the cell key. DO A and SDO A performed CPR in an effort to save the Subject's life.

According to SDO A, he/she then ran from the Subject's cell to inform the Pacific Patrol Division Watch Commander of the medical emergency. He/she returned and assisted DO A with lifesaving efforts. They moved the Subject into the hallway to allow more room to perform CPR. SDO A obtained the Automated External Defibrillator (AED) and he/she and DO A utilized the machine to assist with lifesaving efforts.

Lieutenant A, assigned as the Watch Commander, requested the assistance of two police officers and directed that a rescue ambulance (RA) be requested. At 0831:12 hours, Pacific Patrol Division Police Officer C assigned to the Area Command Center (ACC) contacted CD and requested an RA to respond to Pacific Station for a male, approximately 30 years, unconscious, breathing.

Police Officers D and E responded to the jail and assisted DO A and SDO A with lifesaving efforts. Prior to arriving in the jail, Officer E, who is a CPR instructor, obtained a second AED. At 0827 hours, Officer E administered a dose of nasal Narcan spray to the Subject in case he was suffering an opioid overdose. Officer E coordinated lifesaving efforts and provided direction to LAPD personnel prior to LAFD arrival. When LAFD arrived, Officer E relayed pertinent medical information to paramedics.

At 0837 hours, LAFD Firefighter Paramedics arrived at scene. Firefighter Paramedics contacted subsequently a doctor at the hospital, who pronounced the Subject dead at 0902 hours.

According to Lieutenant A, once it was determined that an In-Custody Death (ICD) had occurred, he/she requested the response of Pacific Division supervisors. The Pacific Jail section was cordoned off with crime scene tape and preserved for FID investigators and the Los Angeles County Medical Examiner-Coroner. The involved officers were separated and monitored until FID arrived at scene.

Body-Worn Video (BWV) and Digital In-Car Video (DICV) Policy Compliance

NAME	TIMELY BWV ACTIVATION	FULL 2-MINUTE BUFFER	BWV RECORDING OF ENTIRE INCIDENT	TIMELY DICV ACTIVATION	DICV RECORDING OF ENTIRE INCIDENT
Officer B	Yes	Yes	Yes	Yes	Yes
Officer C	Yes	Yes	Yes	Yes	Yes
Officer I	Yes	Yes	Yes	Yes	Yes
Officer J	Yes	Yes	Yes	Yes	Yes

Los Angeles Board of Police Commissioners' Findings

The BOPC reviews each Categorical Use of Force (CUOF) incident based upon the totality of the circumstances, namely all of the facts, evidence, statements and all other pertinent material relating to the particular incident. In every case where applicable, 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). For In-Custody Death (ICD) Cases, the BOPC may also make specific findings for policy violations regarding the following adjudication areas: Inmate Intake Procedures; Inmate Welfare Procedures; Inmate Emergency Medical Procedures; and Post-in-Custody Death Procedures. Based on the BOPC's review of the instant case, the BOPC made the following findings:

A. Tactics - Administrative Disapproval: Officers A and B.

B. Inmate Intake Procedures - Not Consistent with Established Criteria: Officers A, B, SDO A, DO A, and Sergeant A.

C. Inmate Welfare Procedures - Consistent with Established Criteria: SDOs A & B and DOs A & B.

D. Inmate Emergency Medical Procedures - Consistent with Established Criteria: SDO A, DO A, Officers D and E.

E. Post-In-Custody Death Procedures - Consistent with Established Criteria: SDO A, Lieutenant A, and Captain A.

Basis for Findings

- In making its decision in this matter, the Commission is mindful that every "use of force by members of law enforcement is a matter of critical concern both to the public and the law enforcement community. It is recognized that some individuals will not comply with the law or submit to control unless compelled to do so by the use of force; therefore, law enforcement officers are sometimes called upon to use force in the performance of their duties. It is also recognized that members of law enforcement derive their authority from the public and therefore must be ever

mindful that they are not only the guardians, but also the servants of the public. The Department's guiding principle when using force shall be reverence for human life. Officers shall attempt to control an incident by using time, distance, communications, and available resources in an effort to de-escalate the situation, whenever it is safe, feasible, and reasonable to do so. As stated below, when warranted, Department personnel may use objectively reasonable force to carry out their duties. Officers may use deadly force only when they reasonably believe, based on the totality of circumstances, that such force is necessary in defense of human life.

Officers who use unreasonable force degrade the confidence of the community we serve, expose the Department and fellow officers to physical hazards, violate the law and rights of individuals upon whom unreasonable force or unnecessary deadly force is used, and subject the Department and themselves to potential civil and criminal liability. Conversely, officers who fail to use force when warranted may endanger themselves, the community and fellow officers." (Special Order No. 4, 2020, Policy on the Use of Force - Revised.)

The Commission is cognizant of the legal framework that exists in evaluating use of force cases, including the United States Supreme Court decision in Graham v. Connor, 490 U.S. 386 (1989), stating that:

> "The reasonableness of a particular use of force must be judged from the perspective of a reasonable officer on the scene, rather than with the 20/20 vision of hindsight. The calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split-second judgments – in circumstances that are tense, uncertain and rapidly evolving – about the amount of force that is necessary in a particular situation."

The Commission is further mindful that it must evaluate the actions in this case in accordance with existing Department policies. Relevant to our review are Department policies that relate to the use of force:

Use of De-Escalation Techniques. It is the policy of this Department that, whenever practicable, officers shall use techniques and tools consistent with Department de-escalation training to reduce the intensity of any encounter with a Subject and enable an officer to have additional options to mitigate the need to use a higher level of force while maintaining control of the situation.

Use of Force – Non-Deadly. It is the policy of the Department that personnel may use only that force which is "objectively reasonable" to:

- Defend themselves;
- Defend others;
- Effect an arrest or detention;
- Prevent escape; or,
- Overcome resistance.

Use of Force – Deadly. It is the policy of the Department that officers shall use deadly force upon another person only when the officer reasonably believes, based on the totality of circumstances, that such force is necessary for either of the following reasons:

- To defend against an imminent threat of death or serious bodily injury to the officer or another person; or,
- To apprehend a fleeing person for any felony that threatened or resulted in death or serious bodily injury, if the officer reasonably believes that the person will cause death or serious bodily injury to another unless immediately apprehended. Where feasible, a peace officer shall, prior to the use of force, make reasonable efforts to identify themselves as a peace officer and to warn that deadly force may be used, unless the officer has objectively reasonable grounds to believe the person is aware of those facts.

In determining whether deadly force is necessary, officers shall evaluate each situation in light of the particular circumstances of each case and shall use other available resources and techniques if reasonably safe and feasible.

> **Note:** Because the application of deadly force is limited to the above scenarios, an officer shall not use deadly force against a person based on the danger that person poses to themselves, if an objectively reasonable officer would believe the person does not pose an imminent threat of death or serious bodily injury to the officer or another person.

The Department's Evaluation of Deadly Force. The Department will analyze an officer's use of deadly force by evaluating the totality of the circumstances of each case consistent with the California Penal Code Section 835(a), as well as the factors articulated in Graham v. Connor. (Special Order No. 4, 2020, Policy on the Use of Force - Revised.)

An officer’s decision to draw or exhibit a firearm should be based on the tactical situation and the officer’s reasonable belief that there is a substantial risk that the situation may escalate to the point where deadly force may be justified. (Los Angeles Police Department Manual.)

Detention

- While on routine patrol, Officers A and B observed the Subject walking in the middle of the roadway. According to Officer A, he/she remembered the Subject from a previous contact and knew he had been on probation. While speaking with the Subject, officers conducted a want and warrant inquiry which revealed a felony warrant for the Subject’s arrest. Based on the totality of the circumstances, officers had reasonable suspicion to detain the Subject.

A. Tactics

- **Tactical De-Escalation Techniques**
  - ***P****lanning*
  - ***A****ssessment*
  - ***T****ime*
  - ***R****edeployment and/or Containment*
  - ***O****ther Resources*
  - ***L****ines of Communication*
    (Use of Force - Tactics Directive No. 16, October 2016, Tactical De-Escalation Techniques)

Tactical de-escalation does not require that an officer compromise his/his safety or increase the risk of physical harm to the public. De-escalation techniques should only be used when it is safe and prudent to do so.

Planning – According to Officer A, this was the first time he/she and B worked together. Before their start of watch, they discussed tactics, including contact and cover roles, traffic stops, pedestrian stops, and the PATROL acronym. Officers A and B also discussed that their roles could change depending on the situation.

Assessment – During their encounter with the Subject, officers assessed the Subject's demeanor and actions. According to Officers A and B, the Subject was calm and relaxed, so they responded in kind. By remaining calm, officers were able to arrest the Subject without incident.

Time and Redeployment and/or Containment – While speaking to the Subject, Officers A and B remained seated in the police vehicle. Officers A and B did not advise CD of their Code Six (i.e., arrival-on-scene) location before contacting the Subject. While these decisions placed Officers A and B at a significant tactical disadvantage, as discussed below, officers were able to arrest the Subject without incident.

Other Resources – During Officers A and B's encounter with the Subject, he/she remained cooperative and was taken into custody without incident, thus officers did not require additional resources.

Lines of Communication – As officers were patrolling the area, Officers A and B discussed crime trends in the area. Observing the Subject, whom he/she recognized from a previous encounter, Officer A told Officer B that he/she was going to conduct a consensual encounter with the Subject. Officer A parked the police vehicle next to the Subject and spoke to him. The Subject provided officers with his name and date of birth. As Officer B used the MDC, Officer A continued to speak with the Subject. After officers determined the Subject had a felony warrant for his arrest, they communicated his warrant status with each other, exited their vehicle, and detained him without incident.

During its review of this incident, the BOPC noted the following tactical considerations:

- **Code Six**

  Officers A and B did not advise CD of their Code Six (i.e., arrival-on-scene) location before initiating contact with the Subject, whom they observed walking in the roadway. After a want and warrant inquiry revealed the Subject had a felony vandalism warrant for his arrest, Officer B advised CD of their Code Six location.

  The BOPC noted that the Use of Force Review Board (UOFRB) assessed Officers A and B's adherence to the Code Six policy. The UOFRB noted that when the officers first observed the Subject, he was walking in the roadway with an additional male. The UOFRB opined that Officers A and B had sufficient time to advise CD of their Code Six location before contacting the Subject. Although Officers A and B described the initial contact as a consensual encounter, the UOFRB noted that both officers were aware of crime trends in the area and that they intended to contact the Subject. The UOFRB also noted that Officer A recognized the Subject from a previous encounter and knew he had been on probation. Regardless of whether the officers had reasonable suspicion or were attempting to develop it through a consensual encounter, the UOFRB opined that they were conducting a field investigation and should have notified CD of their Code Six location before initiating contact with the Subject. By failing to do so, the UOFRB opined that Officers A and B placed themselves at a tactical disadvantage as there may have been a delay from responding officers had Officers A and B needed assistance.

  Based on the totality of the circumstances, the BOPC determined that the tactics employed by Officers A and B were a substantial deviation, without justification, from Department-approved tactical training.

- **Pedestrian Contacts**

  Officer A and B remained seated in their police vehicle while speaking with the Subject and conducting a want and warrant inquiry. The Subject stood approximately 15 feet away from the passenger side of the police vehicle. As the Subject paced the sidewalk, Officer A repositioned the police vehicle several times to see him. After the inquiry revealed that the Subject had a felony warrant for his arrest, Officers A and B exited the police vehicle.

  The BOPC noted that the UOFRB assessed Officers A and B's decision to initiate contact with the Subject while seated in the police vehicle. The UOFRB noted that Officers A and B were aware of crime trends in the area. The UOFRB also noted that Officer A recognized the Subject from a previous encounter and knew that he had been on probation. The UOFRB was critical of the officer's decision to initiate contact with the Subject while seated in their police vehicle. The UOFRB opined that Officers A and B's tactics placed them at a significant disadvantage by restricting their mobility and limiting their ability to control the Subject's actions. The

UOFRB also opined that allowing the Subject to freely walk alongside the police vehicle further jeopardized the officers' safety.

Based on the totality of the circumstances, the BOPC determined that the tactics employed by Officers A and B were a substantial deviation, without justification, from Department-approved tactical training.

The BOPC also considered the following Adjudication Areas:

Adjudication Area No. 1: Inmate Intake Procedures

Custody Transfer Communication

- Following his arrest for a felony vandalism warrant, the Subject was booked into custody at Pacific Jail. The booking process involved verbal and nonverbal communication between Officers A, B, SDO A, and DO A. After the booking process was completed, the Subject was transferred to the custody of CSD personnel.

  The BOPC noted that the UOFRB noted that documents associated with the Subject's booking were completed by Officers A and B and approved by CSD officers and supervisors. The UOFRB also noted that surveillance video depicted Officers A and B communicating with CSD personnel during the booking process.

  Based on the totality of the circumstances, the BOPC determined that the custody transfer communication of Officers A, B, SDO A, and DO A was consistent with established criteria.

Booking Process

- Sergeant A interviewed the Subject and completed the Adult Detention Log (LAPD form 06.19.00). The Subject did not complain of injuries or illnesses. After the intake interview, Officer B interviewed the Subject and completed the Los Angeles County Unified Arrestee Medical Screening Form (SH-R-422). The Subject stated that he did not have medical concerns and denied that he regularly used alcohol or drugs. Officer A searched the Subject's shoes with negative results and removed the shoelaces. Officer A did not search the Subject's socks. According to Officer A, he/she would not be expected to search an arrestee's socks for a felony warrant arrest but would have had he/she completed a strip search.

  Officer A completed a Booking Approval (LAPD Form 12.31.00) and presented it to Sergeant A for approval. During his review of the Subject's CCHRS report, Officer A did not note the Subject's eight prior narcotics-related arrests. Officer A did not seek approval to conduct a strip search nor did he/she notify Sergeant A that the Subject had marijuana or a syringe. After reviewing the Subject's CCHR and the Booking Approval, Sergeant A checked the boxes indicating he/she reviewed the Subject's criminal history and that he/she did not approve a strip search.

Officers A and B escorted the Subject into Pacific Area Jail to begin the booking process; they did not conduct a secondary physical search of the Subject's person before transferring him to CSD personnel. SDO A completed the computer data entry while DO A performed the Livescan Tenprinter process, including capturing the Subject's photographs and fingerprints. Before escorting the Subject to his cell, DO A completed a metal detection wand search of the Subject's person but did not conduct a physical search of the Subject or his clothing. After booking the Subject into custody, Officers A and B left Pacific Jail. According to the FID investigation, Officer B only recalled conducting one pat-down search of the Subject's person while at the scene of their initial contact and he/she did not complete a subsequent search of the Subject before booking him into Pacific Jail.

The BOPC noted that the UOFRB noted that per Department policy, an arrestee shall not be given a strip search unless the arrest involved a controlled substance, or there is a reasonable and articulable suspicion that the arrestee is concealing contraband or weapons. The UOFRB also noted that in determining whether to conduct a strip search, employees should consider the totality of the circumstances (e.g., the nature of the offense, the arrestee displaying behavior that would lead officers to believe he/she is concealing contraband or weapons, the arrestee's criminal record, etc.). In this case, the Subject was arrested for a felony vandalism warrant. At the time of his arrest, he had marijuana and a syringe, which he referred to as a "rig." Although the syringe appeared to be new, this may have been an indication that the Subject had narcotics yet to inject. Also, the Subject's criminal history reflected eight arrests for narcotics-related offenses. The UOFRB opined that based on the factors of the Subject's arrest and his criminal history, Officers A and B should have requested to perform a strip search. Based on the same information, the UOFRB also opined that Sergeant A should have directed the officers to perform a strip search.

In terms of a physical search of the Subject's person and clothing, the UOFRB opined that DO A did not follow Department policy when he/she failed to conduct an independent physical search of the Subject's person/clothing when he was transferred into his/her custody. Also, based on Officers A, B, and DO A's statements and the jail's surveillance video footage, the UOFRB concluded that Officers A and B did not perform a thorough search of the Subject's person/clothing before transferring him to CSD.

Concerning the requirement that officers remain with an arrestee, the UOFRB noted that Officers A and B accompanied the Subject through the entire booking process.

Based on the totality of the circumstances, the BOPC determined that Officers A, B, DO A, and Sergeant A's booking process was not consistent with established criteria.

Juvenile Booking Procedures

- As the Subject was an adult at the time of this incident, Juvenile Booking Procedures are not applicable to this incident.

Medical Screening and Classification/Segregation

- Officer B completed page one of the Los Angeles County Unified Arrestee Medical Screening Form, SH-R-422, in which the Subject indicated that he had no medical conditions, did not feel suicidal, and did not regularly use alcohol or drugs. The Subject signed the document. Officer B printed his/her last name, serial number, and date on the appropriate line. Officer B provided his/her name, serial number, and date on the second page of the document under the "Arresting Deputy/Officer Observation" heading.

  The BOPC noted that the UOFRB noted that during the booking process, SDO A reviewed form SH-R-422 and determined the Subject did not have any medical conditions that would preclude him from being housed at Pacific Jail and that he did not need medical treatment. The section labeled "Jailer Observations" was completed but it is undetermined if questions 1-8 were "Yes" or "No" due to one continuous line crossing diagonally through both boxes of each question. An ink stamp containing the name and ID number for SDO A appears across the "Jailer Signature" and "Employee/Id Number" box at the bottom of the document. The form does not contain a hand-drawn signature and the date and time boxes were left blank.

  The UOFRB also noted that Los Angeles Police Department Classification Assessment Form (05.36.00), Part A, was properly completed by Officer B, and Part B was properly completed by SDO A. Part C, Record of Medical Screening, was not completed as Pacific Jail does not have Jail Dispensary personnel and the Subject did not provide any indication that he needed to be seen by medical personnel. The questions listed in Part D were not addressed and an ink stamp containing the name and ID number for SDO A appears across the "Reporting Employee" and "Supervisor Approving" signature boxes at the bottom of the document. The form does not contain a hand-drawn signature and the date and time boxes were left blank.

  The UOFRB opined that the Subject was evaluated and medically screened by both Officer B and SDO A. Based on this evaluation, SDO A placed the Subject in general housing. The UOFRB noted that the Inmate Classification Assessment Form, Part A, was thoroughly completed by the booking officer, Officer B, after which the Pacific Jail supervisor, SDO A, reviewed and stamped the form, indicating that he/she approved the classification assessment.

  The UOFRB noted that it is both Officer B and SDO A's responsibility to accurately complete all sections of the Arrestee Medical Screening form and that the

Classification Assessment form is a critical component in determining whether or not an inmate is segregated at Pacific Jail, housed in the general population or transferred to a regional jail for housing.

Based on the totality of the circumstances, the BOPC determined that Officer B's actions in completing both the Classification Assessment and Arrestee Medical Screening form were consistent with established criteria. The UOFRB also opined that although the Subject's classification and segregation were consistent with established criteria, the failure by SDO A to properly fill out the required documents and personally sign and date the documents was not consistent with established criteria.

Suicide Prevention

- The UOFRB noted that nothing in the investigation indicated that the Subject expressed or displayed suicidal ideations. Additionally, the Los Angeles County Coroner's Officer determined that the Subject's death was accidental.

  Based on the totality of the circumstances, the BOPC found that the Inmate Intake Procedures employed by Officers A, B, SDO A, DO A, and Sergeant A were not consistent with established criteria.

Adjudication Area No. 2: Inmate Welfare Procedures

Safety Checks

- While the Subject was housed at Pacific Jail, SDOs A & B, and DOs A & B used the Guardian Compliance Report System to complete the inmate well-being checks. The compliance report showed, and FID investigators confirmed, that during their shifts, SDOs A & B, and DOs A & B conducted the required safety checks approximately every 30 minutes until the last check at approximately 0822 hours when the Subject was found unresponsive in his cell.

  A review of the Death Investigation, Los Angeles Police Department Form 03.11.00, noted that at approximately 0822 hours, Pacific Jail personnel responded to the Subject's cell to get him ready for court. The Jail personnel knocked on the Subject's cell multiple times; however, he was "non-responsive."

  The BOPC noted that the UOFRB noted that per Title 15, DOs are required to conduct hourly safety checks of inmates. In addition to the hourly safety checks mandated by the State of California, the LAPD Jail Operations Manual § 1/250 mandates an additional check every hour of inmates housed in the jail facility, for a total of two checks per hour. The safety checks are documented on a handwritten log as well as the Radio Frequency Identification (RFID), Guardian Management System, which digitally records each safety check. The UOFRB noted that according to the FID investigation, all required safety checks of the Subject were

conducted while he was at Pacific Jail. During that time, CSD personnel conducted in-person safety checks no less than every 30 minutes, logging the time the check was completed via the Guardian System, which was also captured on surveillance video footage. Based on the available evidence, the UOFRB opined that CSD personnel looked for signs of life during the checks and did not see any indication that he may be in distress until 0822 hours.

Based on the totality of the circumstances, the BOPC determined that the safety checks of SDOs A & B and DOs A & B were consistent with established criteria.

Pill Call / Sick Call

- The BOPC noted that the UOFRB noted that nothing in the FID investigation indicated that the Subject claimed to be under the care of a medical provider or taking any prescribed medication and as such Pill Call/Sick Call procedures were not applicable.

Dispensary Visits

- The BOPC noted that the UOFRB noted that nothing in the FID investigation indicated that the Subject claimed to be under the care of a medical provider, required medical treatment, or that he was taking any prescribed medication, and as such Dispensary Visits procedures were not applicable.

Cameras and Monitoring

- While incarcerated in Pacific Jail, video surveillance captured the Subject ostensibly removing objects from his clothing. The video footage also captured the Subject holding a foil object near his face/mouth.

  The BOPC noted that during the UOFRB, Captain A told the UOFRB that CSD Divisional Order No. 5, states that the most senior DO shall assign camera monitoring duties and ensure the POD or Block monitoring rooms are staffed at all times. Captain A went on to clarify that only CSD regional jails have PODs or Block monitoring rooms. Captain A stated that Pacific Jail does not have a POD or Block monitoring room. Therefore, the mandate to staff the monitoring room at all times would not apply to Pacific Area Jail. Captain A also stated that in the case of Pacific Jail, audio/visual monitoring may supplement but not substitute direct visual observation of an arrestee. During their investigation, FID investigators reviewed surveillance camera footage from the booking area at Pacific Jail and determined that at the time the Subject manipulated the foil object, SDO A and DO A were engaged in administrative activities and not able to monitor the surveillance television screens.

  Captain A further stated that CSD regularly deploys two DOs at Pacific Area Jail. Many of the DOs' duties require two officers, such as preparing arrestees for

transportation to court, preparing meals, feeding arrestees, escorting arrestees to shower facilities, and dealing with uncooperative arrestees. In some cases, while booking individuals, DOs have to step away from the booking counter to complete the mandated Title 15 checks.

Based on the totality of the circumstances, the UOFRB opined that SDOs A and B, and DOs A and B's camera monitoring was consistent with established criteria as outlined in CSD Divisional Order No. 5.

Based on the totality of the circumstances, the BOPC found that the inmate welfare procedures employed by SDOs A & B and DOs A & B were consistent with established criteria.

Adjudication Area No. 3: Inmate Emergency Medical Procedures

Cell Entry and Notification

- At approximately 0822 hours while conducting a safety check, DO A observed foam near the side of the Subject's mouth. Unable to determine the Subject's well-being, DO A called out to SDO A and they entered the Subject's jail cell. DO A immediately began CPR and directed SDO A to notify the watch commander that an RA was needed. SDO A then ran out of the jail and notified Officer C that they had a man down and needed an RA.

  The BOPC noted that the UOFRB noted that when DO A was unable to determine the Subject's well-being, he/she requested SDO A to retrieve the keys to the Subject's jail cell door and join him/her before entering the cell. Although a lone DO may enter a cell in an exigent, life-threatening circumstance or to render medical aid to a lone occupant, it is not required; and SDO A arrived at the Subject's jail cell without delay. The UOFRB noted that after entering the cell, DO A directed SDO A to advise the Pacific Patrol Division Watch Commander that an RA was needed for an inmate requiring emergency medical attention.

  The UOFRB opined that while Department policy mandates that CSD personnel responding to arrestee/inmate emergencies such as a man down shall broadcast a Code Blue, this protocol is different in Area jails such as Pacific Jail. The UOFRB noted that this is mainly due to the staffing levels at area jails and that the broadcast of a Code Blue is only recognized by CSD and Medical Services Division (MSD) personnel. The Code Blue broadcast causes an immediate response by DOs and medical personnel who bring with them a gurney and a suicide response kit. In this case, SDO A and DO A were the only CSD personnel assigned to Pacific Jail at the time of the incident, were in direct communication with each other, and were able to assist one another without delay. Based on the totality of the circumstances, the UOFRB opined that in this situation a Code Blue broadcast was not warranted.

  Based on the totality of the circumstances, the BOPC determined that SDO A and

DO A's cell entry and notification were consistent with established criteria.

Medical Assistance and Rescue Ambulance Request

- As DO A began CPR, SDO A notified Officer C that they had a man down and needed an RA. In response, Officer C requested an RA to respond to Pacific Station for the Subject. Upon SDO A's return to the Subject's cell, he/she assisted DO A with lifesaving efforts. To allow more space to perform CPR, SDO A and DO A moved the Subject into the hallway. To assist with lifesaving efforts, SDO A obtained the AED. Officer C notified Lieutenant A of the medical emergency. In response, he/she requested additional medical assistance from Officers E and D.

  Before reaching the jail, Officer E obtained a second AED device and Narcan spray; however, the AED did not recommend a shock. According to the FID investigation, at approximately 0827 hours, Officer E administered a dose of nasal Narcan spray to the Subject in the event he was suffering an opioid overdose. Officer E provided direction to LAPD personnel until the arrival of LAFD personnel. Officer E relayed pertinent medical information to paramedics and the LAFD personnel worked with LAPD and CSD personnel to revive the Subject. The Subject did not respond to lifesaving efforts.

  The BOPC noted that the UOFRB noted that immediately upon entering the Subject's jail cell and seeing the Subject in medical distress, DO A began performing CPR as SDO A advised Officer C to request an RA. Although SDO A did not personally contact CD to request an RA, Officer C did so at his/her behest. SDO A obtained an AED and returned to the Subject's cell to assist with life-saving efforts. The UOFRB also noted that shortly thereafter, Officers E and D arrived at the Subject's jail cell with a second AED and assisted in life-saving efforts.

  Based on the totality of the circumstances, the BOPC determined that Officers E, D, DO A, and SDO A's medical assistance and rescue ambulance request were consistent with established criteria.

  Based on the totality of the circumstances, the BOPC found that the inmate emergency medical procedures employed by SDO A, DO A, and Officers D and E, were consistent with established criteria.

Adjudication Area No. 4: Post In-Custody Death Procedures

Notifications and Title 15, 30-Day Review

- At approximately 0837 hours, Lieutenant A notified the Pacific Patrol Division, Acting Commanding Officer, of the incident. After the Subject was pronounced dead, Lieutenant A notified FID of the incident and directed Sergeant B to notify the DOC of the ICD. According to the FID investigation, the DOC notification was made approximately 15 minutes after the Subject was pronounced dead. At approximately

1045 hours, Captain A arrived at Pacific Jail and assumed incident command. On March 10, 2022, Captain A conducted a Title 15, 30-Day Review of this incident.

The BOPC noted that the UOFRB noted that according to the FID investigation, Sergeant B notified the DOC of the ICD within 15 minutes of the Subject being pronounced dead. The UOFRB also noted on March 10, 2022, Captain A completed the State-mandated Title 15, 30-Day Review of this incident. All areas were addressed.

Based on the totality of the circumstances, the BOPC found that the Post In-Custody Death procedures employed by SDO A, Lieutenant A, and Capitan A were consistent with established criteria.

Additional Tactical Debrief Topics

- **Non-Medical Face Coverings** – Officer A was not wearing a facial covering during the incident as directed by the Chief of Police in May 2020.

Command and Control

- According to the FID investigation, SDO A did not declare him/herself as the Incident Commander (IC), as he/she believed Lieutenant A was the IC. According to Lieutenant A, once it was determined that an ICD had occurred, he/she requested the response of Pacific Division supervisors and ensured the Pacific Jail section was cordoned off with crime scene tape and preserved for FID investigators and the Los Angeles County Medical Examiner-Coroner. Lieutenant A also ensured that the involved officers were separated and monitored until FID investigators arrived at the scene. At approximately 0917 hours Sergeant B notified the Department Operations Center (DOC) of the ICD.

  The BOPC noted that the UOFRB noted that when SDO A arrived at the scene, he/she did not verbally declare him/herself as the IC. However, the UOFRB also noted that he/she was the only supervisor at the scene at that point. The UOFRB further noted that, unlike patrol, CSD supervisors are predesignated as the IC at the start of their shift. This is done to prevent multiple supervisors from responding to an incident unless needed/requested. Therefore, the UOFRB opined that there was no confusion amongst CSD personnel as to who was overseeing the incident. The UOFRB also noted that SDO A assisted with CPR. While the UOFRB would have preferred that he/she had focused primarily on command and control, based on the nature of this incident, the UOFRB did not find this to be a substantial deviation from Departmental training.

  The BOPC determined that the overall actions of SDO A and Lieutenant A were consistent with Department training and their expectations of supervisors during a critical incident.

Tactical Debrief

- In conducting an objective assessment of this case, the UOFRB determined, and the BOPC concurred, that the actions of Officers D, E, DO B, SDO B, Lieutenant A, and Captain A were consistent with established criteria. The UOFRB also determined, and the BOPC concurred, that the actions of Sergeant A, Officers A, B, SDO A, and DO A were not consistent with established criteria. Additionally, the UOFRB determined, and the BOPC concurred, that the tactics employed by Officers A and B, were a substantial deviation, without justification, from Department-approved tactical training.

  Each incident merits a comprehensive debriefing. In this case, there were identified areas where improvement could be made. A Tactical Debrief is the appropriate forum for the involved officers to discuss individual actions that took place during this incident.

  Therefore, it was determined that Officers A, B, SDOs A, B, DOs A, B, Sergeant A, Lieutenant A, and Captain A would attend a Tactical Debrief and that the specific identified topics be discussed.

Requirement to Intercede

- Based on its review of this incident, the BOPC determined that a reasonable officer would not have been required to intercede as no force was used.