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

IN-CUSTODY DEATH – 047-06

Division	Date	Duty-On (X) Off()	Uniform-Yes(X) No()
Van Nuys	06/04/2006		

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

Not applicable.

Reason for Police Contact

Officers A and B arrested Subject 1, who appeared to be intoxicated, at the scene of a burglary and transported her to jail. While in custody, Detention Officers A and B observed that Subject 1 had become non-responsive and jail staff provided medical treatment; however, Subject 1 subsequently died.

Subject	Deceased (X)	Wounded ()	Non-Hit ()
Subject 1: Female, 39 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 and addenda items); the 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 Los Angeles Police Department Command Staff presented the matter to the Commission and made itself available for any inquiries by the Commission.

The following incident was adjudicated by the BOPC on 03/27/07.

Incident Summary

Officers A and B were dispatched to a motel to investigate a report of a burglary in progress. When the officers arrived, they noted that a motel room door had been forced open and observed Subject 1 lying on the bed. The officers handcuffed Subject 1 and escorted her to their police car without incident. The officers noted that Subject 1 appeared to be intoxicated and was sweating profusely.

The officers transported Subject 1 to the police station where Sergeant A completed a pre-booking screening. Subject 1 was then transported to jail for booking. Upon arrival,

Correctional Physician A evaluated Subject 1. However, because Subject 1 attempted to spit on medical staff and refused to allow them to take her vital signs, Correctional Physician A and his staff could not thoroughly examine her. Correctional Physician A refused to clear Subject 1 for booking and directed the officers to transport her to a contract hospital for further evaluation. The officers arrived at the hospital, where Subject 1 was treated for low potassium and alcohol intoxication, and was subsequently released for booking.

The officers returned to the jail with Subject 1, who fell asleep while waiting to be evaluated by medical staff. Noting that Subject 1 was asleep and thus, could not be properly evaluated, Correctional Physician B placed an ammonia inhalant under Subject 1's nose to wake her up. When Subject 1 awoke, Nurse Practitioner A noted that Subject 1 appeared drowsy and exhibited the signs of alcohol and heroin withdrawal. Subject 1 told Nurse Practitioner A that she had ingested alcohol and used heroin.

Subject 1 was cleared for booking and placed in a holding cell, where she was subsequently monitored by detention officers every thirty minutes.

Later that same day, Detention Officer A conducted a sick call with the assistance of Nurse Practitioner B. When Detention Officer A called Subject 1's name and received no response, he asked Nurse Practitioner B if he should wake her up. Nurse Practitioner B advised Detention Officer A not to wake up Subject 1.

Later, while distributing the evening meal, Detention Officer B went to Subject 1's cell window, banged on the door, and yelled, "Dinner!" When Subject 1 failed to respond, Detention Officers A and B entered her cell. Detention Officer B shook Subject 1's shoulder several times and noted that she was non-responsive. Concerned that Subject 1 was in medical distress, Detention Officer A left Detention Officer B alone in the cell with Subject 1 and went to the dispensary to advise Correctional Physician B of the situation. Correctional Physician B and Nurse Practitioner A began Cardiopulmonary Resuscitation (CPR) while Senior Detention Officer A requested a Rescue Ambulance.

When Subject 1 failed to respond, Nurse Practitioner C deployed an Automated External Defibrillator (AED). However, the AED did not activate.

Correctional Physician B performed chest compressions until Los Angeles Fire Department (LAFD) paramedics arrived. Despite the efforts of the paramedics and dispensary staff, Subject 1 did not respond. Subject 1 was subsequently pronounced dead.

Los Angeles Board of Police Commissioners' Findings

The BOPC reviews each Categorical Use of Force incident based upon the totality of the circumstances, namely all of the facts, evidence, statements and all other pertinent material relating to the particular incident. In every case, the BOPC makes specific

findings in three areas: Tactics of the involved officer(s); Drawing/Exhibiting/Holstering of a weapon by any involved officer(s); and the Use of Force by any involved officer(s). All incidents are evaluated to identify areas where involved officers can benefit from a tactical debriefing to improve their response to future tactical situations. This is an effort to ensure that all officers benefit from the critical analysis that is applied to each incident as it is reviewed by various levels within the Department and by the BOPC. Based on the BOPC's review of the instant case, the BOPC unanimously made the following findings.

A. Tactics

The BOPC found Detention Officers A and B's tactics to warrant divisional training.

B. Drawing/Exhibiting/Holstering

The BOPC determined that drawing/exhibiting/holstering did not apply.

C. Use of Force

The BOPC determined that use of force did not apply.

Basis for Findings

A. Tactics

The BOPC noted that when Detention Officers A and B were distributing the evening meal, they discovered Subject 1 was unresponsive. Detention Officers A and B entered the jail cell and determined Subject 1 was in medical distress. Detention Officer A left Detention Officer B in the jail cell and went to find help. The BOPC determined that it would have been tactically safer for Detention Officer A to depress the "Help Button" outside of the jail cell and remain with Detention Officer B. Additionally, the investigation revealed that Detention Officers A and B were not equipped with a handheld radio, which they could have utilized to alert everyone in the facility of the medical emergency and their location.

The BOPC found Detention Officers A and B's tactics to warrant divisional training.

B. Drawing/Exhibiting/Holstering

The BOPC determined that drawing/exhibiting/holstering did not apply.

C. Use of Force

The BOPC determined that use of force did not apply.