

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

**IN-CUSTODY DEATH – 019-16**

<b>Division</b>	<b>Date</b>	<b>Duty-On (X) Off ( )</b>	<b>Uniform-Yes (X) No ( )</b>
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Central	3/27/16		
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<b>Officer(s) Involved in Use of Force</b>	<b>Length of Service</b>
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Does not apply.

**Reason for Police Contact**

The subject was in custody at a jail facility when she was found unresponsive by detention staff.

<b>Subject(s)</b>	<b>Deceased (X)</b>	<b>Wounded ( )</b>	<b>Non-Hit ( )</b>
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Subject: Female, 36 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 and medical 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.

Due to privacy concerns, certain medical information that was presented to the BOPC is not included in this report.

The following incident was adjudicated by the BOPC on January 31, 2017.

## **Incident Summary**

On 3/25/16, the Subject went a local hospital for treatment. The Subject was treated in the emergency room. While in the emergency room, the Subject approached a fellow patient, Patient A, who was lying on a nearby hospital bed. Without provocation, the Subject punched Patient A numerous times in the face with both fists. The Subject was not struck back by Patient A during the altercation. According to Patient A, the attack caused her to momentarily lose consciousness.

Hospital emergency room medical staff standing nearby responded to the attack. The Subject immediately ceased her assault on Patient A as the medical staff arrived. The medical staff did not physically touch the Subject; however, she was given verbal directions to return to her hospital bed. The Subject walked to her curtained hospital bed without any hesitation and under her own power. The medical staff secured the Subject's wrists and ankles to her hospital bed with soft restraints.

Hospital staff called 911, was connected with the LAPD Communications Division (CD) Emergency Board Operator (EBO), and stated, "Two patients in the emergency room had become involved in an altercation and one of them wanted to press charges..."

Just after midnight, Central Patrol Division uniformed Police Officers A and B responded to the hospital for the battery investigation.

Upon their arrival, Officers A and B found the Subject in soft restraints with her wrists and ankles secured to her emergency room hospital bed. According to the officers, the Subject did not have any visible injuries or any complaints of injuries. The medical staff told Officer B that the Subject approached Patient A and hit her. According to Officer B, the medical staff further stated the Subject was grabbed by medical staff and security officers and secured to her bed. According to Officer B, the Subject was angry about being secured to her bed; however, her demeanor, captured in Officer B's Body Worn Video (BWV), depicted her as calm, relaxed, and cooperative.

Note: The hospital surveillance video did not depict medical staff or hospital security having any physical contact with the Subject before Subject returned to her bed. She appeared to respond to verbal commands and immediately returned to her curtained hospital bed.

Officer B activated his Body Worn Video (BWV) and interviewed the Subject, who waived her Miranda Rights and stated she punched the other patient because the other patient had abused the Subject's son. Patient A stated she had never met the Subject before this incident and did not know her or her son.

The Subject was arrested for felony battery. The doctor on duty cleared the Subject for booking and discharged her from the hospital.

The Subject was transported to the Central Community Police Station for booking approval. While in transit, the Subject asked for a cigarette several times, and inquired about her bail and her hospital discharge paperwork. The transportation of the Subject was captured (video and audio) on the Digital In-Car Video System (DICVS).

After Officers A and B arrived at Central Community Police Station with the Subject, they presented her to the Central Patrol Division Watch Commander, who asked the Subject basic intake questions. The Subject stated she understood why she was there, denied being sick, ill, or injured, and stated she had no other concerns. According to the Watch Commander, the Subject appeared coherent and very forthright.

The officers completed the arrest paperwork, obtained booking approval, and transported the Subject to the Metropolitan Dispatch Center (MDC) for booking.

Officer A asked the Subject the designated questions on the medical screening forms, and recorded her answers on the form. The Subject denied feeling suicidal or wanting to hurt herself; however, she did indicate that she had mental health issues.

Note: During the investigation, Officer A was asked by FID if he had any reason to believe that the Subject would be a danger to herself or to others, to which he replied, "No, Sir." As previously indicated, Officer A knew that the Subject had, without provocation, physically attacked another patient at the hospital. He also knew, after completing the medical screening form that the Subject said she had mental health issues, but did not ask any follow-up questions to determine the nature of those issues.

The Subject was evaluated by the medical staff at the MDC Dispensary. She was initially seen by Medical Services Division (MSD) Registered Nurse A, who spoke with the Subject and completed the required MSD forms. Nurse A, based on her own evaluation of the Subject and the fact that the Subject did not have any complaints, believed the Subject was suitable for placement in general housing.

The Subject, as part of the protocols established by MSD, was also evaluated by Physician's Assistant (PA) A. As part of her assessment, PA A reviewed the MSD forms initiated by Nurse A, and the medical documentation the hospital provided by the arresting officers. PA A noted the Subject's prior medical history on the forms from the hospital, medication she was currently taking, and information regarding a mental health diagnosis. PA A noted that the Subject was seen and was medically cleared for booking by the hospital doctor. According to PA A, she was not concerned by any of the medical history documented on the hospital medical records or on the MSD forms. PA A prescribed a medication for the Subject.

Physician's Assistant A also asked the Subject if she had any suicidal or homicidal ideations. The Subject denied having either. According to PA A, it is her practice to not only ask her patients about having suicidal or homicidal ideations and noting their verbal

response, but also paying particular attention to their demeanor during the assessment as the verbal and nonverbal responses may conflict. It was PA A's belief that the Subject did not display any indication she was at risk, approved her to continue to receive her medication, and cleared her to be booked at MDC and housed in the general housing unit.

Note: Both Nurse A and PA A reviewed the documentation from the hospital, which indicated that the Subject had mental health issues and showed that the Subject was currently prescribed and taking medications related to those mental health issues. Both Nurse A and PA A also noted that the Subject's response and demeanor, upon hearing the results to one of the tests they had administered, was unusual. Both made the determination that they did not have concerns about the Subject that would cause them to believe that the Subject needed to be confined other than in general population.

Officers A and B escorted the Subject to a booking window, where Custody Services Division (CSD) Senior Detention Officer (SDO) A completed the data entry portion of the booking procedure. According to Officer B, during the booking process, the Subject stated she was cold and requested additional clothing. Officer B retrieved a blue long-sleeved shirt from the Subject's property for her to wear while in custody. After booking, the Subject was placed in a holding cell to wait for fingerprinting and a booking photograph.

At the start of each watch, detention personnel attend a roll call and receive their assignments. Detention personnel then respond to their assigned Pod to receive a briefing and relieve the prior watch. The purpose of the briefing is to pass on any identified concerns from the prior watch regarding the inmates or condition of the custody facility with the intent to maintain a safe and secure environment.

Detention personnel are mandated to conduct "Safety Checks." The California Code of Regulations, Title 15, Section 1027, requires hourly safety checks of inmates. A safety check is defined as a direct, visual observation performed at random intervals to provide for the health and welfare of the inmates. According to the detention personnel interviewed, they conduct the Title 15 safety check at or near the top of the hour. During these checks, detention personnel physically monitor each inmate and look for signs of life or obvious signs of distress. If necessary, detention personnel enter the cells to verify the health and welfare of the inmates. Per the CSD Manual, detention personnel will conduct a second safety check approximately 30 minutes after the Title 15 safety check. All safety checks are documented on an Observation Record form to verify their completion, and are captured via the MDC surveillance video.

According to MDC personnel, the first safety check performed by the new watch is referred to as a "roll call." This safety check is consistent with the Title 15 safety check, and also involves detention personnel examining each inmate's wristband. The

information contained on the wristband is compared with a published list, thereby ensuring the welfare of each inmate and verifying each inmate is accounted for.

The following information was established from witness statements, MDC surveillance video, recorded phone calls, and written documentation:

After completing the booking process, detention personnel escorted the Subject and other female inmates to the female housing section identified as East Pod. The Subject was cooperative and placed into general housing identified as East D Block.

The Subject selected a top bunk within East D Block and went to sleep. Custody Services Division SDO A, and Detention Officers (Dos) B and C, were assigned to the East Pod and reported having no issues with the Subject during their shift that ended at approximately 0700 hours that morning. The Subject remained asleep during this time.

On Saturday, March 26, 2016, at approximately 6:30 a.m., CSD Police Officer C, and DOs D and E, came on duty, attended roll call, and were assigned to the East Pod. According to Officer C, the prior watch provided a briefing and indicated there were no issues or concerns with any of the inmates.

The Subject remained asleep in her bunk until mid-morning hours. Upon waking up, she walked to the restroom and throughout the day continued to make numerous trips to the restroom during her stay in D Block. A review of the MDC surveillance video determined that the Subject's interaction with other inmates was minimal; however, she did appear to have several conversations with Inmate A. According to Inmate A, while in D Block, the Subject was calm and they discussed their individual criminal charges; however, the Subject never discussed any desire to injure or kill herself.

According to the MDC Dispensary medical records, the Subject was to be given medication every afternoon. According to MDC surveillance video, an MDC Dispensary staff member arrived at D Block to dispense medication. The dispensary staff member was pushing a wheeled cart as she approached the cell door. The Subject immediately approached the door and it appeared she was provided something [medication] from the dispensary staff, before walking back toward her bunk.

Later that afternoon, the Subject made a phone call from D Block to her mother. During the recorded phone conversation, the Subject explained the altercation at the hospital that resulted in her arrest. This conversation was recorded. All inmate phone calls contain an audio warning that the phone conversation may be recorded or monitored. They talked about her bail, her upcoming court date, and future phone calls. The Subject's mother told the Subject she would be present in court on Tuesday. They wished each other a Happy Easter, expressed their love for each other, and concluded their phone call.

At approximately 6:30 p.m., CSD SDO F, and DOs G and H came on duty, attended roll call, and were assigned to the East Pod. They reported to the control tower and

received a brief from the prior watch. The only concern reported by the prior watch was a complaint from the Subject about feces on the toilet in D Block.

According to DO G, the prior watch briefed SDO F. SDO F then shared the information with DO G that the prior watch had concerns about the Subject going upstairs all day to use the bathroom.

Shortly after coming on duty, DO G had first contact with the Subject when he and DO H conducted their first safety check ("roll call") in D Block. DO G said that the Subject was fine during this interaction and presented her wristband as requested.

DO G had another contact with the Subject when she (the Subject) inquired about her medication and stated she wanted to take it before bedtime. DO G explained to her that the dispensary managed the distribution of medication and detention officers did not have control over their schedule. According to DO G, the Subject appeared satisfied with the explanation. According to DO G, the Subject was later provided her medication by MDC Dispensary staff and promptly went to sleep.

In the early morning hours of Sunday, March 27, 2016, just prior to the end of the duty shift, SDO F was informed that the upstairs and downstairs toilets in D Block were clogged and overflowing. To facilitate the plumbing repairs, all sixteen of the inmates in D Block had to be relocated to the available two-person cells located in B Block. The inmates were asked to gather their bedding and personal items and to line up adjacent to the D Block cell door. The inmates were directed to exit D Block and walk up the stairs to an available two-person cell. The custodial officers did not dictate cell assignments. At random, the Subject and Inmate A were the first two inmates to go up the stairs and were directed to the first cell, cell EB-208. The next two inmates went into the adjacent two-person cell. This process was repeated until all inmates were transferred out of D Block.

SDO F notified an unknown supervisor of the plumbing issue and the need to move inmates; however, this was not documented on the CSD Watch Supervisor's Log.

While conducting the safety checks in B Block, DO G, spoke with the Subject. DO G conducted safety checks of cell EB-208 three times, at approximately 30 minute intervals, before the shift ended. During one of those safety checks DO G noticed the Subject was wearing a Teenage Mutant Ninja Turtles shirt. DO G told the Subject he was a Michelangelo (one of the Teenage Mutant Ninja Turtles characters) fan and they briefly talked about the Ninja Turtles. The Subject then inquired about when they would be going back to D Block. DO G explained the necessity of repairing the plumbing issue and then cleaning up the cell before allowing anyone back inside. He told the Subject that as soon as that was finished she would be returned to D Block. According to DO G, the Subject was smiling, pleasant, and seemed satisfied with the explanation.

During yet another safety check, DO G saw the Subject on the phone inside her cell and believed she was having a conversation with a family member. DO G conducted his

last safety check just prior to ending the duty shift. According to DO G, the Subject again asked about moving back to D Block. DO G reported that the Subject was smiling and did not appear to be distraught during these contacts.

Telephone call records indicate the only telephone call made from cell EB-208 occurred at approximately 7:45 a.m. There was no record of any calls being made prior to the final safety check conducted by DO G.

DO G returned to the control tower to await the arrival of the next watch. While there, he received numerous alerts via the intercom system that someone in cell EB-208 (the Subject's cell) was attempting to communicate with the control tower. DO G answered the intercom and spoke with the Subject. According to DO G, the Subject sounded fine but was again asking when they would be moved back to D Block. DO G reassured her that someone would come to her cell to talk with her and that they would soon be moved to D Block. According to SDO F and DO H, they did not have any conversations with anyone via the intercom system. However, DO H did hear DO G engage in one conversation in which the inmate was asking when they were going to be moved.

According to Inmate A, at some point during the time Inmate A and the Subject were in cell EB-208, the Subject was aggressive, hyper, and acted belligerent as she yelled and kicked at the door to cell EB-208. According to Inmate A, the Subject stated, "Let me out. Let me out. I'm suicidal. If you don't let me out, I'm going to hurt my celly [cellmate], so you have to come up here now...I'm a mental patient. Please let me out. I'm thinking --- I'm having thoughts of killing myself." Inmate A stated the Subject did not physically assault her. Inmate A stated some of these outbursts were over the intercom while some of it was said as the Subject paced around the cell. This behavior was not heard or witnessed by MDC personnel or any of the inmates interviewed during this investigation. Because surveillance video cameras were not positioned inside cell EB-208 or focused toward the interior of the cell none of this activity was captured, and investigators were unable to identify exactly when this reported behavior occurred.

According to Inmate A, the Subject repeatedly asked the detention officers when they were going to be moved back to D Block. The detention officers continued to let her know that they would be moved back soon.

Inmate A at one point fell asleep in her bunk. When she awoke, she said she found the Subject sitting on the floor near the cell door with a shirt wrapped around her neck. The Subject was pulling on each end of the shirt as she repeatedly stated, "I'm about to take my life." According to Inmate A, the shirt was not tied to any object. Inmate A yelled at the Subject to stop and the Subject complied by removing the shirt from around her neck. Inmate A did not alert the MDC personnel regarding any of the Subject's behavior as she believed the Subject was only displaying dramatic behavior to draw attention to herself.

According to DO G, the Subject was very relaxed and cordial during all of their interactions. During subsequent interviews, SDO F, and DOs G and H reported they

were not aware of the Subject or any inmate complaining of being suicidal or appearing distraught in any way.

At approximately 6:30 a.m., CSD DOs D, I, and J came on duty, attended roll call, and were assigned to the East Pod.

DO D was the first to respond to the control tower and was briefed by SDO F. According to DO D, SDO F advised him to keep an eye on the Subject, whom he thought was "acting a little strange." No further explanation of the Subject's behavior was provided or sought. According to DO D, he relayed this information to DOs I and J.

Senior DO F denied that he advised DO D about any concerns with the Subject. He stated he briefed DO D and advised him only of the plumbing issue. After the plumbing issue was corrected and the cell was cleaned, according to SDO F, all inmates were to be relocated back to D Block.

According to DO I, DO D advised him only of the plumbing issue. No mention was made of the Subject's conduct or behavior.

According to DO J, DO D told him the prior watch indicated the Subject was being uncooperative and was displaying strange behavior; therefore, the Subject would remain in cell EB-208. DO J indicated this briefing occurred prior to him conducting his first safety check, which was determined to have been conducted at the top of the hour. No further explanation of the Subject's behavior was provided or sought by either DO J or DO D.

At the top of the hour, DO J completed the first safety check of his watch. During this safety check, he approached the cell door of cell EB-208 and verified the identity of the Subject and Inmate A by visually inspecting their wristbands as they presented them for viewing. According to DO J, he noted no significant behavior or statements during this safety check with any of the inmates.

DO D reported he was alone in the control tower when he received an alert via the intercom system from cell EB-208. He answered the call and the inmate stated she was "getting claustrophobic." DO D did not know which inmate was making the statement, but he did advise the inmate that they would soon be moved back to general housing.

DO D stated that at the time he advised the occupant(s) of cell EB-208 via the intercom that they would be moved back to general housing, he had not yet made the decision to keep the Subject in that cell. He estimated this intercom communication occurred at approximately 7:30 a.m. However, DO J stated that DO D advised him the Subject was to remain in cell EB-208 prior to his first safety check.

About 25 minutes later, DOs D and J conducted the next safety checks. DOs D and J independently conducted the safety checks on level one and level two of B Block, respectively. They noted nothing of significance during these checks.



At approximately 7:45 a.m., the Subject called her mother from the telephone within cell EB-208. The time stamp of the recorded phone call was 7:45:15 a.m. This phone call was recorded. During the 47-second conversation, the Subject greeted her mother by saying, "Good Morning, Mama, Happy Easter." Her mother asked the Subject to call back later that day so everyone could wish her a Happy Easter. During the call, the Subject asked her mother the time, and was told it was 7:45 a.m. They then ended the phone call.

Investigators obtained copies of all MDC surveillance video relative to the Subject, which accounted for approximately 88 hours of video. This included video specifically from a fixed surveillance camera that continually covered the exterior of cell EB-208's door. The camera was on the opposite side of the cell block and the interior of cell EB-208 cannot be seen. However, it was later discovered that 21 minutes of this specific video feed was not captured. The above phone call was made after the period of the missing video. There was contact between detention staff and the Subject both prior to and after the period of time that would have been covered by the missing video, and she was in the company of Inmate A that entire time.

Once the plumbing issue was resolved, DOs J and I prepared to transfer the inmates from B Block back to D Block. According to DO J, per DO D, the Subject was to remain in cell EB-208. The information obtained from SDO F during the change of watch briefing caused DO D to have concerns that the Subject would be a disruption if she were to remain housed with the general population inmates.

Just prior to 8 a.m., DO J walked upstairs toward the cell doors while DO I remained downstairs. DO J approached the cell door of cell EB-208 and found the Subject sitting on the floor adjacent to the door with her back against the north wall and her feet stretched out across the doorway. DO J asked the Subject to move to her bunk. According to DO J, although she could not remember the exact quote, she believed the Subject stated, "No", or "I'm not going to move." Within minutes, DO D opened the cell door to cell EB-208 from within the control tower. DO J asked Inmate A to exit the cell. The Subject did not move or speak as Inmate A stepped over her and exited the cell. Inmate A was directed to walk down the stairs to DO I and was secured in D Block while the Subject remained in cell EB-208. According to Inmate A, the Subject was standing near the door as she (Inmate A) exited the cell, and was not removed because she had threatened the detention officers. The remaining inmates, initially moved from D block to B Block, were relocated back to D Block without incident.

At approximately 8:25 a.m., DO I walked upstairs to cell EB-208, to conduct the next safety checks. At the same time, DO D was conducting the safety checks in the cells downstairs. The downstairs inmates were not part of general housing inmates who had been transferred due to the plumbing problem. DO I looked inside cell EB-208, and observed the Subject laying on the floor on her right side with her feet toward the cell door. Initially, DO I did not think that it was unusual and did not believe the Subject was in distress. He knocked on the window, received no response and began shouting at

the Subject. After receiving no response from the Subject, DO I called out to DO D to come upstairs immediately. DO I told DO D that the Subject was not moving or waking up. DO D contacted the control tower and asked DO J to open the cell door to cell EB-208.

Note: Video evidence shows that nobody entered the Subject's cell between the time Inmate A was removed and the time of the 8:25 a.m. safety check.

About a minute later, DO J opened the door to cell EB-208 from within the control tower. DO I stepped inside the cell and observed clothing tied to the telephone cable leading from the telephone to the handset. The clothing led down to the Subject and disappeared under her body. DO I shook the Subject with his hands as he called out to her. DO I then focused on the clothing leading under the Subject's body and determined it was wrapped tightly around her neck. DO I immediately unwrapped the clothing from around the Subject's neck and began feeling for a pulse, but did not find one.

DO D, via the radio, called for backup and for the medical staff from the dispensary to respond. DO K was the first backup officer to arrive. He met with DOs I and D who were standing outside the cell. DO K entered the cell and observed the Subject laying on her right side. He verified she was not conscious, not breathing, and was without a pulse. DO K rolled the Subject onto her back and immediately began chest compressions while DO I tilted the Subject's head back to open her airway. About 4 minutes had transpired between the time the Subject was found unresponsive and the time CPR was initiated.

At approximately 8:30 a.m., dispensary staff arrived at cell EB-208. The dispensary staff utilized an Automated External Defibrillator (AED) device, an Ambu-bag, and also unsuccessfully attempted to start an intravenous (IV) line. They continued life-saving measures until the paramedics arrived. The Subject remained unconscious and without a pulse.

Los Angeles Fire Department (LAFD) personnel arrived at scene and continued life-saving measures. At approximately 9:00 a.m., LAFD personnel transported the Subject to the hospital.

The Subject failed to respond to the emergency medical treatment and was pronounced deceased by an Emergency Room doctor.

On March 31, 2016, Medical Examiners from the Los Angeles County Department of Coroner performed a post-mortem examination of the Subject's remains. They concluded that the Subject had a furrow that was consistent with a ligature being bound around her neck. The Coroner's examination determined that the Subject did not have any internal neck trauma or hemorrhage. According to the examiner, the above-described furrow and lack of trauma or hemorrhage was consistent with the Subject

being hanged as opposed to being strangled by an individual. The examiners ruled the Subject's cause of death was hanging and that the manner of death was suicide.

### **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.

#### **A. Tactics**

Does not apply.

#### **B. Drawing/Exhibiting of a Firearm**

Does not apply.

#### **C. Use of Force**

Does not apply.

#### **D. Additional**

The Commission noted the following issues:

- The investigation revealed that Officers A and B did not contact MEU after the Subject told them she had mental health issues, as required by Los Angeles Police Department Manual, Volume 4, Section 260.20. This issue was brought to the attention the officers' current respective commanding officers and addressed through training at the divisional level.
- The investigation revealed that DO D had directed another detention officer to leave the Subject in the cell to segregate her from the general population without the prior approval of a supervisor as required by Los Angeles Police Department Jail Operations Manual 2012, Volume 2, Section 204.06. This will be addressed in a Personnel Complaint.
- The investigation revealed that DOs D and I did not immediately begin CPR on the Subject as required by Los Angeles Police Department Jail Operations Manual 2012, Volume 2, Section 214.31. This will be addressed in a Personnel Complaint.

- In an effort to avoid future incidents of this nature, the phones inside the jail facilities cells are currently scheduled to be replaced in 2017 with telephones that do not have cords to prevent inmates from attaching articles of clothing to the telephones.
- Policy Review – As a result of this incident, the Director of the Office of Special Operations initiated a project to review the Department’s current policy in regards to when an officer is required to contact MEU. The policy currently requires that an officer notifies MEU whenever a person in custody is suspected of having a mental illness, regardless of whether or not the person who is in custody is having an active mental health crisis; however, in order to meet the criteria for special confinement, an inmate’s behavior must suggest that the individual is a present threat to themselves or other inmates.
- In the FID investigation, the issue of the Subject’s death notification to the next of kin is addressed. As reported by FID, it is the responsibility of the Coroner’s Office to make death notifications to the deceased’s next of kin; however, at times in the past, the FID investigators have made those notifications and then advised the Coroner’s Office of such notification. In this case, the hospital did not notify the Coroner’s Office of the Subject’s death. In fact, the Coroner’s Office was not made aware of the death until FID investigators contacted them to coordinate the autopsy. As a result, the Subject’s family was not notified of her death in a timely manner and her mother, unaware of what had occurred, appeared at court for the Subject’s next scheduled appearance. At the court, the Subject’s mother was directed to contact MDC to obtain the status of her daughter. MDC personnel in turn referred her to the Coroner’s Office.

Since this incident occurred, the Department has established a Family Liaison Section, which will establish immediate liaison with the family of a decedent and then maintain contact with those family members throughout the entire administrative investigation and adjudication process.

- The BOPC directed the Inspector General’s office to:
  1. Review all In-Custody Deaths that have occurred in LAPD jail facilities over the last five years to determine whether any trends or recurrent issues are associated with those cases.
  2. Review current Department policies and procedures regarding the intake, screening, and classification of arrestees entering jail facilities to determine whether existing standards are sufficient to identify physical and/or mental-health-related issues and whether these policies and procedures are consistent with best practices.
  3. Develop a codified review and adjudication process for all In-Custody Deaths.