Sixth Office of Independent Review **Annual Report**

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Foreword

by Michael J. Gennaco
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September 30th of this year marked the end of OIR's second three-year contract cycle with the County of Los Angeles. The experience of being "up for renewal" ended well for my colleagues and me, in the sense that we appreciate the decision of the Board of Supervisors to renew its commitment to the OIR model of oversight for another three years. As individuals and as a group, we look forward to continuing our work as real-time monitors of the country's largest Sheriff's Department.

The renewal process was also, however, an appropriate occasion for a review of OIR's performance and effectiveness. After the president of the deputies' labor union challenged the necessity of OIR in remarks to the Board during a public meeting in September, the Supervisors responded by calling for a formal evaluation. Meanwhile, the milestone had already prompted my colleagues and me to begin an internal assessment of where we've come from, where we'd like to go, and how our relationship with the Department has evolved in the six years of our existence.

The County's Chief Executive Office issued its audit report just a few weeks ago. It provides a useful overview of OIR's different functions, and comes to conclusions about our role that are favorable. The report captures the essential features of our model, which include access, regular communication with Department decision-makers (including the Sheriff), and the ability to report out to the public. It also recognizes what we have tried to cultivate — an arrangement in which our participation brings accountability while allowing the Department to take advantage of its own expertise and resources. The report is available on the County's official web site, and I encourage interested readers to judge for themselves.

Despite the report's conclusions, the president of the union continued to express skepticism in public remarks; on the other hand, a different union official has subsequently reached out to us on a matter of mutual concern. We welcome any willingness on the union's part to interact with us in open-minded ways, and we

remain convinced that a regular dialogue could be beneficial to both parties. As we have stated repeatedly, our role is not to ensure that management will "win" or that the system will "get" deputies in cases involving alleged misconduct. Instead, we promote the fairness and thoroughness and consistency of the process — principles that most deputies would seemingly find acceptable and desirable.

We also believe that we have an obligation to provide information to the public — consistent with legal restrictions and privacy rights — about OIR's assessments of internal investigations into misconduct and related issues. That commitment to transparency guides our annual reports and quarterly discipline updates, two means by which public can learn more about the Department, help contribute to its accountability, and evaluate the ongoing role of oversight in LASD's workings.

As for our internal self-assessment, that process has helped me realize that OIR is at an interesting moment in its history. We have gradually surmounted the largest challenges that faced us in 2001: learning the workings of the Department, beginning to participate in existing review processes, and making sure we had a voice in a culture that was unfamiliar with direct outside oversight. We have established core functions regarding the review of misconduct investigations, officer-involved shootings, and other critical incidents. Certainly, we have benefited from the willingness of Department executives to include us and respond thoughtfully to our views. Therefore, the challenge now has less to do with creating a presence and more with remaining adaptable as the Department itself evolves.

The Department itself is in transition, with an unusually high number of recruits entering the training Academy and beginning their careers, and an unusually high number of top managers likely to retire in the next several months. Both of these phenomena are cyclical to an extent: they are functions of budget realities, the continuing growth of the county and the Department, and adjustments to retirement benefits that have enabled dozens of high-ranking supervisors to call it a career in the knowledge that their financial futures are secure.

OIR is tracking these developments at both ends of the career arc. With the large influx of new deputies and the struggle to recruit (law enforcement is contending with vacancies throughout southern California), it is important that the Department maintains its high entry standards and monitors the effects of rapid turnover — especially in the custody facilities where deputies have traditionally begun their career. At some facilities, deputies who themselves have limited experience are serving as training officers for the brand new personnel, and the importance of strong leadership and careful attention at the supervisory level has never been greater.

Another strain on the field training officer program is the increasing demand for seasoned deputies to step up enforcement of gang related crimes, reducing the pool of experienced FTO deputies. With all of this influx and movement of deputies through the Department, we are pleased to note that the Training Academy has invited us to "plug in" to its various programs — including at the new recruit level — in a variety of new ways. The outreach is designed to raise our profile among rank and file deputies, eliminate misconceptions about our role, and take advantage of the perspective we can bring to the Department's work at all levels.

As for the anticipated spate of retirements, we once again have occasion to recognize that good systems are critical, but that true effectiveness requires the hand of good people. As much as change is a way of life in any large agency, we are struck by how many departures are expected at the executive level, and the well-respected shoes that the Department will need to fill. Relationships have always been central to our ability to exchange ideas and influence the review process in meaningful ways. Our expectation, then, is that the new captains, commanders, and chiefs who will be moving into new responsibilities will share their predecessors' grasp of the OIR model and their commitment to make it work. We certainly intend to develop and foster those relationships as much as possible from our end.

One of our priorities revolves around the Internal Affairs Bureau and how it is perceived and supported at the highest levels of the Department. Though no contemporary police agency could ever do away with its mechanisms for investigating allegations of misconduct, there are clearly some people in law enforcement — and within the Sheriff's Department — who certainly *wish* that it could be so. They often continue to harbor outdated and stereotypical ideas about IAB as a "rat squad," and they bristle at the suggestion that anything beyond their own high standards is needed to regulate officer behavior. Frequently, they dismiss outside scrutiny as uninformed and inherently hostile, and they perpetuate an "us against them" attitude that isolates officers from the community and even their own management.

When people with this mindset move into positions of authority, they certainly affect their department's internal affairs function in subtle but nonetheless influential ways: they can route investigations and force reviews away from IAB and toward "unit level" handling whenever possible, they can disparage Internal Affairs as an assignment (which both weakens morale at IAB and shrinks the pool of rational, talented officers who might consider serving there), and they can chill the impulses of other, subordinate managers concerned about misconduct.

Without overtly changing a single policy or protocol, such a philosophy could soon have a powerful — and negative — influence on a law enforcement agency.

There's no question that life as the subject of an investigation can easily alienate and frustrate a deputy, or that a protracted discipline process can easily become counterproductive. The concern of Department executives is warranted in this regard. The answer, however, is not to undermine IAB or to create a false dichotomy between "hard-working cops" and "second-guessers."

We take the view that Internal Affairs should be a central, valued component to an agency's credibility and effectiveness. Investigations that are thorough, fair and effective help address allegations of misconduct in the best possible ways: by providing the basis for exonerating innocent deputies, correcting the wrongs of culpable ones, and removing those who have so significantly disgraced the Department that they are no longer entitled to wear its badge.

A vigorous and effective IAB helps to uphold the Department's standards and preserve its credibility in the eyes of the public. Moreover, the expertise of investigators who review shootings and force incidents often provides the basis for executives to make changes in policy or training that benefit the entire Department. Finally, a number of IAB "graduates" who have ascended in rank have told us how much they value the insight and experience they gained in that unit. The Department would do well to continue to recognize that effective IAB investigators are excellent candidates for other critical assignments and responsibilities in the organization.

We continue to appreciate the tone that Sheriff Baca has set since helping to bring OIR into existence in 2001. His clearly stated belief in the value of oversight has facilitated our work and has allowed us to develop close and productive relationships with Internal Affairs personnel — whose bureau, not coincidentally, is located in the same building as our own. With IAB as the contact point for many of our important communications with the Department, and with its investigations as the foundation for many of our reform efforts, we have had a chance to participate meaningfully in the LASD review process. Accordingly, a strong and effective IAB is central to our own continued influence. As new leaders are promoted or accept new responsibilities within the Department in the coming months, we hope that the example set by their predecessors — of respect for IAB and a commitment to its vitality — continues to prevail.

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This year's report, like its predecessors, provides an overview of OIR's activities and important events in the Sheriff's Department, and an update on important stories and topics we've covered in the past. Sprinkled throughout are examples from actual cases that have made their way through the review process in the last several months. We also describe the policy initiatives we have worked with the Department to implement as part of our monitoring function.

Unfortunately for us, it will also be the last Annual Report to feature the contributions of our colleague Ilana Rosenzweig, who left Los Angeles and OIR for a new position in Chicago at the end of August. Mayor Richard Daley, Jr. selected Ilana — after a nation-wide search — as the director of his city's Office of Professional Accountability, an oversight entity with new powers to monitor the Chicago Police Department. The challenges will be formidable: Ilana will be managing more than eighty civilian employees, all while attempting to navigate famously choppy waters between the police, the politicians, and the public there. It is fortunate, then, that she brings such impressive reserves of wisdom and energy to her new assignment.

Ilana was one of OIR's six original attorneys, and is the second to leave us. (The Honorable Ray Jurado took the bench for the Los Angeles County Superior Court in May of 2006.) Ilana came to us with the attributes of a talented litigator: keen analysis, attention to detail, and tenacity. Throughout her tenure here, she combined those traits with a genuine interest in law enforcement issues and a respect for the Sheriff's Department's good work. She wanted to help the Department be better, and more often than not succeeded. Certainly, she made OIR better in the first six years of its existence, and we wish her the very best.

PART ONE In-Custody Death Issues for LASD

The Death of Inmate Gavira

Following the apparent suicide of Ramon Camarillo Gavira, an inmate at Men's Central Jail, in 2002, troubling allegations surfaced regarding the cause of the inmate's death, including the suggestion that deputies actually murdered Mr. Gavira and covered up the murder to make it appear a suicide. These claims surfaced publicly in May 2006, with the most egregious allegations being that a female deputy had taunted, harassed, and beaten Mr. Gavira while he was in custody and intimated that she was responsible for his death. Much of the reported information recounted allegations from a lawsuit filed by Mr. Gavira's family against the County and the LASD. That lawsuit was subsequently settled.

After these claims became public, OIR was asked to review the allegations and provide insight into the evidence in this case. While OIR was able to reach conclusions about some of the allegations — conclusions that do not substantiate the most serious of the accusations — the failure of LASD to thoroughly investigate some of those allegations at the time of the death created a factual deficit that makes it impossible to answer all of the claims. In OIR's view, it is that shortcoming that is the most troublesome: namely, that the investigative protocols in effect at that time did not ensure a thorough and contemporaneous review of the circumstances leading up to the death of Mr. Gavira. As a result, the "findings" of LASD with regard to this case have been met with skepticism and distrust by some and left the Department struggling to rebut some of those allegations. However, since the Gavira incident, the Department has been on a road to reform that will hopefully ensure thorough and contemporaneous investigations into all significant circumstances surrounding inmate deaths. While even a mature and robust investigation may not provide clear-cut answers to all questions, the Department will at least be able to demonstrate that it performed a thorough investigation in search of answers to those questions.

Factual Background

An LASD patrol deputy arrested Mr. Gavira for driving under the influence of alcohol on a Saturday afternoon. Pursuant to typical practice, Mr. Gavira spent the rest of the weekend in the station jail and was transported to the Compton courthouse on Monday morning. Following his court appearance, LASD transported Mr. Gavira to the Inmate Reception Center ("IRC"). He spent the night and most of the next day at IRC, being classified and then evaluated by five different members of custody, medical, and Department of Mental Health staffs. At the end of these screenings, he was ordered to have his blood sugar monitored, was prescribed medications consistent with a post alcohol syndrome protocol, was deemed a low suicide risk,[1] and was placed on the "psych line" to be evaluated by the Jail Mental Health Evaluation Team ("JMET")[2] at a later time.

Mr. Gavira was cleared for general population housing and transferred to Men's Central Jail ("MCJ") There, a deputy assigned him to a disciplinary housing module, not because Mr. Gavira had misbehaved or broken any jail rules, but because he was reported to have had a problem with other inmates in the IRC holding cell and he stated that he was concerned about being assaulted and did not want to be housed with other inmates. The deputy explained that the only single-man cells available were in the jail's discipline module, and Mr. Gavira agreed to be housed there.

Mr. Gavira arrived in his cell in MCJ around 9:00 p.m. that night, and left very early the next two mornings to be transported to court on an LASD bus. On both days, he returned to MCJ late in the evening. Mr. Gavira did not have his blood sugar checked or receive his medications on either of his two days in MCJ because, the records reflect, he was in court (or in transit between his cell and court) when the medical personnel attempted to find him.

1 At the time, the relevant forms the mental health staff was required to fill out did not provide the option of selecting "no" suicide risk. The psychiatric social worker selected the lowest risk option and classified Mr. Gavira a "low" risk.

2 Each JMET team consists of a deputy and a mental health clinician tasked with, among other things, the identification and assessment of mentally ill inmates in custody who may be in need of mental health treatment. JMET operates based on referrals from custody staff who make recommendations by recording inmates' names on a centrally-located JMET log. JMET is part of the LASD command structure; the teams do not report to DMH leaders.

When Mr. Gavira returned from court the second day, he had been sentenced and was to serve two more days in jail. In reality, given the Department's early release policy in response to jail overcrowding, Mr. Gavira was scheduled to be released later that night. When he returned to MCJ , another MCJ deputy escorted him to the correct housing module. While this deputy, and others who saw Mr. Gavira that evening, reported that he seemed lost and disoriented, all testified that he had no visible injuries and did not complain of any pain. An inmate working as a trusty on Mr. Gavira's row corroborated this report.

Approximately 30 minutes after Mr. Gavira was last seen entering his cell, an MCJ deputy was conducting his regular safety row check[3] when he discovered Mr. Gavira hanging from his cell gate by a rolled up sheet tied around his neck. He immediately summoned other deputies to assist. While there was some delay caused by the deputies' failure to obtain the Suicide Intervention Kit[4] from the module officers' booth, per LASD policy, the evidence indicates that the deputies' worked diligently and in good faith to resuscitate Mr. Gavira at the cell. All of the inmates who commented on this issue believed that deputies were doing what they were supposed to do — trying to save Mr. Gavira's life. The deputies continued CPR until paramedics arrived and took over efforts to resuscitate Mr. Gavira. Paramedics transported him to Los Angeles County Medical Center, where he was pronounced dead a short time later.

According to the written reports of the various responding deputies, somewhere between one and three minutes passed between the time Mr. Gavira was found hanging and when deputies began CPR. This unfortunate delay, albeit slight and with no evidence that it occurred out of spite or malice, stemmed in part from deputy decision-making that was potentially contrary to LASD policy, and the potential accountability of the deputies should have been addressed during the jail unit-level inquiry into the circumstances surrounding Mr. Gavira's death, but was not.

3 Title 15 of the California Code of Regulations requires deputies to periodically check on the safety and welfare of each inmate. In the disciplinary module that housed Mr. Gavira, Title 15 checks occurred every 30 minutes.

4 The suicide kit contains a cut-down tool to be used in case of hanging, CPR mask, towels, and latex gloves. One deputy estimated that it took the deputies 15 to 20 seconds to loosen the ligature around Mr. Gavira's neck, presumably a few seconds longer than it would have taken to simply cut the sheet with the appropriate tool. He then had to run back to the module booth — approximately 120 feet — to obtain a CPR mask. Thus, the deputies' failure to pick up the Suicide Intervention Kit delayed the availability of tools specifically designed to deal with suicides and slightly slowed resuscitative efforts.

Allegations of Misconduct

Following the death of Mr. Gavira, the following allegations were brought forward: that Mr. Gavira had been mocked and severely beaten, causing contusions on the top of his head, broken ribs, and bruising over his entire body, even his feet and toes; that he had been inappropriately housed in "the hole;" and that the jail ignored Mr. Gavira's medical and mental health needs. Most concerning was the further allegation that Mr. Gavira had not hanged himself, but rather had been manually strangled by a deputy who then staged it to look like suicide.

These allegations largely stemmed from inferences drawn from the autopsy results and the statements of three other inmates housed on the same row as Mr. Gavira. One of these inmates sent a note to Homicide Bureau detectives subsequent to Mr. Gavira's death in which he alleged that a female deputy harassed and "manhandled" Mr. Gavira by pushing him around, grabbing his arm, pushing his face into the wall and reaching into his pants to yank his genitals, making some statement about his "huevos." In addition, this inmate alleged that the deputy ignored Mr. Gavira's statement that he was suicidal and needed help. In the end, this inmate told Homicide investigators there was no doubt that Mr. Gavira had killed himself. He believed, however, that deputies should have done more to get Mr. Gavira help, and that the deputy's abuse actually led to the suicide.

Three other inmates interviewed by Homicide detectives agreed that Mr. Gavira's death was a suicide, stating they heard or saw Mr. Gavira return to his cell after court and then did not hear anything else or see any deputies on the row until deputies found Mr. Gavira hanging and commenced CPR.

One of those three inmates echoed some of the concerns expressed by the note-writing inmate, saying that Mr. Gavira had some problems with staff, including a female deputy who taunted him regarding the size of his "huevos." Though this inmate did not see any deputies using force on Mr. Gavira, he stated that it appeared to him on the night before Mr. Gavira's death that he was injured because he walked slowly and somewhat hunched over.

One additional inmate housed on the same row as Mr. Gavira later came forward and was deposed in the course of the litigation, though he refused to give a statement to Homicide investigators at the time of Mr. Gavira's death. This inmate testified that, among other things, he saw the female deputy grab Mr. Gavira and hit him between the legs, saying "where's your huevos?" He said that when Mr. Gavira returned from court that night, the same female deputy went to Mr. Gavira's cell and told him, "you're never going home," then walked away laughing. A short time later, Mr. Gavira was found hanging in his cell.

In all, three inmates provided troubling accounts of deputy behavior, yet no two report an incident happening in the same way at the same time. This potentially undermines their credibility. Still, there are some common themes to these inmates' statements, most notably the claim the female deputy used the word "huevos" to taunt Mr. Gavira.

Medical Evidence

It was alleged that Mr. Gavira's body, when observed post-autopsy, was covered with bruises and abrasions and had several broken ribs, two broken clavicles, and intestinal bleeding, all of which was used to suggest that Mr. Gavira was severely beaten prior to his death, tortured, or even murdered. OIR reviewed the autopsy report as well as the depositions of some of the parties' medical experts.

The medical evidence presents a picture of an inmate with numerous injuries at the time of his death, including a furrow with abrasions around the neck, fractures to a bone and cartilage in the neck, multiple rib fractures, and various contusions and hemorrhages. It is clear, however, that none of those injuries — with the exception of the neck injuries — were the cause of Mr. Gavira's death; he died of asphyxiation.

Not surprisingly, the parties to the litigation disagreed about the inferences to be drawn from the injuries. The most contentious issue was the neck fractures. Plaintiffs' and defendants' hired experts disagreed on the significance of both. Plaintiffs argued the neck fractures were indicative of manual strangulation and not hanging, and defendants' experts presented a contrary opinion. However, the theory that Mr. Gavira was killed when he was manually strangled by others rests entirely on plaintiffs' expert interpretation of the significance of this injury. No witnesses, including inmate witnesses, even suggest that such a scenario occurred on the night that Mr. Gavira was found hanging from his cell. Accordingly, without more, there can be no determination that Mr. Gavira was in fact killed at the hands of another person.

As to the broken ribs, contusions, and other non-fatal injuries, plaintiffs attributed these to beatings Mr. Gavira suffered during his several days in custody, while defendants' experts asserted that at least some of these injuries could have been the result of CPR performed by deputies, moves used to take Mr. Gavira down from the cell gate, or the autopsy procedures themselves. Mr. Gavira's testicles — a critical area of his body in relation to the allegations made by the inmates — were devoid of detectable injury. To the degree that some of the injuries may have been the result of assaultive behavior against Mr. Gavira, the examination

of those injuries in and of themselves cannot pinpoint precisely when they happened, how they happened, or why they happened.

As will be further discussed below, it is these unanswered questions that called for a more robust and comprehensive investigation into the cause of Mr. Gavira's non life-threatening injuries. Was Mr. Gavira beaten by inmates at IRC where he apparently had a problem with other inmates? Was he abused during his trips to court on the bus or in the holding cells in Compton? Or was he subjected to inappropriate force by deputies while he was out of his cell at Men's' Central Jail? While, as we discuss below, there was some attempt to achieve answers to these questions, the Department's inquiry was not sufficiently scoped or focused to definitively resolve these issues.

The Department's Review of the Death

Within hours of responding to the scene, the two Homicide detectives assigned to the case found significant evidence that Mr. Gavira's death was a suicide. Mr. Gavira had been housed in a single-man cell. Only deputies had access to Mr. Gavira in his cell, and none of the inmates interviewed claimed that deputies were on the row at the time he died. The detectives found the deputies they interviewed to be credible and their statements consistent with each other. Even after the detectives learned about the broken ribs and other injuries to Mr. Gavira, they did not change their assessment that the cause of death was suicide, because the coroner reported to them that none of those injuries would have caused Mr. Gavira's death.

The Homicide detectives were very clear that the scope of their investigation was limited solely to finding the cause of Mr. Gavira's death and determining whether there had been a homicide. It was a narrowly focused investigation, and once they had formed the opinion that Mr. Gavira's death was a suicide and not a homicide, they did not view it as their investigative role to learn who or what caused his non-life threatening injuries. They also did not see it as their responsibility to find out why Mr. Gavira had killed himself, so one inmate's allegations that a deputy had driven Mr. Gavira to suicide were not significant to their investigation. Nor was it the responsibility of the Homicide investigators to assess whether any personnel had violated Custody Division policies or to judge the effectiveness of the medical or mental health care the LASD provided Mr. Gavira prior to his death.

Because the allegations of misconduct by deputies were outside the scope of their investigative focus, the Homicide detectives properly turned the matter over to

Men's Central Jail for any administrative investigation. Jail supervisory staff at Men's Central Jail conducted a limited unit-level inquiry or review and determined there was no evidence of deputy misconduct sufficient to warrant a more extensive investigation.[5]

OIR's Review and Conclusions

Consistent with OIR practice, we did not conduct a separate investigation of the incident. Rather, our review focused on reviewing LASD's homicide investigation, administrative inquiry, and some of the issues that have arisen from the subsequent civil litigation related to the death. In this review, OIR focused on those documents that originated from LASD and numerous deposition transcripts.

It has been alleged that Mr. Gavira was denied medical care and inappropriately housed in "the hole." Further, it was alleged that Mr. Gavira was severely beaten, tortured, and murdered. OIR's findings regarding each of these allegations, along with OIR's concerns about the inadequacy of the administrative investigation into the allegations of deputy misconduct and the source of Mr. Gavira's various injuries, are addressed in turn below.

1. Medical Care

Over the course of his three days in MCJ, Mr. Gavira did not receive the medication and medical monitoring prescribed for him by medical personnel for alcohol withdrawal and diabetes because he was in transit to and from court at the time medications were dispensed. The Department, at the time, had no efficient system in place to accommodate the medication needs of the scores of inmates traveling to court on a daily basis, but there is no evidence of any deliberate effort to deny treatment to Mr. Gavira.

In 2002, the challenge of getting medical care to inmates who spend most of the day attending court appearances and therefore cannot be found in their cells was not unique to this case. Since Mr. Gavira's death, jail leadership has devised a

5 Within LASD, the term "investigation" is reserved for either a criminal investigation or a formal administrative investigation that may lead to discipline and that is conducted by either IAB or at the unit level. An "administrative investigation" triggers the provisions of the Peace Officer's Bill of Rights and thus has several formal requirements. LASD uses terms such as "inquiry" or "review" to describe other preliminary fact collecting exercises that are often used to assess whether to conduct a full blown administrative investigation.

new system intended to remedy this problem. Because jail managers determined it was not feasible, for budget and personnel reasons, to dispense medication to inmates in each of the County's courthouse lock-ups, LASD decided to address this issue by distributing medications during the early morning court lines and later in the evenings when inmates return from court. Nursing staff now receives a list of inmates scheduled for court and cross-references that list against their pill call lists. At MCJ, nurses then meet inmates at a central location between the jail and IRC while inmates are on their way to the buses that will take them to court. In the evening, inmates returning from court after the last pill call may self report their medication needs and be escorted to the clinic by custody staff to obtain their medication. Medical Services Bureau nursing staff also accesses the court line lists in the evening to check for discrepancies between prescribed and dispensed medications. If they determine an inmate has missed his evening dose because of a late return from court, they are instructed to contact the relevant module deputy to facilitate the inmate's movement to the clinic to receive his medication.

OIR has attempted to learn from LASD how well this system is working. However, despite our repeated requests, statistics that would show inmates are receiving their medications, even on days they must leave the jail to attend court, have not been forthcoming. OIR will continue to pursue this area of inquiry to learn whether there still remain systemic hurdles to the effective dispensing of medication to inmates housed in the County jails. In addition, it is incumbent on the Department to regularly perform such audits to learn to what degree the system in place is working.

Also during the IRC screening process, the psychiatric social worker referred Mr. Gavira to the Jail Mental Health Evaluation Team for further psychiatric evaluation and care. The MCJ deputy who initially assigned Mr. Gavira to the disciplinary module likewise recommended Mr. Gavira be evaluated by JMET. During Mr. Gavira's next two days in custody, the JMET team did not see him. There are two possible explanations for this. First, JMET personnel work regular daytime hours, and Mr. Gavira was either on a bus or at the Compton courthouse for all of those hours on the days before his death. It is not clear whether JMET staff attempted to visit him, but even if they had, they would not have found him at MCJ.[6]

6 We have not seen any records demonstrating whether JMET actually attempted to visit Mr. Gavira or whether they were waiting for completion of the withdrawal protocol. Current JMET protocol requires the team to document any attempt to visit an inmate, as well as the reason for any decision to not evaluate an inmate whose name appears on the referral log.

A second explanation is that JMET generally does not follow up with inmates suffering post alcohol syndrome until the three-to seven-day protocol for withdrawal is over, at which time a person's psychiatric condition and the need for psychiatric medication can be more clearly evaluated. Therefore, when the social worker recommended placing Mr. Gavira on the JMET line for further psychiatric evaluation, it was with the belief that he would not be seen by JMET for at least another several days.

2. Housing Assignment

There is no evidence that the deputy's decision to assign Mr. Gavira to a disciplinary housing module so that he could be housed in a single-man cell was in violation of LASD policy or was anything other than a good faith effort to protect Mr. Gavira, who reportedly was having problems interacting with other inmates, feared being assaulted, and asked to be housed by himself. If the MCJ deputy had not assigned Mr. Gavira to the disciplinary module, his options were limited to housing him at MCJ either in a four- or six-man cell or in a dorm with as many as 160 inmates, where he would have been in danger of being victimized as he reportedly feared.

Contrary to the allegations that were later made, housing in the disciplinary module did not impact Mr. Gavira's access to medical or mental health care. If the mental health screening performed at IRC had shown Mr. Gavira to be suicidal and/or mentally ill, he would have been housed at Twin Towers Correctional Facility on a mental health floor with suicide precautions and regular access to psychiatric care. But, as noted above, the psychiatric social worker concluded after her evaluation that Mr. Gavira was a low suicide risk and not suffering from mental illness. All inmates at MCJ have equivalent access to medical and mental health care, regardless of whether they are housed in general population or discipline.

The decision to house Mr. Gavira in the disciplinary housing module has been described as sending him to the "hole," with the implication that the housing decision had a punitive effect. In fact, the practical reality of Mr. Gavira's time in custody did not differ much as a result of this decision. Pursuant to jail practices at the time of this incident, even if housed in a general population dorm or cell, Mr. Gavira would not have received his prescribed medication, because he still would have been in court at the time the medications were distributed. And multi-man cells or dorms at MCJ are generally no less dark, dank, loud, and depressing than the disciplinary module to which Mr. Gavira was assigned.

Moreover, because Mr. Gavira spent nearly all of his two days in custody at MCJ attending court appearances, most of the restrictions placed on disciplinary module inmates would not have impacted him. Though he may have been prohibited from having visitors while housed in the disciplinary module, visiting hours had ended by the time Mr. Gavira returned from court on those days. Again because he was in court, Mr. Gavira would have missed any opportunity for outdoor recreation time he may have had in a general population cell but did not have in the disciplinary module. The notable exception to this lack of impact is that in a dorm or multi-man cell, Mr. Gavira would have had easy access to a telephone located in each cell, which he was not provided in the disciplinary module.

Given the information and options available to the MCJ deputy as he decided where to house Mr. Gavira, he made a decision that was within LASD policy. Nonetheless, in 2002, the Department's method for making inmate housing decisions was somewhat arbitrary and vested much discretion in individual deputies working throughout the Custody Division. The LASD recently implemented a new system for assigning inmate housing locations. Beginning in 2006, all initial inmate housing decisions are made by the Central Housing Unit at IRC. Inmates now leave IRC with assigned housing, and MCJ (and other jail facility) personnel have less discretion about where to place inmates, at least initially. As the new housing unit currently operates, however, deputies at each jail facility still have the ability to make "harmony moves." For example, if the Central Housing Unit assigns an inmate to an MCJ dorm, but deputies working that dorm notice he is having trouble getting along with other inmates, they may move him to an available cell in another part of the jail.[7] The Central Housing Unit is still evolving, taking on additional necessary and appropriate responsibilities as it becomes able. OIR is working with the Custody Division and monitoring the progress of this new unit.

We hope that, at a minimum, this incident provides a cautionary tale about the need for jail staff to more fully check out allegations of inmate assaults and investigate the details surrounding them rather than relying solely on impromptu measures to accommodate inmates' reported fears or concerns.

7 In reality, it would be very difficult today to move an inmate such as Mr. Gavira into a single-man cell, because the jail, through its Central Housing Unit, is using all of its available single-man cells to house high security inmates.

3. Deputy Misconduct

It was alleged that Mr. Gavira was severely beaten, tortured, and even murdered. However, even without considering the inherent credibility issues of inmates, the not uncommon motivation for inmates to provide false or exaggerated information about jail staff, and certain inconsistencies in their testimony, even the worst of the inmates' claims do not support these more sinister allegations. Two inmates report they saw the female deputy pushing Mr. Gavira around, smacking, grabbing, and mocking him, but no one claims to have seen any deputy administer a severe beating or any kind of torture, and no inmate alleges facts to support a murder scenario. Indeed, none of the actions attributed to deputies by the inmate witnesses would likely account for the kinds of bruises and broken bones discovered during Mr. Gavira's autopsy.

There are, in addition, several factors particularly relevant to the three inmates' credibility in this case, including one inmate's somewhat checkered history working as an informant for the female deputy he accused of harassing Mr. Gavira, and the fact that another inmate did not provide his account of the events until years later. The three inmates differ substantially on numerous key points, and two of the three claim that the female deputy was on the row just before Mr. Gavira's death, a time when the evidence and other witnesses demonstrate she was not on duty or at the jail.

None of the deputies who came into contact with Mr. Gavira during his brief incarceration at MCJ reported any use of force or anything much out of the ordinary in their dealings with Mr. Gavira. The female deputy testified she does not remember Mr. Gavira and steadfastly denied all of the allegations leveled by the inmates. On the day Mr. Gavira died, her shift did not begin until over 30 minutes after Mr. Gavira was found hanging in his cell, and she remembers hearing about the suicide in the locker room as she got ready to begin her shift. Unfortunately, although it would likely have been easy to do so at the time, the truncated LASD investigation into misconduct allegations did not include formal interviews of staff in an effort to verify or corroborate this account.

Homicide interviewed all of the deputies who played a role in the response to Mr. Gavira's suicide about their contacts with Mr. Gavira just prior to his suicide and their role in the resuscitative efforts. However, neither the Homicide detectives nor any custody official ever questioned these deputies about any earlier contacts they may have had with Mr. Gavira, nor did anyone from Homicide specifically ask them about the charges made by the three inmates who named the female deputy as an instigator.

It is possible that the deputies were unkind, abusive, or even cruel to Mr. Gavira, but that the inmates' attempts to embellish created inconsistencies in their accounts. It is also possible the three inmates who alleged deputy misconduct somehow came together to fabricate a claim, but only got the most rudimentary details straight. In any event, based on the evidence available, these allegations of deputy misconduct can only be considered unresolved.

The inability to make a determination about the inmates' allegations regarding the treatment allegedly suffered at the hands of the deputy rests in large part on the failure of LASD to conduct a robust formal inquiry into them. Only six inmates were interviewed, the accused female deputy was never formally interviewed as a subject of the investigation, and the cursory review by LASD leaves a factual deficit which makes it difficult to adjudicate the inmates' claims. That shortcoming on the part of LASD demonstrates a breakdown in the responsibility to fully investigate claims of misconduct and does a disservice to the inmate as well as the accused deputy, whose adamant denials are as unsubstantiated as the allegations themselves.

Investigative Shortcomings

1. Allegations of Deputy Misconduct

LASD conducted a unit-level inquiry into the allegations raised by inmates that deputies taunted, insulted, and assaulted Mr. Gavira. An MCJ lieutenant completed the "Administrative Review." His review consisted of an interview of the inmate who had sent a note to Homicide investigators accusing the female of taunting Mr. Gavira, a conversation with the accused female deputy, some contact with that deputy's supervisors, correspondence with a sergeant and a deputy who had used one of the inmates as an informant, and a conversation with one of the Homicide detectives.

Based on this review, the lieutenant concluded that the accusation that the female deputy mistreated Mr. Gavira was baseless and that no further administrative action was needed.

Unfortunately, this unit-level inquiry relied too heavily on what the lieutenant perceived of the Homicide detective's oral description of the inmate interviews. At the very least, he should have reviewed the Homicide detectives' report of their investigation in order to obtain a more complete picture of what they did and did not do and what the inmates had told them. For example, the lieutenant reported that Homicide interviewed all of the other inmates on the row. In fact,

the detectives interviewed just four of the up to 25 inmates other inmates who lived in that module — enough to satisfy themselves that Mr. Gavira had been alone in his cell at the time he hung himself. Interviews of these other inmates would have been helpful in either substantiating or refuting many of the allegations that came to light during the subsequent litigation in this case.

The Homicide detective also reportedly told the MCJ lieutenant conducting the unit-level inquiry that none of the inmates corroborated the accusations made by the note-writing inmate. But Homicide detectives did not specifically ask any of these inmates to comment on these allegations. In addition, the lieutenant does not report any allegations made by the second inmate who came forward at the time with accusations against the female deputy. The administrative investigation into the events surrounding Mr. Gavira's death should have uncovered this inmate's allegations, either through independent interviews or a more thorough review of the Homicide investigation, or both.

Furthermore, other than questioning the accused female deputy, the MCJ lieutenant did not conduct his own interviews of any other deputies. Though Homicide had talked to all of the deputies working in the relevant module at and around the time of Mr. Gavira's death about their immediate response to the situation, no Department personnel ever questioned them about any earlier contacts they may have had with Mr. Gavira, nor did anyone specifically ask them about the charges made by the inmates.

2. The Source of Mr. Gavira's Injuries

The Homicide investigators did not consider it their responsibility to discover the source of Mr. Gavira's injuries that may have pre-existed the suicide. They accepted the coroner's representation that the broken ribs were the result of CPR and understood that none of the injuries were the cause of Mr. Gavira's death. Once they formed the opinion that the death was a suicide, any responsibility to discover the cause of Mr. Gavira's other injuries belonged to supervisory personnel at MCJ.

As the MCJ lieutenant conducted his inquiry into the allegations against deputies, he also sought to discover how Mr. Gavira might have been injured. He made inquiries to try to determine what had occurred to Mr. Gavira on the day of his death both at court and on the bus from court, but indicated he was unable to identify who was with Mr. Gavira either in the court lock-up or in the IRC holding cells on his return from court. He did, however, identify and interview seven inmates who were on the bus with Mr. Gavira, none of whom was aware of any problems. The deputies who were on the bus crew were interviewed by their watch commander and stated that they were not aware of any problems on the bus.

Unfortunately, the Department personnel looking into this matter overlooked significant sources of information that may have provided insight into the cause of Mr. Gavira's injuries or his possible reasons for committing suicide. For example, no one questioned why Mr. Gavira was moved from one module to another in the very early morning of his second day at MCJ. One of the three inmates who accused the female deputy of misconduct testified that when Mr. Gavira first came to his module, he was limping and walking hunched over, as if injured. Also according to this inmate, Mr. Gavira spent that night crying and talking to himself. The failure to look into the reason for the middle-of-the-night housing move and Mr. Gavira's behavior and experiences in the earlier assigned module left unanswered questions that fermented into allegations of cover-up and abuse.

Likewise, the failure to learn about and then look into the report by MCJ and IRC personnel that Mr. Gavira had trouble with other inmates at the IRC holding cell before he was housed at MCJ created another significant information gap. The nature and circumstances of Mr. Gavira's conflict with other inmates were neither documented nor verified by IRC or MCJ personnel. If, in fact, Mr. Gavira had been subjected to physical abuse at the hands of inmates at IRC, it could well explain the bruises and other injuries found on Mr. Gavira at the autopsy. In addition, no Department personnel talked to potential witnesses at the court where Mr. Gavira appeared and was sentenced on July 11. The bailiff, the clerk, and Mr. Gavira's own attorney may have observed some injuries or other difficulties Mr. Gavira suffered. Questions such as these that arise near the time of an incident but remain unanswered often come back later, where they create suspicion about deputy behavior.

Unfortunately, the MCJ's unit-level inquiry into the circumstances surrounding Mr. Gavira's death were not necessarily inconsistent with the Department's investigative expectations in 2002. Since that time, greater scrutiny is expected at the outset of any inmate suicide or potential homicide. Internal Affairs is tasked with rolling to the scene and conducting an initial assessment of the death to identify whether any administrative issues need to be explored further. OIR is also part of that initial rollout response and offers its views with regard to identification of issues and the appropriate scoping of any subsequent investigation. Finally, the reform efforts in revamping the inmate death review process will provide yet another opportunity to ensure a robust response to any issues or questions surrounding each death in the jail. While there are often no guarantees in the jail environment, OIR is hopeful that if an event such as the death of Mr. Gavira were to occur today, LASD's investigation into the circumstances surrounding the death would be more thorough and exacting.

IAB and OIR Responses to Inmate Deaths

At the time of this incident in 2002, the Internal Affairs Bureau ("IAB") was not routinely notified and did not regularly roll out to the scene of an inmate death, unless there was some initial indication that the death was the direct result of contact with a Department member. Thus, in a situation like the death of Mr. Gavira, where there was no immediately preceding contact with a Department member and the first impression was that he had committed suicide, the LASD protocols did not require IAB to respond. Rather, sole responsibility for contemporaneously investigating the death fell to the Homicide Bureau.

As discussed above, because of the unique roles of the Homicide Bureau and IAB, this arrangement had its shortcomings. Homicide Bureau focuses on whether the events that lead to the death were criminal, but not on whether any of those events violated LASD policies, implicated systemic shortcomings, or indicated a need for additional training. In this case, as well as other suicide and inmate homicide cases, OIR became concerned that because IAB was not notified and did not begin a review immediately, the quality of the LASD administrative inquiries or investigations suffered. Accordingly, OIR, IAB and LASD agreed that IAB should receive immediate notification of all in-custody deaths, except those that are obviously the result of natural causes (such as an inmate with a lengthy illness housed in a hospital ward). As of December 2005, IAB, by policy, is required to receive immediate notification of all inmate suicides, and immediately respond and commence a review of the incident. In addition, IAB and Homicide Bureau have developed a protocol to insure that IAB can investigate any relevant LASD policy issues while Homicide Bureau continues to focus on the cause of death and any potential criminal charges. See attached IAB Management Directive # 50, Roll Outs Involving Inmate Deaths.

When the on-call IAB Lieutenant is notified of an in-custody death, he will immediately page the on-call OIR attorney. The on-call OIR attorney can then travel to the scene of the death to provide input and guidance into the IAB review of the incident. This allows OIR to follow the review from the outset of the homicide and IAB inquiry. As OIR has assumed an increasingly greater role in the Department's response to inmate deaths, we have noted shortcomings in the administrative review of inmate deaths that occurred before the implementation of the Homicide/IAB protocols. Indeed, the present case is a good example of why the Department must ensure a contemporaneous and wide-ranging review not only of the cause of death but also any allegations or indications of misconduct by deputies preceding the death, any issues involving the medical care provided the inmate, and any issues raised regarding jail personnel's response to the death. Because, in this case, the Department did not have an investigative protocol

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COUNTY OF LOS ANGELES

SHERIFF'S DEPARTMENT

"A Tradition of Service"

OFFICE CORRESPONDENCE

DATE: September 26, 2005
FILE NO.:

FROM: KARYN MANNIS, CAPTAIN
INTERNAL AFFAIRS BUREAU

TO: ALL SWORN PERSONNEL
INTERNAL AFFAIRS BUREAU

SUBJECT: **MANAGEMENT DIRECTIVE #50**
ROLL OUTS INVOLVING INMATE DEATHS

Purpose
This directive establishes procedures for Internal Affairs Bureau Roll-Out Team Investigators to follow regarding an Inmate Death (natural, accidental, homicide, or suicide).

Policy
When the Internal Affairs Bureau On-Call Lieutenant is notified of an inmate's death, he shall confirm that Homicide Bureau is responding. IAB personnel will only respond if Homicide responds. The IAB Lieutenant shall evaluate the information, determine the appropriate makeup of the responding team, and ensure that those personnel are notified.

> Note: If the inmate death occurred during or after physical contact with a Department member, the DIS Hit Shooting protocol shall be followed.

Homicide Bureau is the primary investigating unit and is responsible for the criminal and/or death investigation of those inmate deaths to which they respond. At the scene, Homicide Bureau is responsible for sharing preliminary information with the Internal Affairs Bureau team in the forum of an informational briefing, including a walk through of the scene.

Internal Affairs Bureau is responsible for conducting a preliminary administrative review of those inmate deaths to which they respond.

If it is determined that there *are* potential policy violations, the IAB Lieutenant will confer with the concerned Unit Commander about initiating an immediate administrative investigation. If the concerned Unit Commander requests an immediate administrative investigation, the IAB Lieutenant will consult with the Homicide Lieutenant about the investigation and the need for IAB investigators to interview witnesses, and/or involved employees. Any interviews conducted by the IAB investigators shall be conducted separately after Homicide Bureau's interviews. Based on the Homicide Lieutenant's decision, if interviewing a witness or involved employee by the IAB investigator would jeopardize the criminal/death investigation, that interview will be deferred until a later date. IAB investigators shall confer with the Homicide investigators before conducting the later interview(s).

Note: If there is a need for the scene to be maintained for the IAB investigators after the Homicide investigators have completed processing the scene for their investigation, the IAB Lieutenant shall consult with the Homicide Lieutenant about turning the scene over to the IAB investigators when Homicide is done.

If an immediate administrative investigation is initiated, the handling IAB investigator will be responsible for obtaining an IV number and ensuring that the Request for an IAB Investigation memo is obtained from the concerned Division Chief. All administrative investigations shall include Homicide Bureau's completed investigation.

If *no* potential policy violations are identified, the IAB Lieutenant shall notify the concerned Unit Commander, who will be advised that no policy issues were identified and an administrative investigation is not warranted at this time. If documents were collected and/or interviews conducted during the administrative review, the entire package shall be forwarded to Custody Support Services for their disposition.

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sufficiently robust to address each of these areas of inquiry, it unfortunately left unanswered questions about the source of Mr. Gavira's injuries and other issues surrounding his several days in custody.

Conclusion

The review of Mr. Gavira's death demonstrates the lessons that can be learned from a critical event such as this. OIR sees it as its responsibility to help the Department in identifying those lessons so that personnel can be held accountable, systems can be improved, and the potential for future critical incidents can be reduced.

Another Troubling Inmate Death and Investigation

In 2003, an inmate died under suspicious circumstances while being housed at Twin Towers Correctional Facility ("TTCF"). The Death Review in this case was delayed for an inordinately long period of time and was not convened until March 2006, 974 days after the inmate's death. OIR became involved in this matter shortly after the Death Review, when an individual with knowledge of the case beyond what was presented at the Death Review gave us additional information and asked us to probe the matter. Though we ultimately concluded that the Homicide Bureau had done a thorough job investigating the inmate's death, the cause of which was undetermined, we discovered a number of issues with the Department's review of his death and its response to some systemic problems presented.

The inmate was arrested by another local law enforcement agency for allegedly assaulting another resident at an in-patient mental health facility. He was being treated there for a mental illness and was regularly receiving medications. At that facility, the inmate had a documented history of aggressive behavior toward staff and of inflicting injuries upon himself by, for example, banging his head on the wall. But mental health staff there also noted that, when medicated, he was usually quite stable.

After three days in LAPD custody, the inmate was transferred to the Los Angeles County jail. He was screened at intake by medical and mental health personnel at IRC, who sent him to the mental health floor in TTCF for housing and further evaluation. Though he reported that he was on psychotropic medications and lived at a mental health hospital, the Department of Mental Health employees who evaluated him, both at IRC and TTCF, did not obtain the treatment records from the in-patient facility where he had resided and been treated for at least the

prior year. Those records would have revealed a history of prescribed medications. The inmate was not immediately diagnosed and did not receive any medication while housed at TTCF.

Six days after he arrived in LASD custody, the inmate went down in his single-man cell with lacerations to his head and severe bruising over much of his body. An inmate trusty notified deputies that the inmate was "man-down." Deputies responded and pulled him from his cell to administer first aid. He became resistive and combative — hitting, kicking, and spitting at the deputies — and deputies responded by putting handcuffs and a spit mask on him. Nurses also responded to assist, and the inmate was transported to the medical clinic at TTCF for further treatment. On the way to the clinic, the inmate went into respiratory distress, and he was transported to a County hospital, where he died six days later without ever regaining consciousness.

The medical examiner that conducted the autopsy opined that the event initiating the inmate's eventual demise derived from blunt force trauma inflicted by another. The County Coroner, however, disagreed and concluded that the manner of death was undetermined, but that the trauma evidenced by the bruising on his body was a factor in his demise.

Immediately after the death, Homicide Bureau detectives responded to investigate the circumstances and cause. They interviewed numerous nurses, deputies, and inmates, as well as staff from the mental health facility where the inmate had been arrested. They also met with the medical examiner to discuss the possibility that his death was caused by another. The inmate had been housed in a single-man cell and there were no reports of conflicts with other inmates. Two other inmates claimed they had seen deputies beat the inmate on the days before and the day he went down in his cell. However, their stories had serious flaws and were not consistent with the physical evidence, the statements of all the nurses and deputies, or even each other. Two inmate trusties described seeing the inmate engaged in bizarre behavior inside his cell, including shadow boxing and making erratic bobbing movements with his head. One of those inmates also reported hearing thumping noises coming from the area of the inmate's cell shortly before he went down. The staff at the prior mental health facility at which he had been housed provided the detectives information about his history of self-destructive behavior when unmedicated and unstable, including shadow boxing and banging his head on the wall. In the end, Homicide detectives concluded that there was no criminal act involved in the inmate's death.

As in the case of Mr. Gavira's death, no administrative investigation was opened at the conclusion of the Homicide investigation. In the investigative regime and

the LASD protocols then in place, this failure was more understandable here, however, because Homicide did a much more extensive investigation that went on for many months and did not result in the same unresolved issues and unanswered questions as did the investigation in the earlier inmate death. Nonetheless, there were some administrative issues that should have been explored outside the criminal investigation, including questions about the mental health care the inmate received while in TTCF, an apparent breakdown in communications between IRC and the mental health staff regarding records of his prior treatment at the in-patient facility from which he was arrested, and the failure of TTCF deputies to perform required safety and security checks.

One of the fundamental problems in the review of this case was that the Department's Death Review was not convened for over two years. This past year, in reaction to the Department receiving a concern about the way in which the Department had reviewed the circumstances of this death, OIR was requested to conduct a review. To that end, OIR reviewed the autopsy report, as well as the Homicide file, medical records, and other documents gathered by the Custody division relating to the inmate's incarceration and death. We also met with the Coroner and medical examiner and talked to others with knowledge of this case. In the end, we concurred with the view of the Homicide investigators that no credible evidence suggested the inmate's death was the result of a homicide. While it is impossible to say precisely what caused the traumatic injuries that ultimately led to his death, given his history and lack of psychotropic medication, the most likely scenario is that those injuries were self-inflicted.

We encouraged the Department to convene a follow-up review of the inmate's death with the goal of clearing any lingering suspicions and resolving any remaining administrative issues. We believe this goal was accomplished because the meeting's participants were willing to openly share their knowledge, state their opinions, and fully engage in the details of the review. In short, it was a model of meaningful review for an inmate death.

This historical incident again highlights the problems inherent in an untimely and less-than-robust system for investigating and reviewing inmate deaths. The more than two-year delay in initially bringing the inmate's death to Death Review, in and of itself, made it all too easy to conclude that the Department was unwilling to confront the truth. While its openness in the follow-up review largely put those concerns to rest, the Department and the objectives behind Death Review would have well been better served if this thorough review had been completed within a reasonable time of the inmate's death.

Changes in the LASD Inmate Death Investigation and Review Process

OIR reported last year on the LASD's Inmate Death Review process. At that time, we were critical of the Death Review meetings for what we deemed a missed opportunity to meaningfully examine all the circumstances surrounding an inmate's death with an eye toward enhancing accountability and assessing the need for broader systems reforms. We have been encouraged by the willingness of Custody managers to engage us on some substantive reforms of the Death Review process. OIR now regularly attends a meeting in advance of each Death Review at which Custody Support Services personnel discuss the issues and circumstances surrounding each death. OIR has the opportunity to review documents and, where appropriate, request that additional information be gathered in advance of the Death Review. At least in part as a result of this enhanced preparation, OIR has observed a greater willingness on the part of Custody managers to tackle some of the difficult issues presented by inmate deaths. OIR has identified additional areas for improvement in inmate Death Reviews and looks forward to continuing our productive working relationship with Custody leaders to address these issues.

The greatest improvement in the process for reviewing in-custody deaths has been Custody's willlingness to convene timely reviews. When we reported on this issue last year, we were particularly concerned about the length of time it took for an inmate's death to be presented at a Death Review meeting. We raised this issue with Custody managers, and they readily agreed to work to eliminate the backlog of cases and establish a practice of conducting more timely reviews. At the end of 2006 and the first months of 2007, Death Reviews were convened at a near-frenzied pace until all of the inmate deaths from 2006 and earlier had been reviewed. For the rest of 2007, Custody has conducted bi-monthly Death Reviews, so that reviews of most of the 27 deaths between January 1, 2007 and August 1, 2007 were convened within 60 days.

Promptness has brought a substantial improvement in the quality of the reviews. In the past, when Death Reviews occurred in many cases a year or more after the inmate's death, OIR observed a reluctance to meaningfully engage in some issues, often because the time to hold anyone accountable had passed, a decision about disciplinary issues had already been made outside the Death Review process, or because the issue just did not seem as pressing as it may have closer in time to the incident that raised it. Now, with Death Reviews being convened within weeks or months of an inmate's death, there is a greater sense that what happens at Death Review actually matters. The best example of this is the frequency with which Custody officials are willing to order IAB investigations into the circumstances surrounding an inmate's death. This stands in sharp contrast to the lack

of engagement of Custody officials in the details of the two cases described above and their reluctance to conduct administrative investigations into the circumstances surrounding those deaths.

The Internal Affairs Bureau's expanded roll out criteria — which now include a wide spectrum of jail deaths, as noted above — complement these improvements in the way the Department investigates and reviews inmate deaths. The Internal Affairs Bureau responded positively to our recommendation to roll to the scene of more inmate deaths and is coordinating well with the Homicide Bureau at the scene of these deaths. The LASD's new eagerness to address inmate death issues on an administrative level is demonstrated by the following cases.

CASE

An inmate was accused of murdering his cellmate in the mental health housing area of Twin Towers Correctional Facility. Deputies responded to another inmate's "man down" call and found the suspect standing in the two-man cell while his cellmate lay motionless in a pool of blood on the floor. After resuscitative attempts by nurses and paramedics failed, he was pronounced dead at the scene. Homicide detectives responded to begin the criminal investigation. IAB investigators also responded, to look into whether there were any administrative issues presented by the circumstances of the inmate's murder. Custody officials ordered an IAB investigation the next day.

IAB quickly determined that deputies had properly completed the legally-mandated security checks just over 30 minutes prior to the "man down" call. At that time, both inmates were alive, seemingly well, and were not exhibiting any unusual behavior or signaling any type of difficulty. The deputies also properly responded to the distress call, running to the inmates' cell, promptly summoning nurses and paramedics, and detaining the suspected assailant. The IAB investigation dug much deeper than these surface issues, though.

The investigation was thorough and completed promptly. The responsible IAB sergeant interviewed 34 witnesses, including the deputies and custody assistants on duty around the time of the incident, those who had worked the same module on the day the suspect inmate was transferred to the victim's cell, a deputy who responded to a fight several weeks earlier in which the suspect inmate had been injured, the sergeant who had handled some inquiries from a member of the public prior to the murder, Medical Services Bureau staff who had come into contact with both inmates, Department of Mental Health staff who had responsibility for treating both the suspect and victim inmates, and an inmate who previously had been housed with the suspect inmate. OIR regularly consulted with the IAB investigator during the course of this investigation. Homicide detectives interviewed 25 other inmate witnesses and the suspect inmate as part of their investigation.

The IAB investigation focused on whether jail personnel had missed any signs warning of trouble between the two inmates and the procedure by which they had come to be housed together. Based on all the information gathered, jail officials concluded — and OIR concurred — that the inmate's death was not attributable to misconduct by any LASD personnel. No subjects were named and no discipline was ordered.

Deputies in the module at the time of the alleged murder did not have a clear view into the inmates' cell due to the structure of the jail. While every cell has certain blind areas where inmates can conceal their activities, the cell in which the murder occurred was particularly difficult to see into because of a pillar partially blocking the window in the door. In any event, deputies and custody assistants are not expected to watch every cell at every moment. An inmate who wants to hide his behavior from deputies has significant opportunities to do so. Deputies do walk through the modules at various intervals, depending on the security concerns of the inmates housed there, to check on the well-being of each inmate. All of the deputies interviewed during the course of the IAB investigation indicated they never saw any signs of trouble between the suspect and victim inmates, nor did they see any prior injuries to the victim.

Whenever one inmate attacks or kills a cellmate, the jail must examine the decision-making process that put those inmates together in a cell. In the jail's mental health housing modules, DMH practitioners make the decisions about the module in which to place a certain inmate based on various treatment needs, but individual cell assignments are left up to custodial staff, who assign inmate housing based almost entirely on space availability. While these two inmates provided custody staff with no signs that they were incompatible — they lived together without significant incident for nine days — the case does raise the question of whether there are more appropriate ways for determining which inmates should be housed together.

Also at issue in the IAB investigation was how the LASD handled the reports of a third party who contacted the Department with concerns about the inmate who later became the suspect in the death of his cellmate. The investigator found that the LASD passed those communications on to the persons who could most appropriately address her concerns.

CASE

Earlier this year, another inmate was attacked by his cellmate at Twin Towers Correctional Facility. Again, deputies responded to a "man down" report promptly, summoned medical assistance, and rendered appropriate emergency first aid. Nonetheless, the inmate

died several days later. The Jail Investigative Unit and Homicide investigated the criminal aspects of this incident, and with OIR's encouragement, Custody opened an immediate Internal Affairs investigation into the various administrative concerns raised by the circumstances of this homicide.

One aspect of the case is particularly noteworthy, and is demonstrative of the Department's reinvigorated commitment to quickly investigating the circumstances of inmate deaths and fixing any systemic problems uncovered. As the media reported extensively, the suspect inmate came to Twin Towers on a transfer from state prison. Unfortunately, LASD did not learn until after the fact that the suspect inmate, while in state custody, had been accused of killing his cellmate. The paperwork that came with the inmate from state prison did not contain anything concerning this accusation, and the routine screening performed upon his intake into the jail did not uncover it.

Though the jail had never seen an outcome this serious, this was not an isolated problem. Prior to this event, the California Department of Corrections and Rehabilitation (CDCR) did not routinely provide information concerning an inmate's behavioral problems or disciplinary record when it transfered an inmate into County custody. In the wake of this Twin Towers homicide, OIR worked with the Department and CDCR to coordinate a meeting to discuss this information-sharing issue. This resulted in a productive ongoing dialogue between the two entities and a change in CDCR policies and practices, which now require state prisons to provide documentation regarding inmates' disciplinary histories when those inmates are transferred to county jail facilities anywhere in the state.

CASE

A 76-year old inmate went down in a dorm at North County Correctional Facility and subsequently died. He had been seated on his lower bunk and, when he tried to get up, he fell and struck his head on the floor. While being treated for the resulting laceration, he complained of chest pains and was transported by ambulance to the hospital, where he was treated for various ailments, went into cardiac arrest, and died three days later. An NCCF sergeant interviewed several inmates assigned to bunks near the deceased inmate's. All said that the inmate had been in poor health, and none noted anything unusual about the fall or the circumstances surrounding it. Even though the facts suggested this elderly inmate died from natural causes, because the deceased inmate had gained notoriety for his role in the murder of an LAPD officer decades earlier, both Homicide and IAB investigators responded to the scene to insure there was no suspicious activity. The on-call OIR attorney likewise rolled out. In the end, the coroner determined the inmate had died of natural causes. However, the case did raise the issue of whether this particular inmate, given his age and background, should have been housed in a more appropriate location than a general population dormitory. Housing older

inmates is an ongoing problem for the jails, and the LASD used this case as an occasion to renew its efforts to create specialized "old man" dorms or housing units.

Jail Suicides

In our Fifth Annual Report we discussed the problem of jail suicides and the absence of a clear and consistent protocol for preserving the scene and other evidence and for investigating the circumstances of the suicide. Each jail suicide potentially reveals issues in inmate care, screening or security measures, we recommended that Internal Affairs Bureau include all inmate suicides in its expanded roll out protocol. Jail deaths by suicide continue to be a tragic fact of the custody system, but the increased scrutiny that the Depart-ment is willing to direct toward these incidents is appropriate and will help the Department evaluate both its inmate care and its investigative protocols.

C A S E

An inmate trustee discovered another inmate hanging in a single cell by a noose made from a bed sheet. The inmate alerted module deputies who ran to the cell, cut the inmate down, and began to administer CPR. Jail nurses took over CPR shortly until paramedics arrived and took the inmate to the hospital. Death was pronounced a short time later. Both Homicide detectives and Internal Affairs investigators rolled out to the scene, as did OIR. At first the facts did not appear complicated, but Homicide soon identified significant issues. A deputy, among the first to attempt life saving aid to the inmate, admitted that, soon after the suicide was discovered, he had falsified some hand written entries on the row check chart in order to shield himself and his partner from criticism. The deputy believed that the row checks had actually been accomplished in a timely fashion but that they had not been properly documented. Custody managers became aware of this confession and considered a quick "pre-investigation" disciplinary measure that would achieve both accountability and positive reinforcement of truth-telling. While the deputy's candor and conscience were praiseworthy, as was the Department's effort to achieve a prompt disciplinary resolution, OIR believed that significant questions remained unaddressed. Was the inmate appropriately screened and housed for psychological problems? How long had the inmate been hanging in the cell? What other evidence might help determine whether the falsely documented row checks had actually taken place? These and other questions went to systemic issues that could extend beyond this one incident. In view of this and the Department's recent experience with the litigation that can grow from insufficient early investigations — see The Death of Inmate Gavira, above — OIR urged the Department to launch a formal investigation of the suicide. Following a timely death review, Custody managers did just that.

This case also highlighted the longstanding need for a simpler, more reliable method of documenting inmate welfare checks throughout the custody system.

Jail staff are required by law to do a close visual check on inmates' welfare at various intervals around the clock. The custody facilities currently use one of two methods to document these checks. Module deputies either hand mark their required periodic (usually hourly) inmate welfare row checks on a chart attached to a clipboard, or they use an obsolete electronic counter to register the time of the row check. The old electronic system often malfunctions and the "honor system" clipboard method often leads to problems and ambiguities following emergency incidents. Consequently, OIR has monitored with great interest the Department's two-year effort to replace these methods with a reliable multi-purpose computerized scanner. After frustrating hardware and software setbacks, the Department has successfully completed a long-term test of a hand-held scanner system in parts of Men's Central Jail, probably the most demanding environment in the custody system. OIR has recently urged the Custody command staff to expand the use of this successful hardware to the entire system and has received assurances that this will be done on a priority basis.

CASE

A detainee at the federal immigration facility administered by LASD committed suicide by stepping outside his dormitory late one night, climbing high into a tree in the exercise yard and hanging himself with a rope woven from bed linen. He was not discovered until hours later the following morning. The detention facility is a low security operation where the movement of detainees is not as restricted as in the jails and LASD staff members are not required to check on the welfare of detainees as frequently. Violence is rare, as are suicides. Nevertheless, the executive responsible for the facility ordered an administrative investigation of the incident. While the investigation identified no policy violations or negligence by LASD, it allowed jail administrators to scrutinize systemic weaknesses that could be addressed to improve inmate welfare and security at the facility. The investigation led to several corrective actions including installing alarms on dormitory back doors and changing the procedure for scheduling staff meal breaks.

PART TWO Celebrity Justice and the LASD

Equal Treatment Under the Law

By far the most media attention devoted to the workings of the Sheriff's Department this past year involved the arrest of one celebrity and the jailing of another. While the media frenzies in both often devolved to a circus atmosphere, the way in which the Department dealt with these individuals sparked serious complaints about perceived unequal treatment and celebrity justice. In addition, the celebrity arrest highlighted issues of privacy rights of individuals versus the public's interest in knowing when deputies make arrests. The jail case raised additional issues of jail crowding, truth in sentencing, and tensions between various components of the criminal justice system. While OIR's primary role is ensuring that LASD addresses allegations of policy violations appropriately and holds people accountable for provable violations, that role cannot be explained outside the framework of these broader issues.

An indisputable fact underlying these cases is that celebrities are unlike average citizens in the attention their activity generates. The media and a significant segment of the general public display extraordinary interest in any action taken by a celebrity, no matter how mundane or trivial. Celebrities create a "situation" whenever they venture into the public, followed by paparazzi and other onlookers.

When dealing with celebrities, law enforcement officers must walk a fine line between improper preferential treatment and legitimate, necessary adaptation to the challenges posed by the famous. Thus, when a celebrity utters outrageous comments following his arrest or is required to serve a jail sentence, law enforcement realizes that there will be heightened public interest, not because of what has been said or the circumstances of the arrest, but because of who the "actor" is. And when a celebrity is incarcerated, law enforcement must treat her differently to some degree because of security and safety issues and potential disruption of jail functions that the celebrity's mere presence will cause. The challenge faced by law enforcement executives is to carefully manage that differential treatment while ensuring that their personnel do not become "star struck."

The Arrest of a Celebrity: Investigation into LASD Actions

In the summer of 2006, a Sheriff's Deputy arrested Mel Gibson on suspicion of drunk driving. While the high profile of Mr. Gibson guaranteed an intrinsic level of attention, details that emerged within a day or two of the arrest greatly expanded the scope of the controversy. First, a media outlet revealed that Mr. Gibson had behaved obnoxiously at the time of his arrest, and had allegedly made a number of inflammatory and bigoted comments. Then allegations emerged that the Department had improperly sought to keep the alleged inflammatory statements made by the arrestee from review by altering the original police report. Other charges of preferential treatment followed as well.

In response to these allegations, the Department launched a full investigation. One initial priority was a criminal investigation into the leak of confidential information to the media outlet that broke the story. Though some have characterized this as an attempt by the Department to retaliate against the source of the information because of the embarrassment to the Department the leak created, the improper distribution of confidential material is a serious matter. That investigation continues, and no definitive conclusions have been reached.

Meanwhile, the Department has concluded its internal review of many of the other allegations of preferential treatment.[1] As detailed below, after the exhaustive investigation, the Department found that three employees had violated policy in their handling of the celebrity's release from custody; they received discipline accordingly. As to the remainder of the completed issues, the Department found no violations of policy.

During the course of the extremely thorough investigation, IAB conducted numerous interviews and collected, reviewed, and transcribed hundreds of pages of investigative materials. OIR suggested several leads and follow up investigation, which IAB completed. The following is a summary of the Department's findings:

The Excising of the Inflammatory Material from the Arrest Report

The Department found that when the arrest report was first prepared, it contained inflammatory comments allegedly made by Mr. Gibson incident to arrest. The initial response from first and second level supervisors was to order that the comments be entirely stricken from the police report as unnecessary. However, before being implemented, that instruction was modified by the unit commander,

1. After the conclusion of the "leak" investigation, there may be additional findings of policy violations and/or preferential treatment surrounding this aspect of the case.

who proposed that the comments not be included in the narrative of the report but that they be placed instead in a supplemental report.

According to the unit commander, his intent behind his instruction was to preserve all relevant information about the remarks, but to present it to the District Attorney in a way that would limit the media's initial access. Based on the unit commander's instruction, the remarks attributed to the arrestee were included in a supplemental report as opposed to the original arrest report. In spite of speculation that the Sheriff or other top Department executives directed this action on behalf of Mr. Gibson, the unit commander indicated that the decision to segregate the remarks was solely his. The subsequent investigation revealed no evidence that this decision, or any other decision about the treatment of Mr. Gibson, was suggested or influenced by anyone higher in the Departmental hierarchy.

The information regarding the inflammatory remarks was, in fact, preserved in a supplement and forwarded to the District Attorney's office for review and full consideration of what charges, if any, to file against Mr. Gibson. As with any other police report, the fundamental reason for its preparation is to give the prosecutor all relevant information necessary to inform decisions about filing charges. In this case it was clear that the Department did document and did provide the information that later became so controversial, which satisfied its primary obligations in this matter.

Nonetheless, the unusual manner in which that information was conveyed — specifically, the segregation of the "remarks" section into a supplemental report that was not available to the media — certainly bears further attention. The dissemination of information about arrestees is the continued subject of much comment and litigation. The rules and guidelines about what material can, should, and must be made available to the media are far from settled. Indeed, law enforcement agencies have a difficult task in balancing competing values regarding the privacy rights of individuals, the tactical importance of confidentiality in certain investigations, and the public's right to know when police action is taken. Accordingly, OIR intends to work with the Department to continue to develop consistent practices that strike a legal and appropriate balance between these various competing principles.

The Description of the Arrest as Having Been "Without Incident"

After the arrest of Mr. Gibson became known but before the alleged inflammatory remarks were leaked, a departmental spokesman described the arrest as "without incident." Once the inflammatory remarks became public — along with information derived from the report that Mr. Gibson had bolted toward his own vehicle

rather than get into the radio car, requiring the deputy to grab his arm — the allegation surfaced that the Department had misled the media into believing that nothing untoward occurred in the arrest. In the arrest report, the deputy indicated that, once he had placed his arm on Mr. Gibson to stop him, he had handcuffed the arrestee "without further incident." While the better argument is that the strident remarks and Mr. Gibson's brief attempt to walk away belied the idea that the arrest was "without incident" — at least in the common vernacular — that characterization of the arrest did not amount to a violation of Departmental policy. In addition, it should be recognized that the person who made this comment publicly apologized for using that phrase to describe the arrest.

The Videotaping of Mr. Gibson at the Station

After the arresting deputy transported Mr. Gibson to the station, and because it was reported that the arrestee had been behaving belligerently during his transport from the field, he was videotaped at the behest of station supervisory personnel. It was later alleged by one Department member that a supervisor told him she had deliberately erased a tape of the incident because Department personnel had made inappropriate remarks on it. The investigation revealed that there were three videotapes used in an attempt to record the arrestee's time at the station. The supervisor who ordered the taping indicated she had made two tapes using a station camera but then because the batteries died, she used a different camera for the third tape. When she reviewed the tapes, she noticed that the third tape contained only static and snow. Because the third tape was of no evidentiary value, she did not book it into evidence. The supervisor flatly denied both the intentional erasing of the tape and her alleged comment about seeking to conceal inappropriate remarks.

By the time the investigation into the missing third tape had commenced, the camera used to attempt to record the third tape could not be located. However, there was information obtained from non-involved station personnel that the video camera in question had experienced operating problems. While certainly the problem with the third videotape should have been contemporaneously documented and the problematic tape and camera preserved, IAB obtained insufficient evidence to establish the allegation about intentional erasures. In the future, defective equipment and even failed attempts to videotape events should be documented to avoid suspicions and subsequent charges of intentional manipulation of taped evidence.

Mr. Gibson's Use of the Station Phone

Toward the end of Mr. Gibson's stay in the holding facility, his cell phone was returned to him, but it was inoperative. At that point, he was permitted to use the county phone in the holding area but was also unsuccessful in reaching his intended party. According to station personnel, cell phones do not generally

work in the holding area and arrestees about to be released are regularly allowed to use the county phone to arrange for someone to pick them up. Because of the common station practice affording arrestees the ability to use the phone, the use of the station phone in this instance did not amount to a violation of policy and did not constitute favored treatment.

Mr. Gibson's Release

Mr. Gibson had been in the holding cell for several hours when the station shift change occurred. The on-duty watch commander instructed another supervisor that she wanted to be present during the release of the arrestee so she could ensure all appropriate procedures were followed. Some time later, another supervisor from the field came into the station and determined that it was appropriate to begin the release procedures. The station supervisor, who had been told by the watch commander to notify her, came into the holding area and noticed that the release procedures had commenced. Rather than ensure that the watch commander was notified, the station supervisor allowed the release procedures to be completed.

The station jailor conducted the release procedures under the supervision of the field supervisor. A review of the release procedures demonstrated that the proper signatures required for the "notice to appear" citation were not obtained nor was the arrestee's palm print obtained on the booking slip. Both of these procedures are standard protocols for release of arrestees from the station.

The jailer was found to have violated station policy for failing to carry out the appropriate release procedures. The field supervisor was found to have violated policy for beginning release procedures without checking with station supervision and failing to ensure compliance with station release procedures. Finally, the station supervisor was found to have violated policy for failing to ensure the watch commander was contacted once he learned that the release process had begun.

The jailer and field and station supervisors received discipline as a result of their violations of policy.

The Transport of Mr. Gibson from the Station After Release

After the release paperwork had been prepared, albeit missing a signature and palm print, the two supervisors involved in the release of Mr. Gibson decided that it would be preferable to personally drive Mr. Gibson to the tow yard to pick up his car. One of them used his patrol car to transport Mr. Gibson to the tow yard, a distance of approximately eleven miles. This decision was made without any

consultation with the watch commander. The proffered reason for the decision was to avoid having Mr. Gibson encounter any paparazzi while in the lobby waiting for a taxi or for someone to pick him up. While the supervisors suggested that other arrestees had been given rides in the past, neither could identify another similar occasion in which this had been done. Because the Department determined that there was an insufficient legitimate law enforcement reason for this transport and it opened the Department up to an accusation of favorable treatment, the supervisors involved in the decision were found to have violated policy. This finding was part of the basis for discipline for the supervisors in conjunction with the actions described above relating to Mr. Gibson's release.

Potential Lack of Professionalism in the Holding Area

During the investigation, information came to light that perhaps station personnel had allowed non-essential station employees into the holding area to view Mr. Gibson while he was in custody, though there was no legitimate reason for them to be there. The investigation did not produce sufficient evidence to establish that this occurred.

The Alleged Stops of Mr. Gibson in 2003 and 2005

It was publicly alleged that in 2003 and 2005, Mr. Gibson was stopped for suspicion of reckless driving and released without any citations being issued. The public source of this information did not follow up on a request to be interviewed about this allegation. A review of departmental records for the time frame did not reveal any information about earlier stops of Mr. Gibson by Sheriff's Department personnel. While a stop and release could well not have generated any documentary information, without more specific information being provided to the Department, this allegation cannot be further pursued.

In sum, the collection and documentation of information incident to the arrest was timely and appropriately provided to the District Attorney so that he could make appropriate charging decisions. Because of a concern about certain information gathered during the arrest falling prematurely into the hands of media sources and because there was no clear Departmental guidance provided on how to handle the scenario presented, supervisors made spontaneous decisions with regard to how to package the information and describe the arrest. While these decisions do not indicate a violation of Department policy, and were fairly sensible, they do point out the need for creating a thoughtful and systemic approach for how to handle future similar scenarios.

The unauthorized dissemination of information about the arrest cannot be countenanced and the investigation into that concern and related matters remains pending. The other allegations of favored treatment once Mr. Gibson was taken into custody reveal shortcomings by a jailer and two supervisors who failed to ensure completion of routine release procedures, decided to drive Mr. Gibson away from the station without a sufficient law enforcement reason for doing so, and failed to enlist the station watch commander in these decisions were found to have violated policy and were disciplined accordingly. As detailed above, the remaining allegations were not supported by the evidence gathered during an exhaustive, fair, and thorough investigation.

The Incarceration of a Celebrity

In the summer of 2007, LASD was challenged in various ways by the high-profile incarceration of Paris Hilton, an episode that devolved into controversy and intense criticism of the Sheriff. As is often the case, the intense media scrutiny had both positive and negative dimensions. While it contributed to an environment that seemed absurdly overheated at times, it also produced informative and intelligent reporting about the jail system. Along the way, it brought several issues of equal justice to the public's attention and prompted worthwhile debate and discussion. The coverage dissipated, of course, once Ms. Hilton finally was released, but the Department's scrutiny of both the situation and its own handling of it has continued.

The reality is that LASD contends every day with inmates, who, for various reasons, need to be treated differently than the general population of the jail. This may be because outside affiliations, the charges they are facing, or their mental or physical conditions make them especially vulnerable to risk from other inmates and/or the jail experience itself. Ms. Hilton's celebrity certainly put her into this category. The use of special measures to maintain her safety and prevent her notoriety from being exploited was both necessary and reasonable. Indeed, to ignore her celebrity status and the intense media interest in her incarceration would have exposed Ms. Hilton to serious risks of harm and the Department to far greater criticism and near-certain civil liability.

It is to the Department's credit that it recognized — and sought to address — a number of logistical problems arising from Ms. Hilton's celebrity. For example, LASD pre-planned to ensure that LASD employees or other inmates would not attempt to improperly profit from her incarceration. For the most part, LASD succeeded in this regard. The imagined scenarios of exploitation or sensationalism — her jail outfit or half-eaten sandwich showing up on eBay, pictures being

sold of her "behind bars," and a number of others — did not materialize. This is a credit to the professionalism of LASD's personnel, and to the precautions taken by supervisors prior to and during Ms. Hilton's time in jail.

The subsequent evaluation of LASD's conduct has recognized, then, that "special treatment" was not inherently inappropriate. The question instead — across a range of related allegations — has been whether legitimate reasons existed for any unusual steps that the Department took in accommodating Ms. Hilton. The most prominent of these steps related to her highly publicized (and quickly negated) release to home detention within a few days of entering custody. There were other allegations as well, though: that she received new uniforms, special mail deliveries, improper phone access, a freshly prepared cell, and undue consideration from LASD supervisors. Again to LASD's credit, it made a complete inquiry into those allegations.

Ms. Hilton's Release to Home Detention

Much public attention has already been focused on the length of Ms. Hilton's incarceration, her transfer to home detention with electronic monitoring after serving a few days, and her subsequent court-ordered re-incarceration. The outrage over "celebrity justice" that attended her initial release was understandable and even predictable. However, it also largely overlooked the fact that Ms. Hilton had already served far more time than other individuals convicted of the same offense in Los Angeles County. (Several news accounts did discuss this point cogently.) The standard early release is a function of significant overcrowding throughout the county jail system. Given the non-violent nature of her offense and the relative lack of threat she posed to the community, Ms. Hilton could have been released within hours without deviating from the Department's existing protocols.

Instead, the Department made the initial decision to incarcerate her without the overcrowding "discount" that has been a reality in the jails for several years. This was in keeping with the judge's explicit instructions, and presumably was a reflection of the Department's sensitivity to public interest and to the potential messages about equal justice that Ms. Hilton's experience could convey. This inclination seems ironic in light of what ultimately transpired, but the decision about what percentage of her sentenced jail term Ms. Hilton would be required to serve ultimately fell within the Sheriff's discretion as the authority responsible for administration of the county jail system.

Unfortunately for all concerned, Ms. Hilton's health issues complicated an already delicate situation within hours of her arrival. The decision to release her

after a few days was the result of consultations between Sheriff Baca and medical personnel who were treating Ms. Hilton. That it constituted "special treatment" seems clear — it is extremely rare for the Department to release someone from jail early due to medical issues. Again, though, "special" is not intrinsically improper or illegitimate, and the Department's decision must be viewed through the prism of the particular circumstances pertaining to this inmate.

In this case, two treating physicians for Ms. Hilton — both of whom worked for the County, not the Sheriff's Department — were so concerned about the well being of their patient that they raised their concerns directly with the Department and on their own initiative, recommending that she be released. This step by the doctors was highly unusual, and a good faith reliance on the opinions of these medical professionals provided the foundation for the Department's re-assessment of the incarceration. Still, it did not mandate the switch to home detention: the Department deals each day with hundreds if not thousands of inmates with serious mental and physical problems, and of course successfully handled the balance of Ms. Hilton's term when the judge ordered her back to jail. Instead, the Department was exercising its discretion.

Allegations of Misconduct by Department Personnel

Several other allegations also led to inquiries and a formal administrative investigation into possible misconduct by LASD personnel. The administrative investigation into an allegation that a Department member took a photograph of Ms. Hilton in custody and may have inappropriately provided her with food is still pending. The result of the inquiries into other conduct that was characterized as potentially improper, though, is that the conduct either did not occur or had a valid rationale.

Consistent with one allegation, for example, it was determined that whenever Ms. Hilton walked past them in the jail's corridors, other inmates were ordered to face the wall. A critic could certainly portray this as an extreme over-indulgence of one person's sensibilities at the expense of the many. However, it is sound security procedure to require inmates to turn away whenever someone classified as being at a heightened risk of attack by inmates is moving through the jail, as it gives escorting deputies more time to react if another inmate attempts to initiate an assault. Prior to Ms. Hilton's arrival in jail, there were several stories of inmates bragging that they would try to attack her. Therefore, this precaution appears to have been justified and prudent.

Several allegations of special treatment did not address security measures, but rather other conditions of Ms. Hilton's incarceration. For example, it was reported that she received new uniforms instead of recycled ones, previously worn by other

inmates. While this allegation is true, the facts behind the decision to order new uniforms are more complex than a simple desire to coddle a celebrity. Because the jail had time to prepare for all of the circumstances accompanying Ms. Hilton's incarceration, it realized that it no longer had any jail uniforms in Ms. Hilton's presumed size. When jail officials requested uniforms in the appropriate size from the custody laundry, they learned that old uniforms in that size had been removed from regular circulation and that finding the correct uniforms would require personnel to sort through existing warehouse supplies. Jail officials decided it would be easier to have the custody sewing shop make new uniforms rather than undertake this search effort. The jail ordered a number of new uniforms, all of which have been put into regular circulation for use by other inmates.

Of course, one could still assert that it was only Ms. Hilton's celebrity status that caused the Department to think about their uniform size shortage, and that there would not be the same custom order for any other inmate coming into the system. However, regardless of the reasons, the supervisor *was* conscious of the issue ahead of time, and the choice to facilitate delivery of a range of jumpsuit sizes inured to the benefit of a range of inmates — not just Ms. Hilton. As such, it seems more than defensible.

The frequent visits from high-ranking Sheriff's Department officials and special deliveries of mail that Ms. Hilton received — including some from the Captain herself — similarly struck some observers as inappropriate, but here Ms. Hilton's notoriety strained the usual protocols. A Department commander was directed to inspect CRDF and meet with Ms. Hilton each day to address the security issues attendant to her incarceration, including the rumor that paparazzi would make a covert attempt to enter the facility. The Captain also frequently visited to ensure that all the special security measures CRDF had implemented to prevent anyone from snapping a photo or trying to take advantage of Ms. Hilton were being enforced. The Captain did sometimes deliver mail to Ms. Hilton's cell during these visits. Ms. Hilton received unprecedented amounts of mail but was only permitted to have a limited number of letters in her cell at a given time. The majority of mail Ms. Hilton received, including letters that poured in even before she arrived at CRDF, was forwarded to her attorney's office. Other mail was screened according to the jail's normal protocol, but because anything associated with Paris Hilton in jail had a bizarre value to certain interests outside the jail, only assigned individuals were permitted to deliver her mail. For the sake of convenience, the Captain sometimes would pick up a bundle of screened letters on her way to visit Ms. Hilton and would exchange those letters for the ones previously given to her.

Nor were Ms. Hilton's access to a cordless phone and a late night phone call to

Barbara Walters a clear indication that the Department was inappropriately "star struck." No CRDF policy limits the hours during which inmates can use the phone. In the CRDF clinic where Ms. Hilton served the majority of her time, inmates only have access to a cordless phone as a matter of security and convenience, as many of the inmates housed there would require custodial or medical staff assistance to move them to a phone outside the clinic. Inmates' access to the cordless phone is left to the discretion of the deputies and can depend on how busy they are, whether the inmate is being cooperative, and many other factors. The inquiry revealed that Ms. Hilton did have liberal access to the phone during her time in the CRDF clinic, but also showed there were times when Ms. Hilton was denied phone access because other inmates had asked to use the phone before her.

Another allegation of "special treatment" levied against the Department is that Ms. Hilton's jail cell had been steamed cleaned prior to her arrival. As part of the jail's ongoing efforts to combat the MRSA virus, cells are routinely steam cleaned. Ms. Hilton's cell was among those cleaned several days before she turned herself in to serve her sentence.

Finally, some observers alleged that the Captain of CRDF helped Ms. Hilton prepare to leave jail by giving her scissors to cut her hair and helping her "primp." The Internal Affairs inquiry revealed insufficient evidence that these actions, in fact, occurred.

LASD's investigation into these matters was thorough. While the investigation into these allegations certainly revealed treatment of Paris Hilton that differed from other inmates, it also demonstrated that the differences were the result of legitimate concerns regarding Ms. Hilton's safety and security, as well as LASD's need to maintain normal operations of its jails with minimal disruption. The extraordinary media coverage and intense public interest in this case required the Department to use some creativity and exercise its discretion in the implementation of the various restrictions and protocols that were in place for Ms. Hilton's protection (and to minimize the likelihood of problems with other inmates or staff).

Though criticism of some of the Department's decisions regarding Ms. Hilton's incarceration was understandable, that criticism is fairest and most useful when it occurs in a context of accurate information and clear understanding. This case resulted in healthy discussions both within and outside the Department about ways to improve the Department's communication with the public on these important issues. The Department has a role in fostering the public's understanding by welcoming thorough and fair investigations in matters of public concern. While no proven instances of misconduct have yet emerged from the case, the intensity

of public interest tested the Department's decisions and actions in a way it should always be prepared to withstand.

In the handling of Ms. Hilton's case, the important and difficult issues of jail overcrowding, the early release program, truth in sentencing, and alternative methods of serving a sentence all managed to come into play. Those same thorny issues beleaguer the Department daily, but Ms. Hilton's celebrity became a somewhat distorting prism for the public's scrutiny of them. With so much exclusive focus on her, what was lost for many people was the fact that, because of the size of the inmate population in Los Angeles County, female inmates regularly serve a very small fraction of their sentence — or no sentence at all. What was not so clearly understood in the uproar is that, while the Department wishes it could, it often cannot honor the preferences of the judiciary about how much actual jail time a defendant should serve. And what was not clearly illustrated was how the overcrowded jails and concomitant reduced sentences being awarded in Los Angeles County remove the incentive for non-violent defendants to serve their sentence through electronic monitoring or other means — instead, they know they must only endure a severely truncated trip to jail.

The incomplete depiction of the arithmetical gymnastics that now figure into how an inmate's sentence is calculated because of space constraints, concerns about over detention, state laws and other factors as applied to this case caused a significant portion of the general public to think that Ms. Hilton was getting a "sweet deal" because of who she was. In reality, this particular celebrity ended up spending much more time in custody than anyone else in her situation would likely have done.

The public cannot be blamed for failing to understand and support a bewildering system of calculating jail time. It is a system that changes as the jail population, available facilities, and other intractable factors ebb and flow and, at least for the female inmates, does not come close to mimicking the sentences handed down by the judges. We are cognizant that all the "hoopla" to the side, this event caused some light to be shone on these issues. It promoted healthy discussion both within and outside the Department about how jail sentences are served, and how they can become not only more understandable to the people of Los Angeles County, but also more sensible.

PART THREE Shootings and Force

Executive Force Review Committee: Deadly Force and the Discipline Process

As we have discussed in past reports, the Department has an elaborate protocol for reviewing all deputy-involved shootings, all bites by the Department's police service dogs, and a percentage of other serious force cases (usually involving significant injury to the suspect). The Executive Force Review Committee is a panel of high-ranking and experienced supervisors that hears a detailed factual presentation about each incident, consults with various interested parties (including an attorney from OIR), and then renders judgments for purposes of further action. Outcomes could include individual accountability (up to and including discipline) for the officers, designated individualized or department level training, individualized or station level briefings, proposed reforms to policy and procedure, and/or further study regarding questions about tactics, equipment, or other relevant issues.

Monitoring the work of the Executive Force Review Committee and participating in its analysis of cases has been a central part of OIR's protocol since 2001. We continue to be impressed with the thoughtfulness and thoroughness of the process. We also appreciate the Committee's willingness to consider these cases broadly and to view them as learning opportunities for the Department. This holistic approach to critical incidents is, in OIR's view, one of the strongest features of the Department's internal review process. It is also a model that other agencies could constructively emulate.

Still, one of the questions that the Department and we periodically wrestle with relates to whether and when performance failures by well-intentioned officers, in the context of critical incidents, should be a subject for discipline. This issue is especially acute during the review of an officer-involved shooting. Against a backdrop of heightened public scrutiny (and, frequently, litigation), the Department must conduct a rigorous review of the incident and devise a remedial course of action that recognizes the interests of the public, the Department, and the involved personnel.

When deadly forced is used, the first priority for any review is an assessment of the legal justification for the officer's actions. For every hit shooting involving a deputy, the Department's Homicide Bureau conducts an investigation into the incident and presents its book of evidence to the District Attorney's Office for review. In the overwhelming majority of cases, the D.A. finds no basis for taking prosecutorial action against the shooter deputy, and often affirmatively finds that the shooting was justified by the threat that was either posed by the suspect and/or reasonably perceived by the shooter.[1]

The question of whether the shooting was legal is a crucial but narrow one. It focuses on the instant that the trigger was pulled, and properly so, but the events leading up to that critical decision are also worthy of close attention. The Department's Executive Force Review Committee reviews the shooting (and other critical events, such as non-hit shootings and force incidents that lead to significant injury) from a broader administrative perspective. It determines whether policy violations occurred, what the response to identified violations should be, and what steps the Department should take to address other implicated issues of policy, procedure, supervision, equipment, and/or training.

The substance and vigor of this administrative review is greater than it once was within the Committee. This trend, which we have cited in previous Annual Reports, is especially noteworthy in light of law enforcement's traditional reluctance to be perceived as "undermining" or "piling on" when officers have struggled or displayed poor tactics in the context of a dangerous or traumatic encounter. In fact, in our experience, the tendency among law enforcement agencies that perform these reviews is to function as "cheerleader" as often as scrutinizer. The concern is understandable, and the impulse to provide support is a positive one. It is important, however, that the Department also maintains a commitment to careful scrutiny of these incidents, and takes steps to address the issues they implicate.

Many of the incidents are extremely straightforward, and in other instances the deputies respond to complex challenges with exemplary planning and execution. Frequently, though, the tactical decisions and the individual actions or omissions that comprise a shooting incident are more debatable. OIR has consistently taken the position that the Department should address policy violations and performance lapses directly. This is, however, easier said than done, particularly in shooting cases. It is also true that, even when the EFRC panel determines that discipline is appropriate in a given case, the grievance and appeals process can and does negate the efforts and judgment of the committee on occasion.

1 In fact, the District Attorney's Office has not filed criminal charges against a deputy in connection with a single shooting incident since OIR started, and for many years prior to 2001 as well.

CASE

A driver who was operating his car erratically refused to pull over when deputies attempted a traffic stop, and ended up in a lengthy vehicle pursuit that circled through the streets of his own neighborhood. Eventually, deputies developed a plan to deploy a "spike strip" that would disable the suspect's car when he drove over it. Seeing their opportunity, a pair of deputies worked together to place the strip as the suspect approached. However, a couple of problems arose: for one thing, the deputy who actually handled the strip had not gone through the required training, and he placed himself in danger while attempting to position the device as the suspect drove toward him. As he scrambled out of the way, the suspect went over the strip, which failed to function properly. Meanwhile, the other deputy, seeing the suspect veer in the direction of the first officer, perceived a deadly threat to his partner and fired several rounds to protect him. The suspect was killed.

The EFRC found that the shooting itself was in policy considering the state of mind of the shooting deputy. However, the EFRC determined that the deputy who deployed the spike strip had done so in an unsafe manner, jeopardizing his safety and forcing his fellow deputy to use deadly force. It was further learned during the shooting investigation that the deputy who deployed the spike strips had not had any formal training in the use of them. As a result, and in concurrence with OIR, the EFRC disciplined the deputy who deployed the spike strips.

It was also learned from this review that several patrol stations do not have sufficient spike strips working in good order at their disposal, sufficient deputies properly trained in the use of spike strips, and sufficiently accurate in-service sheets informing supervision about who, in any one shift, does have the appropriate training in the use of this equipment. The Training Bureau was tasked with working to shore up the inventory and training of this tool — an example of the constructive collateral outcomes that the review process often yields.

The deputy who received discipline grieved the imposition and based on that grievance, the patrol region executives removed the disciplinary finding and decided to handle the matter solely as a training issue. While certainly the training on spike strip deployment was an important piece in responding to the issues emanating from the shooting, OIR disagreed with the elimination of the disciplinary component. In OIR's view, the decision by the deputy to place himself in peril and force his fellow deputy to use deadly force was so below the performance standards expected of him, that the discipline afforded him should have remained.

Beyond the reluctance to critically second-guess officers who have been in a shooting, there is also the analytical challenge of parsing through split-second

decisions and assessing them fairly and constructively. Often, the officer's "state of mind" becomes of paramount importance. This adds a subjective component to the assessment that complicates the effort to apply an appropriate standard. Certainly, this also creates the potential for vigorous challenge of discipline in the civil service process.

CASE

Two deputies contacted the sole occupant of a vehicle parked on the side of a rural road. Deputy A walked to the passenger side of the car while his partner, Deputy B, approached the driver. Deputy B obtained the suspect's driver's license and learned via his patrol vehicle's Mobile Digital Terminal that the suspect was wanted on a felony warrant and should be considered armed and dangerous. Deputy B notified Deputy A of this fact over their handheld radios as he returned to the suspect's car. Deputy B asked the suspect to get out of the vehicle, but the suspect instead reached for the ignition key in an attempt to start the vehicle and flee. Deputy B opened the driver's door and grabbed the suspect's arm to pull him out of the car. As that struggle was ongoing, Deputy A leaned in through the passenger's window in an attempt to gain control of the suspect. He struggled with the suspect with one hand while he held his gun in the other.

Nonetheless, the suspect was able to start the car and put the car in gear. Realizing he could be hit or dragged by the vehicle, Deputy B pulled away. Deputy A was stuck in the car momentarily as it pulled away, but eventually was able to free himself. Because he could not see his partner, he feared Deputy B was being dragged by the vehicle and fired his weapon once at the fleeing suspect's car. This shot did not strike the suspect or disable the vehicle. Deputy A then realized Deputy B was unharmed, and both deputies returned to their patrol car to chase the suspect vehicle. After a short pursuit, they apprehended and arrested him.

The Department's Executive Force Review Committee reviewed this incident and recommended a suspension for Deputy A for violating the "Performance to Standards" policy. The Department concluded that Deputy A had made poor tactical decisions — leaning into the suspect's vehicle, not adequately communicating with his partner, and firing his weapon at the vehicle without sufficient justification — that endangered himself as well as his partner.

The case went to arbitration before the County's Employee Relations Commission, which overturned the Department's three-day suspension. The arbitrator disregarded the opinion of the LASD Commander who testified in support of the Department's decision and, relying mainly on the testimony of a deputy who also served as the president of ALADS, concluded that Deputy A acted reasonably and in accordance with the Department's standards.

The overturning of EFRC decisions by hearing officers (and the attendant undoing of Departmental discipline) threatens to discourage the exercise of that remedial option — a consequence OIR understands but urges the Department to resist.

Another illustrative case involved a hit shooting in which the suspect was killed at the end of a foot pursuit. The suspect, who had been attempting to get over a fence in a residential neighborhood, instead turned to confront the deputy. The deputy had closed distance with his gun, and in the ensuing contact he believed that the suspect was trying to take the weapon from him. He fired once, killing the suspect, who was himself unarmed.

In reviewing this case, the EFRC panel found the shooting to be justified and in-policy because of the threat the deputy perceived in grappling with the suspect. However, the Committee took a different view of the deputy's actions prior to the shooting. It found that the deputy had fallen short of Departmental expectations to the point that he violated the policy requiring performance to standards. Specifically, the Committee cited two things: that the deputy had improperly split from his trainee — whom he had ordered to detain the passenger in the suspect's car as the suspect fled — and that the deputy's decision to close distance to the suspect with his weapon drawn pointed had precipitated the fatal round.

OIR concurred with this analysis, and with the Division Chief's subsequent decision to reduce the discipline from five days to two before imposition. Nonetheless, the deputy grieved the case in spite of the proferred "discount", and it eventually made its way on to the schedule of the Employee Relations Commission. It was set for hearing this year — more than four years after the shooting itself.[2]

In the final days before the hearing, the parties began to talk about a possible resolution. The Division Chief who now had responsibility for the case saw a number of arguments in favor of settling it. He had come to believe that the chances of prevailing were middling at best, due to the ambiguity of the tactical standards that the deputy had allegedly failed to meet. He pointed to ERCOM's established reluctance to uphold suspensions in cases involving the deputies' tactical choices and responses to danger: when standards are at all gray, the state of mind of the involved deputies has tended to trump analysis about how those choices compare to Departmental preferences. He also cited the deposition testimony that a Department executive had given in connection with the wrongful death suit filed by the suspect's family in which the executive had opined that

2 This time gap obviously strains the effectiveness of the discipline system as a managerial tool, and adds to the burden of deputies seeking vindication.

the tactics were potentially reasonable.[3] At certain points (which the deputy was likely to emphasize in his hearing), that testimony supported the idea that Department standards — unless specific and explicit — must be interpreted in conjunction with the individual deputy's state of mind and need for discretion in a given situation.

Additionally, the Chief made the point that the same fact pattern would be governed today by a new and different policy relating to foot pursuits. This reality lessened the need for the Department to push its position in this older case for purposes of "making a statement" and prospectively influencing the behavior of deputies. Finally, because the case had been a somewhat high profile one, and had been a source of some contention between the Department and ALADS, the Chief believed there was wisdom to resolving it at a point when the Department still had control over the result.

To his credit, the Chief consulted openly and repeatedly with OIR during this process, listening to all the competing arguments and weighing his options with thoughtfulness and a strong sense of responsibility. OIR took the position that the case could be won and should be pursued. While recognizing the vulnerability that the Department feels when taking its cases to the outside forum of ERCOM, OIR believes the best response is sound investigations, clear decision-making, and cogent presentations at hearing. All of these elements were either in place or potentially in place had the Department chosen to move forward. Instead, the Department and the deputy agreed to a change that rendered the allegations "unresolved" and eliminated the discipline.

Though that outcome was somewhat discouraging, a subsequent case had a different result.

CASE

Deputies responding to a call of an armed robbery in progress identified a U-Haul truck as the suspect vehicle and began to follow it. Conscious that they were near a school during daytime hours, they decided to wait until they were clear of the area to attempt to stop the truck. The suspect driver stopped on his own, however, directly across from the school and mid-way down a block of a relatively busy street. By this time, additional deputies in several patrol cars had responded. One of those deputies, Deputy Z, passed by the stopped U-Haul on his way to set a traffic break at the next intersection.

3 The suit settled in 2005 with a payout of several hundred thousand dollars to the family.

As the truck stopped, the back gate was slightly open and deputies could see feet in the back of the truck. The driver surrendered, but two suspects emerged from the back of the truck and fled in different directions. One scaled a fence and ran through the schoolyard, where he was eventually caught by a number of deputies who went in foot pursuit, and the other ran down the street toward Deputy Z's radio car. Deputy Z exited the vehicle, pointed his weapon at the suspect, and ordered him to stop. The suspect looked at Deputy Z but continued to run, now reaching into his pants pocket. The suspect turned the corner and kept running, with Deputy Z following, ordering the suspect to stop and remove his hand from his pocket.

After a short pursuit, the suspect stopped, turned, and looked at Deputy Z while reaching deeper into his pocket. Given the suspect's repeated failures to heed his commands to show his hands, Deputy Z believed the suspect was reaching for a weapon and fired two rounds. Both missed, and the suspect again started running away from the deputy. A very short distance later, the suspect again turned toward Deputy Z, who fired two additional rounds, striking the suspect in the wrist and thigh. The suspect fell to the ground and deputies took him into custody. Deputies discovered a cell phone, but no weapon, in the suspect's pocket.

The EFRC found the shooting was justified, given the deputy's reasonable belief that the suspect possessed a weapon. (Deputies were responding to a robbery call in which the suspects were reportedly armed, and both the Aero unit that was tracking the pursuit and another deputy who was following in his car to assist Deputy Z confirmed that the suspect was reaching into his pocket in a manner that made them believe he was armed.) However, the Committee found fault with the deputy's tactics — jeopardizing his own safety by driving past the U-Haul truck, positioning his radio car in a potential line of fire, and leaving the cover provided by his vehicle to engage the suspect as he ran toward him — and recommended the deputy be disciplined.

Executives at the Region disagreed with the EFRC panel's assessment of the shooting and, at least initially, did not believe the deputy should be disciplined. While such a decision is within the Region's discretion, the Chief sought a meeting with the chair of the EFRC and OIR in an attempt to reach consensus on an appropriate outcome. After a lengthy meeting with a detailed discussion of the facts of the case and an open exchange of views, the Chief and EFRC chair agreed on a disposition that reduced the number of days off and grounds for discipline but still found policy violations by the deputy. OIR concurred in this outcome.

In particular, we were impressed with the way the process worked in this case, the thoughtfulness with which the involved Department executives approached the matter, and the time they were willing to devote to mastering the facts of the case and considering the tactical issues involved. Importantly, by reaching out to the chairperson of the EFRC (as well as OIR), the Chief ensured that all aspects of the review received a thorough airing and still maintained his decision-making prerogative.

Summary of Anti-Huddling Issue/Status:

In our 2006 annual report, OIR described its discussions with the Department and non-Department parties, including the District Attorney's office, about the Department's practice of allowing deputies — shooters and/or non-shooters — to meet in a group with their designated legal representative to discuss the circumstances surrounding a shooting. Those discussions included an examination of several issues, including the maintenance of the integrity of an investigation of deputy-involved shootings, avoidance of the perception of an unfair and partial investigation, consideration of Department personnel and space for separation of involved members, and ensuring the Department meets the emotional and physical needs of the involved personnel. Our 2006 annual report also described the Department's meet and confer process with the various unions which represent Department deputies and adoption of the revised Department's policy. A copy of the revised policy in its entirety was included in last year's report.

OIR continues to monitor the Department's implementation of this revised policy and to refine its implementation. With extraordinary ease and effectiveness, the Department has trained the appropriate Department personnel on the revised policy requirements. The Department's training instructed its supervisors that in a deputy-involved shooting, a non-involved supervisor is responsible for the following:

1. Ensuring that after the provision of the public safety statements, involved and witness deputies in a shooting do not communicate with each other about the circumstances of the shooting among themselves or in a group meeting with their legal representative before being interviewed by the Department's internal investigators;

2. At the scene of the shooting and after the public safety threat has diminished, ensuring that the involved deputies and witness deputies are separated or do not communicate with each other or discuss the circumstances of the shooting and the involved deputies and witness deputies are transported back to the

station by either a non-involved supervisor or separately by non-involved deputies;

3. At the station, ensuring that either the involved deputies and witness deputies are separated or prevented from communicating or discussing the circumstances of the shooting until interviewed by the Department's internal investigators; and

4. Ensuring that while the involved deputies and witness deputies may each discuss his or her role in the shooting with his or her legal representative before being interviewed by the Department's internal investigators, this communication with legal counsel does not occur in a group setting.

Moreover, the Department has created a deputy-involved shooting supervisor checklist, which further assists supervisors to ensure that appropriate Department protocols are followed. The checklist set forth protocols regarding a supervisor's responsibilities at the scene of a shooting and at the station. The protocols include discussions about the handling and securing the scene, identifying and separating involved and witness deputies and civilian witnesses and the transporting of involved and witness deputies and civilian witnesses to the station. Pursuant to OIR recommendations, the Department agreed to modify the checklist to clarify the responsibilities of the supervisors. While the Department has made available the unmodified checklist to supervisors, it has been slow to do the same with the modified version.

Furthermore, pursuant to an OIR recommendation, the Department agreed in each shooting incident to document whether the supervisor has followed the adopted policy and protocols set forth in the checklist.

High Volume Shootings Revisited

In May 2005, at the terminus of a low speed vehicle pursuit that circled repeatedly through a small neighborhood in Compton, deputies surrounded the suspect vehicle. When the suspect driver started the vehicle again and collided with a patrol vehicle, deputies opened fire. Ten deputies fired a total of 120 rounds. The suspect was hit by two bullets and wounded in the arm. One of the deputies was also hit — fortunately in his ballistic vest — by "friendly fire." Other bullets entered several nearby houses.

OIR was asked to review the incident and evaluate compliance with existing force policies, shortcomings of those policies and training issues that may have

contributed to the incident. OIR's report — see Fifth Annual Report as well as full text at www.laoir.com — identified policy problems and documented the Department's reaction to the training and tactics shortcomings demonstrated by the incident.

A January 2006 shooting, also in Compton, where deputies shot 52 rounds into a house, sometimes without a discernable target, and did not hit the suspect, demonstrated that the issues highlighted by OIR and others within the Department were not likely to go away without more concerted effort. The Department formed a commander's panel to serve as the core of a working group to study the phenomenon of high volume shootings, to identify problems and their sources and to recommend solutions. In our Fifth Annual Report, we reported that this working group had shown a promising start but appeared to have stalled in its journey towards concrete changes. Now we are pleased to report that the working group has finished its work and produced an excellent set of relevant recommendations.

The aim of the working group was to look for patterns common to high volume shootings in general rather than to focus on the most dramatic incidents. The working group also recognized that some high volume shootings are necessary and well managed, and positive lessons can be extracted from those. It is hoped that the task force's conclusions and recommendations will be applicable to a variety of situations in the future and will help reduce their frequency as well as the dangers inherent in high volume shootings.

The working group recommended, among other things, that:

- Field supervisors be directed to leave the station more often and increase their presence and affirmative supervision in the field.
- Department trainers emphasize "critical incident self-deployment" concepts to encourage deputies to assume other roles at an incident instead of taking a place "on the firing line."
- The Department expand the successful "Team Training" program administered by the Special Enforcement Bureau in one field operations region to the other two regions.
- Training and availability be adjusted to encourage increased use of the AR-15 patrol rifle, preferable in some circumstances for its control and accuracy.
- The LASD weapons certification regimen requires periodic qualification in the use of the patrol shotgun.
- Patrol training and practice develop the full potential of "less-lethal" force options, such as the "Stunbag Shotgun," the ARWEN baton gun (and the anticipated more modern replacement), and the "pepperball" gun.

- Personnel deployment ensure an adequate staff of dedicated mobile range instructors so that mobile firing ranges are more frequently available and can provide remedial training in addition to shooting qualification.
- The Department establish a database of shooting incidents that would facilitate future study.

OIR commends the LASD for focusing its considerable creativity and experience on the troubling phenomenon of high volume shootings. The working group was receptive to OIR's input throughout the process that produced its final recommendations. We will monitor the department's progress with interest as it moves forward to prioritize and implement these proposals.

EFRC: Training, Tactics and Supervision

As discussed above, even when a use of force is within Department policy, EFRC and OIR continue to give consideration to potential tactical and training issues. In 2007, for example, OIR monitored a Department investigation of a shooting that occurred during a routine patrol of an area.

CASE

Deputies on special assignment were patrolling an area that recently had experienced a high number of nighttime burglaries. Two deputies observed a man walking on a sidewalk and, given the lateness of the hour, the reported burglaries and the area's isolation, decided to contact him. The deputies drove their patrol car near the man and from inside their patrol car, called out to him. The man appeared surprised by the deputies' presence and placed his left hand into his left front pants' pocket. While still in the patrol car, Deputy A, the driver of the patrol car, withdrew his service weapon, pointed it at the man and ordered him to show his hands. The man began fumbling with his waistband. Deputy A then ordered the man to come to the patrol car and place his hands on the patrol car's hood. Initially, the man hesitated; however, he then walked to the patrol car on the driver's side and placed his hands on the patrol car.

Once the man placed his hands on the patrol car's hood, Deputy B drew his service pistol and exited the patrol car. From across the hood, Deputy B pointed his pistol at the man, and at this time, Deputy A saw the man again reach toward a front pants' pocket. Deputy A ordered the man to keep his hands visible. When the man refused to remain still, both deputies approached the man and tried to restrain him against the patrol car. Deputy A told Deputy B to handcuff the man. Deputy B placed one cuff on the man's left wrist, and while Deputy A held both of the man's hands, Deputy B kicked the man's legs apart. A gun then fell to the ground from the man's pant's leg.

At this time, the man turned to his left, kicked the gun under the patrol car and tried to break free of the deputies' grasp. To prevent the man from escaping, Deputy A tackled the suspect to the ground, and the man and the two deputies then fell to the ground.

While on the ground, the man began to struggle with the deputies, and at one point, he grabbed Deputy A's gun which had been re-holstered. To prevent the man seizing his pistol, Deputy A grabbed the man's hand and tried to remove it from his pistol. When Deputy A was unable to remove the man's hand from his pistol, he shouted to his partner, Deputy B, "He's got my gun. Shoot him." Although the man verbally denied having the pistol, he pulled even harder to remove it from Deputy A's holster. When Deputy B saw the man removing the pistol from Deputy A's holster, Deputy B fired twice into the man's back. The man then released his grip on Deputy A's gun and subsequently died from the gun shot wounds.

Because of the threat to the deputies' lives, EFRC commanders determined the shooting to be within Department policy. The man who was struggling with the deputies was non-compliant and was arming himself with Deputy A's gun. When Deputy B fired his shots, the man was removing Deputy A's gun and arming himself. The OIR attorney who monitored this shooting review concurred that the shooting was within Department policy; however, the attorney had several concerns about the deputies' approach of a man whom they believed was armed and non-compliant. First, if Deputy A felt sufficient threat to draw his service weapon before physically contacting the man, re-holstering his service pistol was a questionable tactic when he approached a non-compliant and possibly armed person. Second, Deputy B's re-holstering of his service weapon to handcuff the suspected armed man left both deputies vulnerable. After discussions with both the OIR attorney and EFRC commanders, the unit commander agreed to institute routine discussions and training for deputies on special assignment regarding methods of approaching suspected armed persons and proper handcuffing techniques.

Also in 2007, OIR monitored a use of force case that involved a sergeant deploying a taser on a non-compliant person. Even though the force used was within Department policy, EFRC and OIR analyzed the sergeant's tactics before deploying the taser.

CASE

Department patrol personnel received a radio call regarding a fight near a fairly busy intersection. As personnel responded to the area, they received additional information that a robbery had recently occurred in the same area and the information provided about the two robbery suspects matched the description of two of the persons involved in the fight.

The first responder to the fight scene was a sergeant. As the sergeant arrived on scene, she pulled her patrol vehicle behind a group of nine persons and ordered the individuals to stop and place their hands on the patrol vehicle's hood. Except for one person in the group, everyone in the group complied with the sergeant's orders. The person who refused to comply walked around the patrol vehicle to its rear and away from the sergeant and the group of persons. The sergeant, who was alone and who had not requested back-up assistance, got out of the patrol vehicle and attempted to grab the non-compliant person's arm. The non-compliant person pulled away from the sergeant and continued to walk away. At some point, while walking away from the sergeant, the non-compliant person, who matched the description of one of the robbery suspects, turned and reached toward her waistband. The sergeant fired her taser a single time and struck the non-compliant person in the back. Assisting deputies arrived and took the non-compliant person, who had fallen to the ground, into custody. A subsequent field show-up as well as the recovery of property taken during the robbery confirmed that the non-complaint person and another individual in the group were involved in the earlier robbery.

As a result of extensive discussions between the OIR attorney responsible for monitoring the Department review of the force, EFRC commanders and Department training experts, a consensus was reached that while the sergeant's use of force was within Department policy, there were certain weaknesses in the sergeant's tactics and decisions. First, the sergeant should have requested back-up before contacting the group of nine persons. Given that the sergeant was greatly outnumbered by the group of individuals and that she had information indicating that the robbery suspects may have been among those comprising the group, officer safety dictated that the sergeant wait for assisting units before contacting the group. Second, once the sergeant made contact with the group, rather than turn her back on the group of persons and follow the non-compliant person, the sergeant should have detained the group and waited for assistance before attempting to detain the non-compliant person. Third, when confronted with a deadly force scenario, the sergeant used less than lethal force. The sergeant believed that the non-compliant person might be armed with a weapon, and the circumstantial facts supported that belief. Before the sergeant contacted the group, she had received information of a fight at the intersection, a recent robbery near the intersection, and descriptions of the suspected robbers. The non-compliant person matched the description of one of the suspected robbers.

The sergeant's tactics and decisions heightened the risk of danger to herself and deviated from Department training. While the OIR attorney and EFRC commanders recognized that the deployment of the taser prevented possible death of the non-compliant person, the OIR attorney and EFRC commanders agreed that relevant training was in order for the sergeant, and they worked together to determine and recommend specifically tailored training for the sergeant.

CASE

Deputies were flagged down by a child who told them that a man was threatening people with a knife at his apartment building and had already stabbed the child's father in the leg. The deputies called in back-up units and talked to the suspect's relatives in the building's courtyard. They pointed out the suspect behind a heavy metal screen door in a ground floor apartment. Other units arrived, including a field sergeant, who deployed the deputies in a semi-circle in front of the suspect's door. One deputy with a Taser was placed to the side of the door. The sergeant assigned himself to operate a video camera. The deputies tried to calm the suspect whom they could see inside the door holding several knives and other sharp objects and mumbling to himself. They enlisted the help of the suspect's brother as well to try to persuade the suspect to come out of the apartment without weapons, but to no avail. Suddenly, the suspect burst out of his door brandishing the knives and ran toward the deputy holding the Taser. This deputy fired the Taser but missed. He then moved quickly away from the charging suspect. Several deputies, including the sergeant who had to drop the video camera, opened fire with handguns and shot the suspect fatally. A total of twenty-seven rounds were fired, striking the suspect seventeen times. The suspect's brother was also accidentally shot in the leg during the confusion.

Following an extensive analysis of the incident in the Executive Force Review process, the panel of Commanders concluded that, while the deputies' use of deadly force was justified, the sergeant had failed to evaluate the situation tactically and to deploy the available resources soundly. They found, among other things, that the sergeant had:

- Failed to recognize the situation as a "barricaded suspect" and deploy other less lethal weapons such as the bean bag shotgun and the Arwen rubber baton gun or to request a special weapons team.
- Failed to safeguard the welfare of a member of the public, the suspect's brother.
- Failed to avoid a foreseeable crossfire situation.
- Failed to accurately assess the level of threat posed by the suspect, and
- Compromised his ability to supervise a critical incident by attempting to videotape it himself.

The Commander's panel found that these tactical errors amounted to a violation of the Department's performance standards and imposed significant discipline on him.

PART FOUR Policies and Updates

Inmate Search Policy

OIR frequently receives letters and telephone calls from inmates and their family members complaining about various aspects of the inmate's incarceration in one of the County's jails. A common complaint is that deputies improperly searched the inmate's cell and either seized, lost, or destroyed some items of that inmate's personal property. The Sheriff himself sometimes hears directly from inmates about their problems and complaints, and he became concerned that the Custody Division's policies regulating cell searches did not do enough to protect inmates' legitimate expectations regarding their property. The Sheriff directed Custody to reform its inmate search policy, and OIR worked with Custody personnel on this task.

Searching inmates' housing areas is a vital function of any custody operation and is necessary for the safety of both deputies and inmates. The most effective way to limit inmates' ability to produce pruno (home-made alcohol made from fruit) and manufacture and possess weapons or other contraband is to frequently search their cells and seize any contraband found. Indeed, we have argued in past reports that the jails should do more to ensure that all inmate housing areas are searched on a regular basis. At the same time, we agree with the Sheriff that searches have to be conducted in a manner that respects inmates' property rights. The revised inmate search policy emphasizes the dual goals of (1) using searches to preserve the security of the facility by controlling contraband and (2) minimizing the likelihood that inmates' legitimately-owned property will be destroyed.

Two major changes to the former policy aim to accomplish this latter goal. Both are rooted in OIR's observations that many inmate complaints about cell searches could be resolved with more appropriate supervision and adequate documentation. First, the revised policy requires that the module or floor sergeant be notified prior to the start of any housing area search, and that a sergeant or senior deputy be present during the entire search. Second, the policy makes it the responsibility

of the sergeant or senior deputy to complete a search report and submit it to the watch commander, to be maintained for at least 90 days. The sergeant or senior deputy is to remain in the housing area to handle any complaints until all inmates have returned.

Finally, the revised policy provides specific direction regarding how to handle inmate's property, including how to deal with the personal items of inmates who are and are not present for the search, what to do with personal property in excess of the allowable amount, and what property is required to be disposed of or destroyed. Taken as a whole, the policy reflects an appropriate regard for inmate rights and establishes substantive changes that should improve the situation.

Use of Force to Restrain Medical Patients

Field Operations Support Services ("FOSS") asked OIR to consult on the development of a new Field Operations Directive to provide guidance to deputies who may be called upon to forcibly restrain medical patients. This issue originated with concerns by leaders of the Field Operations Regions that their deputies were not doing enough to assist paramedics or other medical personnel with patients who unintentionally exhibit violent behavior as a result, for example, of overdose, mental instability, or seizure. The reported unwillingness of deputies to assist, they believed, resulted from a lack of clarity in the Department's force policy, uncertainty about how to document such force, and a hesitance to use force that might later be deemed unreasonable. Without a clear mandate and guidance on these issues, the Field Ops leaders were concerned that deputies would stand down when the Depart-ment wanted them to step up and handle these challenging situations. OIR initially worried that deputies lacked standing to intervene in these situations and that the use of force to restrain medical patients could create significant liability for the Department. However, after several meetings with FOSS, Field Ops leaders, and the Department's legal counsel, we better understood the Department's imperative and worked with the Department counsel's to reach a consensus on the standing issue.

OIR reviewed FOSS's initial draft of the proposed Field Ops Directive, conducted some legal research, and made numerous suggestions for re-working that draft. FOSS personnel were receptive to OIR's suggestions and worked hard to create a sound directive that accomplishes the Department's goal of providing guidance and direction to field deputies who face the demanding task of responding to violent, non-criminal, medical patients.

The pertinent part of the Field Ops Directive states:

"It is our policy to provide appropriate public safety services at the scene of an emergency. This includes the use of force to restrain medical patients, or other individuals, when objectively reasonable. This standard is met where the deputy has objective, specific and articulable facts leading to a belief that the subject poses a risk to the safety/security of themselves or others."

The Directive further makes it clear that the use of force in a medical situation does not create a requirement or expectation that the patient will be arrested or cited for resisting the deputy. It also instructs deputies who apply restraints to a subject in the field to accompany the subject to the hospital, but provides that deputies generally are not to be dispatched to hospitals or other medical facilities for the purpose of controlling patients. Finally, the Directive mandates deputies to adhere to the use of force reporting requirements contained in the LASD's Manual of Policy and Procedures.

Vehicle Pursuit Policy

This past year LASD implemented a revised vehicle pursuit policy. LASD's old pursuit policy was already recognized as a leader in the field in its balancing of the need to apprehend criminal suspects and the need to safeguard innocent lives that could be affected by a pursuit. The revision made some minor changes to the language delineating appropriate and inappropriate pursuits. It also emphasized the responsibility of all participants to ensure that pursuits are conducted within policy and without unauthorized participation by extra deputies.

Under state law, a law enforcement agency can acquire immunity from liability for damages resulting from pursuits of vehicles if the agency has an appropriate policy and training regarding vehicle pursuits. This past year the legislature amended the immunity statute, requiring LASD to reexamine this pursuit policy and revise it to bring it into compliance with the new standards. At the same time, as a result of our examination of several vehicle pursuits, OIR had a few suggested revisions to the pursuit policy. As a result, OIR and LASD collaborated to revise the vehicle pursuit policy.

OIR's primary focus was to ensure that the Watch Commanders responsible for managing the pursuit at the station are provided accurate information about the pursuit in order to properly manage it. In addition, OIR sought language to ensure that patrol cars involved in a pursuit are properly identified, and that unauthorized participants are expressly excluded. OIR also focused on helping LASD better utilize the valuable resource of helicopter support. The expertise of Aero Bureau personnel, and the obvious advantages their perspective affords them, make the

mode" if the pursuit is terminated, and helping the watch commander learn in real time the units that are in the pursuit.

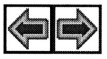
One of the remarkable features of the process in our view was the relative speed with which LASD tackled this reform, without sacrificing careful thought and analysis. In part, this was motivated by the state statute's requirement that the policy be implemented by a date certain — but it certainly proved what the Department can accomplish when properly motivated. As we have said before, similar projects have lain fallow for too long periods of time when there are no externally or artificially imposed deadlines. OIR is not immune from this phenomenon with regard to our own projects and goals, and we certainly mean to draw inspiration from this successful experience.

Another noteworthy aspect of the process occurred during the "meet and confer" phase. With any change in policy that has an arguable potential impact on the working conditions of deputies, LASD oftentimes agrees to (or is obligated to) "meet and confer" with representatives of the employees' unions to receive input from them before finalizing the policy. In this case, LASD offered to "meet and confer" with the two unions who represent the majority of peace officers. One union agreed to meet, studied the policy, and offered helpful suggestions that were accepted by the Department. The other union refused to meet, presumably in an effort to resist any change imposing new restrictions on the deputies. While this approach might have its advantages, and while the disagreement with the policy may have been a principled one, the bottom line was that the non-participating union had no input in a reform that was ultimately ratified and implemented.

OIR worked closely with LASD to achieve worthwhile goals in reforming the vehicle pursuit policy. OIR was impressed by the thoughtful way LASD addressed these important issues and balanced competing concerns. In the end, LASD has a policy that governs pursuits in a newly effective way.

OIR's Role in Ensuring Effective Investigations: The Witness Canvass

Recently, OIR's review of a deputy-involved shooting investigation raised a potential issue regarding the evidence-gathering process. While the results of the investigation demonstrated that the shooting was in policy, a review of the investigative report indicated a shortcoming in the witness canvass that had occurred at the time of the incident. After a critical event such as a shooting, one of the investigative tasks is to canvass the area for potential civilian witnesses. In a residential area, this includes knocking on doors to ensure that stray bullets



5-09/210.00 PURSUITS

The Sheriff's Department's pursuit policy is a comprehensive plan to ensure that pursuits, when necessary, are managed as safely as possible and adhere to all applicable State laws. Because the policy is comprehensive, sworn personnel must understand it in its entirety. This will ensure proper coordination between Units, Bureaus, supervisors and managers. Pursuant to state law, all sworn members shall certify, in writing, that they have received, read, and understand this policy. In addition, the Department shall provide regular and periodic training regarding this policy. The Training Bureau, Leadership and Training Division, shall ensure that appropriate records of this certification and required training are maintained.

Definition of a Pursuit

A pursuit is an active attempt by the driver of a departmental vehicle to stop a moving vehicle whose driver is attempting to avoid apprehension through evasive driving tactics or, after a reasonably short period of time, fails to stop after red light and siren have been activated. Following a vehicle whose driver is attempting to evade, or has failed to yield, after a reasonably short period of time, whether accomplished with or without red lights activated and siren sounding, and regardless of the terminology used to describe these acts, is also a pursuit.

Policy Governing Pursuits

It is the policy of the Sheriff's Department that pursuits are permitted only when the necessity of immediate apprehension outweighs the degree of danger created by the pursuit, and only when in compliance with this policy and applicable state laws.

The purpose of this policy is to secure a balance between protecting the public against personal injury, death, or property damage and law enforcement's duty to enforce the law and apprehend violators. It is also intended to provide guidance for the management, control, and tactics associated with pursuit operations as required by state law. Since there are numerous situations which arise in law enforcement that are unique, it is impossible for this policy or any standard operating procedure to anticipate all possible circumstances. Therefore, this policy is intended to direct as well as guide a sworn member's discretion in matters of vehicular pursuits.

Initiating Deputies, Supervisors, and Watch Commanders engaged in any pursuit operation will be responsible for providing the Unit Commander objective reasons for initiating, continuing, and terminating a vehicle pursuit. Consideration must be given to the extent of danger the suspect poses to the public beyond the act of evasion itself.

Revised 06/24/07 (Implementation July 1, 2007)
Revised 02/22/99
04/01/96 MPP

haven't hurt residents and to identify persons who may have seen or heard events related to the shooting. Deputies assigned to conduct the witness canvass then prepare a report including whether the deputy was successful in locating occupants within the residences, if so, whether the resident had something of note to report, and a brief synopsis of any substantive information provided. This information is then provided to the Homicide Detectives, and any occupants who indicate that they were witnesses to the event are interviewed in more detail.

In this case, a witness canvass did occur. However, the canvass sheets showed that a canvassing deputy had identified a potential witness in the residence next to the yard in which the shooting took place. However, according to the report, because the resident did not speak English and the deputy could not converse effectively in Spanish, no substantive information was taken from the witness. The investigative report showed no follow-up by responding deputies to learn whether the witness had any observations that might have been of value to the investigation.

The circumstance presented here is of concern for at least two reasons. First, the loss of a potentially important statement due to a language hurdle falls short of the standard for thorough investigations LASD has had a tradition of upholding. Second, the lapse could easily be perceived as a disregard of witnesses who do not speak English. In LASD, where there are a number of deputies at every busy station who speak Spanish, it should not be difficult to locate a deputy who could obtain potential information from a Spanish only speaker.

The shortcoming in the witness canvass was presented by OIR to the units responsible for the deputies who performed the canvass, and the supervisors immediately recognized the need to address the situation. A briefing was then held with involved personnel reminding them of the need to conduct a thorough canvass and the importance of not allowing language hurdles to prevent a thorough accounting of witnesses. It should be noted that the deficiency that emerged in this case is not reflective of a widespread problem — indeed, it has not been observed before in the hundreds of shooting investigations it has reviewed to date. OIR will continue however, as part of its primary duties, to carefully review shooting investigations. If similar deficiencies present themselves, a greater response by LASD may be in order.

DUI Reduction Project

In 2004, OIR began reporting about arrests of LASD employees for drunk driving because such arrests had shown a sudden increase over the previous few years.

DUI arrests had averaged between 10 and 15 per year for the previous five years but rose about 90% to 24 arrests that year. Sadly, the number of DUI arrests of Department employees has remained steady at that high plateau ever since.

OIR reported that Men's Central Jail custody training had introduced a training course for its personnel focused on off-duty misconduct, drinking and "career survival" and had successfully reduced the disproportionately high number of MCJ deputies showing up in the yearly DUI statistics. OIR commended the education-based effort and recommended that the program be replicated throughout the custody system.

That said, the only basis for encouragement is that the total annual DUI numbers do not appear to be going up anymore. This is good, but the Department appears to be stuck on this statistical plateau. The total employee arrests have remained in the mid twenties for the third straight year. Even the apparent downward trend reported in September of 2006 proved to be ephemeral and DUI arrests were back up to the statistical plateau by the end of the year. This is not good.

Last year, we noted that the Department had recognized this unhappy trend and had taken the equivalent of emergency measures by instructing supervisors to impose higher discipline for founded charges of drunk driving.

This year, the Department has decided to centralize and broaden its DUI reduction strategies. Using the OIR reports on the DUI problem as a jumping off point, Department executives formed a DUI task force to evaluate the best countermeasures against this unfortunate trend. The task force included experienced supervisors from many areas of the Department as well as participation from OIR. The main purpose of the task force was to develop practical prevention efforts that could reduce off duty drinking and driving among LASD employees. The task force studied patterns among the DUI arrestees to determine which employees were at greatest risk of driving under the influence and what combination of education and deterrence would dissuade them from becoming yet more Departmental DUI statistics. The task force looked at five years of DUI incidents (97 arrests) as well as 27 non-DUI incidents ending in arrests of employees for alcohol-related fights, disturbances and disputes. The task force dug down beneath the surface of the data to determine which members of the Department were at greatest risk of an alcohol-related arrest. Its most salient findings were that more than half of the DUI arrestees were young deputies at their first duty assignment within the Department; the likelihood of an individual being a repeat offender is very low — less than 2%; and a small but disturbing fraction of alcohol related incidents involved brandishing or alleged brandishing of firearms by the Department member. This led the task force to conclude that prevention

and intervention strategies were important to pursue as well as the more conventional post-incident treatment and discipline options.

The task force adopted the philosophy that there may not be a one-size-fits-all technique to reduce DUIs to an absolute minimum. Instead, it attacked the problem through several different recommendations:

- Refine the Custody Division Training Program and make the program available to all Department members
- Develop a training video showing the impact of alcohol on handling a firearm
- Offer a reward for the most creative prevention program department-wide
- Develop a peer based "safe ride home" program
- Require all Department members to confer with Employee Support Services Bureau following involvement in any incident preliminarily identified as alcohol-related
- Increase the availability and accessibility of the Peace Officer's Fellowship and other Alcoholics Anonymous groups
- Revise standard discipline for members involved in DUI, including greater consistency, a general increase in suspension time for a standard DUI and additional discipline for aggravating factors such as a collision or failure to cooperate with arresting officers
- Revise the "Guidelines for Discipline" to reflect the usage, threatened usage, or negligent usage, of a weapon as a discipline enhancing circumstance to alcohol-related misconduct
- In disciplinary settlements, include constructive corrective action such as requiring the employee to provide briefing training to peers regarding the personal and professional ramifications of drinking and driving
- Revise procedures so that a founded DUI or other alcohol-related misconduct results in an "Improvement Needed" evaluation for the affected evaluation period
- Revise policy so that a founded DUI or other alcohol-related misconduct precludes the affected member from a patrol training, bonus appointment, or promotion for a period of one year
- Make all Department members aware of the above, along with the reasoning supporting these changes, through the issuance of a Sheriff's Bulletin.

In the course of doing its research, the task force also discovered that it was difficult to track alcohol-related employee arrests accurately. It has recommended a change in the internal documentation of such incidents so that these significant trends can be tracked more effectively in the future.

It is important to note that so far this year, custody deputies account for 50% of DUI arrests. This trend too has remained consistent over the last few years. This shows that the off-duty DUI problem is a tenacious one and not easily solved by a single stratagem. The task force has pursued potential solutions with imagination and flexibility. OIR commends the task force on its new multi-faceted approach and its continuing efforts to find effective corrective action to reduce drunk driving and other alcohol-related misconduct among employees. We will monitor the Department's follow through on these recommendations with great interest.

Management Option: The Transfer

As we have said elsewhere, the sanctions available to Department decision makers when members violate policy are very limited. However, recent law has reminded supervisors of another managerial option available to address situations in which a certain employee or set of employees have resulted in a working environment that results in a non-cooperative or nonproductive relationship with co-employees. In *Benach v. County of Los Angeles*, 149 Cal.App.4th 836 (2007), the Sheriff's Department was faced with a situation in which a number of co-employees had reported that a deputy's presence in a unit had resulted in a "less than harmonious working environment." Based on this information, the Department decided to transfer the deputy from the unit — not based on any violation of policy nor for any punitive purpose — but in order to dissipate the friction that had existed between the deputy and his co-workers. The transfer did not result in any loss of rank or salary for the deputy. When the deputy challenged the transfer through litigation, the Court found that the transfer was not punitive and that the Department decision maker had "reasonably determined it was both expeditious and in the Department's best interests" to transfer the deputy away from the unit.

Since the publication of this case, OIR is aware of other occurrences in which the Department has engaged in "harmony transfers." While, ironically, the Department is barred from using transfers as discipline in response to a policy violation, the Department does have the management discretion to transfer an employee in order to further, in its judgment, the harmonious functioning of the unit. It is important that when such a transfer is effectuated that the salary or rank of the employee is not harmed.

OIR does not advocate the "forced transfer" as a panacea for dealing with all perceived poor employee performance. Managers unwilling to try to correct or ameliorate employee performance may be tempted to simply rely on transfers in dealing with a "problem" employee. In most situations, leadership should first

try to address straight on the issues identified rather than send the employee away to potentially be "someone else's problem." Forcing an employee to "find a new home" is evidence not only that the employee has failed but some evidence that the supervision of the employee has also failed. However, in some situations, particularly when management has tried unsuccessfully to ameliorate the problem, when the employee's interaction with his or her peers has hurt the smooth functioning of the unit, or when a group of employees has brought dysfunction to the unit, the "harmony" transfer should be considered as a sound management option.

Overdetentions and Erroneous Releases

In our Sixth Report (at pp. 65-67) we discussed the problem of inmates being detained too long or released too early as the result of errors made by LASD or Superior Court personnel. As we mentioned in that report, last year there was community attention on the detention of inmates beyond their sentences. We noted that LASD, in fact, is significantly better at ensuring it does not detain inmates beyond their term. In 1997 there were more than 600 overdetentions. In 2005 there were fewer than 80. In 2006, there were 61. And for the first three quarters of 2007 there were 42 overdetentions. Far fewer inmates are released in error, with only 12 erroneous releases during this same period.

As we mentioned in our last report, LASD had implemented a review procedure for all overdetentions and erroneous releases that included input from both IRC and Court Services. Over the past year these meetings have continued on a mostly regular basis. In general, the meetings are convened bi-monthly, though several cancellations in the past year created a backlog that could only be cleared by holding monthly meetings for several months.

OIR continues to be impressed by the open and thoughtful discussions at these overdetentions/early release meetings. There is a diligent effort to understand the source of the errors that cause inmates to be held beyond their legal terms. There also appears to be a focus on addressing systemic issues. As the practice of reviewing these events on a regular basis continues, the meetings derive increasing benefit from the cumulative knowledge of the group.

Where the issues are personnel related — where the overdetention was caused solely by the carelessness of clerical staff — OIR has started to see a greater willingness to hold individuals accountable. While Court Services routinely holds its personnel, including supervisors, responsible for errors that lead to overdetentions or erroneous releases, IRC has been less willing to do so. However, IRC does recognize that certain individuals do not have the skills necessary to perform

certain tasks. It tracks personnel errors to observe any patterns of particular staff members repeatedly committing similar errors. While it remains reluctant to impose discipline in the form of days off, it is actively pursuing Performance Log Entries, counseling, retraining, and, when those do not prove effective, transferring individuals to different assignments more appropriate to their abilities.

Based on our observations in these meetings, it appears that LASD is taking appropriate measures to deal with the errors that lead to overdetentions and erroneous releases. These review meetings, however, are key to that effort. We were disappointed when they were cancelled for several months and a backlog of cases to be reviewed built up. We are reassured that IRC re-doubled its efforts to work through that backlog quickly and is again current, reviewing incidents 60 to 90 days after they happen.

WCSCRs

In the Fifth Annual report (at pp. 61-63) we discussed LASD's efforts to complete the investigations for WCSCRs that were initiated between September 1999 and December 2003. This year we again audited the WCSCR records to determine whether LASD had remained current and was completing WCSCR reviews in a timely manner or again had a significant number that were pending. In June, 2007 we ran a report to determine the number of WCSCRs that were initiated between January 1, 2004 and December 31, 2006 and had not yet been completed. That report revealed that there were nearly 600 WCSCRs still pending from that time period, which had not been returned to the Discovery Unit for entry in PPI. Some of these WCSCRs had not had a completed review, others may have had a complete review, but had not been forwarded through all the necessary channels to get them to the Discovery Unit and entered into PPI.

We were disappointed to see that LASD had fallen behind again so soon after completing its project to clear the back log. We spoke with the LASD supervisor heading the Discovery Unit who indicated that she too was following the matter and had already begun to notify units of their outstanding WCSCRs.

We also discussed a deficiency in PPI that prevented the units, and their divisions, from having accurate information about which WCSCRs a unit was responsible for. PPI tracked the unit that took in the complaint, the station where the incident occurred, and the unit the employee who was the subject of the complaint was assigned to. PPI did not track which unit was assigned to do the review of the allegations in the WCSCR — and, depending on circumstances, it could be any of those units. The PPI reports that purported to identify outstanding WCSCRs, therefore provided faulty and incomplete information.

As a result of our discussions, two things occurred. First, renewed pressure was placed on units to complete their outstanding WCSCRs and return them to the Discovery Unit. Those efforts have paid off in the form of a significant reduction in outstanding WCSCRs from the time period.

Second, the Discovery Unit began discussions with the Data Systems Bureau to modify PPI to add a data field to track the unit assigned to complete the WCSCR and to modify the PPI reports to have one that would report pending WCSCRs based on the unit assigned to complete them. The changes to PPI were supposed to be completed in July.

OIR is hopeful that using these new reports, units and their divisions will be able to stay on top of the pending WCSCRs and there will be far fewer delinquent reviews. OIR is concerned, however, about the Discovery Unit's limited resources. The unit has had a difficult time maintaining permanent employees to enter the information from the WCSCRs (and other packages, like force packages) in a timely manner when they are returned from the units. Currently, the Discovery Unit prioritizes making an entry to indicate that the package has been received — thus allowing any reports on PPI to be accurate. However, entry of the substantive information regarding the results of the WCSCR review is delayed until there is time to do it. As a result, there are many WCSCRs that, while returned from the units to the Discovery Unit, have not been fully entered in PPI and the result is still listed as "pending."

As OIR did with the claims responses, OIR will continue to follow the WCSCRs to monitor whether, now that LASD has cleared the second backlog, it can continue to remain current and whether it can do a better job of entering the information into PPI in a timely manner. OIR will also encourage the division Chiefs to use the new PPI reports to better track the performance of their units.

PART FIVE Issues and Solutions

Copley Press, Civil Service and the Issue of Police Transparency

In August of 2006, the California Supreme Court issued a decision in the *Copley Press vs. County of San Diego* case that had important implications for police oversight. The case involved efforts by a San Diego newspaper to obtain access to records relating to the discharge of a San Diego County deputy sheriff, and to his subsequent appeal through the County's Civil Service Commission. In a nutshell, the case pitted freedom of information against the privacy interests of officers.

More specifically, the case turned on the meaning of "personnel records" within the California Penal Code's confidentiality provisions for peace officers. The Copley Press maintained that, because the Civil Service Commission is a separate and independent entity from the Sheriff's Department, records arising from its proceedings should not be protected by that statute. The Court disagreed, and held that the records at issue were, in fact, exempt from public records production requirements.

While the specific points at issue may have seemed arcane to outsiders, the consequences of the decision were wide-ranging in their influence on public access and transparency. The Los Angeles County Civil Service Commission, for example, immediately closed its hearings relating to peace officer cases, and stopped the flow of publicly available information regarding those proceedings and their results. Similarly, the Los Angeles Police Department also changed its practices regarding disclosure and public access to records. Agencies throughout the state, including various citizen complaint boards and other public review entities, were also forced to make adjustments that shuttered long-existing windows into how police misconduct is addressed.

The officers' stated concerns are not trivial: they question why the exercise of their appellate rights in cases of alleged misconduct should come at the expense of the privacy to which they are entitled at earlier stages of disciplinary

proceedings; moreover, they argue that public access to their individual records could compromise their safety, given the dangerous people whom officers routinely antagonize in carrying out their duties.[1] At the same time, those articulated concerns must be weighed against the value of heightened accountability and public awareness.

The issue attracted considerable media attention, and led to proposed legislation that was designed, in effect, to reinstate the pre-*Copley* status quo. Law enforcement employee associations, however, opposed it vigorously and successfully, and the bill failed in Sacramento earlier this year.

Meanwhile, the effects of the *Copley Press* decision had an immediate impact on OIR's established practices. Most of these revolved around the Civil Service Commission's newly restrictive approach to its hearings and results. OIR attorneys had regularly begun to attend the Civil Service Commission's weekly hearings a few years ago, recognizing that they constitute a crucial — and often the final — stage of significant discipline cases. Results at Civil Service can be dramatic, unpredictable, instructive, or all three.

Virtually all employees receiving significant discipline either enter into a settlement agreement with the Department or, if such is not achievable, appeal their case to Civil Service. The ensuing adversarial process puts the fairness and soundness of the Department's case to a test that produces a variety of potentially useful insights. These include subject areas ranging from investigative techniques to the need for clarification in policy or refinement of charging decisions and approaches to testimony. Certainly, the perspective of the aggrieved officers and their counsel is noteworthy as well.

Additionally, the results of the civil service process sometimes reveal flaws and inconsistencies in that process itself. OIR commented on the challenges presented to the Department by the civil service system in its last report, and we think it is important to continue to observe this important county office up close in order to provide feedback and ideas about reform to the Sheriff's Department. Indeed, the Sheriff's Department itself needs to maintain an updated and objective view of civil service in order to continue to improve its internal investigative processes.

1 To our knowledge, no actual case had emerged of officer safety being compromised by the public availability of records prior to *Copley*.

In the immediate aftermath of the *Copley Press* decision, OIR attorneys were first allowed to remain, then excluded from these closed sessions, despite a protest from the Sheriff's Department's counsel. Weeks later, however, the Commission agreed to reopen the question in an effort to determine whether OIR attorneys were better characterized as members of the public or as third parties who, because of their established monitoring role with the Sheriff's Department, were "essential" in the eyes of the Department and therefore entitled to stay. The deputies' union took the lead role in challenging OIR's presence, and a serious of legal arguments and hearings ensued over the course of several weeks.

While attorneys litigated the issue of OIR's presence, an important discipline case reached its resolution behind closed doors. The Sheriff's Department had imposed a 25-day suspension on a deputy for failing to report his involvement in an off-duty bar fight, and for leaving an injured person at the scene without providing assistance to police authorities or medical personnel. Some of the evidentiary hearings as well as the final hearing before the Civil Service Commission, in which both parties offered arguments on whether the hearing officer's factual findings and legal conclusions should be affirmed, were held during the time when OIR was excluded from all peace officer proceedings. Consequently, when the Civil Service Commission reduced the suspension from 25 days to 3 days, OIR was unable to assess the unraveling of the discipline or offer advice to the Department about how to insulate future cases from such an outcome.

Eventually, however, the Commission did decide to allow OIR to resume its presence at the closed hearings as part of its established duties as an oversight entity. Since April of this year, OIR has been able to resume its monitoring function at these important proceedings. We appreciated the Commission's willingness to wrestle with a complicated issue over a series of hearings, and of course we were heartened by the result.

The following case examples offer a window into the importance of the civil service process as a "critical stage" in the Department's efforts to administer discipline.

CASE STUDIES

The Department discharged a deputy based on an incident in which the deputy, while off-duty, vandalized the home of a former girlfriend. (The investigation had also revealed lesser policy violations relating to the deputy's misuse of authority in conjunction with that same relationship.)

The deputy had acknowledged his wrongdoing and taken responsibility for it. He argued that, while significant discipline was appropriate, discharge was excessive. He cited his long career and glowing performance evaluations, and characterized his personal problems as an anomaly that did not reflect on his ongoing ability to be a good employee. The Department considered these points and, with OIR's input and concurrence, ultimately rejected them in favor of its original decision. The case then proceeded to Civil Service for the deputy's appeal.

Though the deputy raised several potentially strong points in his favor at the Civil Service hearing, the Department had also considered each of them carefully prior to finalizing the discharge, and it remained steadfast as it presented its own case to the Hearing Officer. In the end, the Hearing Officer recommended that the Commission uphold the discharge, and it unanimously did so.

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In its Fourth Annual Report, OIR described an incident that revolved around an off-duty DUI case and implicated three deputies. (See Fourth Annual Report at p. 94.) One of them had been involved in a traffic accident after drinking, and had allegedly sought to avoid accountability by obscuring the circumstances of the incident — including the fact that she had been driving the car in the first place. The deputy resolved the criminal charges against herself by pleading no lo contendere to a misdemeanor charge of driving under the influence.

When the case went through the administrative discipline process, the Department decided to discharge the deputy with OIR's concurrence. (The other two subject deputies — one of whom was a passenger during the accident and had injured her nose — received lesser suspensions for their actions, which included inappropriate interference with the law enforcement investigation on the night of the incident.)

Deputy A exercised her right to grieve her discharge with LASD executives. She not only maintained that discharge was excessive, but also took the position that the Department's decision to suspend her without pay during the internal investigation had been an abuse of discretion. With input from OIR, LASD held firm on both fronts.

Deputy A appealed to the Civil Service Commission, and a Civil Service hearing officer recommended that the Commission find that the Department abused its discretion by suspending Deputy A without pay after she informed the Department that Deputy B had not in fact suffered a broken nose and that the Department discharge of Deputy A was excessive. The Civil Service hearing officer then recommended that the Commission reduce Deputy A's discipline from the discharge to a 20-day suspension.

LASD challenged the hearing officer's recommended findings by raising objections to the Civil Service Commission itself. After hearing arguments from both parties, the Civil Service Commission determined that as a matter of law, the Department had acted appropriately when, based on the District Attorney's filing information, it suspended Deputy A without payment during its internal investigation, but upheld the hearing officer's reduction in discipline to a 20-day suspension.

***

A sergeant with a long history of minor disciplinary issues was found to have violated policy and fallen short of his expected performance as a supervisor, based on two separate incidents. In one, he sent a demeaning message to a deputy who had summoned his assistance in handling a call; in the other, he initially failed to respond to requests for his presence at a residence fire, apparently due to his desire to continue attending to some paperwork. The Department, in consultation with OIR, decided to impose a 25-day suspension for the two incidents.

This was a stern response, but one that reflected careful thought. It placed appropriate emphasis on the standards to which the Department holds its supervisors, and it gave proper weight to the pattern of previous misconduct that showed the need for strong measures.

Because of the care that had gone into the Department's position, and the sound managerial principles it reflected, OIR considered the subsequent grievance process especially noteworthy. The case eventually made its way to the Civil Service Commission, and both sides presented their arguments clearly and effectively. In the end, the hearing officer's recommendation — which upheld the Department's findings and discipline, and tracked the rationales quite comprehensively — was ratified unanimously by the Commission itself.

Patrol "Challenges"

The media featured a story in early October about "contests" that one patrol supervisor had sponsored among his station's personnel: after establishing a goal for a particular 24 hour period (such as arrests, automobile impounds, or contacts with gang members), the station would track which group brought in the highest numbers and would publicize the results internally. The story struck a chord and generated national attention for a few days. Little of that attention was welcome for LASD, but the Department's subsequent response has been creditable.

Part of the story's staying power as a media event flowed from the sharply divided public reaction. For many of those who called the talk shows or contributed to Internet commentaries, the creativity and motivational impulse of the supervisor were cause for celebration. Frustrated over crime and other sources of societal

tension, these people tended to see any "crackdown" as a good thing, and they took the position that only those who break the law need worry when officers are especially galvanized. ("Can I get them to come to my town?" was a typical sentiment from this camp.) On the other hand, those who view law enforcement more skeptically, whether from hard-earned experience or otherwise, expressed outrage at the idea of deputies being "turned loose" to generate numbers — presumably at the expense of appropriate priorities or even the civil rights of their targets.

The Department took several steps to address the issue and the concerns that it raised. As usual, the reality of the contests lay somewhere between the extremes. For example, the only prize at stake was "bragging rights," thus vitiating some of the fears about problematic incentives compromising deputy judgment. Moreover, a careful look at the records from the contest days in question provided additional perspective: the arrest statistics were comparable with those from regular days during the same month, and several of the actual cases involved responses to calls for service as opposed to deputy-initiated contacts or observations. (These latter encounters that would more readily invite suspicion about motives.) Though one of the arrests was rejected for prosecution by the District Attorneys office, the others led to filed charges — a testament to their legitimacy and the strength of supporting evidence. Some of those filed charges have already resulted in guilty pleas while the others remain in the system. As for the impounds, the criteria for those are relatively straightforward and relate to the license status of the driver in a traffic stop. Accordingly, they are less subject to officer discretion or abuse, and in fact are a growing priority as a mechanism for addressing the problems created by unlicensed and uninsured drivers.

At the same time, the contest concept has obvious flaws. For every "law and order" taxpayer congratulating the Department for the burst of activity, there could easily be one who questions why gimmicks are needed to motivate people who collect a good salary and have important responsibilities. More troubling is the idea that, however well-intentioned the challenges might have been, they could easily have skewed the priorities of deputies and tainted their assessment of that shift's encounters and challenges. Most problematic is the possibility that deputies might be tempted to play fast and loose with issues such as "probable cause" and "reasonable suspicion", and/or cause the shading or fabricating of evidence in order to drive up their arrest total. Certainly, the contests needlessly handed a sword to the defendants who may wish to challenge the circumstances and conditions of their own arrest on one of the days in question.

The contests were not a secret, but they were also not intended to become a matter of public knowledge, and when the story broke, it left the Department in

the position of seeming tone-deaf, even among those not inclined to assume the worst. The public has every right to expect law enforcement to be treated as serious business and a solemn trust. Anything that undermines our confidence in the deputies' exercise of discretion and authority is inherently problematic.

The Sheriff himself recognized this from the moment he was contacted by the media about the challenges. While expressing support for the intentions of the supervisor, he made it clear that the contests were a mistake in his view and would not be recurring. He emphasized that quality of arrests and other activities must always take precedence over quantity. The memorandum he issued to the patrol region captured his ideas well and put the challenges into appropriate perspective.

An Allegation of Bias

A lawsuit filed in federal court by a deputy sheriff recently gained considerable media notoriety. The deputy claimed that he had been harassed because he was a whistle blower exposing racially biased law enforcement and fraud within the Department. He also asserted that Department supervisors had made it virtually impossible for him to work at his job, and thus engaged in "constructive discharge," even going so far as to bother him at home when he was recovering from an injury. Specifically, the lawsuit alleged that the deputy had been criticized for failing to arrest African-Americans and that his supervisors had told him he should falsely charge African-Americans, plant evidence on them and file false police reports against African-Americans. He further implied that these practices were widespread unofficial policy of the Department.

It is OIR's practice to review civil claims and lawsuits because we believe that, upon some occasions, a claim or suit may reveal an incident that constitutes misconduct that would not otherwise come to our attention and would not give rise to an administrative investigation or appropriate corrective action. Consequently, OIR took a strong interest in the plaintiff deputy's allegations because they purported to reveal a pattern of discriminatory law enforcement by the deputy's supervisors as well as retaliatory behavior by the Department against those who criticize it or investigate or reveal fraud and misconduct. OIR reviewed the deputy's written allegations as well as his responses in depositions, conferred with the Department's attorneys and with the deputy's former supervisors, as well as Department risk management personnel.

Despite the deputy's disturbing allegations, after reviewing the record, OIR could find no substantial facts to support the allegations that the deputy was pressured

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COUNTY OF LOS ANGELES

SHERIFF'S DEPARTMENT

A Tradition of Service

DATE: October 25, 2007

OFFICE CORRESPONDENCE

FILE NO.

FROM: LEROY D. BACA
SHERIFF

TO: THOMAS P. ANGEL, CHIEF
FIELD OPERATIONS REGION III

DAVID L. FENDER, CAPTAIN
LAKEWOOD STATION

SUBJECT: **CHALLENGES OR COMPETITIONS**

Last week, details emerged in the public about "challenges" or "competitions" that a lieutenant had recently encouraged among the deputies in his station. The idea was to promote different types of enforcement activity over a 24-hour period, and to see which city within the station's jurisdiction could produce the highest totals.

I have spoken with the lieutenant who sponsored these events. I know him, and I believe his intentions were good: to boost morale and to increase productivity by appealing to the competitive spirit of deputies and urging them in the direction of specific goals. Nonetheless, I wish to make it clear that I find such contests to be an inappropriate means of carrying out our mission.

The quality of the actions we take as officers must always take precedence over the quantity. It must be remembered that each arrest and impound is subject to scrutiny by the criminal justice system and deserving of our highest standards. Accordingly, it is important that our law enforcement actions be undertaken in order to withstand that subsequent review. We must never give the public – or each other - reason to doubt the seriousness and professionalism with which we carry out our duties and exercise our considerable authority. The competitions called into question these principles.

The reputation of the Sheriff's Department is something each one of us helps to shape every day. I am grateful for the countless acts of bravery, integrity, and service with which our personnel have contributed so positively to that reputation. The chance to add to that legacy is a "challenge" I encourage each of you to embrace with each shift.

LDB:sm

to engage in racially biased policing. The Department appeared to have done a diligent job looking into the allegations and reconstructing an accurate timeline of events. Furthermore, the deputy's job performance had become the focus of remedial mentoring — what he characterized as targeting him and coming after him — long before he began to share any of his allegations with his supervisors. The logical mechanism for retaliation was therefore backwards and made no sense.

OIR concluded that there were no discernable facts at the heart of the plaintiff's allegations and that he had not made his allegations known to the Department until long after he claimed he had been harassed by the Department for "whistle blowing."

The Superior Court recently reached a similar conclusion, granting a summary judgment against the remainder of the deputy's case and in favor of the Sheriff's Department, ruling, in part that, "No reasonable jury could conclude that [the deputy] had a good faith belief that the Sheriff's Department was defrauding the federal government"…and that "No reasonable trier of fact could find, based on the evidence in the records, that any retaliation against [the deputy] resulted from his investigation of illegal billing."

Problems in Court: Issues in Deputy Testimony

Not uncommonly, peace officers are accused of testifying falsely or inconsistently to support criminal charges against persons charged of a crime. Often these accusations are part of a defense strategy to undermine the jury's confidence in the veracity of the witness officer in order to get out from under the charges. Sometimes, the allegations are initiated by a convicted defendant who is unhappy with the result of the criminal proceeding. Because of this, each allegation may be motivated by interest in avoiding responsibility for the substantive offense for which the complainant has been charged. Nonetheless, it is incumbent upon law enforcement to carefully review these allegations, and where appropriate, take action.

One difficult scenario is the situation in which a clear discrepancy occurs between a written or oral recitation of the facts and testimony during a criminal proceeding. The law enforcement agency has to decide whether the discrepancy was a result of a mistake or a deliberate attempt to manipulate the truth. Because the conduct at issue is so potentially serious — and has such obvious civil rights implications for the defendant—, the assessment of "what went wrong" is especially important. At the same time, it is especially challenging, relying as it does on an assessment of the deputy's subjective state of mind.

CASE

A deputy testified in a court proceeding in a manner that was inconsistent with earlier renditions of the facts. In a prior rendition, it was understood that the deputy's partner had recovered the firearm that was the basis for the charge. At the court proceeding, the witness deputy had testified that he had actually recovered the firearm. The allegations against the deputy were presented to the district attorney for consideration of perjury charges but the district attorney declined to file those charges based on insufficient evidence of willfulness or bad motive on behalf of the witness deputy.

After the criminal declination was received by LASD, the internal affairs investigation was concluded and it was determined that the deputy had erred in testifying rather than intentionally fabricating evidence. It was determined that this mistake resulted in two policy violations: violation of the performance expectations of LASD that a deputy will testify accurately and a failure of the deputy to adequately prepare for testimony at a court proceeding. The deputy was disciplined as a result of the policy violations.

This case demonstrates that sometimes the evidence from integrity investigations does not always neatly distinguish between deliberate misrepresentation and carelessness. In even these "mistake" cases, however, as this case scenario shows, it is incumbent upon the Department to hold deputies accountable for not performing to expectations in one of the most critical elements of their job responsibilities.

Force Reporting: Supervisor Duties and Accountability

LASD has one of the most progressive force reporting requirements among law enforcement. That requirement demands prompt reporting to a supervisor when force is used. The reporting of force then triggers certain responsibilities for the supervisor in order to ensure a thorough review of the force.

CASE

Two deputies were involved in detaining a female suspect. Eventually a supervisor responded to the field and the deputies relayed an account of their actions to him. The supervisor incorrectly determined that the actions of the deputies did not amount to force and did not ensure adequate documentation or review of the force. Eventually LASD determined that the deputies had met their reporting requirements but that the supervisor had violated policy by failing to recognize that the deputies' description of their actions amounted to force. The supervisor eventually admitted full responsibility for the failure to properly document and review the force and agreed to significant discipline.

In addition, at the recommendation of OIR and at the Captain's request, the supervisor agreed to use this incident as a learning experience for the station and agreed to mentor new sergeants at the station regarding determining and directing proper reporting procedures.

In OIR's estimation of this case, the Department correctly found that the culpability for the reporting and reviewing of force in this case lay at the supervisor's door. While deputies need to be held to a high standard as a result of the obvious awesome trust placed in them, supervisors must be held to an even higher standard still. It is a testament to a functioning system when this is done, and it is heartening that the supervisor in this case accepted responsibility and agreed to make the experience one of learning and instruction.

Making Discipline Remedial and Effective: The Station Briefing

Except in situations in which the policy transgression is so severe that the offending deputy should no longer be afforded the right to carry the Sheriff's star, discipline behind violations of policy is meant to be remedial and effective. By far the most frequent discipline afforded deputies who are found to have violated policy is days of suspension. The theory behind such an imposition is that the financial loss will prove a deterrent to that deputy to avoid future transgressions. The theory also assumes that the knowledge by deputies that there may well be a financial cost for violating policy will deter them from such violations. While there is some logic to the theory, the imposition of suspension days for violations of policy does little to address the actual reasons behind many violations of policy. For example, deputies who drive while intoxicated off duty may have more fundamental issues with respect to alcohol that a straight suspension by itself cannot directly address. A deputy who is involved in off duty domestic violence may also be in need of assistance that days of suspension will not likely provide.

There are several reasons why suspension days are the most frequent disciplinary options by law enforcement agencies. First, such a disciplinary "sentence" has traditionally been the way in which law enforcement has dealt with violations of policy — borrowing from principles found in the criminal justice system. Second, an imposition of a suspension is relatively easy to assess: one identifies

1 Within the LASD, each patrol station has its own Detective Bureau to investigate crimes initially handled by its patrol deputies. Specialized bureaus, such as Homicide and Family Crimes (now called the Special Victims Bureau) also exist to investigate certain types of crimes.

the violation, looks to the Department's Guidelines for a sentencing range, and then imposes discipline within that range. Finally, and perhaps most importantly, County rules and agreements between Department executives and employee associations have cemented the imposition of suspension as one of very few options available to LASD executives to address a violation of policy.[2]

Recently, there has been a move by Department leaders — at the urging and with full support of the OIR — to find more holistic ways of addressing policy violations. Perhaps the most recent illustration of this initiative are cases in which Department members violate policies specifically relating to tactical issues or in which they deploy tactics in deputy-involved shootings and other force incidents that fall significantly below LASD's expectations.

CASE

A man armed with a knife was surrounded by responding deputies. At one point, the man dropped the knife and a deputy rushed towards the man. Before the deputy could apprehend the man, he had picked up the knife, and fearing for his life, the deputy and a number of other deputies opened fire on the man, striking him several times in the upper torso. After the shooting was reviewed administratively, the Department determined that the deputy's decision to close distance was tactically unsound and found that he had violated policy. A formal notification was made to the deputy, informing him of the Department's intent to suspend the deputy for a number of days.

The deputy decided to grieve[3] the discipline. Prior to the grievance, OIR had discussed the case with the unit commander and suggested that should the deputy acknowledge an understanding of the tactical mistakes and if he was willing to prepare a station briefing to fellow deputies regarding the shooting and "lessons learned," that the unit commander might consider offering a settlement to the deputy in which the deputy's suspension days would be held in abeyance.[4]

At the grievance, the deputy accepted a settlement in which he would, among other conditions, agree to conduct a briefing to his peers on the shooting incident. After preparing an outline that was reviewed by the station training lieutenant, the deputy conducted the briefing. By all accounts, the presentation was illuminating and beneficial to both the deputy and his peers. Pursuant to the settlement, the suspension days of the deputy were held in abeyance.

As noted above, one of the impediments to this type of resolution is that the Department cannot require a deputy to undertake remedial action such as providing a briefing, but must do so through negotiating a settlement agreement with the deputy. Fortunately, in the above featured case, the deputy did agree

to brief the incident as a "lessons learned" experience to be shared with his peers — a decision consistent with the finest tradition of LASD leadership. Moreover, since this occurrence, in other cases involving substandard tactical decision-making, other unit commanders and executives of the Department have effectively dialogued with involved deputies and their representatives and have deployed briefing as a centerpiece of a remedial plan. This trend is indicative of resolve by Department members to support strategies that ensure accountability but also take a more creative and constructive approach.

In another variation on the theme of remediation as a component of the discipline process, OIR worked with the Department in a recent case to add an "apology" provision to a settlement agreement in a case involving offensive off-duty conduct.

CASE

A deputy became involved in a dating relationship with a married woman that ended unhappily. At one point, in the aftermath of a breakup, the deputy allegedly engaged in several inappropriate behaviors directed at the husband of his former girlfriend. He also wrote the husband a graphic and hostile letter that both husband and wife considered extremely disturbing. Eventually, while attending an off-duty social event that involved several guests, including the former girlfriend, the deputy became drunk and belligerent. He behaved rudely to responding officers from another agency, and was also disrespectful to a supervisor from his own station who came to the scene.

The Department packaged the different cases together and determined that a lengthy suspension was appropriate. OIR concurred. However, after several months had passed, the deputy initiated contact with Department executives in an effort to grieve the discipline and potentially get a reduction prior to the start of his Civil Service hearing. Without consulting OIR — in spite of the fact that the Department's protocol clearly called for such a consultation before action was taken — an executive reached a tentative agreement to reduce the discipline by more than half.

OIR found out about this development before arrangements for the new settlement agreement were completed. The assigned attorney arranged a meeting with the executive who had authorized the changes in discipline, and asked about the rationale. One of the key prongs of the decision was the deputy's acceptance of responsibility (reportedly sincere, if belated) and his acknowledgment that the behavior at issue was inappropriate. If true, this would be a favorable development — and one that could become even more meaningful in OIR's view if there was an accompanying action. OIR asked that the deputy include letters of apology to the involved officers as a condition of the settlement. The executive agreed, and the apology became part of the new deal.

Accountability After a Failed Prosecution

The Department recently completed its review of a sexual assault prosecution that had ended in acquittal; in addition, the court took the rare step of finding that the defendant was factually innocent of the charges. The defendant then became the plaintiff in a civil lawsuit and prevailed again — a highly publicized outcome that meant substantial liability for the County. The results of both trials, and the vigorous challenges to the detective's actions that emerged in those proceedings, prompted the Department to examine what had occurred with an eye toward addressing possible misconduct.

While there was some sentiment that the outcome of this case justified discharging the detective, several factors would have made it unlikely to sustain a discharge under LASD Policy and Guidelines and Civil Service Rules and, in OIR's view, made removal from the Detective Bureau rather than discharge the appropriate outcome. These factors can be grouped into two categories: (1) There was no persuasive evidence that the deputy purposefully lied or exhibited a malicious intent to frame the suspect, as had been alleged in the civil lawsuit; and (2) broader training and supervision failure issues impacted the quality of the investigative work in this case.

There is no question that the deputy performed substandard work in the investigation that led to the suspect's arrest and incarceration. Among other things, he took inadequate notes, failed to record interviews or document them in a timely way, did not work with a partner, and failed to document other details of the investigation. Though the suspect's lawyers apparently were able to frame this sloppy work in a way that allowed the civil jury to imply recklessness or malicious intent, the LASD analysis concluded that there was insufficient evidence to establish that the detective's actions amounted to a deliberate intent to frame the criminal defendant.

Following the ICIB and IAB investigations, the Department concluded that, while the errors at issue amounted to significantly substandard detective work, they were not the product of a willful intent to harm the suspect. Indeed, many of the deputy's later misstatements can be attributed to his failure to take good notes and document his investigative activities. As to the lack of malicious intent, in its decision not to prosecute the detective, the District Attorney reviewed the evidence forthcoming from the ICIB investigation and agreed that there was no evidence that the deputy purposefully lied in an attempt to frame the suspect. This finding, with which OIR concurred, was obviously critical to the question of whether discharge — or even criminal prosecution of the deputy — was a necessary response.

The involved deputy is a long-standing member of the Sheriff's Department who was a successful patrol deputy for more than 10 years. While he proved to be gravely ineffective as a detective following his assignment to his station's Detective Bureau, there is little reason to think that this deputy, based on his past experience, cannot return to a deputy assignment and perform that work.

Further, the deputy's poor performance in this case significantly reflected the Department's failures in training and supervision. The deputy was a relatively junior member of the Detective Bureau, and the criminal investigation involved the kidnapping and attempted molestation of a young victim. According to LASD protocols, the case should have been referred by the station to the Family Crimes Bureau,[1] and certainly should not have been handled by such an inexperienced detective. Compounding this, the deputy worked with very little or no supervision. Unfortunately, the failure to closely supervise the detectives' work was not grossly out of line with common practice in the station's Detective Bureau at the time. There was no system in place for detecting the kind of shoddy work exhibited in the this case, no enforcement of a policy that required detectives to document their work in a timely way, and no accountability to the supervisors assigned to the Bureau. These factors, as much as this particular deputy's individual performance, led to the unfortunate outcome in the suspect's case. Accordingly, OIR would have pushed to have the supervisors also named, in addition to the handling deputy, as subjects in the IAB investigation and subject to potential discipline, but both of them have retired, and one has since passed away.

The station at which this incident occurred has taken steps to remedy the problems in its Detective Bureau since the suspect's acquittal. In 2003, the station assigned a new lieutenant to take over the Bureau. He realigned the Bureau and implemented a number of reforms, most notably a requirement that supervisors track any cases that have been open for more than 30 days and follow up with detectives regarding their activities in those cases. OIR will monitor these reforms in an effort to prevent any reoccurrence of the failed supervision that happened in this case.

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A Belated Discharge

A patrol sergeant noticed erratic driving and pulled an SUV over with a male driver and passenger and walked up to the driver's window. The supervisor smelled the strong odor of burnt marijuana coming from the interior of the vehicle. When the driver told the sergeant that his driver's license was suspended, the driver was removed from the vehicle and detained in the sergeant's radio car. Then the sergeant returned to the vehicle to question the passenger, whom he recognized as a civilian Sheriff's Department employee who worked at the station. The employee identified the driver as a friend named "Maurice." This conflicted with the full name the driver had given, which was indeed his true name. The LASD employee was also the owner of the car. He was drunk and had allowed the friend to drive. A small amount of marijuana and a metal smoking pipe were found in the car. More significantly, the friend was an active gang member with a criminal record. This was known to the employee, who had been stopped 2½ months earlier in the company of this same friend. At that time the friend had been arrested on an outstanding warrant and the employee had been ordered never to associate with this specific gang member or any other known criminals.

Department employees, both sworn and civilian, are subject to a rule against "prohibited association" with "persons who are under criminal investigation or indictment or who have an open and notorious reputation in the community for criminal activity." The purpose of this rule is to reduce the likelihood that employees could be subject to coercion by criminal associates or otherwise risk the security of other employees or community members or the integrity of criminal investigations.

This was not the first time the employee had caused the Department concern because of his associations. A year earlier, the employee had come to the station on his day off and entered an unauthorized part of the station jail to visit with two friends who had just been arrested for burglary. He had a brief conversation with them before he was discovered by the jailer and ordered to leave. He explained that he had come to the station because the arrestees had called him. After this incident, he received a 3-day suspension for violating station jail rules. At the time, OIR urged more severe discipline for this violation of policy, including a longer suspension. We believed that the evidence showed that the employee had purposely spoken to the arrestees before the station detectives could and that this supported an imposition of more significant discipline for interfering with an investigation. We also concluded that the employee's performance record and prior problems showed that he had failed to accept the special responsibilities of an employee of the Sheriff's

Department. We were also concerned that the employee, who was a close relative of a high County official in another department, may be receiving favored treatment because of his family connection and that this would undermine employee confidence in the disciplinary system.

For these reasons, OIR took its concerns to the executive level in the employee's chain of command. That effort, however, was unsuccessful. OIR decided not to pursue the matter to the highest level of the Department when it received assurance that the employee would be transferred to another part of the County where he was much less likely to encounter his problematic friends. Unfortunately, this transfer never occurred.

Months later, when the employee was pulled over in his SUV with the gang member at the wheel, it was clear that the employee's problem was a persistent one not subject to correction through the disciplinary system. Moreover, the potential risk the employee posed to Department security was no longer merely speculative. OIR had reviewed other cases where employees had been discharged for similar instances of "prohibited association," "false statements" and "insubordination" and recognized that it would be inconsistent and unfair to not discharge this employee. OIR received some support for this position when discussing the matter with LASD command staff, but not enough to overcome the inclination by the Department to retain the employee. Accordingly, this time we pursued the case with the Sheriff himself, who agreed with OIR that the employee could not be retained by LASD.

Eventually, the employee was allowed to resign in lieu of discharge. We raised no objection to the "forced resignation" because it caused no detriment to the Department and was consistent with past Department practice. The employee resigned. His disciplinary record reflects that all charges against him were founded.

APPENDIX A

LASD/OIR

Working to Achieve Systemic Change – Year Six

OIR Identification of Systemic Problem	OIR Recommendation	LASD Response	Implementation of OIR Recommendation
Inmate death reviews not being conducted on a timely basis.	Provide timely death reviews.	LASD providing timely death reviews	Yes, see pages 21-25.
Need to ensure LASD compliance with anti-huddling regimen after deputy-involved shootings.	Develop training for supervisors regarding their responsibilities for compliance.	Training developed for supervisors.	Yes, see pages 46-47.
Need to ensure supervisors have aid on-scene to detail responsibilities at deputy-involved shootings	Develop checklist for supervisors.	Checklist developed.	Yes, see pages 46-47.
Need to have accountability to ensure compliance of anti-huddling rules	Develop documentation responsibility for supervisors.	Documentation responsibility developed.	Yes, see pages 46-47.
No comprehensive study of shootings in which high volume of rounds fired.	Study high volume shootings.	Working group formed, studied shootings, developed recommendations.	Yes, see pages 47-49.
Insufficient criteria to govern inmate searches.	Develop inmate search policy.	Inmate search policy developed.	Yes, see pages 53-54.

OIR Identification of Systemic Problem	OIR Recommendation	LASD Response	Implementation of OIR Recommendation
Insufficient criteria regarding use of force to restrain medical patients.	Develop guidelines to provide sufficient criteria for restraining medical patients.	Directive developed.	Yes, see pages 54-55.
Vehicle pursuit policy needed to be updated.	Update vehicle pursuit policy	Vehicle pursuit policy updated.	Yes, see pages 55-56.
Witness canvass not sufficiently conducted.	Provide briefing on need to complete witness canvass.	Briefing provided.	Yes, see pages 56-58.
Off duty DUIs continue to occur at a significant rate,	Develop strategies to address off duty DUI incidents.	Strategies developed.	Yes, see pages 58-61.
Transfers as a management option underused.	Develop options to use transfers.	Transfer option developed and used.	Yes, see pages 61-62.
Service Comment Reports not being timely completed.	Keep SCR's current.	SCR project brought current.	Yes, see pages 63-64.
Station briefing underused as a remedial option.	Use station briefing more regularly to address tactical and other policy shortcomings.	Station briefings used more regularly.	Yes, see pages 75-77.