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

IN-CUSTODY DEATH – 051-15

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

Pacific 6/22/15

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

Does not apply.

Reason for Police Contact

The subject was in custody at a jail facility. The subject was found unresponsive by a detention officer during an inmate inspection.

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

Subject: Male, 52 years of age.

Board of Police Commissioners' Review

This is a brief summary designed only to enumerate salient points regarding this Categorical Use of Force incident and does not reflect the entirety of the extensive investigation by the Los Angeles Police Department (Department) or the deliberations by the Board of Police Commissioners (BOPC). In evaluating this matter, the BOPC considered the following: the complete Force Investigation Division investigation (including all of the transcribed statements of witnesses, pertinent subject criminal history, and addenda items); the relevant Training Evaluation and Management System materials of the involved officers; the Use of Force Review Board recommendations; the report and recommendations of the Chief of Police; and the report and recommendations of the Inspector General. The Department Command staff presented the matter to the BOPC and made itself available for any inquiries by the BOPC.

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

The following incident was adjudicated by the BOPC on May 24, 2016.

Incident Summary

On June 19, 2015, shortly before midnight, officers responded to a radio call of a robbery. During that investigation, the Subject was arrested without incident, and transported to a police station. On June 20, 2015, the Subject was brought into the hallway outside the Watch Commander's office. The station security interior video camera captured Watch Commander, Sergeant A, document the Subject's intake on the Adult Detention Log. According to Sergeant A, he asked the Subject if he was sick, ill, or injured, and the Subject advised that he was not. Sergeant A documented the Subject's responses on the Adult Detention Log. The Subject was then placed into a temporary Holding Tank. Officer A was captured on the station security video communicating with the Subject. According to Officer A, he asked the Subject if he had any medical problems, and the Subject advised that he did not. According to the video, Officer A did not write down the Subject's responses to the medical questions. When interviewed, Officer A stated he asked the medical questions primarily to determine where the Subject would need to be booked and housed.

During the booking process, Officer B completed a Los Angeles County Unified Arrestee Medical Screening Form with the Subject. The screening form indicated the Subject did not have any medical problems. The Los Angeles County Unified Arrestee Medical Screening Form was signed by the Subject.

Upon completion of the booking process, the security video depicted Detention Officer A escort the Subject to Cell J3, where the Subject remained throughout his incarceration. According to Detention Officer B, the Subject was housed separately in Cell J3 because of his foul foot odor.

On June 22, 2015, Detention Officers C and D were the personnel assigned to the Pacific Jail.

> **Note:** Policy requires that inmate inspections be conducted at 30 minute intervals. The investigation revealed deviations from inspection protocols. There were instances where the detention officers who were conducting the visual inspections of Cell J3 signed more than one line with different times on the Jail Inspection Record log -- one line for the time they were actually at the cell, and one or more lines for additional times for inmate inspections that were either missed or had yet to occur.

On June 22, 2015, at approximately 1015 hours, the jail security video depicted the Subject climb down from his position on the top bunk and place himself between the west wall of the cell and the west end of the bunk. The Subject was standing on the floor, facing toward the end of the bed with his back to the wall. At approximately 1022 hours, the Subject removed himself from that position by moving to his right, and a small and narrow open space on the south side of the bunk.

At approximately 1042 hours, the jail security video depicted the Subject again climb from his position on the top bunk and place himself between the west wall of the cell and the west end of the bunk. This time, the Subject was standing, facing toward the wall with his back to the west end of the bunk. The Subject remained in this position and appeared to talk to himself and move his arms as he stood in place.

When asked about the Subject's behavior, Detention Officer D stated that while conducting inmate inspections the Subject appeared to be "unstable." Detention Officer D formed this opinion because the Subject was talking to himself.

When asked whether the Subject was a danger to himself, Detention Officer C stated that he did not feel the Subject was a danger to himself and that many arrestees talk to themselves.

> **Note:** The Jail Operations Manual requires that a jail supervisor evaluate an arrestee's behavior when it would indicate the possibility for a severe mental disorder. The act of talking to oneself was not interpreted by the involved Detention Officers as evidence of a severe mental disorder that would require notification be made to a jail supervisor.

At approximately 1201 hours, the jail security video depicted Detention Officer C arrive at Cell J3 to provide lunch and conduct an inmate inspection. According to Detention Officer C, inmate inspections were to be conducted by any Detention Officer available for each inspection period. Detention Officer C did not open the cell door but placed the Subject's lunch on the pass through opening of the cell door. He then returned to document the inmate inspection time of 1201 hours on the Jail Inspection Record for each cell. The jail security video depicted that the Subject was wedged between the bunk and the wall and was moving at the time Detention Officer C served him lunch. According to Detention Officer C, he told the Subject, "Hey sir. Got lunch," and the Subject mumbled something in return.

> **Note:** Detention Officer C did not recall the Subject being in a position between the bunk and the wall. He stated, "I didn't recall him being wedged in there until the actual incident. From – from my recollection he was just in that general area, you know, sometimes flailing and just from my view he was – he was, you know, alive and well."

At approximately 1215 hours, the jail security video depicted the Subject begin to convulse for approximately 30 seconds. As the convulsions subsided, the Subject appeared to slide downward until his upper chest/back became wedged between the top horizontal bar of the bunk and the wall. The Subject remained motionless after the convulsions subsided.

At approximately 1246 hours, the jail security video depicted Detention Officer C arrive at Cell J3 to conduct an inmate inspection. Detention Officer C looked through the window of Cell J3. He then turned his attention to the Jail Inspection Record affixed to

the cell window. According to the jail security video, Detention Officer C wrote on two lines of the Jail Inspection Record. On one line, he wrote "1230" indicating the time of 1230 hours, his serial number indicating who conducted the check, and "1" indicating how many inmates were in the cell. On the second line, Detention Officer C wrote "1255" indicating the time of 1255 hours, his serial number and "1" for the number of inmates in the cell.

After Detention Officer C signed the Jail Inspection Record, the jail security video depicted him again look through the window of Cell J3. At the time of this inmate inspection, the interior lights of Cell J3 were off. Detention Officer C noticed the Subject was "wedged" between the west end of the bunk and the west wall of the cell. The Subject was facing the west wall. Detention Officer C described that the Subject's feet were on the floor, his hands were down to his sides, his face was pressed against the wall, and his mid/upper torso appeared "wedged" between the wall and the top horizontal bar of the bunk.

At approximately 1247 hours, the jail security video depicted Detention Officer C return to the booking area. Detention Officer C stated he went to the booking area to turn on the cell light and obtain assistance from his partner, Detention Officer D. However, Detention Officer D was on a "citizen phone call" and Detention Officer C returned to Cell J3.

At approximately 1248 hours, the jail security video depicted Detention Officer C return to Cell J3 and open the cell door to better visually check on the Subject's wellbeing. Officer C stated he was unable to see whether or not the Subject was breathing.

According to Detention Officer C, although he was concerned for the Subject's welfare, he did not feel comfortable entering the cell alone because he was cognizant that the Subject might have created a ruse to lure him into the cell. At approximately 1249 hours, the jail security video depicted Detention Officer C close the cell door and respond to the booking area. Detention Officer C was at Cell J3 for 29 seconds before returning to the booking area. Detention Officer C stated he returned with the intent to obtain the assistance of Detention Officer D. Detention Officer C advised Detention Officer D that he needed assistance checking on the Subject.

At approximately 1249 hours, the jail security video depicted Detention Officers C and D return to and enter Cell J3. Detention Officer C tapped the Subject on the shoulder. According to Detention Officer C, he tapped the Subject a few times and called out, "sir, sir," with no response.

At approximately 1250 hours, the jail security video depicted Detention Officers C and D close the cell door and respond to the booking area. Detention Officer C continued to the Watch Commander's office and advised Watch Commander Lieutenant A that he possibly had a deceased inmate in the jail. Lieutenant A secured his pistol, obtained gloves, and directed Sergeants B and C to advise the Divisional Captains.

Meanwhile, at approximately 1251 hours, the jail security video depicted Detention Officer D return to Cell J3 and tap on the window. After Detention Officer D received no response from the Subject, the jail security video depicted him walk back to the booking area. At approximately 1251 hours, the jail security video depicted Detention Officers C and D return to Cell J3.

At approximately 1252 hours, the jail security video depicted Lieutenant A arrive at Cell J3. Detention Officer C opened the cell door. Detention Officers C and D entered and attempted to dislodge the Subject's body, but were unsuccessful. The jail security video depicted Detention Officer C pull on the Subject's left arm while Detention Officer D pushed forward on the Subject's back. Detention Officer C described that he pulled on the Subject's left arm; Detention Officer D described that he pushed on the Subject's right arm and shoulder. Detention Officer C attempted to locate the Subject's pulse on his neck and wrist but was unsuccessful. Lieutenant A requested a Rescue Ambulance (RA) for the Subject.

At approximately 1253 hours, the jail security video depicted Lieutenant A attempt to locate the Subject's pulse on his neck. According to Lieutenant A, he could not detect one. The jail security video also depicted Captains A and B, and Sergeant B arrive at Cell J3. Captain A assumed the role as Incident Commander (IC) and ensured an RA had been requested.

At approximately 1254 hours, the jail security video depicted Lieutenant A again check the Subject's neck for a pulse. According to Lieutenant A, he could not detect one. Lieutenant A and Detention Officer D continued to attempt to dislodge the Subject's body in the same manner as before.

At approximately 1254 hours, the video depicted Sergeant D arrive at Cell J3. According to the CD audio timestamp, at 1256:00 hours, Sergeant D used his handheld radio to request that the Fire Department personnel bring extraction tools. At approximately 1256 hours, the video depicts Sergeant D check the Subject's left wrist for a pulse. According to Sergeant D, he did not detect a pulse.

According to the CD audio timestamp, at 1256:53 hours, Sergeant B used his handheld radio to inquire whether an RA was en route, which was confirmed by Communications Division.

At approximately 1300 hours, the jail security video depicted Los Angeles Fire Department (LAFD) personnel arriving. The jail security video depicted Los Angeles Fire Department personnel checking for the Subject's pulse and hooking him up to a heart monitor. At approximately 1304 hours, the jail security video depicted LAFD personnel utilizing a Portable Cutter/Spreader Rescue Tool to cut through the metal support bars of the bunk in order to free the Subject from his position between the bed and the wall. According to LAFD Firefighter/Paramedic A, the Subject was pinned and could not be worked on. Therefore, the Subject was extricated and laid on the bunk

where the medical assessment continued. At 1309 hours, Firefighter/Paramedic B determined the Subject was deceased.

Captain A ensured that Detention Officers C and D were separated and monitored by supervisors and made notification to Real Time Analysis and Critical Response (RACR) Division. Captain B assumed the role of IC when Captain A left to make notifications. Captain B ensured the crime scene was secured and the appropriate crime scene documentation was completed.

A subsequent autopsy examination by the Department of Coroner (DOC) determined that the subject died as a result of asphyxia as a consequence of idiopathic epilepsy. The manner of death was deemed by the DOC to be accidental.

Los Angeles Board of Police Commissioner's Findings

The BOPC reviews each Categorical Use of Force incident based upon the totality of the circumstances, namely all of the facts, evidence, statements and all other pertinent material relating to the particular incident. In most cases, 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). In this incident, there were no tactical issues identified, none of the involved officers drew their duty weapons, and there was no use of force. Therefore, there were no findings applicable. Based on the BOPC's review of the instant case, the BOPC unanimously made the following findings.

A. Tactics

Does not apply.

B. Drawing/Exhibiting of a Firearm

Does not apply.

C. Use of Force

Does not apply.

Additional

The investigation revealed several issues, outlined below:

- Documentation – The investigation revealed multiple times where the detention officers who were conducting the visual inspections of cell J3 had signed more than one line with different times on the Jail Inspection Record while inspecting the inmates. Captain C, Commanding Officer, Custody Services Division (CSD) was advised of the matter and initiated a personnel complaint investigation.

- Effective Encounters with Mentally Ill Persons – The investigation revealed during the Subject's incarceration, he was heard mumbling to himself throughout his stay, which could be a sign of a mental illness, yet a supervisor was not requested by the DOs to evaluate him. This issue was brought to the attention of the current Commanding Officer of CSD. Captain D advised that he has implemented new procedures to ensure that a supervisor will now be staffed during each shift and all CSD personnel will be required to attend mental health training.

- Lighting – A review of the video footage from the jail security cameras revealed that the lights in the jail cell where the Subject was housed were turned off many times throughout his detention. Per Jail Operations Manual, Inmate Inspections, Section 1/150, lights shall be left on at all times. The issue was brought to the attention of Captain D, who advised that it has been addressed through training at the divisional level.

- Automated Time Keeping System – The investigation revealed the automated time keeping system that digitally records inmate inspections as detention officers visually inspect the inmates was inoperable during the Subject's incarceration due to maintenance. As a result, the detention officers were required to manually log their inspection on the Jail Inspection Record. Captain D advised that the system is currently online and functional. Furthermore, protocols were established to conduct audits of the system.

- Repositioning of Jail Beds – The investigation revealed that cell J3 was only intended to house a single inmate, therefore the presence of a bunk bed was unnecessary. Captain D advised that as a result of this incident he submitted a request to Facilities Management Division (FMD) to remove all bunk beds from single occupant cells and replace them with single beds that would abut two walls to eliminate the gaps on both sides of the bed.