

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

**IN-CUSTODY DEATH – 105-06**

<b>Division</b>	<b>Date</b>	<b>Duty-On (X) Off()</b>	<b>Uniform-Yes(X) No()</b>
Van Nuys	11/03/2006		

<b>Officer(s) Involved in Use of Force</b>	<b>Length of Service</b>
Does not apply.	

**Reason for Police Contact**

Officers A, B, and C responded to a domestic violence (DV) radio call. Officers A and B arrested Subject 1, who they believed to be under the influence of alcohol. While en route to jail, Subject 1 became aggressive, and Officers D and E assisted with placing a hobble restraint device on him. Subject 1 committed suicide in the detention cell.

<b>Subject</b>	<b>Deceased (X)</b>	<b>Wounded ( )</b>	<b>Non-Hit ( )</b>
Subject 1: Male, 40 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 11/06/07.

**Incident Summary**

Officers A and B were assigned a DV radio call. Officer C also acknowledged the call. Domestic violence Advocates A and B (trained personnel who provide immediate support and short-term assistance to DV victims) accompanied Officer C during his response to the location.

When Officers A and B arrived at the location of the call, they advised Communications Division (CD) of their status and location and met with Victim 1. Officer C and Advocates A and B arrived shortly thereafter.

Victim 1 told the officers and advocates that she and her boyfriend of approximately two years, Subject 1, became involved in an argument while seated in her car in a nearby parking lot. During the argument, Subject 1 punched Victim 1 in the face multiple times and bit her above the eyebrow. Victim 1 said Subject 1 grabbed the car keys from her hand. Fearing further attack, Victim 1 fled the vehicle on foot. Subject 1 then left the location driving Victim 1's vehicle. Victim 1 used her cellular telephone to contact police.

Based on the information provided by Victim 1, Officer C advised Officers A and B that he would complete the domestic violence investigation. He requested that Officers A and B remain in the area, in the event that Subject 1 returned to the location. Officers A and B left the specific call location, but did not update CD of their status.

During the course of his investigation, Victim 1 advised Officer C that Subject 1 was calling her cellular telephone. Victim 1 answered the telephone, and Subject 1 told her she could retrieve her vehicle from his residence.

Shortly thereafter, Officer C contacted Officers A and B via his radio and requested they return to his location. Upon arrival, Officers A and B were advised of Subject 1's telephone calls. Based on the information provided by Victim 1, the officers formulated a plan to respond to Subject 1's residence arrest Subject 1, and retrieve Victim 1's vehicle. Officers A and B informed CD of their status.

Officers A and B parked near Subject 1's residence and observed Victim 1's vehicle in the driveway with the driver's side door opened. Officer C, Advocates A and B, and Victim 1 waited around the corner from the location. Officer B contacted CD and advised that he and Officer A were at the location.

While standing at the passenger side of Victim 1's vehicle, Officer A observed Subject 1 seated inside the vehicle and alerted Officer B. Officer B then issued commands to Subject 1 and directed him to exit the vehicle. Subject 1 complied and was handcuffed without incident by Officer B, who was deployed at the rear of the vehicle on the driver's side.

Officers A and B placed Subject 1 under arrest and secured him in the back of their police vehicle.

Upon contacting Subject 1, Officer A smelled a strong odor of alcohol emitting from Subject 1's breath and observed that his eyes were bloodshot and watery. Officer A formed the opinion that Subject 1 was under the influence of alcohol. Officers A and B transported Subject 1 to the police station to obtain booking approval. While en-route to the station, Subject 1 acted somewhat belligerent.

Once at the station, Subject 1, who remained handcuffed, was placed a detention cell. Officer A then advised Sergeant A of the circumstances surrounding Subject 1's arrest.

Sergeant A conducted a pre-booking interview of Subject 1, who acknowledged the reason he was arrested and indicated that he was not sick, ill or injured. During the pre-booking process, Subject 1 was banging on the door of the detention cell.

Officer A completed the Arrest Medical Screening Form. While completing the form, Officer A noted that Subject 1 did not have any injuries or medical problems, was not in possession of prescribed medication but appeared to be under the influence of alcohol.

Officers A and B then placed Subject 1 in the police vehicle to transport him to jail in order to complete the booking process. Subject 1 was placed into the rear seat of the vehicle directly behind Officer B, who was seated in the front passenger's seat.

Shortly after leaving the police station, while the police vehicle was stopped at a red light at an intersection, Subject 1 began kicking the rear door and slamming his head against the plastic partition separating the front and rear interior of the police vehicle. Subject 1 also slammed his head against the rear door glass. Officer A ordered Subject 1 to stop his actions. However, Subject 1 refused and continued hitting his head against the plastic divider. Officer A then pulled over to the curb, stopped, and exited the police vehicle to apply a Hobble Restraint Device (HRD) to Subject 1's legs. Neither Officer A nor B contacted CD regarding Subject 1's actions or to advise that they were stopping to apply the HRD.

Meanwhile, Officers D and E were also at the intersection and observed the police vehicle occupied by Officers A and B and Subject 1. Officer E could see that Subject 1 appeared agitated. Officers D and E opined that Officers A and B might need assistance and negotiated the police vehicle in a position directly behind that of Officers A and B's.

Officers D and E stopped and exited their police vehicle and walked over to Officers A and B, who were removing Subject 1 from the back of the police vehicle. Although Subject 1 was handcuffed, he was struggling with the officers by moving his arms and feet back and forth.

While standing outside of the police vehicle, Subject 1 made several comments about making a telephone call. Officer A told Subject 1 to calm down and that once he was booked in the jail, he would be able to make a telephone call. Subject 1 calmed down and allowed Officer A to apply the HRD on his legs above the knee.

Officers A and B escorted Subject 1 back to the rear door of their police vehicle and assisted him back to a seated position. Officer D walked to the opposite rear passenger side door of the police vehicle and assisted by placing the seat belt around Subject 1 and securing it in place. The clasp of the HRD was placed between the rear vehicle door and door frame. The door was then closed, which secured the clasp.

Officers A and B returned to their police vehicle and continued transporting Subject 1 to the jail facility. Subject 1 remained calm during the remainder of the ride.

When Officers A and B arrived with Subject 1 at the jail facility, they decided to keep Subject 1 restrained using the HRD, given his prior actions while inside the vehicle. Due to the positioning of the HRD, Subject 1 was able to walk into the facility with minimal assistance from Officers A and B.

Once inside jail facility, the officers were unable to locate a vacant holding cell. Principal Detention Officer A inquired as to Subject 1's status and was told that Subject 1 had refused to cooperate with them or answer their questions. Principal Detention Officer A directed Officers A and B to take Subject 1 to a vacant cell.

Officers A and B entered the cell, conducted a pre-booking search of Subject 1, and removed his shoelaces, belt, and other personal property in the presence of Principal Detention Officer A. Officer B then removed the HRD from Subject 1's legs and the handcuffs from his wrists without incident. Both officers exited the cell and had no further contact with Subject 1.

At some point during this process, Officer A met with Detention Officer A, who was assigned to the booking area and was responsible for booking incoming arrestees. Detention Officer A reviewed Subject 1's Medical Screening Form and noticed that the line requiring Subject 1's signature was blank. Officer A told her that Subject 1 had refused to sign the form. Detention Officer A wrote "Refused" on the signature line. Detention Officer A never saw Subject 1 or dealt with him.

Detention Officers B and C were assigned to conduct routine welfare checks of cells during their assigned shift. Detention Officer B conducted a welfare check of Subject 1's cell and observed Subject 1 inside the cell by himself and lying on the bottom bunk bed. According to Detention Officer B, Subject 1 was facing away from him and was using the upper bunk's mattress as a cover. Subject 1 was awake, talking to himself and using profanity.

In a subsequent welfare check of Subject 1's cell, Detention Officer B observed that Subject 1's mattress was on the floor and that Subject 1 was hanging from the side of the bunk bed in an awkward position with a tee shirt tied around his neck. Subject 1's knees were bent, he was facing the bunk bed, and appeared unconscious. Detention Officer B activated the emergency alarm button, which resulted in the immediate response of Principal Detention Officer A and Detention Officer D.

Principal Detention Officer A directed a staff member to contact 9-1-1 and Detention Officer B requested the Arrestee Suicide Prevention Kit.<sup>1</sup> Detention Officers A, B, and D entered the cell to assist Subject 1.

Detention Officer B stood directly behind Subject 1, wrapped his arms around Subject 1's chest under his armpits and raised him upward to relieve the tension from the tee

---

<sup>1</sup> The Arrestee Suicide Prevention Kit contains a hook-style cutting instrument, a cardiopulmonary resuscitation mask, towels, scissors, and alcohol wipes.

shirt tied around his neck. At the same time, Detention Officer D attempted to cut the shirt around Subject 1's neck from the bed rail using the hook-style cutting instrument. However, the shirt was thick and the hook was ineffective in cutting the material. Principal Detention Officer A used his radio and requested that a pair of scissors be brought to the cell.

Senior Detention Officer A observed that Detention Officer D was having difficulty cutting the shirt, removed a pair of scissors from the Suicide Kit and began cutting the material from around Subject 1's neck.

Detention Officer B laid Subject 1 down on the floor of the cell. Detention Officer B believed he felt a faint pulse on Subject 1, as did Doctor A, who responded to the cell and began resuscitation efforts.

Personnel from the Los Angeles City Fire Department (LAFD) arrived on scene and began administering emergency medical treatment to Subject 1. Subject 1 was transported to the hospital and 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 Officers A, B, C, D, and E's tactics to warrant divisional training.

#### **B. Additional**

The BOPC found Sergeant A, Officers A, B and C, and Detention Officer A's administrative actions to warrant divisional training.

### **Basis for Findings**

#### **A. Tactics**

The BOPC noted that Officers A, B and C demonstrated initiative when they decided to conduct a follow-up investigation in an attempt to take Subject 1 into custody.

Additionally, upon observing Subject 1's actions in the back seat of Officers A and B's police vehicle, Officers E and D stopped and made themselves available to assist.

Additionally, after Subject 1 was restrained with a HRD, Officer D assisted Officer A and B in seat belting Subject 1. Had Officer B attempted to seat belt Subject 1, he would have had to reach across Subject 1, thereby increasing his chances of being assaulted by Subject 1.

Jail personnel also made several prudent tactical decisions upon noticing Subject 1 hanging from the bunk. Detention Officer B immediately summoned help by activating a panic alarm and did not enter the cell until additional personnel arrived. Additionally, Detention Officer B appropriately lifted Subject 1's body in an attempt to remove the pressure on Subject 1's neck while additional personnel attempted to remove the ligature.

As in most tactical situations, there were several areas where improvements could be made and lessons could be learned. Officers A, B and C decided to conduct a follow-up investigation and attempt to arrest Subject 1 for the perceived felony charge. Neither Officers A, B nor C notified a supervisor of their intent to conduct a follow-up investigation. Additionally, it would have been tactically advantageous for Officers A, B and C to request an additional unit to respond with them to the follow-up location.

The investigation was unclear as to what position Officers A and B were in when they ordered Subject 1 out of his vehicle, but the officers were reminded of the importance of using available cover.

Officers A and B did not notify CD of their location and status when they stopped to apply the HRD to Subject 1. It would have been prudent for the officers to have requested an additional unit and supervisor to respond prior to removing Subject 1 from the vehicle. This would have ensured that they had adequate personnel and supervision to assist them if Subject 1 continued his aggression and a use of force were to occur. Officers D and E stopped and made themselves available to Officers A and B; however, they also did not notify CD of their status and location.

Officers A, B, D and E did not formulate a tactical plan of action prior to removing Subject 1 from the vehicle.

The investigation revealed that all jail personnel acted appropriately and followed related policies and procedures. The BOPC determined that no actions, or inaction, by jail personnel contributed to Subject 1's death; therefore, the BOPC did not issue findings for the jail personnel involved in this incident.

The BOPC found Officers A, B, C, D, and E's tactics to warrant divisional training.

## B. Additional

The BOPC noted several administrative concerns involving the officers and Sergeant A. To begin with, Officers A and B did not conduct a sufficient investigation prior to requesting booking approval for the felony Penal Code section, including not confirming that the specific elements of the requested booking charge were actually present. Additionally, Sergeant A approved the felony booking charge without verifying that the required elements were sufficiently met (e.g., confirmation of visible injuries, review of photographs depicting injuries, etc.)

Furthermore, Officer C contacted Officer B prior to booking Subject 1 and advised him that the elements for a felony charge were not met. Officer C advised Officer B to book Subject 1 on the appropriate misdemeanor charge. Officer B inappropriately crossed out the felony booking charge and wrote in the misdemeanor charge on the booking approval signed by Sergeant A. In this instance, a second booking approval was required upon changing the booking charge. It was also noted that when the booking charge was changed to a misdemeanor, the “conditions for non eligibility for release” section of the booking approval was not completed as required.

Officer C completed the arrest report face sheet and statement form indicating that Officer B advised Subject 1 of his *Miranda* rights. Officer B denied advising Subject 1 of his *Miranda* rights and stated that he was unaware that his name had been placed in the advising section of the report, indicating that the suspect’s *Miranda* rights had been given.

The BOPC noted that Subject 1 had a previous arrest for narcotics possession, and the crime that he was being booked for was one of violence. Each factor warranted a pre-booking strip search; however, one was not performed. Although current policy states that such prior arrests may be considered as a factor in determining whether to conduct a strip search, the BOPC concluded that a strip search would have been appropriate in these circumstances.

Lastly, the BOPC noted that, during the booking process, Detention Officer A met with Officer A regarding the fact that the signature portion of the Unified Arrestee Medical Screening Form for Subject 1 was blank. Based on her discussion with Officer A, Detention Officer A wrote “Refused” on the signature line of the form. This action was inconsistent with Department policy, which states, “the detention officer shall verify the refusal with the arrestee. If an arrestee continues to refuse to sign the form, the detention officer shall initial the arrestee signature box next to the officer’s initials. Detention officers shall ensure that any necessary special confinement or in-custody care is provided.” According to Detention Officer A, she never saw or dealt directly with Subject 1.

The BOPC found Sergeant A, Officers A, B and C, and Detention Officer A’s administrative actions to warrant divisional training.