COUNTY OF LOS ANGELES
OFFICE OF THE COUNTY COUNSEL

648 KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET
LOS ANGELES, CALIFORNIA 90012-2713

MARY C. WICKHAM
County Counsel

TELEPHONE
(213) 974-1609
FACSIMILE
(213) 626-2105
TDD
(213) 633-0901
E-MAIL
rgranbo@counsel.lacounty.gov

May 31, 2018

TO: CELIA ZAVALA
Acting Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: ROGER H. GRANBO
Senior Assistant County Counsel
Executive Office

RE: **Item for the Board of Supervisors' Agenda**
County Claims Board Recommendation
Brian O'Neal Pickett, et al. v. County of Los Angeles, et al.
Los Angeles Superior Court Case No. TC 028173

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary, and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

RHG:scr

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Brian O'Neal Pickett, et al. v. County of Los Angeles, et al., Los Angeles Superior Court Case No. TC 028173 in the amount of $1,750,000 and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Sheriff's Department's budget.

This wrongful death lawsuit concerns allegations of excessive force by Sheriff's Deputies during an attempted apprehension.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME		Brian O'Neal Pickett, et al. v. County of Los Angeles, et al.
CASE NUMBER		TC028173
COURT		Los Angeles Superior Court
DATE FILED		June 18, 2015
COUNTY DEPARTMENT		Sheriff's Department
PROPOSED SETTLEMENT AMOUNT	$	1,750,000
ATTORNEY FOR PLAINTIFF		The Sweeney Firm
COUNTY COUNSEL ATTORNEY		Millicent Rolon
NATURE OF CASE		This is a recommendation to settle for $1,750,000 a State-law civil rights and wrongful death lawsuit filed by the minor children of Brian Pickett alleging that Sheriff's Deputies used excessive force against Mr. Pickett and caused his death. The Deputies deny the allegations and contend their actions were reasonable. Given the high risks and uncertainties of litigation, a reasonable settlement at this time will avoid further litigation costs. Therefore, a full and final settlement of the case in the amount of $1,750,000 is recommended.
PAID ATTORNEY FEES, TO DATE	$	235,725
PAID COSTS, TO DATE	$	82,668

Case Name: Gilbert – Pickett, et. al v. County of Los Angeles, et al.

Summary Corrective Action Plan

The intent of this form is to assist departments in writing a corrective action plan summary for attachment to the settlement documents developed for the Board of Supervisors and/or the County of Los Angeles Claims Board. The summary should be a specific overview of the claims/lawsuits' identified root causes and corrective actions (status, time frame, and responsible party). This summary does not replace the Corrective Action Plan form. If there is a question related to confidentiality, please consult County Counsel.

Date of incident/event:	January 6, 2015, at 11:21 p.m.
Briefly provide a description of the incident/event:	**Gilbert – Pickett, et. al v. County of Los Angeles, et al.** Summary Corrective Action Plan 2017-031 On January 6, 2015, at 11:21 p.m., two uniformed Los Angeles County deputy sheriffs, assigned to Century Station, responded to a family disturbance call at the location on 123rd Street in Los Angeles. Upon arrival, the decedent's mother advised the deputy sheriffs that the decedent (her son), was acting erratically in her house and had been smoking methamphetamine and phencyclidine (PCP) during the course of the day **Note**: Phencyclidine is a dissociative drug that has a history of adverse side effects such as hallucinations, mania, delirium, and disorientation. The decedent's mother further advised the decedent threatened her and her daughter (the decedent's sister), calling them "bitches and cunts," then described in graphic detail how he would urinate on them and be "inside them," as he choked them to death. The decedent's mother advised the deputy sheriffs she considered the decedent's threats to be valid due to his aggressive behavior, previous episodes of violence, and previous assaults against her. The decedent's mother said she feared for her life and the safety of her daughter. The decedent's mother told the deputy sheriffs she wanted the decedent to be arrested, and she would follow through with criminal charges against him. The decedent's mother warned the deputy sheriffs the decedent had fought with deputies and police officers in the past and had been tased several different times during his encounters with law enforcement. The deputy sheriffs entered the home and made contact with the decedent in the bathroom. They found the decedent standing on the bathroom counter, squatting in the sink and starring at a mirror. The decedent aggressively told the deputy sheriffs, "Fuck cops! Fuck deputies! Get the fuck out of my house! You guys are not welcome here! I did not call you!" The deputy sheriffs asked what happened between him and his mother. The decedent replied, "That's not my mother, that's my bitch." The two deputy sheriffs backed away from the bathroom and made a plan to not engage the decedent until a field sergeant and additional deputy sheriffs could arrive.

Upon the arrival of the field sergeant and additional deputy sheriffs, they were briefed about the incident by the initial responding deputy sheriffs. A detailed spoken tactical plan was created and each deputy sheriff was given instructions and assignments, in order to safely contact and arrest the decedent.

The tactical plan and assignments were as follows:

- One deputy sheriff was assigned as a "contact" person, who would be responsible for talking to the decedent and would give calm and controlled verbal commands.
- One deputy sheriff was assigned a Taser.
- Two deputy sheriffs were assigned as "hands on" to control and handcuff the decedent if/when possible.
- An additional deputy sheriff was assigned to standby in the hallway between the living room and bathroom with a second Taser, in case the first Taser was ineffective.

The field sergeant video interviewed the decedent's mother confirming her account of events the decedent had been acting irrational all day, appeared to be under the influence of PCP, and had graphically threatened to kill both her and her daughter. The decedent's mother said she feared for her life and wanted the decedent arrested.

The deputy sheriffs and the field sergeant went to the bathroom and stood in the hallway. They saw the decedent was no longer on the sink, but standing on the floor in front of the mirror. The decedent was breathing heavy and appeared more agitated than during the first encounter. Due to the small bathroom and narrow hallway, the deputies were approximately two to four feet away from the decedent.

The first deputy sheriff gave the decedent several commands to place his hands behind his back and step out of the bathroom. The decedent refused each series of commands. The decedent appeared to get more agitated as he clenched his fists and turned abruptly toward the deputy sheriffs.

The second deputy sheriff saw the decedent's actions and feared that he was about to be attacked. The second deputy sheriff fired his Taser, striking the decedent in the chest. The Taser had little effect on the decedent. The decedent continued to clench his fists and move his arms up and down as he took a few steps backward.

> **Note:** Because the initial Taser deployment had not incapacitated the decedent, and the decedent appeared to still pose a serious danger of assaulting the deputy sheriffs, the second deputy sheriff did not release the trigger of the Taser. Holding the trigger caused the Taser to continue sending an electrical charge past the initial five-second activation cycle.

As the decedent moved backwards, he turned and fell face down into the empty bathtub. The deputy sheriffs rushed into the bathroom and attempted to control and handcuff the decedent. Although the Taser was still activated, the decedent was still uncooperative and resistive. The decedent thrashed his arms around and kicked back his legs "like a donkey" as he shouted, "you're not going to get me." Due to the confined

	area and the decedent's violent resistance, the deputy sheriffs were unable to handcuff him in the bathroom. The third and fourth deputy sheriffs lifted the decedent out of the bathtub, carried him into the hallway, and put him on the ground. Once in the hallway, the decedent continued to violently thrash his arms and legs and the deputy sheriffs struggled to handcuff him. The first deputy sheriff was able to control and pin the decedent's ankles to the back of his legs as the third and fourth deputy sheriffs were able to control his arms for handcuffing. **Note**: The second deputy sheriff continually depressed the Taser trigger, from the initial deployment until the decedent was handcuffed. The recorded time showed a continuous 29 second Taser deployment. The Taser's use was stopped immediately after the deputy sheriffs handcuffed the decedent. After being handcuffed, the decedent continued to violently thrash and kick at the deputy sheriffs. The first and fourth deputy sheriffs applied a "Ripp Hobble[1]" to restrain the decedent's legs and reduce his ability to kick them. **Note:** At no time did any of the deputy sheriffs clip the Ripp Hobble to the decedent's handcuffs to complete a Total Appendage Restraint Procedure (T.A.R.P.). The decedent was carried into the living room area where deputies laid him on his left side. The deputy sheriffs monitored the decedent's airway, breathing, and pulse as they requested and waited for paramedics. The decedent had a pulse, was breathing, did not appear to be in distress, and did not have any significant visible injuries. Just as paramedics arrived, the decedent was found to have gone into cardiac arrest. Emergency lifesaving efforts were performed. The decedent was transported via ambulance to Saint Francis Medical Center. The decedent arrived at the emergency room at 10:16 p.m. in full cardiac arrest. Advanced cardiac life support was given to the decedent but was unsuccessful. The decedent was pronounced dead in the emergency room at 10:39 p.m.

1. Briefly describe the **root cause(s)** of the claim/lawsuit:

A **Department** root cause in this incident was the deputy sheriff's use of the Taser against the decedent for 29 seconds. Another **Department** root cause in this incident was the deputy sheriff's application of the Ripp Hobble on the decedent to restrain his legs.

[1] The "Ripp Hobble" is a one-inch wide polypropylene webbed belting with a one-inch wide steel, alligator-jawed, friction-locking clip on one end and a steel-snap swivel clip on the other end. By using the webbed belt on the locking clip side, a loop can be placed around a person's legs or ankles to maintain better control of the person's legs.

A **non-Department** root cause in this incident was the decedent's failure to comply with the lawful orders of the Los Angeles County deputy sheriffs.

Another **non-Department** root cause in this incident was the decedent's previously undiagnosed significant medical conditions coupled with the effects of methamphetamine use.

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

The incident was investigated by the Sheriff's Department Homicide Bureau to determine if any criminal misconduct occurred.

The investigation revealed that the decedent sustained one Taser dart in the center chest and the second in the lower left rib area. He also sustained a small laceration near his left eye and abrasion on his left side of his face.

The toxicology indicated that the decedent had evidence of cocaine, marijuana, and methamphetamine in his system at the time of his death. PCP was not detected in his system.

On October 26, 2016, the Los Angeles County District Attorney's Office concluded the deputy sheriffs applied lawful force in detaining the decedent and are not criminally responsible for his death. The Los Angeles County District Attorney's Office will take no further action in this matter.

This incident was investigated by representatives of the Sheriff's Department's Internal Affairs Bureau to determine if any administrative misconduct occurred before, during, or after this incident.

On October 5th, 2017, the results of the administrative investigation were presented to the Executive Force Review Committee (EFRC) for evaluation.

The EFRC determined the tactics and use of force were within Department policy. No recommendations were made and no further action was taken.

Re-current briefings have been implemented on an ongoing basis. These briefings incorporate scenario-based situations similar to this incident. Special attention has been focused on how to make contact with individuals who are under the influence of narcotics and/or interactions with people who are mentally ill. Also discussed is the phenomena known as "excited delirium."

The second deputy sheriff deployed a Taser against the decedent and held the trigger, causing a continuous electrical activation that lasted 29 seconds, well beyond its normal five-second cycle.

Research into the function of the Taser indicates this is not a Taser device malfunction, but rather an intended design function. If a Taser trigger is pulled and released, the Taser will run for a five-second cycle. If during the five-second cycle the safety trigger is turned to safe, the Taser will stop the electrical activation.

The Taser was also designed to work continuously as long as the trigger is held. The ability to maintain a longer activation gives the user the ability to maintain an electrical activation against a violent person, enabling them to safely restrain the person in an effort to stop the threat.

In this incident, 29 seconds represents the amount of time the decedent was initially tased, lifted out of the bathtub, placed on the floor in the hallway, and handcuffed.

A person is considered hobbled when they are handcuffed, their ankles are held together with a Ripp Hobble restraint device, and the clip end of that device is not connected to the handcuffs.

The Department's use of force options chart identifies the Ripp Hobble as a valid force option for a resistive individual.

The Ripp Hobble can be an effective tool to restrain a person(s) legs when they are violently kicking and may cause property damage, hurt themselves, or someone else.

3. Are the corrective actions addressing Department-wide system issues?

☐ Yes – The corrective actions address Department-wide system issues

☒ No – The corrective actions are only applicable to the affected parties.

Los Angeles County Sheriff's Department

Name: (Risk Management Coordinator)

Scott E. Johnson, Captain
Risk Management Bureau

Signature: [signature] 155206

Date: 10-17-17

Name: (Department Head)

Karyn Mannis, Chief
Professional Standards and Training Division

Signature: Karyn Mannis

Date: 10-24-17

Chief Executive Office Risk Management Inspector General USE ONLY

Are the corrective actions applicable to other departments within the County?

☐ Yes, the corrective actions potentially have County-wide applicability.

☒ No, the corrective actions are applicable only to this Department

Name: (Risk Management Inspector General)

Destiny Castro

Signature: Destiny Castro

Date: 10/25/2017