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

IN-CUSTODY DEATH – 040-21

Division	Date	Duty-On (X) Off ( )	Uniform-Yes (X) No ()
Van Nuys	7/24/21		

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

Not applicable.

Reason for Police Contact

On Saturday, July 24, 2021, at approximately 1427 hours, during a wellness inspection of an inmate at Valley Jail Section (VJS), detention officers (DOs) discovered an inmate in medical distress. Despite lifesaving efforts, the inmate was pronounced dead by the Los Angeles Fire Department (LAFD).

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

Female, 29 years of age.

Board of Police Commissioners' Review

This is a brief summary designed only to enumerate salient points regarding this In-Custody Death (ICD) 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 (FID) 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, including any Minority Opinions; the report and recommendations of the Chief of Police; and the report and recommendations of the Office 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 June 28, 2022.

Incident Summary

On Friday, July 23, 2021, at approximately 1400 hours, Police Officers A and B responded to a radio call at a convenience store.

Upon arrival to the location, Officers A and B met with the clerk at the store and determined a female committed a felony robbery and fled the location. While canvassing the area for the Subject, Officers A and B located a female matching the Subject's description sitting on a sidewalk just north of the store.

According to Officer A's Body-Worn Video (BWV), at 1428 hours, Officers A and B detained the Subject without incident. Officer B handcuffed the Subject and conducted a pat-down frisk search for weapons. Officer B did not locate any weapons or contraband concealed on the Subject's person.

According to Officer A's BWV, at 1446 hours, uniformed Officers C and D arrived at scene and assisted with the investigation. Officers determined there was probable cause to arrest the Subject for robbery and transported her to the North Hollywood station.

Upon arrival to the station, the Subject was screened by Sergeant A. During the intake questioning, the Subject informed Sergeant A that she was, *"dehydrated,"* and, *"thirsty."* The Subject also stated her *"stomach kind of hurts."* Sergeant A indicated Subject's responses to his/her questions in the comments portion of the Adult Detention Log.

According to Officer B's BWV, at 1515 hours, Officer B inspected temporary holding Tank No. 1 for contraband and advised Officer A, *"Tank one's clear."* Both officers escorted the Subject into Tank No. 1 and removed her handcuffs. The Subject repeated to the officers that she was, *"dehydrated,"* and stated, *"I need a nurse."*

According to Officer B, during the medical screening questionnaire, he/she informed the Subject she would be examined by medical staff at Valley Jail Section (VJS). The Subject indicated that she did not require immediate medical attention.

Officer B inspected both of the Subject's shoes and later provided her with a cup of water.

While at North Hollywood station, Officers A and B conducted a criminal history inquiry on the Subject, which revealed she had 13 prior narcotics-related arrests. Officers A and B completed an LAPD Booking Approval Report and presented it to Sergeant A.

Under the advisement of Detective A, Sergeant A authorized the Subject to be booked for California Penal Code section 211, Robbery. Due to the Subject's extensive narcotics arrest history, Sergeant A authorized strip and visual body-cavity searches to be conducted on the Subject.

At 1635 hours, Officers A and B activated their BWVs and re-entered Tank No. 1. Officer B handcuffed the Subject without incident and escorted her to their patrol vehicle. The Subject was transported to VJS for booking.

According to Officer B's BWV, at 1652 hours, Officers A and B arrived at VJS with the Subject and escorted her into the facility without incident. Both officers deactivated their BWV.

At 1654 hours, Officers A and B escorted the Subject into the VJS 100-Block, female housing area where the Subject was checked in by Custody Services Division (CSD), Detention Officers (DOs) A and B. Officers A, B, and DO A, escorted the Subject to Cell No. 109C, where strip and visual body-cavity searches were conducted.

At 1657 hours, Officers A and B conducted strip and visual body-cavity searches on the Subject. DO A was present during the entirety of both searches and assisted Officers A and B with inspecting portions of the Subject's clothing.

According to Officer B, during the searches, he/she requested the Subject's clothing, one article at a time. Officer B inspected the fabric, the seams, and the pockets of each article of clothing and verified no contraband was present.

After the Subject removed all of her clothing, Officer B directed her to turn around and separate her feet. Officer B directed the Subject to squat down and cough three times. Officer B directed the Subject to stand up and to bend over at the waist. Officers A and B visually inspected the Subject's rectal and vaginal cavities.

According to Officer A, the Subject bent over, and coughed. Officer B directed the Subject to turn around and inspected the inside of her mouth.

At the conclusion of the searches, the Subject put her clothing on and was handcuffed. No contraband was discovered and the Subject fully cooperated throughout the search process.

At 1703 hours, Officers A and B escorted the Subject to the dispensary where she was examined by CSD, Doctor (Dr.) A.

According to Dr. A, he/she examined the Subject and as a result of the examination placed her into a sobering cell. At 1735 hours, after Dr. A had completed the examination, the Subject was booked by Officers A and B for the robbery charge. Officers A and B returned to North Hollywood station where they completed the arrest report.

The Subject was photographed and fingerprinted by CSD personnel. At 1819 hours, the Subject was escorted to segregated Cell No. 109A.

An LAPD Sobering Cell Inmate Welfare Form was placed on the window outside the Subject's cell. Over the course of the next 5½ hours, various DOs conducted the required Title 15 wellness inspections on the Subject every 30 minutes. The DOs documented each inspection on the handwritten Sobering Cell Inmate Welfare Form.

In addition to the Sobering Cell Inmate Welfare Form, the DOs used the required Guardian Radio Frequency Identification System (RFID) and digitally recorded each wellness inspection.

At approximately 1830 hours, CSD, DOs C and D reported for duty and assumed responsibility over the 100-Block, Female Security.

Over the next 12 hours, DOs C and D were assigned to the Female Security area. DOs C and D continued the sobering cell protocol and conducted 30-minute wellness inspections on the Subject. DOs C and D recorded the inspections using the handwritten Sobering Cell Inmate Welfare Form and the RFID System.

At approximately 2304 hours, DOs C and D along with Senior Detention Officer (SDO) A, escorted the Subject to the dispensary where she was examined and cleared from the sobering cell protocols by CSD Registered Nurse (RN) A. The Subject was escorted back to Cell No. 109A. DOs C and D continued to conduct the required wellness inspections**.**

On July 24, 2021, at 0459 hours, DO D conducted the 0500 hours wellness inspection on the Subject. Approximately three minutes after DO D left the Subject's cell, the Subject used the toilet.

Approximately 18 minutes after the Subject used the toilet, the Subject sat on the bed and appeared to be manipulating a small, light-colored object. The Subject dropped and picked up the object multiple times as she appeared to be falling asleep. At 0534 hours, the Subject appeared to hold the object up to her nose, possibly ingesting a substance.

Approximately 21 seconds later, Subject leaned forward and appeared to fall asleep for approximately 18½ minutes.

At approximately 0552 hours, the Subject sat up and the light-colored object was visible, sitting on the bed. Moments later, the Subject leaned forward and once again appeared to fall asleep.

Approximately 30 seconds later, the light-colored object fell onto the floor. The Subject picked the object up and laid down on the bed, underneath the blanket.

On July 24, 2021, at 0630 hours, DOs E and F reported for duty and assumed responsibility over the 100-Block, Female Security. The Subject was still being housed

alone in Cell No. 109A, while nine additional female inmates were housed in the various cells throughout the 100-Block at the time.

According to DO E, a DO assigned to 100-Block, Female Security, is responsible for an inmate's overall well-being -- providing meals, showers, access to telephone calls, and other things an inmate may need.

Also according to DO E, during every mandated 30-minute wellness inspection, he/she always ensured each inmate was alive and breathing. If an inmate was asleep during an inspection, while outside the cell, DO E would look to see if the inmate's chest was rising, using a flashlight when necessary. On occasions where DO E is unable to see an inmate's chest rise and fall, he/she would enter the cell and wake up the inmate to verify their condition.

According to DO F, at the start of their watch, he/she met with the departing DOs and was briefed on each inmate. DO F was advised that the Subject was previously sobering from the night before and slept most of the night.

At 0701 hours, DO F conducted his/her first Title 15 wellness inspection of the 100-Block. According to DO F, during that first inspection, he/ she discovered that the Subject was sleeping. DO F woke the Subject up and verified her wellness.

According to the surveillance video, as DO F made contact with the Subject, she sat up, with her left hand placed against the mattress and her right arm underneath the blanket. The Subject appeared to move her right arm behind her back toward her lower body.

DO F recognized the Subject from previous encounters with her while she was detained at VJS.

According to DO E, at approximately 1230 hours, while feeding the Subject lunch, she asked for a second serving of food. The Subject never mentioned she wasn't feeling well. DO E brought her a second meal.

At 1251 hours, the Subject was seated on the jail cell bed inside Cell No. 109A, when she reached into the front of her pants with her left hand. At 1300 and 1331 hours, DO E conducted the Title 15 wellness inspections. The compliance monitor report for both inspections indicated, "*Well-being Check Inmate and Cell OK."*

At 1333 hours, three minutes after DO E conducted a wellness inspection, while seated on the bed, the Subject appeared to unwrap a small object and placed the contents onto the back of her left hand. The Subject held the back of her left hand up to her nose as she appeared to be holding her right nostril closed.

The Subject appeared to be ingesting the substance she placed on her hand. She proceeded to repeatedly wipe her nose. The Subject momentarily manipulated the object before she appeared to conceal it inside the back of her pants with her left hand.

Over the course of the next 12 minutes, the Subject's head began to nod up and down as if she was falling asleep. At 1345 hours, the Subject stopped moving while in a seated position, with both of her legs crossed in front and her upper body leaning forward.

At 1358 hours, DO F conducted a wellness check on the Subject. While standing at the cell window for 13 seconds, DO F banged on the glass window three times and shined his/her flashlight on the Subject. The surveillance video captured the Subject's upper body making slight movements up and down approximately five times while DO F stood at the window.

DO F observed the Subject's forehead touching her feet and heard what he/she believed to be the Subject snoring. DO F advised FID investigators that the Subject was breathing at the time of this wellness inspection.

At 1405 hours, DO F accompanied RN B to the Subject's cell during his/her routine medical rounds. While standing with RN B, DO F recalled hearing the Subject make a sound.

According to RN B, he/she walked up to the Subject's cell and noted that she was sitting funny and snoring. RN B asked the Subject if she needed any help. When the Subject didn't respond, RN B believed the Subject was asleep and walked away. That was the only contact RN B had with the Subject prior to her being found in medical distress.

Twenty minutes later, at 1425 hours, DO E conducted a Title 15 wellness inspection. According to DO E, when he/she initially approached the cell, he/she observed the Subject seated on the bed leaning forward. DO E could not see the Subject's chest rising. DO E used his/her flashlight to help take a closer look.

DO E shined his/her flashlight on the Subject and banged on the window with the flashlight several times. DO E changed positions and shined his/her flashlight on the Subject through an opening in the cell door. DO E moved back to the window, shined his/her flashlight on the Subject, and banged on the window several more times.

DO F responded to the Subject's cell and shined a flashlight on the Subject through the cell window.

At 1427 hours, DO E unlocked the Subject's cell and entered. DO E raised the Subject's torso off her legs and placed her on her left side. According to DO E, while doing so, he/she heard the Subject let out a single gasp of air as the Subject rolled onto her back. DO E observed the Subject's eyes were closed and her lips were purple.

At 1428 hours, DO E used his/her police radio and requested additional officers to Cell No. 109A over the VJS radio frequency.

Simultaneously, at 1428 hours, DO F pushed the emergency button outside of the Subject's cell, sounding an alarm throughout the facility, alerting additional DOs to respond.

DO E moved the Subject onto the cell floor and began chest compressions as SDO B and several additional DOs arrived at the cell.

At 1429 hours, Dr. A, Nurse B and RN C arrived at the Subject's cell. Over the next 13-minutes, CSD staff performed life-saving measures.

According to Communications Division (CD) records, at 1429:47 hours, VJS personnel requested an LAFD, Rescue Ambulance (RA) response over Van Nuys Base Frequency.

At 1442 hours an RA staffed by Firefighter (FF) Paramedics arrived at scene. Approximately 4 minutes later an LAFD Engine with additional paramedics arrived at scene. LAFD and CSD personnel worked together in an attempt to revive the Subject. The Subject failed to respond to medical treatment and was declared deceased at 1518 hours.

Force Investigation Division (FID) investigators conducted additional interviews of CSD and VJS personnel related to the In-Custody Death ICD of the Subject.

FID investigators interviewed DO A. As indicated in the FID report, on July 23, 2021, DO A was on-duty assigned to the VJS, 100-Block, female housing area, when the Subject was brought into his/her assigned area by two LAPD officers.

DO A accompanied the officers as they escorted the Subject to Cell No. 109C, where strip and visual body-cavity searches were conducted.

According to DO A, he/she has been a DO at VJS for almost five years and has performed strip and visual body-cavity searches. The procedure DO A has followed while conducting the searches was how he/she was taught early in his/ her career by his/her training officer.

According to DO A, due to an increase of contraband being smuggled into the jail system by arrestees, VJS has a standing practice requiring DOs to monitor all strip and visual body-cavity searches conducted on arrestees as they are brought into the jail.

DO A recalled being present during the entire July 23, 2021, strip and visual body-cavity searches conducted on the Subject by two LAPD officers. Based on DO A's training and experience, the search he/she witnessed conducted on the Subject was thorough, the Subject cooperated the entire time, and no contraband was recovered. According to DO A, if he/she had witnessed the officers conduct searches of the Subject that were not thorough, he/she would have said something to the officers.

FID investigators also interviewed DO D. DO D and his/her partner, DO C, reported for duty on July 23, 2021, at 1830 hours. From 1830 hours through 0630 hours, DOs C and D were assigned to the VJS, 100-Block, female housing area where the Subject was being detained.

DO D has been a DO assigned at VJS for approximately eight years. According to DO D, a DO is responsible for booking arrestees and maintaining an inmate's well-being, which includes 30-minute safety checks.

DO D's understanding of Jail Division policy as it related to the monitoring of the CCTV system was supplemental to wellness inspections. Supplemental means that it helps the DOs view the arrestees aside from the normal safety checks and someone should always be monitoring the CCTV system. According to DO D, when they are unable to monitor the system, the normal practice is to call a third DO to conduct the monitoring.

When FID investigators asked DO D if he/she and DO C ensured the CCTV system was always monitored during their 1830 hours through 0630 hours shift, DO D recalled one instance when he/she and DO C, along with SDO A, left the block to escort the Subject to the dispensary. DO D could not recall if arrangements were made for a third DO to monitor the system.

Based on a review of the 49 minutes of video during DO C and D's 12-hour shift, FID investigators determined a fourth DO was in the office with the CCTV monitor while the Subject was escorted back and forth from the dispensary. However, there were several other times when DOs C and D were outside of the office and the video did not depict a third DO enter the room.

DO D recalled that when he/she reported for duty on July 23, 2021, he/she was provided information regarding all the female arrestees in custody. DO D specifically recalled being advised that the Subject was segregated in Cell No. 109A because her behavior was unpredictable and she was under assessment. DO D explained an assessment meant the DOs were required to wake up the Subject every 30 minutes during their safety checks to verify her well-being.

According to DO D, at some point during her shift, the Subject was cleared from sobering status protocol.

DO D recalled that the following morning, on July 24, 2021, at 0630 hours, he/she and DO C were relieved by DOs E and F. DO D recalled, during the information exchange, he/she advised DOs E and F that the Subject was up and down and making awkward movements.

According to DO D, all the required Title 15 safety checks were completed every 30 minutes, and the Subject was always found to be alive and breathing. DO D never observed the Subject in possession of contraband, moving in a suspicious manner, or in medical distress.

FID investigators interviewed DO C. According to DO C, he/she has been a DO for 21 years. DO C has been assigned to VJS his/her entire career.

According to DO C, a DO is responsible for completing safety checks every 30 minutes. If an inmate is under sobering protocol, the DOs are required to wake the inmate up every 30 minutes. DO C stated his/her primary duty is to check on the inmates.

Regarding Jail Division policy, according to DO C, DOs are always required to monitor the CCTV. If one DO is doing safety checks, the other DO is supposed to be in the room, monitoring the CCTV.

If there was a situation where both DOs were unable to monitor the CCTV, they are required to get a third DO to come to their monitoring room or have someone view the CCTV from another part of the jail.

DO C could not recall an instance when the CCTV was not monitored. According to DO C, his/her memory of the Subject was limited, but he/she recalled that the Subject was under sobering protocol when he/she began her shift at 1830 hours. Sometime during her shift, DOs C, D, and an unknown SDO brought the Subject to the dispensary where she was cleared from sobering protocol.

At one point, DO C recalled seeing the Subject standing in Cell No. 109A, leaning against the wall, starring at the ceiling.

If DO C had ever noticed the Subject in medical distress, he/she would have pushed the emergency alarm and called for assistance over the radio. If DO C had observed the Subject in possession of contraband, he/she would have brought the Subject out of the cell and asked her to turn it over. If the Subject had refused, with the approval of a supervisor, a strip search would have been conducted. The Subject would have then been brought to the dispensary if any substance was swallowed.

The Subject cooperated the entire time while in custody. DO C never observed a change in her behavior. Nothing significant about the Subject stood out to DO C.

FID investigators conducted a re-interview of DOs E and F, regarding Jail Division policy related to the CCTV monitoring system.

According to DO F, a DO is responsible for monitoring the system while the inmate safety checks are being conducted.

According to DO F, at the time of the ICD, it was the practice at VJS, if a DO was inside their assigned cell block, they weren't required to always monitor the CCTV system. During the July 24, 2021 shift, the 100-Block female security area, CCTV system wasn't always monitored. DO F believed it was not feasible due to personnel staffing shortages and having to complete the various administrative duties. According to DO F,

he/she would stay within the cell block, this way he/she would not have to request assistance.

Since this ICD, changes have been made. When the safety checks are being conducted and one of the two DOs can't monitor the CCTV cameras, they call to have someone do it for them. DO F now ensures the CCTV is always being monitored.

According to DO E, his/her understanding of Jail Division policy is that, as the Title 15 safety checks are being conducted, one DO is supposed to monitor the CCTV system while another DO conducts the inmate safety checks. DO E believed the directive to continuously monitor the CCTV system was not mandatory.

DO E initially informed FID investigators on the day of the ICD that the CCTV system was being monitored in accordance with policy. However, DO E later clarified that the Divisional Order was followed when they could, but there were times when they could not comply with the provisions.

As it related to the ICD of the Subject, DO E could not recall specific instances when the CCTV system was not monitored except for when he/she first discovered the Subject in medical distress. DO E requested DO F to the cell before any request to have a third DO monitor the system.

DO E stated sometimes monitoring the CCTV system is not feasible and provided FID investigators the example; if an inmate is injured, one DO needs to complete a report as the other is still required to conduct the safety checks. According to DO E, since the ICD of the Subject, procedural changes have been made. Whenever the assigned DOs are unable to monitor the CCTV system, they issue a request over the radio for a third DO in the Watch Commander's office or release desk to monitor the system for them.

As indicated in the FID report, according to CD records, at 1429:47 hours, VJS personnel requested an LAFD RA respond to the scene. FID investigators determined the request was made by DO B.

BWV and DICVS Policy Compliance

NAME	TIMELY BWV ACTIVATION	FULL 2-MINUTE BUFFER	BWV RECORDING OF ENTIRE INCIDENT	TIMELY DICVS ACTIVATION	DICVS RECORDING OF ENTIRE INCIDENT
Officer A	No	Yes	Yes	Yes	Yes
Officer B	No	Yes	Yes	Yes	Yes

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 cases of ICDs, the BOPC makes specific findings in these areas: Tactics of the involved officer(s); Inmate Intake Procedures by

any involved officer(s); Inmate Welfare Procedures by any involved officer(s); Inmate Welfare Procedures by any involved officer(s); Inmate Emergency Medical Procedures by any involved officer(s); and Post In-Custody Death Procedures by any involved officer(s). Based on the BOPC's review of the instant case, the BOPC made the following findings:

A. Tactics

The BOPC found Officers A and B, DOs A, C, D, E, and F, SDO B, Sergeant A, and Captain A's tactics to warrant a Tactical Debrief.

B. Inmate Intake Procedures

The BOPC found Officers A and B, DO A, and Sergeant A's inmate intake procedures to be Consistent with Established Criteria.

C. Inmate Welfare Procedures

The BOPC found DOs C, D, E, and F's inmate welfare procedures to be Not Consistent with Established Criteria.

D. Inmate Medical Emergency Procedures

The BOPC found DOs E and F and SDO B's inmate emergency medical procedures to be Consistent with Established Criteria.

E. Post In-Custody Death Procedures

The BOPC found Captain A's post in-custody death procedures to be Consistent with Established Criteria.

Basis for Findings

Adjudication Area No. 1 Inmate Intake Procedures

Custody Transfer Communication

Following her arrest for robbery, the Subject was booked into custody at VJS. The booking process involved verbal and nonverbal communications between Officers A and B, and CSD personnel. After the booking process was completed, the Subject was transferred to the custody of CSD personnel.

The BOPC noted that documents associated with the Subject's booking were completed by Officers A and B and approved by CSD officers and supervisors. The BOPC also noted that surveillance video depicted Officers A and B communicating with CSD personnel during the booking process. The BOPC further noted that the Subject was

placed on sobering assessment and medical segregation, indicating that her physical condition was relayed to VJS personnel.

Booking Process

Due to the Subject's history of narcotics-related arrests, Sergeant A authorized strip and visual body-cavity searches to be conducted at VJS. Arriving at VJS, Officers A and B escorted the Subject into a strip search room. DO A assisted Officers A and B during the strip and visual body-cavity searches. The Subject was cooperative, and the searches were negative for weapons and/or contraband. After booking the Subject into custody, Officers A and B left VJS.

The BOPC noted that per Department policy, an arrestee shall not be given a strip search or visual body-cavity search unless the arrest involved a controlled substance, or there is a reasonable and articulable suspicion that the arrestee is concealing contraband or weapons. The BOPC also noted that in determining whether to conduct a strip search or visual body-cavity search, employees should consider the totality of the circumstances (e.g., the nature of the offense, the arrestee displaying behavior which would lead officers to believe that he/she is concealing contraband or weapons, the arrestee's criminal record, etc.). Here, the Subject was arrested for robbery, not a narcotics-related offense. However, the Subject's criminal history reflected 13 arrests for narcotics-related offenses. Based on the Subject's criminal history, Officers A and B requested strip and visual cavity searches. Based on the same information, Sergeant A approved the searches. The BOPC opined that Officers A and B's request to conduct strip and visual body-cavity searches was appropriate and Sergeant A's approval of their request conformed to Department policy.

In terms of executing the searches, the BOPC noted that while Department policy defines a strip search, it does not dictate the sequence of the search. As indicated above, a strip search is any search wherein an arrestee is required to remove all articles of clothing, or to remove or arrange some clothing, so as to permit a visual inspection of the underclothing, breasts, buttocks, or genitalia of that arrestee. A visual body-cavity search is any search wherein an unclothed arrestee is required to bend at the waist, squat, or to lift or spread the breasts, buttocks, or genitalia to allow visual inspection of the body cavities. During their interviews, Officers A, B, and DO A all described having the Subject disrobe and maneuver in a manner that allowed them to visually inspect her body cavities for contraband. According to DO A, based on his/ her training and experience, the searches were thorough, and all three confirmed the searches were negative for contraband. Based on their statements and the surveillance video footage of the hallway outside the strip search room, the BOPC concluded that Officers A, B and DO A performed thorough strip and visual body-cavity searches.

As it pertains to the efficacy of the searches, the BOPC noted the limitations of strip and visual body-cavity searches. During the visual body-cavity search, Officer B had the Subject squat down and cough while he/she observed the Subject's anus and genitalia. This portion of the search is designed to reveal items secreted in the rectal and vaginal

cavities. However, depending on an item's size, shape, weight, texture, and/or location within these cavities, it is possible it may remain undetected. As such, the BOPC opined that based on the scope of the authorized searches, an item such as the one described in the FID investigation could have gone undetected despite the officers' efforts.

In terms of the requirement that officers remain with an arrestee, the BOPC noted that Officers A and B accompanied the Subject through the entire booking process and medical treatment. Based on the totality of the circumstances, the BOPC opined that Officers A, B, and DO A followed established protocols for the booking process.

Juvenile Booking Procedures

As the Subject was an adult at the time of this incident, Juvenile Booking Procedures are not applicable.

Medical Screening and Classification/Segregation

The Subject was seen by Dr. A, Medical Services Division (MSD), at the jail dispensary for pre-booking medical clearance. According to Dr. A, he/she knew that the Subject had admitted to using methamphetamine before her arrest. Dr. A noted the Subject's "extremely anxious and "bizarre" behavior and her elevated blood pressure and pulse. Based on his/her evaluation, Dr. A provided the Subject with one milligram of Lorazepam and placed her on sobering assessment and medical segregation. The associated paperwork was completed by RN D.

The BOPC noted that the Subject was evaluated and medically screened by Dr. A. Based on his/her evaluation, Dr. A placed the Subject on sobering assessment and medical segregation. The Inmate Classification Assessment Form, Part C - Record of Medical Screening, was completed and signed by RN D. Part C had the Subject marked as "yes" for under the influence of drugs and/or alcohol, sobering cell, history of substance abuse, and mental illness, and a disposition of okay to book.

The BOPC noted that per CSD protocols, the booking officer either approves or denies the recommended classification and segregation by MSD staff. A CSD supervisor then reviews and signs the Inmate Classification Assessment Form. Here, the Inmate Classification Assessment Form, Parts A, B, and D, were completed by the booking officer, DO G; Subject's Housing Classification, Part D, was classified as "Sobering." VJS supervisor, SDO C, then reviewed and signed the form. SDO C approved the Classification and Segregation in Part D. While DO G and SDO C were not considered substantially-involved personnel and MSD staff are not subject to findings, the BOPC opined that the Subject's classification and segregation were appropriate and consistent with established criteria.

Suicide Prevention

The BOPC noted that nothing in the investigation indicated that the Subject expressed or displayed suicidal ideations. Additionally, the Los Angeles County Coroner's Officer determined that the Subject's death was accidental.

Based on the totality of the circumstances, the BOPC determined that the inmate intake procedures applied by Sergeant A, Officers A and B, and DO A were consistent with established criteria.

Adjudication Area No. 2 Inmate Welfare Procedures

Safety Checks and Dispensary Visits

From 1730 hours to approximately 2300 hours, the Subject was on sobering assessment. During that time, CSD personnel completed the Sobering Assessment Form and conducted sobering checks on the Subject. At approximately 2300 hours, DOs C, D, and SDO A escorted the Subject to the dispensary. The Subject was re-evaluated and cleared from sobering assessment protocols by RN A. CSD personnel continued to conduct regular safety checks on the Subject until the point she was found unresponsive in her cell.

The BOPC noted that the Subject was placed on sobering assessment and medical segregation. During that time, CSD personnel conducted safety checks no less than every 30 minutes, logging the time the check was completed and whether the Subject provided a verbal and/or physical response. Per the form, the Subject was awake during each check. The form also indicated that at one point, the Subject was eating an apple, indicating her nutritional needs were addressed. CSD personnel also ensured that the Subject was re-evaluated within six hours of her initial assessment, at which point she was cleared from sobering assessment protocols by RN A. While the DOs did not indicate both their name and serial number in each box, the BOPC opined that the space provided was too small to indicate both legibly.

The BOPC noted that after the Subject was re-evaluated and cleared from sobering assessment protocols, CSD personnel continued to conduct regular safety checks. Per FID investigators, surveillance video footage indicated that the safety checks occurred approximately every 30 minutes, until the Subject was found unresponsive.

The BOPC noted that per the FID investigation, at 1345 hours, the Subject stopped moving while in a seated position, with both of her legs crossed in front and her upper body leaning forward. The Subject remained in this position until approximately 1427 hours, when DO E raised her torso off her legs. The BOPC also noted that between 1345 hours and 1427 hours, the required safety checks were performed as follows. At 1358 hours, DO F conducted a safety check on the Subject. While standing at the cell window for 13 seconds, DO F banged on the glass window three times and shined his/her flashlight on the Subject. The surveillance video captured the Subject's upper body

making slight movements up and down approximately five times while DO F stood at the window. According to DO F, the Subject was breathing at the time of this wellness inspection.

At 1405 hours, DO F accompanied RN B to the Subject's cell during sick call. According to RN B, he/she noticed that the Subject was snoring and sitting cross-legged with her torso hunched forward. RN B also noticed that the Subject's chest was moving. RN B asked the Subject if she needed any help; the Subject did not respond. RN B opined that the Subject was asleep.

At 1425 hours, DO E conducted a safety check. It was during this check that the Subject was found unresponsive.

While the BOPC discussed the possibility of re-evaluating the standards for conducting safety checks, the BOPC opined that the safety checks were consistent with established protocols.

Pill Call / Sick Call

As stated above, at 1405 hours, DO F accompanied RN B to the Subject's cell during sick call. According to RN B, he/she noticed that the Subject was snoring and sitting cross-legged with her torso hunched forward. RN B also noticed that the Subject's chest was moving. RN B asked the Subject if she needed any help; the Subject did not respond. RN B opined that the Subject was asleep.

The BOPC noted that on July 24, 2021, RN B conducted the required sick call. The BOPC also noted that as required, DO F escorted RN B. While CSD personnel did not ask to verify the Subject's wrist band, she was not provided medication at that point. The BOPC noted that during the sick call, the Subject did not respond to RN B's question. The BOPC also noted that according to RN B, the Subject was breathing. Based on his/her observations, RN B opined that the Subject was sleeping.

Cameras and Monitoring

Captain A advised that per Jail Division policy, he/she expected that the CCTV monitoring room was always staffed by at least one CSD officer who was responsible for the regular monitoring of cell cameras. The room was described as an 8-foot by 16-foot room with a large flat screen television mounted to the wall, used by DOs to monitor the surveillance cameras in the jail's female block. While there was a total of 15 cameras in the jail's female block, DOs could set the television to monitor up to 30 cameras throughout VJS. As the number of cameras increased, however, the size of the corresponding picture decreased. It is unknown how many cameras were being displayed on that television during the time of this incident.

During their investigation, FID investigators reviewed surveillance camera footage from inside the female housing area at VJS. Based on their review, investigators determined

there were multiple times during safety checks that DOs C, D, E, and F left the CCTV room unattended. FID investigators also interviewed DOs C, D, E, and F regarding their understanding of the camera monitoring policies and practices. According to DO D, someone should always be monitoring the CCTV system. When DOs were unable to monitor the room, the practice was to call a third DO to monitor the room. DO D recalled one instance when he/she and DO C, along with SDO A, escorted the Subject to the dispensary. DO D could not recall if arrangements were made for a third DO to monitor the system at that time.

According to DO C, DOs were required to always monitor the room. If one DO was doing safety checks, the other DO was supposed to be in the room. If there was a situation where both DOs were unable to monitor the room, they were required to get a third DO to monitor the room or have someone access the cameras from another part of the jail. DO C could not recall an instance when the room was not monitored.

According to DO F, at the time of this incident, it was the practice at VJS that if a DO was inside their assigned cell block, they were not required to always monitor the CCTV system. Due to personnel staffing shortages and having to complete the various administrative duties, DO F did not believe it was feasible to always monitor the room. However, since this incident, when DOs cannot monitor the CCTV cameras, they must call someone to do it for them.

According to DO E, his/her understanding of policy at the time of this incident was that as safety checks were being conducted, one DO was supposed to monitor the CCTV system while another DO conducted the checks. However, DO E believed the directive to continuously monitor the CCTV system was not a "shall," rather it was done when feasible based on staffing.

Based on FID's investigation, the BOPC opined that DOs C, D, E, and F did not adhere to established criteria as outlined in Jail Division policy regarding CCTV monitoring. The BOPC did note that Captain A had taken measures, including several visits to VJS, to ensure that CSD personnel understood his/her expectations and the importance of always staffing the CCTV room and actively monitoring the surveillance cameras. This was also a topic at CSD roll calls.

The BOPC discussed the potential conflict between Divisional Order No. 5 and Section 250 of the Jail Operations Manual, specifically, as it pertains to the monitoring of surveillance cameras. While the Jail Operations Manual refers to the cameras as a supplement to physical safety checks, Divisional Order No. 5 mandates that the CCTV room is always staffed. The BOPC discussed challenges to maintain the mandated staffing of the CCTV room due to staffing shortages. The BOPC discussed the need to reiterate the expectation that the CCTV room is always staffed and that the surveillance cameras are actively monitored as outlined in Divisional Order No. 5, given the role they play in jail safety, specifically suicide prevention.

Based on the totality of the circumstances, the BOPC determined that the inmate welfare procedures employed by DOs C, D, E, and F were not consistent with established criteria

Adjudication Area No. 3 Inmate Emergency Medical Procedures

Cell Entry and Notification

At 1425 hours, DO E conducted a safety check on the Subject. DO E observed her seated on the bed leaning forward. According to DO E, he/she could not determine the Subject's wellbeing. In response, he/she asked DO F for assistance entering the cell. At 1427 hours, DOs E and F entered the Subject's cell. Unable to wake the Subject, DO E raised her torso off her legs and placed her on her left side. According to DO E, while doing so, he/she heard the Subject let out a single gasp of air as she rolled back. DO E observed that the Subject's eyes were closed and her lips were purple. At 1428 hours, DO E used his/her handheld radio to broadcast a Code Blue call (inmate down, possible death), summoning additional officers and medical staff. Simultaneously, DO F used the push-button alarm in the hallway to also alert others of the medical emergency.

The BOPC noted that when DO E was unable to determine the Subject's wellbeing, he/she requested DO F to join him/her before entering the cell. Within approximately 15 seconds of being summoned, DO F arrived at the Subject's cell. Within approximately 45 seconds of DO F's arrival, they entered the cell. The BOPC noted that while policy allows a solo officer to enter a cell, it is not required. Rather, the emphasis is on officer safety, balancing the nature of the emergency, the condition/behavior of the occupant, the type of aid the officer can render, and the necessity to enter the cell. Based on the totality of the circumstances, the BOPC opined that this was not a situation that warranted DO E entering the cell alone. The BOPC further opined that it was prudent for him/her to wait for Officer F before entering the cell.

The BOPC noted that after entering the cell, DO E tried to wake the Subject. Unable to wake her, DO E raised the Subject's torso. Observing that the Subject's eyes were closed and her lips were purple, DO E used his/her handheld radio to broadcast a Code Blue call, summoning additional officers and medical staff. DO E broadcast the Code Blue call within 25 seconds of entering Subject's cell. The BOPC noted that simultaneously, DO F used the push-button alarm in the hallway as a backup to Officer E's broadcast.

Medical Assistance and Rescue Ambulance Request

Discovering the Subject in medical distress, DO E moved her onto the cell floor and initiated cardiopulmonary resuscitation (CPR). At approximately 1429 hours, SDO B, Dr. A, and RNs B and C arrived at the Subject's cell. Using his/her handheld police radio, SDO B requested an RA. Over the next 13 minutes, CSD and MSD staff performed life-saving measures.

At 1442 hours, an LAFD RA staffed by paramedics arrived at the scene. Approximately four minutes later, an LAFD Engine arrived at the scene. LAFD and CSD personnel worked together to attempt to revive the Subject. The Subject failed to respond to medical treatment and was declared deceased at 1518 hours.

The BOPC noted that within approximately 30 seconds of entering the Subject's cell, DO E began moving the Subject to the floor. Within approximately 40 seconds, DO E initiated CPR. DO E was soon joined by CSD and MSD personnel. DO E continued CPR until he/she was relieved by Dr. A. Various personnel, including SDO B, also assisted with CPR. The BOPC noted that during his/her interview with FID, Dr. A described SDO E's chest compressions as "high quality." The BOPC opined that the aid rendered by SDO E was consistent with his/her first aid training.

The BOPC noted that according to CD records, an RA was requested for the Subject at 1429:47 hours. According to the records, CD was advised that the Subject was not conscious or breathing. FID investigators confirmed that SDO B requested the RA and advised CD that the Subject was not conscious or breathing.

Based on the totality of the circumstances the BOPC determined that the inmate emergency medical procedures employed by DOs E, F, and SDO B, were consistent with established criteria.

Adjudication Area No. 4 Post Custody Death Procedures

Notifications and Title 15, 30-Day Review

Within two minutes of the Code Blue call, Principal Detention Officer (PDO) A had contacted Captain A, advising him/her of this incident. At 1518 hours, after learning that the Subject was deceased, Captain A notified the Department Operations Center (DOC) of the ICD. On August 9, 2021, Captain A conducted a State-mandated Title 15, 30-Day Review of this incident.

The BOPC noted that according to the FID investigation, Captain A notified the DOC of the IC within one minute of the Subject being pronounced deceased. The BOPC also noted that on August 9, 2021, Captain A completed the State-mandated Title 15, 30-Day Review of this incident. While the review involved MSD administrative staff members, the BOPC would have liked Dr. A and RNs A, B, C, and D to have been involved in the review process as well. The BOPC acknowledged that MSD is overseen by the City's Personnel Department, not the LAPD.

Based on the totality of the circumstances, the BOPC determined that the post in-custody death procedures employed by Capitan A were consistent with established criteria.

These topics were to be discussed at the Tactical Debrief.

Additional Tactical Debrief Topics

- **Search Incident to Arrest -** Detaining the Subject, Officer B conducted a pat search of her person; no contraband or weapons were located. The Subject was wearing formfitting pants and a bra. Before transporting the Subject to North Hollywood CPS, Officer B removed the Subject's jewelry and placed it in a property bag. Officer B mistakenly believed he/she searched inside the Subject's pockets while at the scene; however, this was done at VJS.

- **Protocols Subsequent to a Categorical Use of Force -** After learning from a supervisor that the Subject had died while in custody, Officer A viewed his/her BWV of this incident. Officer A was not admonished to refrain from viewing his/ her BWV. According to Officer A, he/she viewed his/her BWV "in preparation for an interview." Officer A was interviewed by FID on August 19, 2021. Per Captain B, this issue of admonishing employees was addressed with his/her division's supervisors.

Command and Control

At approximately 1429 hours, SDO B arrived at the Subject's cell. He/she was the first supervisor to arrive at the scene. According to SDO B, he/she believed he/she was the IC. Using his/her handheld radio, SDO B requested an RA. Once it was determined that an ICD had occurred, several VJS supervisors responded to assist. The Female Block was cordoned off and preserved for FID investigators and the Los Angeles County Coroner's Office. The involved officers were separated and monitored until FID arrived at the scene.

The BOPC noted that when SDO B arrived at the scene, he/she did not verbally declare him/herself as the IC. However, the BOPC also noted that he/she was the only supervisor at the scene at that point. The BOPC further noted that, unlike patrol, CSD supervisors are predesignated as the IC at the start of their shift. This is done to prevent multiple supervisors from responding to an incident unless needed/requested. Therefore, the BOPC opined that there was no confusion amongst CSD personnel as to who was overseeing the incident.

The BOPC also noted that SDO B assisted with CPR. While the BOPC would have preferred that he/she had focused primarily on command and control, based on the nature of this incident, the BOPC did not find this to be a substantial deviation from Departmental training.

The BOPC determined that the overall actions of SDO B were consistent with Department training and expectations of supervisors during a critical incident.