

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

IN CUSTODY DEATH 059-06

Division	Date	Duty-On (X)	Uniform-Yes (X)	No ()
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Hollenbeck 05/03/06

Officer(s) Involved in Use of Force	Length of Service
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Officer A	7 years, 7 months
Officer B	10 years
Officer C	9 months

Reason for Police Contact

Subject 1 was riding a Metropolitan Transit Authority (MTA) bus when he requested medical assistance from the bus operator. The operator requested LAFD paramedics and they arrived on scene and examined Subject 1. Paramedics decided to transport Subject 1 to a hospital for medical treatment. En route to the hospital, Subject 1 became combative and assistance from LAPD was requested. Officers responded and assisted with Subject 1. Shortly thereafter, Subject 1 experienced cardiac arrest. Subject 1 was brought to the hospital and expired nine days later.

Subject	Deceased (X)	Wounded	Non-Hit ()
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Subject 1: 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 suspect 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 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 April 30, 2007.

Incident Summary

On April 24, 2006, Subject 1 boarded a Los Angeles County Metropolitan Transit Authority (MTA) bus. The bus was operated by Witness 1. When the bus stopped, Subject 1 requested that Witness 1 call for paramedics because he was "about to die." Witness 1 contacted MTA Dispatch and requested paramedics.

Los Angeles Fire Department (LAFD) Firefighters/Paramedics 1 and 2 received the call and began responding to the scene.

While waiting for paramedics to arrive, Witness 1 observed uniformed Police Officer D across the street at a gas station. Witness 1 approached Officer D for assistance, and during that time Newton Patrol Division uniformed Police Officers E and F, stopped to assist.

Paramedic 1 and Paramedic 2 arrived and contacted Subject 1 on the bus. Subject 1 insisted that he was fine and did not want assistance from the paramedics; however, Subject 1 was unable to answer simple questions posed by Paramedic 1 and Paramedic 2. In addition, Subject 1 was making odd statements, such as saying that he lived with bus driver Witness 1 when Witness 1 denied having ever met Subject 1. The paramedics determined that Subject 1 was unable to care for himself, and decided to transport him to the hospital. Subject 1 was very "animated," but Paramedic 1 and Paramedic 2 were able to coax him off of the bus (with the assistance of Witness 1, who held Subject 1's hand while he exited the bus) and onto the RA gurney.

Paramedic 1 and Paramedic 2 were unable to take Subject 1's vital signs or examine him because Subject 1 became agitated whenever they tried to touch him. Paramedic 1 stated that at one point Subject 1 pulled out a cell phone and threw it across the RA, breaking it. Because of Subject 1's odd behavior, and the fact that he was wearing a shirt that said, "Walk for Autism," they thought that Subject 1 might be autistic or mentally impaired. Paramedic 1 and Paramedic 2 were ultimately able to convince Subject 1 to allow them to transport him to the hospital. Subject 1 was secured with a seatbelt.

Paramedic 1 drove the RA and Paramedic 2 remained in the back with Subject 1 en route to the hospital. They were initially going to go to one hospital; however, they were advised that hospital was closed and they were diverted to another hospital.

Paramedic 1 then entered the freeway enroute to the hospital. Shortly thereafter Subject 1 again became agitated. Paramedic 2 reported that Subject 1 stated something to the effect of, "I see you've got bullets" and "You're going to kill me," or, "Don't kill me." Paramedic 1 heard Subject 1 say something to the effect of, "You've got bullets." Subject 1 began to try to unbuckle the gurney seatbelt. Paramedic 2 was trying to keep the seatbelt on and reassure Subject 1, but Subject 1 was able to remove the seatbelt and stand up. Paramedic 2 cornered Subject 1 in a corner of the ambulance. At some point Paramedic 1 saw Paramedic 2 struggling with Subject 1 in the rearview mirror and pulled onto the shoulder of the freeway. Paramedic 1 came around to the back and entered the ambulance to assist Paramedic 2. According to Paramedic 1, he closed the rear RA doors behind him.

Paramedics 1 and 2 were concerned that Subject 1 would exit the ambulance and enter freeway traffic, possibly injuring himself and/or others. Paramedic 2 and Paramedic 1 tried to restrain Subject 1, who was trying to get to the RA door, and were finally able to do so. At that point Subject 1 was lying on the floor on his right side between the gurney and the bench seat, Paramedic 1 was lying on Subject 1 and holding him down with his bodyweight, and Paramedic 2 was trying to control Subject 1's feet. Paramedic 2 put his knee across Subject 1 to control his legs. The paramedics were then able to get soft restraints loosely

applied to Subject 1's wrists. According to Paramedic 2, he also secured the soft restraints to Subject 1's ankles.

Paramedic 1 and Paramedic 2 stated that Subject 1 calmed down after the soft restraints were applied, and Paramedic 2 was then able to get to his handheld radio. Paramedic 2 requested police backup from LAFD Dispatch, which was soon upgraded to a "Help" call.

LAFD Dispatch contacted LAPD Communications Division (CD) and requested assistance. However, there were miscommunications with LAFD Dispatch regarding the location, resulting in three to four requests for clarification from Paramedic 1 and Paramedic 2. Therefore, according to Paramedic 1 and Paramedic 2, it took approximately nine minutes for LAPD officers to arrive.

Uniformed Police Officers A and B were the first officers to arrive at the location. The officers notified CD that they were at the incident. Officer A stated that, upon approaching the RA, he saw the paramedics struggling with Subject 1. Subject 1 was sweaty, lying on the gurney on his back but trying to get off of the gurney. One paramedic was to Subject 1's right side holding Subject 1's right arm, and the other was at the left holding Subject 1's left arm. According to Officer B, when he approached the RA the paramedics were struggling with Subject 1 and holding him down on the floor between the gurney and bench area, and the paramedics requested that the officers assist them in getting Subject 1 onto the gurney. According to Paramedic 2, once Subject 1 saw the officers, he began to fight again. A struggle ensued, and both Paramedics 1 and 2 stated that they got out of the RA around this point to allow the officers to handle the situation.

Officer B stated that by the time they all got Subject 1 onto the gurney, Subject 1 was already "kind of tired" and not struggling too much. According to Officers A and B, they placed Subject 1 onto the gurney on his back. Officer B held Subject 1's left arm down, Officer A held Subject 1's right arm, and the paramedics strapped Subject 1 onto the gurney.

Uniformed Police Officers C and G arrived on the scene. Officer G stated that he observed Subject 1 restrained to the gurney by his arms, but did not see handcuffs or a Hobble Restraint Device (HRD). According to Officer G, he did not enter the RA. Rather, he instructed Officer C to try to help, but there were at least two officers, as well as paramedics, inside the RA, and therefore there was no room for Officer C to enter.

According to Officer A, he saw an HRD, which was used to secure Subject 1's wrists due to one of the gurney seatbelts being broken. Officer A was unsure who provided the HRD or how it was applied, but at some point he saw Subject 1's left wrist attached with an HRD to the gurney railing. He did not recall who applied the HRD, and did not recall an HRD being used on Subject 1's feet.

According to Captain A, an LAFD Emergency Medical Services Supervisor, when Captain A arrived to the location Subject 1 was already restrained on the gurney with his face down and was handcuffed behind his back. Captain A stated that at this point approximately four to six officers were in the process of applying an HRD to Subject 1, whose ankles were already restrained, and who was already handcuffed, by attaching Subject 1's handcuffs to

his ankles. Captain A stated that Subject 1's legs were still moving.

Captain A observed one paramedic inside the RA sitting on the jump seat. Uniformed Sergeant A arrived at the scene and observed Officers A and B inside of the RA, and other officers outside at Subject 1's feet. Sergeant A stated that Subject 1 was on the gurney, but was still moving around, so she instructed an officer whose identity Sergeant A cannot recall to apply an HRD to Subject 1's feet to prevent him from getting out of the RA. According to Sergeant A, whoever applied the HRD to Subject 1's feet stood outside of the RA at the back of the gurney. One of the gurney's straps was broken, so another HRD was placed on the side rails of the gurney so Subject 1 could not move up. Sergeant A was unsure whether the leg HRD was attached to the gurney, but stated that Subject 1's legs were fully extended.

According to Paramedic 1, after he exited the RA on the side door and came around to the back, which he approximated to have taken a maximum of ten seconds, he observed Subject 1's hands being handcuffed behind his back, Subject 1's legs latched together, and Subject 1's feet straight and latched to the bottom of the gurney. One officer was towards Subject 1's shoulders, one was positioned at Subject 1's hips, one was at Subject 1's legs, and the officers were using their chests and forearms to hold Subject 1 down. Paramedic 1 could not identify any of the officers, but he stated that a fourth officer standing next to him outside of the RA latched the HRD on Subject 1's legs to the gurney.

Paramedic 1 stated that Subject 1 was positioned on his stomach when the handcuffs and HRD were applied, with his head turned to the left. Paramedic 2 gave the same account of Subject 1's position. According to Officer B, he exited the RA once Subject 1 was restrained.

He did not recall an HRD being applied, but did recall Subject 1 strapped to the gurney. Officer A later recalled that an HRD had been applied. According to Officer A, Subject 1 was on his back until he was rolled to his side en route to the hospital. Paramedic 1 stated that one officer (later identified as Officer A) continued to apply pressure to Subject 1's upper torso after Subject 1 was secured.

Paramedic 1 estimated that it took a minute to a minute and a half for officers to get Subject 1 handcuffed and hobbled. Paramedic 2 estimated that between the time he exited the RA when the officers were restraining Subject 1 and when he returned and found that Subject 1 was already restrained, two to three minutes had elapsed.

Once Subject 1 was restrained, Paramedic 1 and Paramedic 2 stated that they came back inside of the ambulance to care for Subject 1, and that they told the officer who was still inside (later identified as Officer A) that they needed to roll Subject 1 to his side in order to properly evaluate him. According to Paramedic 1, at this time Officer A had his right shin on Subject 1's shoulder blade with both of his hands near Subject 1's shoulders, but did not have his full weight on Subject 1.

According to Paramedic 1, upon returning to the RA, Officer A was releasing pressure on Subject 1, and Subject 1 was turned to his right side, rather than the standard LAFD procedure of lying patients on the left side, due to the way Subject 1 was restrained. He

then saw a large amount of drool/froth coming from Subject 1's mouth, and also saw that Subject 1 was sweaty, not alert and had diminished breathing. According to Paramedic 1, Officer A no longer had his hands on Subject 1 at this time. The paramedics told Officer A to release the restraints. Officer A was initially hesitant given Subject 1's previous combativeness, but the paramedics explained to Officer A that Subject 1 was in distress. This exchange took approximately five seconds, and then Subject 1's restraints were removed and Subject 1 was moved to his back. Paramedic 1 stated that he did not know who removed the handcuffs or the HRD. The paramedics determined that Subject 1 needed to go to the hospital and LAFD Captain A got into the back of the RA with Paramedic 2 and Officer A. Paramedic 1 drove to the hospital while Captain A and Paramedic 2 worked on Subject 1. At Captain A's request, Officer B drove Captain A's vehicle to the hospital.

Captain A stated that en route to the hospital, Subject 1 stopped breathing, and Paramedic 2 stated that Subject 1's heart stopped. At the hospital, Officer B was told that Subject 1 was not doing well and was not breathing. Officer B notified Sergeant A, who then responded to the hospital. The medical staff was able to restore Subject 1's heart rate in the emergency room, and Subject 1 was stabilized. Sergeant A contacted Lieutenant A and explained the situation. Lieutenant A informed Sergeant A that if Subject 1 was alive and had no complaint against LAPD, that Sergeant A should just notify the hospital to call them if something happened. According to Sergeant A, "we" contacted County Police at the hospital and told them that if something happened that night, to please let the Department know.

Subject 1 remained at the hospital for several days. On May 3, 2006, Subject 1 was pronounced dead.

On May 9, 2006, Dr. A, Deputy Medical Examiner, performed the autopsy of Subject 1. The cause of death was determined to be "sequelae of anoxic encephalopathy due to atherosclerotic cardiovascular disease." The Autopsy Report indicated that there was up to 80% narrowing of the right coronary artery. Dr. Carrillo wrote that "[c]ontributing to death is the use of cocaine. It is a known hypertensive and arrhythmic agent. The decedent also exhibited signs of cocaine delirium which required restraint by law enforcement." Dr. Carrillo determined that "there is a temporal relationship between the application of handcuffs and leg restraints and the cardiac arrest. The role of the restraint cannot be determined; therefore, the manner of death is undetermined."

On July 25, 2006, Medical Examiner for the Los Angeles County Coroner's Office, Dr. B, contacted the Commanding Officer of the Department's Force Investigation Division (FID) regarding Subject 1's death. On that date, the FID investigation commenced. The FID report states that the delay in commencing the investigation occurred because Subject 1 was a patient of LAFD at the time he arrived at the hospital.

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 adopted as amended the following findings.

A. Tactics

The BOPC determined that Sergeant A, Officer A, and Officer B's, tactics were appropriate, requiring no further action. The BOPC determined that Officers C and G should receive divisional training.

B. Drawing/Exhibiting/Holstering

The BOPC found that drawing/exhibition/holstering does not apply.

C. Use of Force

The BOPC found that use of force does not apply.

Basis for Findings

A. Tactics

The BOPC noted that analysis of the incident identified several instances of prudent tactical decisions and proper actions. Officers A and B had a quick response to the help request, and immediately advised CD of the correct location upon arriving at scene. Officers A and B observed that Subject 1 was visibly sweaty and not cooperating with the firefighters that were attempting to restrain him. A coordinated, controlled and disciplined response was initiated to assist the LAFD personnel.

Upon observing the officers attempting to restrain Subject 1, Sergeant A directed an unknown officer to apply a HRD to Subject 1's ankles. Sergeant A also noted that one of the soft restraint buckles on the gurney was broken and could not be utilized to hold Subject 1 onto the gurney. Sergeant A appropriately evaluated the situation and directed an unknown officer to apply a second HRD from one gurney rail to another and across Subject 1's body to assist in securing him down onto the gurney.

The BOPC determined that Sergeant A's tactics while directing this incident were appropriate, requiring no further action.

As in most rapidly unfolding tactical incidents, there were identified areas where improvements could be made. In this incident, Officers C and G did not carry a HRD on their person as required. By not carrying a HRD on their person, the officers limited their force and restraint options.

Although this issue is not indicative of a deficiency requiring training, Officer G and C's respective commanding officers were directed to discuss the importance of being properly equipped with the officers.

The BOPC noted that Officers B, A and C physically engaged Subject 1 while assisting LAFD personnel with restraining him. Officer A utilized a firm grip and body weight to hold Subject 1's right arm down while Officer B utilized a firm grip and body weight to hold Subject 1's left arm down. Officer C utilized a firm grip and body weight and held Subject 1's ankles. Sergeant A evaluated the extent and specific circumstances of the contact and determined that it did not constitute a reportable Non-Categorical Use of Force incident. The firm grips were used to compel Subject 1 to comply with the officers and the body weight was reasonable to overcome the passive resistance of muscle rigidity and apparent mental illness of Subject 1. Additionally, the officers' actions did not result in an injury or complained of injury to Subject 1. The UOFRB evaluated the circumstances and concurred with the assessment and handling of the incident.

The BOPC determined that Officers B, A and C's actions were appropriate and that Sergeant A accurately applied Department policy in the assessment of the incident and that no further action was necessary.