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

IN-CUSTODY DEATH – 013-23

Division	Date	Duty-On (X) Off ( )	Uniform-Yes (X) No ()
Van Nuys	3/31/2023		

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

Not applicable

Reason for Police Contact

On March 31, 2023, at approximately 1235 hours, an inmate housed at Valley Jail Section (VJS) tore a bedsheet and used it to hang himself and render himself unconscious. After being discovered by a custodian, jail and medical dispensary personnel were immediately summoned and they administered cardiopulmonary resuscitation (CPR). Los Angeles Fire Department (LAFD) paramedics arrived shortly after and took over the inmate's care; however, he did not respond to treatment and was pronounced deceased.

Suspect	Deceased (X)	Wounded ( )	Non-Hit ()

Male, 35 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 (CUOF) 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 (UOFRB) recommendations, including any Minority Opinions; the report and recommendations of the Chief of Police (Chief); 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 3/12/24.

Incident Summary

On Wednesday, March 29, 2023, at approximately 2045 hours, Witness A called Communications Division (CD) to report that his son, the Subject, had assaulted him and his other adult son, Witness B. Witness A also reported that the Subject was possibly under the influence of methamphetamine. In response, CD generated a radio call of a "Battery Suspect There Now."

Foothill Division Officers A and B responded to the call. Upon their arrival, the officers met with Witness A, who advised that he had returned home to find the Subject assaulting Witness B. When Witness A intervened, the Subject struck him on the right side of his jaw, knocking him to the floor. While interviewing Witness A across the street from his residence, Officer B requested an additional unit to respond to their location as the Subject remained inside.

Witness A told Officer A that the previous night the Subject had been "imagining things in the attic."

The officers asked Witness A to call the Subject on the phone and convince him to come out of the house. Witness A called the Subject and said, "Can you come out and talk to the officers? They just want to talk to you…they're going to take you to the clinic."

The Subject told Officer B that he had been in prison for 15 years and was released in 2021. Officer B told the Subject that Witness A wanted him to be arrested. Officer B said, "If I were to take the handcuffs off right now, would you be willing to go to a hospital?" The Subject said, "If my dad takes me, yeah." The Subject told Officer B that he was still trying to adapt to society after his stay in prison.

The officers directed the Subject to exit the residence, and he was taken into custody without incident. After handcuffing and performing a pat-down search of the Subject, Officer B asked him what happened, and the Subject replied, "I just lost it." When Officer B inquired as to what he meant, the Subject stated, "Just hearing shit." Officer B asked the Subject if he suffered from mental illness. The Subject replied he was diagnosed with anxiety and depression while in prison but was not taking medication because he had not seen a doctor.

As captured by their body-worn videos (BWVs), Officers A and B offered Witness A the options of taking the Subject to a hospital or effecting a private person's arrest (PPA) for the alleged battery. Witness A indicated that he wanted the PPA.

When Officer B advised Witness A of the Subject's anxiety and depression, Witness A said that he was unaware of the Subject's condition. Witness A ultimately placed the Subject under PPA for battery.

Officers C and D responded to Officer B's request for an additional unit and transported the Subject to Foothill Community Police Station (Foothill Station).

At 2140 hours, the Subject was placed in holding tank No. 4, where Sergeant A met with him and completed the required intake interview. The Subject responded that he understood why he was arrested, did not have any complaints of injury or illness, and did not have any questions.

Sergeant A told FID that neither the officers nor the Subject indicated that the Subject suffered from any mental illness or was suicidal.

Officer B completed a Los Angeles County Unified Arrestee Medical Screening Form, which reflected that the Subject had high blood pressure and used methamphetamine daily, including on the date he was arrested. On this form, Officer B recorded "no" as the response to Question No. 2, which includes asking the arrestee if "mental health issues" or "hearing things that are not there" applies to them.

Officer B also recorded "no" as responses to Questions No. 6 and No. 8, which ask whether the arrestee has any medical conditions or regularly uses alcohol or drugs, respectively. These responses appear to have been amended to indicate "yes" and were initialed.

While he was in the "holding tank" (cell) at Foothill Station, the Subject told Officer A that he had been diagnosed with depression and anxiety.

During his FID interview, Officer A stated that the Subject did not appear to be "having any mental episode" during his interaction with him/her. Officer A also denied that the Subject had indicated to him/her that he was suffering from depression, anxiety, or any other illness "that night."

Officer A told FID that he/she did not contact MEU because the Subject "didn't meet criteria, um, and the crime supersedes, um, any sort of um, hold even though he did not meet the criteria for a hold, um, but the – the crime always supersedes and – and again he was being placed under arrest for the crime."

Custody Services Division (CSD) Officer E and Detention Officer A, assigned to VJS, responded to an arrestee transportation request at Foothill Station. According to Officer E, he/she reviewed the Subject's booking approval, medical screening, and Custody Transportation Unit forms. In addition, Officer E and Detention Officer A interviewed the Subject and asked the same questions listed on the Los Angeles County Unified Medical Screening Form. Upon reviewing the forms and completing their questions, they determined that the Subject did not require serious medical attention or suffer from mental illness. The Subject was cooperative and they deemed him to be qualified for transport to VJS.

Detention Officer A told FID that he/she assessed the Subject and asked him questions related to medical issues, mental health issues, drug withdrawal, injuries, and whether he needed to see the medical staff. In response to these questions, the Subject told Detention Officer A that he had high blood pressure and used "meth." Detention Officer A was not asked whether he/she had made changes to the Los Angeles County Medical Screening Form after it was filled out by Officer B; however, as previously noted, the

form appeared to have been updated to indicate affirmative responses to the questions regarding high blood pressure and drug use, along with initials.

At 2240 hours, Officer E and Detention Officer A left Foothill Station with the Subject. They drove to Mission Community Police Station (Mission Station), where they picked up an additional arrestee before returning to VJS for booking.

At approximately 2329 hours, the Subject was medically screened by Doctor A at the VJS dispensary for high blood pressure and methamphetamine use. According to Doctor A, the Subject disclosed having a history of anxiety and depression and was prescribed medication but was not taking it. The Subject denied being suicidal, homicidal, or experiencing hallucinations. In addition, Doctor A stated that there was no indication that the Subject's methamphetamine usage raised his blood pressure, pulse, or altered his mental status. As such, Doctor A concluded the Subject did not require a higher level of care and cleared him for booking.

In Part C of the Los Angeles Police Department Classification Assessment form, which was completed by VJS dispensary personnel, it is indicated that that the Subject had been diagnosed with mental illness. A hand-written notation indicating the "type" of mental illness appears to read "depression, anxiety." There is a time-stamp of 11:30 pm alongside this entry.

At approximately 2340 hours, the Subject was booked and Senior Detention Officer A reviewed his intake forms, including the Jail Custody Record and Division Booking Record to ensure that all information was correct. On March 30, 2023, at 0006 hours, Senior Detention Officer A approved the Subject for general housing. At approximately 0018 hours, the Subject was placed in the Male Security Section, general housing Cell 214.

During FID's interview of Senior Detention Officer A, he/she was shown a copy of the form completed for the Subject and signed by him/her, with the time of approval noted as 0006 hours on March 30, 2023.

According to Senior Detention Officer A, based on the version of the form shown to him/her during the FID interview, he/she would have placed the Subject in segregated housing.

On March 30, 2023, at approximately 0630 hours, Detention Officers B, C, and D were assigned to the Male Security Section where the Subject was housed. According to Detention Officer C, during his/her first Title 15 safety check of Cell 214, he/she observed the Subject using the phone and noticed him pacing back and forth. Detention Officer C described the Subject's behavior as being common with inmates, and it did not draw his/her concern.

During what Detention Officer C believed to be the third or fourth safety check, the Subject pointed to the empty cell across from the general housing cell and asked Detention Officer C to move him there because he wanted to be alone and talk to his son.

Detention Officer C stated, “Well, he had a phone there and I told him, ‘There's a phone right there. You could use it.’ He said, ‘No. I want to go in that cell and I want to talk to my kid.’” Detention Officer C added, “Every time we would walk by, he just had his hands out there and he kept on saying he was seeing somebody across the hall. And it was his kid that he wants to go over there and talk to him. Um, pacing back and forth wasn't really a flag but once he started talking or telling me that there's something that's not there. That was a red flag. Second red flag was an arrestee in that cell said, ‘Hey, this guy is kind of weird.’ Once an arrestee tells me, hey - - or tells an officer, hey, this guy's kind of weird, it's like, hey, we better move him away so he doesn't disrupt the rest of the arrestees.”

When asked if he believed that the Subject was hallucinating, Detention Officer C stated, “I don't know it's a tough one. I - - maybe I'm assuming that he sees a kid, but his specific words were, ‘Hey, put me in that cell because I want to talk to my kid.’”

According to Detention Officer C, he/she reviewed the Subject’s booking forms and noticed that he was medically screened for high blood pressure and methamphetamine use but did not notify the medical dispensary staff of the Subject possibly experiencing hallucinations.

Detention Officer C spoke with Detention Officer D regarding the Subject’s conduct and suggested that they move him to a segregation cell. According to Detention Officer D, the Subject became progressively disruptive, making noises while other inmates were trying to sleep. Detention Officer D requested Senior Detention Officer B to meet them outside of the Subject’s cell. According to Senior Detention Officer B, Detention Officer D briefed him/her on the Subject’s behavior and advised him/her that the Subject was disruptive during Title 15 safety checks and toward other inmates. As a result, Senior Detention Officer B approved moving the Subject from general housing to a segregation cell.

According to Senior Detention Officer B, the Subject refused to exit the cell, complained he would not have access to a phone, and told jail personnel that he did not want to be handcuffed. Senior Detention Officer B advised the Subject that he would have access to a phone and would not be handcuffed as long as he did not become a threat to the detention officers. The Subject initially refused to step out of the cell but eventually complied. At approximately 0900 hours, the Subject exited the general housing cell, and as detention officers escorted him, he became uncooperative and stopped walking toward the segregation cell. Detention Officers B and C handcuffed the Subject and completed the escort to Segregation Cell 210B. According to Senior Detention Officer B, despite the Subject’s lack of compliance, there was no use of force. Once in Cell 210B, Detention Officer C removed the Subject’s handcuffs. The Subject remained in Cell 210B without further incident and was allowed to use the phone.

According to Detention Officer A, he/she completed Part-D of the Los Angeles Police Department Classification Assessment Form by marking “No” boxes with letter “X” to indicate that the Subject did not appear to be vulnerable, LGBT, intersex, or Gender non-conforming and his behavior did not indicate the need for other than general

housing. Additionally, Detention Officer A signed, dated, and placed the time he/she completed the form.

According to Senior Detention Officer A, when he/she reviewed the Subject's intake forms, including Part-C and Part-D of the Los Angeles Police Department Classification Assessment Form, he/she noted that the Subject was screened by the dispensary for substance abuse but not mental illness. Additionally, the questions in Part-D of the form were marked with the letter X without circles, indicating that the Subject was not vulnerable, and his behavior did not indicate the need for other than general housing. Based on the review of the forms, Senior Detention Officer A approved the Subject for general housing. He/she placed a black stamp with the letters "GH" on the Division Booking Record form, and signed Part-D of the Los Angeles Police Department Classification Assessment Form.

According to Senior Detention Officer B, he/she updated the Subject's Division Booking Record by placing a red stamp over the original black stamp to indicate that the Subject was moved to a segregated cell and noted the Subject was disruptive in general housing. In addition, Senior Detention Officer B updated Part-D of the Subject's Los Angeles Police Department Classification Assessment Form on the Jail Custody Record and Division Booking Record packets. He/she wrote an X with a circle around it next to the need for other than general housing and segregation. Additionally, he/she changed the housing classification to segregation by writing an X with a circle around it.

FID investigators reviewed the LAPD Classification Assessment Form of the Subject's Jail Custody Record. Investigators noted a mark indicating that the Subject was suicidal had been made under Part-D of the form. When interviewed, Detention Officer A and Senior Detention Officers A and B denied marking the suicidal box. The investigation was unable to determine the source of the mark.

According to Senior Detention Officer B, when an inmate is classified as suicidal, the inmate is placed in a "safety cell." The investigation found no indication that the Subject mentioned being suicidal to any Department personnel and at no time was he placed in a safety cell while housed at VJS.

Senior Detention Officer B told FID that he/she updated the Subject's housing classification to "segregated" on the Los Angeles Police Department Classification Assessment form, Part D, by marking the appropriate boxes using an X with a circle around it. Senior Detention Officer B said that this particular mark indicated a change had been made. Further, Senior Detention Officer B said that if a supervisor had already signed the inmate classification, he/she did not have to sign it himself/herself when he/she made the changes.

On March 31, 2023, at approximately 0630 hours, Detention Officers C, E, and F were assigned to the Male Security Section. At approximately 0700 hours, the detention officers began their Title 15 safety checks, with Detention Officer E conducting the first safety check of the Subject's cell. Based on jail security video, between 0700 hours and 1200 hours, 12 Title 15 safety checks were conducted on the Subject's cell. Eleven of these safety checks were conducted by Detention Officer C. According to Detention

Officer C, throughout his checks, the Subject was cooperative, responsive, and requested to use the phone.

At approximately 1228 hours, Detention Officer F used his/her radio and requested an additional detention officer to respond to the Male Security Section and assist with monitoring the security cameras inside the monitoring room, before he and Detention Officer E conducted meal distribution for the inmates.

Detention Officer G, who was assigned to the dispensary desk, responded to the request. Once Detention Officer G entered the monitoring room, Detention Officers E and F began meal distribution.

According to the timestamp on the VJS video for the 200 Front Hallway, Detention Officer G arrived at approximately 12:22:30 and stood in the doorway of the monitoring room for almost three minutes before entering. Detention Officer G told FID, "When I was standing in the doorway, I pulled out my phone to look at a message and then I put it back in, and I went into the camera room."

When FID asked Detention Officer G about the amount of detail he/she could discern from the cell video monitors, Detention Officer G responded, "Not – some of them I feel like are grainy and we look to the best of our abilities. When I'm back there, I scan all the cameras back and forth, back and forth. But there are some areas that they are not the –like the picture – the quality isn't the best."

The 200 Block Monitoring Room used by the detention officers as an office, was equipped with a 65-inch monitor affixed to the east wall. The monitor provided a rectangular view of 25 individual cameras. The viewing area for each camera measured 6½ inches tall by 9¾ inches wide. At the time meal distribution began, there were 46 inmates housed in the Male Security Section, including the Subject.

At approximately 1230 hours, Detention Officer E approached the Subject's cell and handed him a meal through the door's cell port. Detention Officer E described the Subject as appearing as though he had just woken up. After providing the meal, Detention Officer E briefly spoke with the Subject, who asked what day it was and requested to use the phone. Detention Officer E advised the Subject that the phone was being used, but he/she would bring it to the Subject's cell once it became available. A review of jail security video captured the Subject receiving his meal before sitting down on the lower bunk to eat it. Detention Officer E exited to the main hallway and served meals to the general housing cells with Detention Officers C and F.

Approximately three and a half minutes later and as captured on jail security video, the Subject stood up, walked to the cell door, and stood there for approximately 50 seconds. The Subject walked back and forth between the bunk and cell door before placing his meal tray and paperwork in a corner on the top bunk.

At approximately 1235 hours, the Subject retrieved a bedsheet from the bottom bunk and began tearing it. He then walked to the end of the bunk and looped a strip of the torn bedsheet to the frame of the upper bunk. The Subject paced back and forth for

several seconds before walking to the end of the bunk. He then faced the bed frame and tied two strips of the torn sheet around his neck, forming a knot. The Subject turned and faced the south wall and lowered his body toward the floor in what appeared to be a seated position, causing the strip of the torn bedsheet to act as a ligature. After placing his weight against the ligature, the Subject stretched his legs forward, and kept his arms in front of him. Approximately 41 seconds later, he momentarily raised both arms horizontally out in front of him before appearing to go limp. The Subject ceased all movement approximately five minutes after lowering his body against the ligature. At no point during this time did it appear that the Subject struggled to release the ligature. The Subject remained in that position for the ensuing 18 minutes.

The investigation determined that when the Subject tore his bedsheet and used it as a ligature to hang himself, Detention Officer G was assigned to monitor the camera system. When interviewed, Detention Officer G stated that his/her responsibilities while monitoring the cameras are the safety and welfare of the inmates and the detention officers. Detention Officer G said that he/she observed the Subject eating and did not notice anything unusual. He/she added, “He wasn't doing anything. Because usually I'll scan all the cameras and usually it's happened where there's something that catches your attention, like a movement or something, but nothing happened while I was scanning all the cameras that made me feel something was going on.”

At approximately 1239 hours, Detention Officers C, E, and F finished meal distribution and returned to the monitoring room. As they approached the room, Detention Officer G exited and returned to the dispensary desk.

A review of the jail security video captured Detention Officer G holding a cell phone in his/her right hand as he/she approached the monitoring room. When exiting the monitoring room, he/she can be seen holding a cell phone in his/her left hand and touching its screen several times. When later interviewed, Detention Officer G stated that he/she did not use his/her cell phone while monitoring the cameras and that he/she may have been looking at a text message when he/she exited the room.

Detention Officer G advised his/her supervisors on the morning of March 31, 2023, that he/she had childcare issues and needed to leave at 12:00 p.m. Detention Officer G was asked to stay later, and he/she planned to leave at 2:00 p.m. Detention Officer G told FID, “Um, when I’m exiting the camera room, um, I may have been looking at a text message or the time on my phone. I – I can’t say exactly what but it had to be either one of those.”

Regarding his/her understanding of the cell phone policy, Detention Officer G said, “Um, I know that, you know, we’re allowed to look at our phone, but if something’s going on, we can’t just be, like, scrolling and having conversations. We’re not allowed to just have our phone out.”

A review of the jail security video captured Detention Officer G holding a cell phone in his/her right hand as he/she approached the monitoring room. When exiting the monitoring room, he/she can be seen holding a cell phone in his/her left hand and touching its screen several times. When later interviewed, Detention Officer G stated

that he/she did not use his/her cell phone while monitoring the cameras and that he/she may have been looking at a text message when he/she exited the room.

According to Detention Officer C, upon his/her return to the monitoring room, he/she viewed the cameras and did not notice anything unusual. He/she recalled seeing the Subject in what appeared to be a seated position at the footboard of the bunk, staring at the wall in front of him. The Subject's actions did not draw concern from Detention Officer C.

At approximately 1255 hours, the custodian, who was assigned to empty the trash cans in the jail, entered the 210 hallway. As he/she checked the trashcan outside Cell No. 210B, he/she saw the Subject hanging from the upper bunk. The custodian immediately rushed to the Block Monitoring Room and alerted the detention officers of his/her observations.

Detention Officers C and F immediately ran to the Subject's cell while Detention Officer E remained in the monitoring room and stood by with the "suicide kit" in the event it was needed. According to Detention Officer E, he/she used his/her radio and broadcast "Code Blue" (an inmate in life-threatening situation).

Approximately 30 seconds after being notified of the Subject's condition, Detention Officers C and F arrived at and entered the Subject's cell. According to Detention Officer F, before he/she entered the cell, he/she activated the emergency button on the wall just outside the cell, which alerts jail personnel of the emergency and the location.

According to Detention Officer C, he/she noticed that the Subject was in a "sitting position" but not on the bed and had a cut sheet tied around his neck. He/she described the Subject as motionless and pale. The Subject did not appear to be seated on the ground or the bed. Detention Officer C lifted the Subject's body to lessen the tension of the ligature around his neck. Approximately five seconds later, Detention Officer E entered the cell with the suicide kit and used scissors to cut the ligature between the Subject's neck and the bunk's metal frame. Detention Officers C and F then placed the Subject on the floor in a supine position.

Detention Officer C assessed and determined that the Subject was not breathing and did not have a pulse. He/she directed Detention Officer F to start CPR. While Detention Officer F performed CPR chest compressions, Detention Officer C used a pocket mask respirator to administer rescue breathing while Detention Officer D used his/her radio to request a rescue ambulance (RA) over Van Nuys Base Frequency.

Approximately one minute after the Subject's discovery, dispensary personnel including, Doctor B and Registered Nurses A & B, arrived at the Subject's cell with a gurney. Doctor B directed the nurses to obtain an Automated External Defibrillator (AED), bag valve mask, and "crash cart" from the dispensary. Once the AED arrived, Doctor B ensured that the pads were properly applied and provided oversight as the detention officers continued CPR. It was Doctor B's assessment that CPR was appropriate for the situation and was administered correctly. The AED did not detect a shockable rhythm;

therefore, a shock was not administered. Detention officers and dispensary personnel continued providing CPR until LAFD arrived approximately 15 minutes later.

At approximately 1310 hours, LAFD EMT personnel entered the Subject's cell. Approximately 35 seconds later, LAFD Firefighter-Paramedics A and B arrived at the cell. After attempting advanced life preserving measures for approximately 30 minutes, Firefighter-Paramedic A contacted the hospital and consulted with a doctor, who pronounced the Subject deceased at 1343 hours.

FID reviewed the VJS security video and the associated Radio Frequency Identification (RFID) Compliance Monitor Report. The review determined that the Title 15 safety checks were conducted on the Subject twice an hour, as required by Department policy.

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 A	Yes	Yes	Yes	N/A	N/A
Officer B	Yes	Yes	Yes	N/A	N/A
Officer C	N/A	N/A	N/A	N/A	N/A

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. For in-custody death (ICD) incidents, the BOPC makes specific findings in these areas: tactics of the involved officer(s), inmate intake procedures by any involved officer(s), inmate welfare procedures by any involved officer(s), inmate welfare procedures by any involved officer(s), inmate emergency medical procedures by any involved officer(s), and post in-custody death procedures by any involved officer(s). Based on the BOPC's review of the incident, the BOPC made the following findings:

A. Tactics

The BOPC found the tactics of Officers A, B, C, Detention Officers A, C, D, E, F, G, Senior Detention Officers B, C, and Captain A to warrant a Tactical Debrief.

B. Inmate Intake Procedures

The BOPC found the inmate intake procedures of Officers A, B, C, Senior Detention Officer B, and Detention Officers A & C to be consistent with established criteria.

C. Inmate Welfare Procedures

The BOPC found the inmate welfare procedures of Detention Officers C, E, F, and G to be consistent with established criteria.

D. Inmate Medical Emergency Procedures

The BOPC found the inmate emergency medical procedures of Detention Officers C, E, F, and G to be consistent with established criteria.

E. Post In-Custody Death Procedures

The BOPC found the post in-custody death procedures of Captain A to be consistent with established criteria.

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. The Los Angeles Police Department also recognizes 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. 23, 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 suspect 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.

Verbal Warnings: Where feasible, a peace officer shall, prior to the use of any force, make reasonable efforts to identify themselves as a peace officer and to warn that force may be used, unless the officer has objectively reasonable grounds to believe that the person is already aware of those facts.

Proportionality: Officers may only use a level of force that they reasonably believe is proportional to the seriousness of the suspected offense or the reasonably perceived level of actual or threatened resistance.

Fair and Unbiased Policing: Officers shall carry out their duties, including use of force, in a manner that is fair and unbiased. Discriminatory conduct in the basis of race, religion, color, ethnicity, national origin, age, gender, gender identity, gender expression, sexual orientation, housing status, or disability while performing any law enforcement activity is prohibited.

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.

Factors Used to Determine Objective Reasonableness: Pursuant to the opinion issued by the United States Supreme Court in *Graham v. Connor*, the Department examines the reasonableness of any particular force used: a) from the perspective of a reasonable Los Angeles Police Officer with similar training and experience, in the same situation; and b) based on the facts and circumstances of each particular case. Those factors may include, but are not limited to:

- The feasibility of using de-escalation tactics, crisis intervention or other alternatives to force;
- The seriousness of the crime or suspected offense;
- The level of threat or resistance presented by the suspect;
- Whether the suspect was posing an immediate threat to the officers or a danger to the community;

- The potential for injury to citizens, officers or suspects;
- The risk or apparent attempt by the suspect to escape;
- The conduct of the suspect being confronted (as reasonably perceived by the officer at the time);
- The amount of time and any changing circumstances during which the officer had to determine the type and amount of force that appeared to be reasonable;
- The availability of other resources;
- The training and experience of the officer;
- The proximity or access of weapons to the suspect;
- Officer versus suspect factors such as age, size, relative strength, skill level, injury/exhaustion and number of officers versus suspects;
- The environmental factors and/or other exigent circumstances; and,
- Whether a person is a member of a vulnerable population.

Drawing or Exhibiting Firearms: Unnecessarily or prematurely drawing or exhibiting a firearm limits an officer's alternatives in controlling a situation, creates unnecessary anxiety on the part of citizens, and may result in an unwarranted or accidental discharge of the firearm. Officers shall not draw or exhibit a firearm unless the circumstances surrounding the incident create a reasonable belief that it may be necessary to use the firearm. When an officer has determined that the use of deadly force is not necessary, the officer shall, as soon as practicable, secure or holster the firearm. Any drawing and exhibiting of a firearm shall conform with this policy on the use of firearms. Moreover, any intentional pointing of a firearm at a person by an officer shall be reported. Such reporting will be published in the Department's year-end use of force report.

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.

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. Before discharging a firearm, officers shall consider their surroundings and potential risks to bystanders to the extent feasible under the circumstances.

> **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*.

Rendering Aid: After any use of force, officers shall immediately request a rescue ambulance for any person injured. In addition, officers shall promptly provide basic and emergency medical assistance to all members of the community, including victims, witnesses, subjects, suspects, persons in custody, suspects of a use of force and fellow officers:

- To the extent of the officer's training and experience in first aid/CPR/AED; and
- To the level of equipment available to the officer at the time assistance is needed.

Warning Shots: It is the policy of this Department that warning shots shall only be used in exceptional circumstances where it might reasonably be expected to avoid the need to use deadly force. Generally, warning shots shall be directed in a manner that minimizes the risk of injury to innocent persons, ricochet dangers and property damage.

Shooting at or From Moving Vehicles: It is the policy of this Department that firearms shall not be discharged at a moving vehicle unless a person in the vehicle is immediately threatening the officer or another person with deadly force by means other than the vehicle. The moving vehicle itself shall not presumptively constitute a threat that justifies an officer's use of deadly force. An officer threatened by an oncoming vehicle shall move out of its path instead of discharging a firearm at it or any of its occupants. Firearms shall not be discharged from a moving vehicle, except in exigent circumstances and consistent with this policy regarding the use of Deadly Force.

> **Note:** It is understood that the policy regarding discharging a firearm at or from a moving vehicle may not cover every situation that may arise. In all situations, officers are expected to act with intelligence and exercise sound judgement, attending to the spirit of this policy. Any deviations from the provisions of this policy shall be examined rigorously on a case by case basis. The involved officer must be able to clearly articulate the reasons for the use of deadly force. Factors that may be considered include whether the officer's life or the lives of others were in immediate peril and there was no reasonable or apparent means of escape.

Requirement to Report Potential Excessive Force: An officer who is present and observes another officer using force that the present and observing officer believes to be beyond that which is necessary, as determined by an objectively reasonable officer under the circumstances based upon the totality of information actually known to the officer, shall report such force to a superior officer.

Requirement to Intercede When Excessive Force is Observed: An officer shall intercede when present and observing another officer using force that is clearly beyond

that which is necessary, as determined by an objectively reasonable officer under the circumstances, taking into account the possibility that other officers may have additional information regarding the threat posed by a suspect.

Definitions

Deadly Force: Deadly force is defined as any use of force that creates a substantial risk of causing death or serious bodily injury, including but not limited to, the discharge of a firearm.

Feasible: Feasible means reasonably capable of being done or carried out under the circumstances to successfully achieve the arrest or lawful objective without increasing risk to the officer or another person.

Imminent: Pursuant to California Penal Code 835a(e)(2), "[A] threat of death or serious bodily injury is "imminent" when, based on the totality of the circumstances, a reasonable officer in the same situation would believe that a person has the present ability, opportunity, and apparent intent to immediately cause death or serious bodily injury to a peace officer or another person. An imminent harm is not merely a fear of future harm, no matter how great the fear and no matter how great the likelihood of the harm, but is one that, from appearances, must be instantly confronted and addressed."

Necessary: In addition to California Penal Code 835(a), the Department shall evaluate whether deadly force was necessary by looking at: a) the totality of the circumstances from the perspective of a reasonable Los Angeles Police Officer with similar training and experience; b) the factors used to evaluate whether force is objectively reasonable; c) an evaluation of whether the officer exhausted the available and feasible alternatives to deadly force; and d) whether a warning was feasible and/or given.

Objectively Reasonable: The legal standard used to determine the lawfulness of a use of force is based on the Fourth Amendment to the United States Constitution. See *Graham v. Connor*, 490 U.S. 386 (1989). *Graham* states, in part, "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 test of reasonableness is not capable of precise definition or mechanical application."

The force must be reasonable under the circumstances known to or reasonably believed by the officer at the time the force was used. Therefore, the Department examines all uses of force from an objective standard rather than a subjective standard.

Serious Bodily Injury: Pursuant to California Penal Code Section 243(f)(4) Serious Bodily Injury includes but is not limited to:

- Loss of consciousness;
- Concussion;

- Bone Fracture;
- Protracted loss or impairment of function of any bodily member or organ;
- A wound requiring extensive suturing; and,
- Serious disfigurement.

Totality of the Circumstances: All facts known to or reasonably perceived by the officer at the time, including the conduct of the officer and the suspect leading up to the use of force.

Vulnerable Population: Vulnerable populations include, but are not limited to, children, elderly persons, people who are pregnant, and people with physical, mental, and developmental disabilities.

Warning Shots: The intentional discharge of a firearm off target not intended to hit a person, to warn others that deadly force is imminent.

Detention

Officers A and B responded to a radio call of a "Battery Suspect There Now." Upon their arrival, they met with Witness A, who advised them that the Subject assaulted him and that he wanted a private person's arrest (PPA) for Battery. Officers accepted Witness A's PPA of the Subject and took him into custody without further incident. Based on the totality of the circumstances, officers had reasonable suspicion to detain the Subject.

A. Tactics

The tactics of the substantially involved personnel were not reviewed or evaluated as they were not a factor in this incident. However, Department guidelines require personnel who are substantially involved in an ICD to attend a Tactical Debrief.

During the review of this incident, no Debriefing Points were noted; however, the following Adjudication Areas were discussed:

B. Adjudication Area No. 1: Inmate Intake Procedures

Custody Transfer Communication

Officers A and B accepted the PPA of the Subject for battery. Officers C and D responded to an additional unit request and transported the Subject to Foothill Station. At 2140 hours, the Subject was placed in a holding tank and was met by Sergeant A, who asked the required intake interview questions. The Subject answered that he understood why he was arrested, did not have any complaints of injury or illness, and did not have any questions. Police Officer E and Detention Officer A responded to Foothill Station for an arrestee transportation request and reviewed the Subject's booking approval, medical screening, and Custody Transportation Unit forms. At 2240 hours, Officer E and Detention Officer A left

Foothill Station with the Subject. A transfer of custody was completed from patrol officers to CSD staff once Officer E and Detention Officer A determined that the Subject qualified and was accepted for a transport to VJS.

The UOFRB noted that the documents associated with the Subject's booking were completed by Officers A and B and the detention officers reviewed and approved the Subject for transport to VJS. The UOFRB also noted Officer E and Detention Officer A re-interviewed the Subject and asked the same questions listed on the Los Angeles County Unified Medical Screening Form prior to transport.

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

Booking Process

Officers A and B completed a Los Angeles Police Department (LAPD) Booking Approval Report Form, 12.31.00, and presented it to Sergeant A, who reviewed and signed the Booking Approval. Officers A and B met with Officer E and Detention Officer A, who reviewed the Subject's booking approval, medical screening, and Custody Transportation Unit forms and assumed transfer of custody responsibilities and transported the Subject to VJS. The Subject was medically screened by Doctor A at the VJS dispensary. At approximately 2340 hours, Senior Detention Officer A reviewed his intake forms and approved him for general housing.

Based on the totality of the circumstances, the UOFRB and Chief determined, and the BOPC concurred, that the actions of Officers A, B, E, and Detention Officer A during the booking process were consistent with established criteria.

Medical Screening and Classification/Segregation

Officer B completed the Los Angeles County Unified Arrestee Medical Screening Form SH-R-422, which reflected that the Subject had high blood pressure and used methamphetamine daily, including on the date he was arrested. The Subject signed the document. Officer B printed his/her last name, serial number, and date on the appropriate lines. Officer B provided his/her name, serial number, and date on the second page of the document under the "Arresting Deputy/Officer Observation" heading.

Officer E and Detention Officer A responded to an arrestee transportation request at Foothill Station. According to both transporting officers, they interviewed the Subject and asked the same questions listed on the Los Angeles County Unified Screening Form. They determined that the Subject did not require serious medical attention or suffer from mental illness. The Subject was cooperative and qualified for transport to VJS.

At approximately 2329 hours, the Subject was medically screened by Doctor A at the VJS dispensary for high blood pressure and methamphetamine use. According to

Doctor A, the Subject disclosed having a history of anxiety and depression and was prescribed medication but was not taking it. The Subject denied being suicidal, homicidal, or experiencing hallucinations. In addition, Doctor A stated that there was no indication that the Subject's methamphetamine usage raised his blood pressure or pulse, or altered his mental status. As such, Doctor A concluded that the Subject did not require a higher level of care and cleared him for booking.

The UOFRB noted that during the booking process, Officer B completed the Medical Screening Form, SH-R-422, which reflected that the Subject had high blood pressure and used methamphetamine daily, including on the date he was arrested. Furthermore, Officer E and Detention Officer A reviewed Form SH-R-422 and re-interviewed the Subject with the same questions listed on the Los Angeles County Unified Medical Screening Form. They determined that the Subject did not have any medical conditions that would preclude him from being housed at VJS and he did not need serious medical treatment. The UOFRB noted that the Subject was evaluated and medically screened by Officers B, E, and Detention Officer A. Based on this evaluation, the Subject was placed in general housing.

Inmate Classification Assessment Form, 05.36.00 Parts A/B were completed by Officer B. The Medical Evaluation in Part C was completed at the Jail Dispensary as the Subject was medically screened by Doctor A for high blood pressure and methamphetamine use. Part D was completed by Detention Officer A.

As Detention Officer C continued to monitor the Subject's behavior in general housing, he/she formed the opinion that the Subject should be transferred to a segregation cell. Detention Officer C spoke with Detention Officer D regarding the Subject's conduct and suggested that they change his classification and move him to a segregation cell. According to Detention Officer D, the Subject became progressively disruptive, including making noises while other inmates were trying to sleep. Detention Officer D briefed Senior Detention Officer B on the Subject's behavior and, as a result, Senior Detention Officer B approved moving the Subject from general housing to a segregation cell.

The UOFRB noted that the LAPD Classification Assessment Form 05.36.00 Parts A/B were properly completed by Officer B, and Part D was properly completed by Detention Officer A. Part C, Record of Medical Screening, was completed at the Jail Dispensary as the Subject was medically screened by Doctor A for high blood pressure and methamphetamine use. The questions listed in Part D were addressed and documented with Detention Officer A's name across the "Reporting Employee" section and Senior Detention Officer A's name across the "Supervisor Approving" signature boxes at the bottom of the document. The form contained handwritten signatures and the date and time boxes were dated accordingly.

The UOFRB considered the Subject's behavior of being disruptive during the Title 15 checks and affecting other inmates who were trying to sleep as the cause for Detention Officer C to raise concern to Detention Officer D. The UOFRB addressed this decision and believed that it was reasonable based on the Subject's behavior and established CSD procedures.

Furthermore, the UOFRB noted that it was the responsibility of Officers B, E, and Detention Officer A to accurately and properly complete all sections of the Arrestee Medical Screening and Classification Assessment forms. The UOFRB opined that the proper assessment of an arrestee is a critical component in determining whether an inmate should be housed in general housing, assigned to a segregated cell, or transported to a different facility.

FID investigators reviewed the LAPD Classification Assessment Form of the Subject's Jail Custody Record and noted a marking indicating that the Subject was suicidal had been made under Part D of the form. The marking was absent from the Divisional Booking Record. When interviewed, Detention Officer A and Senior Detention Officers A & B denied marking the suicidal box and the investigation revealed that until the Subject was discovered to have hanged himself, he never demonstrated suicidal behavior or made comments about being suicidal. The investigation was unable to determine the source of the notation.

Note: As a result of this incident, CSD policy has changed to require an initial, serial number, and date to the Jail Custody Record any time an arrestee's classification is changed. CSD is also in the process of creating a supplemental form to document any arrestee housing or classification changes.

Based on the totality of the circumstances, the UOFRB and Chief determined, and the BOPC concurred, that the actions of Officers B, E, and Detention Officer A in completing the Arrestee Medical Screening Form and Inmate Classification Assessment Form were consistent with established criteria. The UOFRB and Chief also determined, and the BOPC concurred, that Detention Officer C's decision to change the Subject's housing from general housing to segregation and Senior Detention Officer B's approval of the change to the Subject's housing were consistent with established criteria.

Suicide Prevention

The UOFRB noted that prior to the Subject hanging himself, nothing in the investigation indicated that he expressed or displayed suicidal ideations. Therefore, the Suicide Prevention protocol was not initiated and therefore not evaluated.

Based on the totality of the circumstances the BOPC determined that the inmate intake procedures employed by Officers A, B,E, Senior Detention Officer B, and Detention Officers A & C were consistent with established criteria.

C. Adjudication Area No. 2 Inmate Welfare Procedures

Safety Checks

While the Subject was housed at VJS, Detention Officers C, E, and F used the Guardian Management System to complete the inmate well-being safety checks. The compliance report indicated that during their shift, Detention Officers C, E, and F conducted the required safety checks approximately every 30 minutes until the last

check at approximately 1230:18 hours, when the Subject was served a meal by Detention Officer E. Based on VJS security video, on March 31, 2023, between the hours of 0700 and 1200, 12 Title-15 safety checks were conducted, 11 of which were conducted by Detention Officer C.

Note: The investigation determined that Detention Officer E used Detention Officer C's log on credentials to operate the Guardian Management System as he did not have credentials of his/her own. As a result of this incident, the CSD Training Unit has been directed to keep and maintain control of all Guardian log on credentials. Probationary Detention Officers will now be issued a log on credential upon graduation from the Detention Officer Academy.

According to Detention Officer C, during his/her first Title 15 safety check of Cell 214, he/she observed the Subject using the phone and noticed him pacing back and forth. Detention Officer C described the Subject's behavior as being common with inmates and it did not draw his/her concern. During what Detention Officer C believed to be the third or fourth safety check, the Subject pointed to the empty cell across from the general housing cell and asked to be moved there because he wanted to be alone and talk to his son. Detention Officer C stated, "Well, he had a phone there and I told him, 'There's a phone right there. You could use it.' He said, 'No. I want to go in that cell and I want to talk to my kid.'" According to Detention Officer C, he/she reviewed the Subject's booking forms and noticed that the Subject was medically screened for high blood pressure and methamphetamine use and that he was approved for general housing.

At approximately 1255 hours, the custodian entered the hallway and checked the trash can outside Cell No. 210B. The custodian observed the Subject hanging from the upper bunk and immediately rushed to the block monitoring room and alerted Detention Officers C, E, and F of his/her observations.

The UOFRB noted that per Title 15, detention officers are required to conduct hourly safety checks of inmates. In addition to the hourly safety checks mandated by the State of California, the LAPD, CSD, 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 with the Radio Frequency Identification (RFID) System, 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 VJS. During that time, CSD personnel conducted in-person safety checks every 30 minutes, logging the time the check was completed via the Guardian Management 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 the Subject may have been in distress until Detention Officers C, E, and F were notified of the Subject's condition by the custodian at approximately 1255 hours.

Based on the totality of the circumstances, the BOPC determined that Detention Officers C, E, and F's safety checks were consistent with established criteria.

Pill Call / Sick Call

The UOFRB noted the FID investigation indicated that the Subject did not claim to be under the care of a medical provider or taking any prescribed medication and as such he did not receive Pill Call/Sick Call visits from the Jail Dispensary staff rendering these procedures not applicable.

Dispensary Visits

The UOFRB noted that the Subject did not visit the Dispensary after his initial medical screening rendering these procedures not applicable.

Cameras and Monitoring

VJS is equipped with a digital surveillance system with cameras fixed at various positions throughout the facility. The detention officers assigned to the 200 Block staff the camera monitoring room to supplement their welfare checks of arrestees via the surveillance system. FID's Video Technology Unit obtained the surveillance video which depicts all of the Subject's movements while in the facility. All the cameras at VJS are blacked-out over the toilet for privacy reasons.

The UOFRB noted that CSD Divisional Order No. 5 states that the most senior detention officer shall assign camera monitoring duties and ensure that the POD or Block monitoring rooms are staffed at all times and that in the case of VJS, audio/visual monitoring may supplement but not substitute for direct visual observation of an arrestee.

FID investigators reviewed surveillance camera footage at VJS and determined that at the time the Subject tore a bedsheet, used it to hang himself, and render himself unconscious, Detention Officers C, E, and F were engaged in distributing meals to arrestees and Detention Officer G was in the monitoring room to monitor the surveillance screens. The UOFRB noted Detention Officer G's statements that it was his/her responsibility to monitor the safety and welfare of the arrestees and the detention officers during the meal distribution. The UOFRB opined that because Detention Officer G was monitoring the meal distribution, which the UOFRB believed to be the greatest threat to officer safety at the time, it was reasonable that he/she could have missed the Subject tearing his bed sheet. The UOFRB also noted that the Subject tied the sheet to the south end of his bunk bed, thus partially obstructing himself from view of the camera as the bunk bed was located between the Subject and the camera, which was affixed to the north wall.

Note: As a result of this incident, CSD policy has changed to no longer issue a bed sheet and a blanket to arrestees housed in a segregated cell at VJS. Arrestees are now issued two blankets in lieu of a blanket and a bed sheet. Additionally, CSD has initiated a project at VJS to remove all bunk beds from segregation cells and install only a single bed configuration.

After the detention officers were notified by the custodian of the Subject's hanging, Detention Officers C and F responded and entered the Subject's cell. Detention Officer E remained momentarily in the camera monitoring room and stood by with the "suicide kit" in the event it was needed. According to Detention Officer E, he/she used his/her radio and broadcast "Code Blue" and quickly responded to the cell to meet with Detention Officers C and F. Jail personnel cut the ligature, placed the Subject on the floor, and immediately initiated CPR. According to FID investigators, the monitoring room was left momentarily unoccupied by jail personnel for approximately one minute as Detention Officer E responded to the Subject's jail cell with the "suicide kit."

The UOFRB noted that in some cases, detention officers may need to step away from the monitoring room in the event of exigent circumstances involving officer safety, medical emergencies within jail facilities, and to complete the mandated Title 15 checks. The UOFRB discussed Detention Officer E's leaving the monitoring room in response to deliver the "suicide kit" and concluded that it was a substantial deviation, with justification, as it was an exigent circumstance and the kit was needed in an effort to preserve life.

Based on the totality of the circumstances, the BOPC determined that Detention Officers C, E, F, and G's camera monitoring was consistent with established criteria.

Based on the totality of the circumstances the BOPC determined that the inmate welfare procedures employed by Detention Officers C, E, F, and G were consistent with established criteria.

D. Adjudication Area No. 3: Inmate Emergency Medical Procedures

Cell Entry and Notification

At approximately 1255 hours, the custodian checked the trash can outside Cell No. 210B and observed the Subject hanging from the upper bunk. The custodian immediately rushed to the camera monitoring room and alerted the detention officers of his/her observations. At approximately 1255:25 hours, Detention Officers C and F entered the Subject's cell, but not before Detention Officer F activated the emergency button on the wall just outside the cell, which alerts jail personnel of the medical emergency and location. According to Detention Officer C, he/she noticed that the Subject was motionless, pale and in a "sitting position," but not on the bed, and had a cut sheet tied around his neck. The Subject did not appear to be seated on the ground or bed. Detention Officer E remained momentarily in the monitoring room and stood by with the "suicide kit" in the event it was needed. According to Detention Officer E, he/she used his/her radio and broadcast "Code Blue" and quickly met with Detention Officers C and F with the suicide kit. Jail personnel cut the ligature, placed the Subject on the floor, and immediately initiated CPR. At approximately 1256 hours, Detention Officer D was directed by Senior Detention Officer C to request an RA and patrol unit Code 3 (with vehicle emergency lights and siren activated) to VJS.

The UOFRB noted that when the custodian observed the Subject's condition, he/she rushed to the camera monitoring room and alerted the detention officers of his/her observations. Detention Officers C and F arrived at the Subject's jail cell without delay, entered the cell together, and provided medical assistance. The UOFRB noted that immediately following Detention Officers' C and F entry into the cell, Detention Officer E responded with the "suicide kit" and assisted with life-saving measures.

The UOFRB noted that Department policy mandates that CSD personnel responding to arrestee/inmate emergencies, such as a man down, shall broadcast Code Blue. The Code Blue broadcast causes an immediate response by detention officers and medical personnel, who bring with them a gurney and a suicide response kit. In this case, Senior Detention Officer C and Detention Officers C, E, and F were the CSD personnel assigned to VJS at the time of the incident. The detention officers were in direct communication with each other and were able to activate the alarm and broadcast Code Blue to all CSD personnel. Based on the totality of the circumstances, the UOFRB and Chief determined, and the BOPC concurred, that in this situation, Code Blue was successfully broadcast to all personnel without delay.

Based on the totality of the circumstances, the BOPC determined that both the notifications of Senior Detention Officer C, Detention Officers C, E, & F and the entry into the Subject's cell by Detention Officers C and F were consistent with established criteria.

Medical Assistance and Rescue Ambulance Request

According to the FID investigation, Detention Officers C and F immediately ran to the Subject's cell while Detention Officer E remained in the monitoring room and stood by with the "suicide kit" in the event it was needed. According to Detention Officer E, he/she used his/her radio and broadcast "Code Blue." At approximately 12:55:25 hours, Detention Officers C and F arrived and entered the Subject's jail cell. Approximately five seconds later, Detention Officer E entered the cell with the suicide kit and used scissors to cut the ligature between the Subject's neck and the bunk's metal frame. Detention Officers C and F placed the Subject on the floor in a supine position and began to administer CPR. Approximately one minute after the Subject's discovery, Doctor B and Registered Nurses A & B arrived at scene with a gurney. Doctor B directed the nurses to obtain an AED, bag valve mask, and "crash cart" from the dispensary. Once the AED arrived, the pads were placed on the Subject's chest, but it did not recommend a shock. Detention Officers C, E, F, and G continued to administer CPR and coordinated lifesaving efforts to the Subject until LAFD personnel responded and relieved them at scene.

Note: As a result of this incident, the CSD Training Unit has been directed to create and implement a scenario based, "Man Down-Code Blue" training, which will include Medical Services. Additionally, the CSD Training Unit has also been directed to create a four-hour block, Standards and Training for Corrections certified, ICD training to be taught in the Detention Officer Academy and for in-service personnel.

According to the FID investigation, Detention Officer D stated that he/she responded to cell 210B following the Code Blue broadcast. He/she stated that he/she heard Senior Detention Officer C yell out, "Hey, call an RA." Senior Detention Officer C then directed Detention Officer D to request an RA. At approximately 1256 hours, Detention Officer D stepped out toward the release desk where there was better radio reception and broadcasted a request for an RA and a patrol unit to respond Code 3 on Van Nuys base frequency.

At approximately 1310 hours, LAFD personnel entered the Subject's cell. Approximately 35 seconds later, Firefighter/Paramedics A and B arrived at scene. LAFD personnel relieved CSD personnel and continued with lifesaving measures but the Subject did not respond. Firefighter/Paramedic A telephonically contacted the doctor at the hospital, who pronounced the Subject deceased.

The UOFRB noted that immediately upon entering the Subject's jail cell and seeing him in medical distress, Detention Officers C, E, F, and G began performing CPR as Senior Detention Officer C advised Detention Officer D to request an RA. The UOFRB also noted shortly thereafter, Doctor B directed the nurses to obtain an AED, bag valve mask, and "crash cart." The UOFRB addressed the lifesaving efforts to the Subject by Detention Officers C, E, F, and G, as they continued to provide lifesaving efforts until LAFD responded to the scene.

Based on the totality of the circumstances, the BOPC determined that the medical assistance and RA request by Senior Detention Officer C and Detention Officers C, E, F, & G were consistent with established criteria.

Based on the totality of the circumstances, the BOPC determined that the inmate emergency medical procedures employed by Senior Detention Officers C and Detention Officers C, E, F, & G were consistent with established criteria.

E. Adjudication Area No. 4: Post ICD Procedures

Notifications and Title 15, 30-Day Review

The UOFRB noted that according to the FID investigation, Captain A notified the DOC of the ICD within approximately 22 minutes of the Subject being pronounced deceased. The UOFRB also noted that on April 25, 2023, Captain A completed the State-mandated Title 15, 30-Day Review of this incident. All areas of the incident were addressed.

Based on the totality of the circumstances, the BOPC determined that the post ICD procedures employed by Captain A were consistent with established criteria.

Command and Control

According to Senior Detention Officer C's statements, he/she heard the "Code Blue" broadcast over the radio and responded to 200 block along with other jail personnel. Senior Detention Officer C stated that he/she was the first supervisor on scene and

that upon his/her arrival to Cell 210B, he/she observed three to four detention officers inside the cell performing CPR on the Subject. Senior Detention Officer C called for Detention Officer D to go to the other end of the hall to broadcast an RA request. Senior Detention Officer C stated that he/she directed the detention officers to rotate administering the chest compressions.

The UOFRB noted that upon his/her arrival, Senior Detention Officer C was the only supervisor at scene. Although he/she did not verbally declare himself/herself as the incident commander (IC), he/she immediately began assessing the incident and giving direction to officers. Rather than take time away from performing the duties of an IC to broadcast his/her role, he/she assumed the role by using active leadership to manage the incident. The UOFRB further noted that unlike patrol, CSD supervisors have predesignated areas of responsibility within the jail at the start of their shift; therefore, the UOFRB opined there was no confusion amongst CSD personnel as to who was overseeing the incident.

The BOPC determined that the overall actions of Senior Detention Officer C were consistent with Department training.

Tactical Debrief

In conducting an objective assessment of this case, the BOPC determined that the actions of Officers A, B, E, Detention Officers A, C, E, F, G, Senior Detention Officers B, C, and Captain A were consistent with established criteria.

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, the Chief directed Officers A, B, E, Detention Officers A, C, E, F, G, Senior Detention Officers B, C, and Captain A to attend a Tactical Debrief and that the specific identified topics be discussed.

General Training Update (GTU)

As no force was used by a Department employee, a GTU was not conducted.

Requirement to Intercede

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

Additional/Equipment

A review of the jail security video captured Detention Officer G holding a cell phone in his/her right hand, at his/her side, as he/she approached the camera monitoring room. When exiting the monitoring room, he/she can be seen holding a cell phone

in his/her left hand and touching its screen several times. When later interviewed, Detention Officer G stated that he/she did not use his/her cell phone while monitoring the cameras and that he/she may have been looking at a text message when he/she exited the room. As this issue was addressed at the divisional level via a Comment Card, with Support Services Group (SSG) and Office of Support Services (OSS) concurrence, the BOPC deemed that no further action was necessary.

Note: As a result of this incident, CSD has initiated the process to install a camera inside the monitoring room of VJS to ensure proper staffing and camera monitoring.

The available evidence supports that all required forms were completed relative to the Subject's intake, and that the responses recorded by Department personnel on those forms reflected the Subject's responses at the time the forms were completed. However, as captured by the BWVs of the arresting Officers A and B, the Subject disclosed a history of anxiety and depression. Although the officers indicated that they did not believe the Subject was experiencing a mental health episode during their encounter with him, it would have been prudent for them to have relayed the information that they received regarding his mental health history to other concerned personnel.

As referenced in the Chief's analysis, proper assessment of an arrestee is a critical component in determining whether an inmate should be housed in general housing, assigned to a segregated cell, or transported to a different facility. In this case, the LAPD Classification Assessment form recovered by FID showed an entry indicating "yes" for mental illness diagnosis, and listed depression and anxiety for the "type" of mental illness. According to Senior Detention Officer A, who approved the Subject's housing in general housing, the information regarding the Subject's mental illness was not shown on the form at the time he/she gave that approval. Senior Detention Officer A told FID that he/she would have approved the Subject for segregated housing if the information regarding his mental illness diagnosis had been indicated at that time.

The investigation established that officers conducted safety checks twice an hour, in compliance with the policy set forth in the Jail Operations Manual.