This is a brief summary designed only to enumerate salient points regarding this 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 July 28, 2009.

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.

**Incident Summary**

On August 24, 2008, at approximately 3:25 p.m., uniformed police officers received a radio call of, “Purse snatch, suspect there now,” and responded to the scene. Upon their arrival, the officers were advised that Subject 1 had grabbed Victim 1’s purse while she was talking on her cellular telephone. Subject 1 was able to pull the purse away
from Victim 1 and flee on foot. The victim screamed for help and several witnesses were able to detain Subject 1 until the arrival of the officers.

The officers arrested Subject 1 without further incident and transported him to the police station. At 3:52 p.m., Subject 1 was subsequently presented to the watch commander. The watch commander asked Subject 1 the required screening questions from the Adult Detention Log. Subject 1’s responses to the questions were as follows:

"Do you understand why you were detained/arrested?" Yes.
"Are you sick, ill, or injured?" No.
"Do you have any questions or concerns?" No.

At 4:48 p.m., Detention Officer A (DO A) booked Subject 1 in the station jail. According to DO A, during the booking process, Subject 1 was yelling at the officers who arrested him and was upset about being arrested. According to DO A, Subject 1 was “tensing up” during the fingerprinting process.

**Note:** Question 14 of the Los Angeles County Unified Arrestee Medical Screening Form, under the Jailers Assessment section, asks, “Is the arrestee suicidal or does his/her behavior suggest a risk of suicide?” to which the response was marked as “No” by DO A. Subject 1 signed the form.

According to DO A, he did not feel comfortable placing Subject 1 in a cell occupied by other inmates because of the behavior Subject 1 had displayed earlier. DO A believed that Subject 1 might cause trouble with the other inmates and decided to place him in a cell by himself. At approximately 5:31 p.m., the booking process was completed and Subject 1 was placed into Cell No. 1. Subject 1 requested some food, which DO A provided. Subject 1 thanked DO A for the food and appeared to be adjusting to his confinement.

**Note:** Documented on the Inmate Classification Questionnaire completed by DO A, “General” was marked under the “Housing Classification” section indicating that it was okay for the Subject 1 to be placed in a cell with other inmates.

**Note:** Cell No. 1 measured approximately 50 square feet and contained two bunks for a maximum capacity of two arrestees.

At 6:00 p.m. and again at 6:30 p.m., DO B conducted a jail inspection of Cell No. 1 and observed Subject 1 awake. DO B documented the time he conducted the inspections on the Jail Inspection Record.

**Note:** Jail personnel are required to conduct welfare checks on all the inmates every 30 minutes and document the time of the inspection, the number of inmates in the cell, and any unusual behavior.
At approximately 6:40 p.m., DO C walked by Cell No. 1 and observed Subject 1 lying down in the bottom bunk. According to DO C, he did not document the time of his inspection on the Jail Inspection Record since he considered it to be an informal inspection and indicated that the next required inspection would be documented at approximately 7:00 p.m.

According to DO D, he conducted jail inspections at 7:00 p.m., 7:35 p.m., and 7:55 p.m. DO D indicated that Subject 1 appeared to be sleeping during these inspections.

The Jail Inspection Record reflected DO B’s entry at 6:30 p.m. with his initials written next to it; however, the time had been overwritten. DO D indicated that he wrote over DO B’s entry when he attempted to make corrections to the log.

According to DO D, Day Watch personnel documented the inspection time that occurred at 5:31 p.m. one row lower than it should have appeared on the log. DO D attempted to correct the log by writing over some of the entries but decided to finish the corrections at the end of his watch. DO D did not have the opportunity to complete the corrections because of the in-custody death.

The Jail Inspection Record reflected five entries made by DO D at 7:30, 7:55, 8:25, 8:00, and 8:25 p.m. DO D indicated that the last two entries “shouldn’t be there and that was my mistake.” DO D also stated that the last inspection he recalled that he completed occurred at 7:55 p.m.

At approximately 8:25 p.m., a vocational worker entered the jail area to empty trash receptacles. At approximately 8:32 p.m., the vocational worker was emptying the trash receptacle outside Cell No. 1 when he observed Subject 1 on his bunk bed lying on his stomach with his head suspended by a “thick white thread” that was tied to the top bunk. The vocational worker observed that “slobber” was coming down Subject 1’s mouth and “his eyes were shut.” The vocational worker ran to the booking area of the jail and notified DOs C and D.

Note: The “thick white thread” was subsequently identified as a pair of white socks that belonged to Subject 1. The socks were tied together and opposite ends were tied to the top bunk, forming a U-shape.

DO C arrived at Cell No. 1, looked through the window, and observed Subject 1 lying face down with his neck resting on the suspended socks. DO C yelled, “Sir.” After receiving no response, DO C entered the cell and grabbed Subject 1 by his left shoulder. Subject 1 rolled off the bunk onto the floor, landing on his back. DO C checked Subject 1’s neck and wrist for a pulse but could not detect any.

DO D arrived at Cell No. 1 and observed Subject 1 lying on his back on the cell floor and DO C checking Subject 1 for a pulse. When he did not detect a pulse, DO C ran to the watch commander’s desk and advised Sergeants A and B that he had an arrestee who was down and appeared to have hanged himself.
Note: According to DO D, he verbally attempted to wake up Subject 1. When he did not receive a response, he conducted two to three chest compressions.

Sergeant B responded to Cell No. 1 and observed Subject 1 lying on his back. Sergeant B checked Subject 1’s neck for a pulse with negative results and utilized his flashlight to check Subject 1’s pupils and did not observe any reaction. Sergeant B returned to the watch commander’s office and advised Sergeant A that there was an arrestee down, unconscious, and not breathing. Sergeant B returned to Cell No. 1 to secure the scene.

At 8:38 p.m., a Rescue Ambulance (RA) was requested.

Note: A review of the Communications Division (CD) audio recording revealed that during the request for the RA, CD asked for Subject 1’s ailment and whether he was breathing. An unknown officer responded by saying, "He's breathing, but it's attempted asphyxiation."

Sergeants A and B indicated that they did not personally request the RA. Force Investigation Division’s attempts to identify the officer who made the broadcast were met with negative results.

At 8:44 p.m., Los Angeles Fire Department (LAFD) personnel arrived at the scene and assessed Subject 1 and declared Subject 1 dead.

Los Angeles Board of Police Commissioner’s Findings

In this situation, the BOPC determined that Subject 1’s detention and arrest were consistent with Department standards. It was established that there was no use of force involved in the detention, arrest, or transportation of Subject 1. Furthermore, the coroner’s report noted the cause of death was the result of hanging. A thorough review of these facts indicates that there was no correlation between the actions of Department personnel and the death of Subject 1.

Therefore, the BOPC concurred with the Use of Force Review Board assessment and their decision not to render findings for this incident.