

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

IN-CUSTODY DEATH – 058-18

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

Central 10/24/18

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

Not Applicable

Reason for Police Contact

Officers responded to a radio call of Domestic Violence. The Subject was arrested at the location and transported to the Los Angeles Police Department (LAPD) Metropolitan Detention Center (MDC) for booking and housing. Two days following the arrest, the Subject was found in medical distress inside his cell. Jail personnel performed lifesaving measures on the Subject until the Los Angeles Fire Department (LAFD) arrived. The LAFD continued those lifesaving efforts and transported the Subject to the hospital, where he later died.

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

Subject: Male, 50 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.

The following incident was adjudicated by the BOPC on October 1, 2019.

Incident Summary

The Victim called 911 to report that the Subject, who was intoxicated and had a history of domestic violence, was yelling, harassing her and their child, and had pulled the Victim's hair. A radio call was subsequently generated by Communications Division (CD).

The radio call was assigned to Officers A and B. Officers A and B responded Code Two to the location and contacted the Victim upon their arrival. The officers conducted an investigation and determined the Subject had battered the Victim.

Officer A communicated with the Subject through his open front door and asked him to step out of his apartment to speak with the officers. When the Subject complied, Officer A handcuffed the Subject's wrists behind his back and placed him under arrest without incident.

Officers A and B both commented that the Subject smelled of alcohol, was slurring his words, and appeared to be under the influence of alcohol. Due to his level of intoxication, they assisted him down a flight of stairs and into their police vehicle, where he was then transported to the police station to obtain booking approval. According to the Victim, the Subject was an alcoholic and drank multiple beers on a daily basis. She did not know how much the Subject had to drink on the day this incident occurred, but she told Officer B at scene that the Subject had started drinking earlier in the evening.

Officers A and B arrived at the police station and documented the Subject on the LAPD Adult Detention Log. The Subject was placed in a holding cell while the officers completed the pre-booking process.

The Watch Commander, Sergeant A, reviewed the detention log and asked the Subject the three required questions listed on the form. The Subject answered, "Yes" that he understood why he was arrested. He answered, "No" when asked if he was sick, ill, or injured. When the Subject was asked if he had any questions, he responded, "*Yes, I have three questions. Why did my wife say that opinion, and is this a sarcastic moment in my life?*" Sergeant A made a written notation on the log that the Subject was "very 390," meaning that he was highly intoxicated.

Officers A and B transported the Subject from the station to the Metropolitan Detention Center (MDC), for booking and housing. When they arrived approximately ten minutes later, Officer B began completing the required Los Angeles County Unified Arrestee Medical Screening Form. Based on the Subject's responses, Officer B checked all the "No" boxes on the form with the exception of question No. 8, which asked if the Subject regularly used alcohol or drugs. In reference to that question, Officer B documented, "Yes" and indicated the Subject used alcohol three times a week, including the day of his arrest.

Officers A and B entered MDC with the Subject to complete the required paperwork and begin the Drop N Go booking process. Shortly thereafter, Officer A escorted the Subject to a holding cell, where he was temporarily housed while jail personnel finalized his paperwork. Officers A and B cleared from MDC shortly thereafter and returned to the station to complete their arrest report.

The Subject was escorted from the holding cell to be photographed and fingerprinted. After that process was completed, the Subject was placed back in the holding cell. During the time the Subject was at MDC, Title 15 safety checks were conducted twice each hour by jail personnel and were documented on a Custodial Services Division (CSD) Observation Record form as mandated by the Department's Jail Operation's Manual.

The Subject was escorted from the holding cell to the dispensary for a medical evaluation. Medical Services Division (MSD) Registered Nurse (RN) A evaluated the Subject and completed the required LAPD Classification Assessment Form. RN A noted on the form that the Subject was under the influence of alcohol and should be placed in a cell with a low bunk. RN A then cleared him for booking.

According to MSD RN B, the Subject disclosed he was a "*daily alcoholic*" when he was first interviewed by medical personnel. Based on that admission, RN B indicated the Subject was periodically monitored for alcohol withdrawals. This additional monitoring was performed by MSD personnel and occurred approximately every four hours during his detention at MDC.

Medical Services Division RN C assisted with the medical intake of the Subject and stated the Subject did not initially disclose he was an alcoholic, even when asked numerous times. Nurse C stated he/she became aware the Subject was a chronic alcoholic only after a subsequent visit by the Subject to the dispensary.

After the completion of the booking process, the Subject was escorted to the third-floor mezzanine, where he was housed in North Block, A Pod, Cell No. 215, a single occupant cell. The Subject had no direct contact with other inmates during his time. He remained in this cell for approximately 28 hours and 46 minutes and was the subject of 57 safety checks.

The following day, the Subject was escorted from North Block, A Pod, Cell No. 215, to South Block, B Pod, Cell No. 115, which was a single occupant cell located on the third floor. The door to this cell contained two windows, one on the upper portion of the door (21 $\frac{3}{4}$ inches in height by 13 inches in width) and one on the lower portion (14 $\frac{3}{4}$ inches in height by 13 inches in width). A cell port (5 inches in height by 16 $\frac{1}{2}$ inches in width) that allowed food, medicine, and other small items to be passed through was located between the upper and lower windows of the door. At various times while in this cell, portions of the Subject's body (hands and upper torso) were visible through the cell port and windows and were recorded on CCTV.

During the time the Subject was housed in Cell No. 115, he had no direct contact with inmates and interacted only with MDC and MSD personnel. He remained in this cell for approximately 16 hours and 47 minutes and was the subject of 33 safety checks. Force Investigation Division investigators reviewed the written CSD records documenting the Title 15 safety checks on the Subject while housed in this cell and compared those with CCTV video footage. No inconsistencies were found.

On the day of the incident, CSD Detention Officers (DO) A, B, and C, along with Officer C, were assigned to the Control Tower inside South Block, B Pod. Their responsibilities included the safe movement of inmates to and from this section of the jail, conducting Title 15 safety checks, inmate feeding, and monitoring the safety of those housed in this section.

Officer C entered South Block, B Pod to conduct a Title 15 safety check. Detention Officers B and C also walked into the same area to escort several arrestees who had been preselected by MSD personnel to be brought to the dispensary for "sick call". According to Officer C, prior to entering the pod, he/she documented his/her presence by recording the time and his/her serial number on a CSD Observation Record Log. Officer C also scanned his/her identification card (ID) at a device located on the west end of the cell block.

Officer C began his/her safety check by walking past the cells located on the south portion of the cell block. When he/she reached the end of the corridor, Officer C climbed the staircase leading to the second level and moved out of view of the CCTV camera. Approximately one minute and 50 seconds later, he/she walked back down the stairs and continued west on the north side of the Pod, passing the Subject's cell and then exiting the cell block. Detection Officers B and C also exited the cell block.

Officer C stated that while doing safety checks, his/her practice was to move at what he/she described as a regular walking pace while focusing on the cells that were on the same side of the pod he/she was on. Officer C was able to view inmates in their cells and determine if they were in distress as well as see obvious signs of life, such as movement, breathing and/or talking, without having to stop in front of each cell. Officer C explained that despite this practice, he/she continued to look around the pod while doing safety checks and was able to view inside the other cells without being right up against their cell doors. Officer C also indicated that he/she did not need to fully turn his/her head to look directly into a cell as he/she walked by it to view an inmate or determine signs of life. Officer C did not have a specific recollection of what the Subject was doing when he/she walked by his/her cell during the previous safety check, but he/she did not notice anything that caused him/her to be alarmed.

In addition to DOs B and C, DOs D and E were also inside South Block, B Pod shortly after Officer C completed his/her safety check. None of these individuals had a recollection of what the Subject was doing or the position he was in at the time.

Nurse B entered South Block, B Pod to dispense medication to inmates and to specifically check on the Subject for signs of alcohol withdrawal. Nurse B indicated that when she did her previous check on the Subject, he was standing by the cell door and conversed with Nurse B. When Nurse B approached the Subject's cell for this check however, Nurse B noticed he was on the floor positioned on his hands and knees. Nurse B tried to get his attention by knocking on the window and speaking to him from outside the cell door, but he did not respond to her. In an effort to further evaluate the Subject, Nurse B walked upstairs to the control tower and asked CSD personnel to assist her in checking on the Subject.

Detention Officers B and C and Officer C exited the control tower and walked with Nurse B back down to the lower level of the pod. Nurse B and DO C approached the Subject's cell followed shortly after by DO B.

Detection Officer C observed the Subject in a kneeling position on the floor with his back facing the window and his right arm resting on his bunk. DO C tapped on the window several times and called the Subject's name to get his attention. When the Subject did not respond, DO C utilized his/her radio and requested his cell be opened. From the control tower, DO A remotely unlocked the Subject's cell door. Detention Officer B then stepped inside to check on the Subject, while DO C, Officer C, and Nurse B stood by the door.

DO A indicated that once he/she unlocked the cell door, he/she attempted to look at a camera monitor in the control tower to view what was occurring in the Subject's cell, but he/she was unable to see inside.

The camera referred to by DO A was located inside the Subject's cell. This camera was later discovered to have been covered with toilet paper, which prevented anyone from viewing inside the cell. Detention Officers C, B, and Officer C indicated they were not monitoring the cameras in the pod at the time of this incident.

According to DO B, when he/she entered the Subject's cell, he/she observed a red liquid in the sink that he/she believed might have been a mixture of juice and vomit. The Subject looked as he was trying to spit; his eyes were open, and he had a "zoned-out" appearance. Nurse B noticed the Subject was perspiring on his forehead and asked him if he was okay. The Subject shook his head but did not respond verbally. Nurse B directed DOs B and C to take the Subject to the dispensary for further evaluation. Detention Officer C then exited the cell and walked to another section of the jail to obtain a wheelchair and brought it back to the Subject's cell.

Officer C and DO B grasped the Subject's right and left arms respectively and lifted him into the wheelchair. Detention Officer C then moved the wheelchair out of the cell and began pushing the Subject along the corridor, while Officer C walked in the opposite direction to begin a Title 15 safety check. Moments later, the Subject appeared to go limp. Detention Officers C and B stopped to adjust the Subject's feet and lifted him by his arms higher in the wheelchair. Nurse B noticed the Subject's head was tilted

downward and that he was not responding to her. Nurse B believed the Subject was in need of immediate medical attention and directed the detention officers to initiate a "Man Down" radio broadcast and then to place the Subject on the floor to begin Cardiopulmonary Resuscitation (CPR).

DO B broadcast a "Man Down" call and then assisted DO C and Nurse B with removing the Subject from the wheelchair. After placing the Subject on the floor, DOs B and C began performing CPR and continued lifesaving efforts until relieved minutes later by medical personnel.

According to CSD Principal Detention Officer (PDO) A, he/she was the watch commander at the time of the incident and heard the "Man Down" call over the radio. He/she ran out of the Watch Commander's office to notify dispensary personnel and found them entering the elevator. He/she accompanied the MSD doctor and MSD RNs to South Block, B Pod. Upon reaching the Subject, the doctor determined that the Subject was not responsive and had no pulse. In addition to continuing CPR, the medical staff utilized an Automated External Defibrillator (AED) and provided rescue breathing with an Artificial Manual Breathing Unit until relieved by LAFD paramedics.

An LAFD Engine arrived at scene and began assisting the medical staff. They were followed approximately five minutes later by a rescue ambulance (RA). The Subject was ultimately removed from the pod and was transported to the hospital.

Officers were assigned by CD and responded to MDC to escort the RA to the hospital. These officers were determined not to be percipient witnesses and were not interviewed for this investigation.

In anticipation that this incident might become an In-Custody Death (ICD), PDO A admonished Officer C and DOs C and B to not discuss the incident and ensured they were separated and monitored. PDO A returned to the Watch Commander's office and directed Sergeant B to respond to the hospital and check on the status of the Subject.

Sergeant B responded to the hospital and stood by while the Subject was medically treated. Sergeant B obtained the Subject's patient number and doctor's information and was advised by medical staff that the Subject was in critical but stable condition and would be admitted to the Intensive Care Unit (ICU).

Lieutenant A, the officer in charge of MDC, contacted FID, and advised that the Subject had gone into cardiac arrest while at MDC. He/she also indicated that the Subject had been transported to the hospital and that he might not survive.

FID Investigators responded to the hospital to assess the Subject's condition. They initially met with the officers who had been assigned to monitor the Subject. They also met with the treating doctor, who advised that the Subject was experiencing liver failure and was bleeding internally. The Subject's condition was described as grave.

As a precautionary measure, FID Investigators responded to MDC to secure and process the scene. The FID Investigators from the hospital also responded to MDC to assist and to ensure all protocols related to separation and monitoring of the involved employees were being followed. FID Investigators also identified the camera systems operated within MDC and the resources required to obtain and recover video that captured the Subject's initial entry into the facility, through the time he was transported by the LAFD.

FID was subsequently notified that the Subject had died and FID contacted the Department Operation Center (DOC) to advise that an ICD had occurred.

Los Angeles Board of Police Commissioners' Findings

The BOPC reviews each Categorical Use of Force incident based upon the totality of the circumstances, namely all of the facts, evidence, statements and all other pertinent material relating to the particular incident. In every case, the BOPC makes specific findings in three areas: Tactics of the involved officer(s); Drawing/Exhibiting of a firearm by any involved officer(s); and the Use of Force by any involved officer(s). Based on the BOPC's review of the instant case, the BOPC made the following findings:

- A. Tactics – Does Not Apply** (No “substantially involved” personnel).
- B. Drawing and Exhibiting – Does Not Apply.**
- C. Lethal Use of Force – Does Not Apply.**

Basis for Findings

- During its review of the incident, the BOPC considered the following:
 - 1. Detention –** The officers received a radio call of a Battery Domestic Violence. When officers arrived at the location, they met with the victim who directed them to the Subject. The officers made contact with the Subject and detained him without incident. The officers' actions were appropriate and within Department policies and procedures.
 - 2. Digital In-Car Video (DICV) Activation –** The investigation revealed that Officers A and B did not activate their DICV when they transported the Subject from the scene of the radio call to the police station. This issue was addressed through training at the divisional level. In addition to training, a Supervisory Action Item was generated for both officers and 60-day audits will be conducted to ensure future compliance.
 - 3. Body Worn Video (BWV) Activation –** The investigation revealed that the officer did not activate his/her BWV when he/she rode in the RA with the Subject to the hospital. This issue was addressed through training at the divisional level and a Supervisor Action Item. Additionally, the area Captain ensured that audits would be

completed regarding the involved officer for a 60-day period, following the Tactical Debrief, to ensure the officer's BWV is being properly activated.

- 4. Camera and Vent Check Protocols** – The investigation revealed that CSD did not have procedures in place to ensure the cameras and vents located inside segregation cells were unobstructed. The commanding officer, CSD, advised that immediately following the In Custody Death, he/she issued an order that CSD personnel were prohibited from placing inmates in any cell with an inoperable or obstructed camera. As a result of this incident, CSD Divisional Order No. 7, published on May 29, 2019, directed CSD personnel to visually inspect a cell for vent coverage and camera obstruction/damage prior to placing an inmate into, and after removal from, a segregation cell. The divisional order codified that at no time shall an inmate be housed in a segregation cell with an inoperable camera. All CSD personnel signed an acknowledgement receipt, which was subsequently placed in the employee's divisional folder.
- 5. Monitoring Video Cameras Inside Control Towers** – The investigation revealed that the CSD personnel interviewed were unclear as to who was ultimately responsible for monitoring the video cameras inside the control towers. The CSD Captain advised that the monitoring of inmates via the camera monitors was incorporated into the Detention Officer Academy curriculum. All CSD personnel were also reminded at both supervisor meetings and roll calls, that it is the duty of all personnel assigned in the control towers to monitor the video cameras in their assigned housing cells. In addition, per CSD Divisional Order No. 7, in addition to the Title 15 checks, officers assigned to housing shall observe the video display of the segregation cells on the monitor and look for signs of medical distress or suicidal activity. All CSD personnel signed an acknowledgement receipt, which was subsequently placed in the employee's divisional folder.
- 6. Supervisor Training to Check the Operational Status of the Camera Systems** – The investigation revealed that all supervisors were provided an overview of the camera process during the training they received upon initial assignment to the MDC. Specific instruction on the operation of the camera system and verification of its operational status was provided through informal, on the job training. The CSD Captain advised that after the incident, additional training occurred for all watch supervisors to ensure a proper audit of the system is conducted at the start of watch. Additionally, the CSD Captain will ensure CSD's training unit works in conjunction with the camera vendor to formalize a training component that CSD can incorporate into their monthly supervisor meetings. The CSD Captain will also ensure a reference guide for camera related operations is created and readily available in the Watch Commander's office.
- 7. Auditing of the Video Cameras** – The investigation revealed that the camera lens and air conditioning vents inside Cell No. 115 were covered by another arrestee and that these obstructions were not discovered and/or documented by MDC supervisors during the 22 days leading up to the Subject's death. According to the CSD Captain,

this issue was discussed during a supervisor's meeting and the Captain was directed to work on improving existing processes.

CSD advised that systems are now in place to ensure the video camera system is monitored appropriately. The Watch Supervisor Daily Report requires mandatory entry regarding the operational status of all the cameras in the facility. Additionally, each regional jail currently provides a daily Morning Report to CSD on the current status of all the cameras in their facility. In turn, CSD submits a Morning Report to SSG, which contains the combined results from all the regional jail camera audits. The CSD Captain further advised that CSD completes a SSG project every two weeks that details the current status of inoperable cameras to include a work order number, the entity responsible for repair, the estimated date of completion, the name of the officer completing the report, and provides updates and reasons for non-repair.

- 8. Tracking System of Video Camera Repairs** – The investigation revealed that camera repair requests were documented in the Watch Supervisor Daily Report and subsequently communicated to the MDC Supply Unit. The CSD Captain advised the previous tracking system did not adequately ensure repairs were completed. To resolve this, the Watch Supervisor is now required to send an email requesting camera repair to the MDC Supply Unit, which tracks the requests. Hard copies of all requests are also maintained by the Supply Unit. As indicated previously, the status of each inoperable camera is captured in the bi-weekly Camera Audit project that CSD submits to SSG.
- 9. Quality of Title 15 Safety Checks** – The investigation revealed that during the Title 15 safety check, Officer C did not appear to stop and/or turn his head to look in the Subject's cell as he walked by. The investigation further revealed that the interior of the Subject's cell was visible from the second-floor walkway during Officer C's safety checks. The CSD Captain advised that the LAPD Jail Operations Manual 2019, Volume 1, Section 150, maintains that a safety check is a direct, visual observation performed at random intervals to provide for the health and welfare of inmates. All police officers assigned to CSD attend a Core Course Training which covers the Department's expectations of Title 15 safety checks. Officer C attended this training and was therefore aware of the Department's expectations. Additionally, watch supervisors conduct two mandatory audits on safety checks per shift, which are documented on the Watch Supervisor Daily Report. Additionally, CSD will continue to discuss the expectation for quality safety checks during daily roll calls and at their regularly scheduled monthly supervisor's meetings.

The BOPC expressed concern regarding the casual appearance of Officer C's Title 15 safety check of the Subject's cell. The BOPC took into account that Officer C would have been able to visually inspect the Subject's cell from the second-floor walkway. The Commanding Officer of CSD was directed to counsel Officer C to conduct more intensive inspections. Based on the totality of the circumstances and absent any evidence to discount Officer C's statement that he was able to see into

the Subject's cell and did not see anything that would have caused him to be alarmed, the BOPC deemed no further action is necessary.

- 10. Documentation of Title 15 Safety Checks** – The investigation revealed that during the time the Subject was housed in North Block, A Pod, a Title 15 safety check was not documented on the CSD observation record. The CSD Captain advised that it is the responsibility of a supervisor to review the CSD observation record to ensure that the required Title 15 safety checks were conducted. This issue has been addressed through training at the divisional level and documented on a Comment Card and in LMS.
- 11. Dispensary Staff Escort** – The investigation revealed that on the day of the incident, the RN was not accompanied by detention personnel during the sick call checks in South Block, B Pod. The CSD Captain advised that Medical Services Division (MSD) policy regarding conducting sick call checks was not specific with regard to the presence of an escort, thereby leaving it to the discretion of the dispensary personnel. The CSD Captain discussed this issue with the MSD Administrator to ensure MSD dispensary personnel operate in accordance with the 2019 LAPD Jail Operations Manual, Volume 2, Section 623, regarding mandatory escorts during sick call checks.
- 12. Protocols Subsequent to a CUOF incident (Documentation on Watch Supervisor Daily Report)** – The investigation revealed that the Watch Supervisor Daily Report incorrectly noted the time that the CSD supervisor responded to the hospital. The CSD Captain advised this issue was addressed through training at the divisional level. In addition, the issue of attention to detail on Watch Supervisor Daily Reports will be discussed at subsequent supervisor meetings.
- 13. Requesting Rescue Ambulance** – The investigation revealed that the request for an RA was done telephonically by CSD personnel who were not at the scene with the Subject. This resulted in the person requesting not being able to advise LAFD dispatch if the Subject was unconscious. The CSD Captain advised that he/she directed each regional jail supervisor to ensure their watch supervisors were aware of the information required by LAFD dispatch to ensure the response of the appropriate emergency medical personnel. In addition, he/she will ensure that a CSD divisional order outlining the above expectations is published and served to all CSD personnel.

Audio/Video Recordings

- **Digital In-Car Video System / Body Worn Video** – The patrol vehicles used during the initial detention and transportation of the Subject to the police station were equipped with DICVS. The involved officers activated their DICVS, resulting in the capture of the officers' response to the original radio call. The DICVS was not activated during the Subject's transportation to the station. The patrol vehicles used to transport the Subject to the hospital were also equipped with DICVS at the time of

the incident. That vehicle DICVS captured the Subject's transportation to the hospital.

- **Other Video** – Various surveillance video cameras in the Metropolitan Detention Center captured the Subject being brought into the facility. The cameras also captured the Subject's subsequent movement throughout the facility and his departure in an LAFD RA.

The surveillance video camera in the South Block, B Pod, captured Officer C conducting Title 15 safety checks as well as the RN conducting a medical check. It further captured the DOs, dispensary personnel, and LAFD providing medical treatment to the Subject.

The BOPC determined that the actions of Custody Service Division personnel did not contribute to the Subject's death. The course and scope of this investigation identified that systems of control were found to be lacking within CSD operations. As such, the Director of the Office of Support Services (OSS) was directed to conduct a command audit of CSD to ensure that the operations are meeting Department standards. Additionally, the Director of the OSS was directed to review intake protocol involving arrestees who are believed to be under the influence of alcohol to determine if they should be housed at CSD or be transported to a hospital.