Ninth
Office of Independent Review **Annual Report**

Michael J. Gennaco
Chief Attorney

Robert Miller
Julie Ruhlin
Deputy Chief Attorneys

Cynthia L. Hernandez
Angelica A. Arias
Diana M. Teran
Bita Shasty
Walter W. Katz
Attorneys

Angie Calderon
Maria Avery
Sylvia Newkirk-Ma
Professional Staff

4900 S. Eastern Ave.
Suite 204
City of Commerce
California 90040
Telephone: 323-890-5425
Facsimile: 323-869-0715
www.laoir.com

July 2011

Contents

Foreword

Hard to believe, but this rollout of our Ninth Annual Report means that we have entered into our second decade as the oversight entity for the Los Angeles County Sheriff's Department (LASD or Department). As illustrated within, this past year new cases have needed to be tackled and others are variants on a familiar theme. Similarly, with regard to systemic issues, new challenges have arisen and recurring ones have reappeared. With regard to both the individual cases and systemic issues, the Office of Independent Review (OIR) continues to provide objective oversight into the Department's handling of these matters. By now, the newness of OIR has worn off and has in many ways been integrated into the fabric of the Department.

Largely as a result of tackling new responsibilities, OIR has undergone significant personnel changes this past year. In the fall of last year, our Board of Supervisors requested and authorized us to develop an oversight program for the County Department of Probation. As a result, original OIR member Robert Miller and OIR Attorney Cynthia Hernandez moved over to begin their oversight work for the Board in the world of Probation. Much as we have been doing with the Sheriff's Department these nine years, reports will be emanating in the future regarding our observations in overseeing the Probation Department.

To regain a full complement of attorneys to oversee the Sheriff's Department, OIR brought on three new attorneys. We are pleased to welcome Diana Teran, formerly of the District Attorney's Office and more recently involved in appellate work; Walter Katz, long-time Deputy Alternate Public Defender; and Bita Shasty, most recently with the State Bar and before that a Deputy Public Defender. We have already benefited from the perspectives brought to bear on our work by Diana, Walter and Bita based on their prior legal and life experiences.

As we enter our tenth year, we are pleased to present you with this report, a catalogue of systemic issues and discrete cases in which we were significantly involved. As an interested reader, please contact us if you have any thoughts, ideas, questions, or suggestions regarding our work.

PART ONE

Alcohol and Substance Abuse

LASD's Focus on Alcohol-Related Misconduct

The Office of Independent Review first addressed off-duty conduct involving DUI arrests of LASD personnel in its *Third Annual Report* published in October of 2004. In that edition, OIR reported what was then believed to be an alarming increase in off-duty employees arrested for driving under the influence. From 1999 through 2003, there were between ten and 15 driving under the influence (DUI) arrests per year. In 2004, however, there were already 16 DUI arrests by June, and that number rose to 24 by the end of the year. After OIR brought this information to LASD's attention, the Department responded by taking a proactive education based approach to the problem. For example, it designed a course for custody personnel which reviews Department policies and procedures regarding appropriate off-duty conduct and the ramifications of misconduct. The following three years, the total annual DUI numbers nonetheless stayed in the mid-20s.

In 2008, the Department created a task force to evaluate the issue and recommend possible countermeasures. OIR participated in this task force. The task force determined more than half of the DUI arrestees were young deputies at their first duty assignment in custody and made a number of recommendations, many of which were implemented. Recognizing that all Department members do not learn or respond to countermeasures in the same manner, the task force adopted a multifaceted approach to the problem.

Training and Education

The Department, for instance, refined the Custody Division Training Program and made the program available to all Department members. It also started requiring employees to confer with the Employee Support Services Bureau (ESS) following involvement in any incident preliminarily identified as alcohol-related. ESS personnel counsels Department members in an attempt to get to the root of the problem and determine if the incident was aberrational or part of a serious alcohol or substance abuse issue. Moreover, the Department distributed a newsletter among personnel and launched a campaign emphasizing the "real cost" of drunk driving. The newsletter/campaign estimated the total cost of a driving under the influence conviction to be over $70,000 based on a detailed analysis of costs including, but not limited to, court fees, legal fees, increased insurance premiums, and lost wages.

Enhanced Discipline

The discipline guidelines were also revised to enhance discipline for personnel involved in alcohol-related incidents. The lengths of suspension for policy violations involving General Behavior, Disorderly Conduct, and Discourtesy or Profanity Toward Others, for instance, were increased with additional discipline imposed when the conduct was alcohol-related and the Department member was belligerent or uncooperative with law enforcement.

3-01/030.05 GENERAL BEHAVIOR

Conduct on or off duty which causes embarrassment to the Department: Alcohol-related & belligerent/uncooperative with law enforcement – 15 days suspension to discharge *(previously written reprimand to discharge).*

3-01/030.06 INAPPROPRIATE/DISORDERLY CONDUCT

Drunk or disorderly in public: Belligerent/uncooperative with law enforcement – 15 days suspension to discharge *(previously 3 days to discharge)*.

3-01/030.15 CONDUCT TOWARD OTHERS

Discourtesy or Profanity Toward Others: Alcohol-related and belligerent/uncooperative with law enforcement – 15 days suspension to discharge *(previously written reprimand to 10 days)*.

The lengths of suspension for on duty use of alcohol and off-duty driving under the influence were also increased with additional discipline imposed for aggravating factors such as a collision and failure to cooperate with law enforcement.

Risky Business

Los Angeles County
Sheriff's Department

A Newsletter of

Risk Management Bureau
Corrective Action Unit

Year Issued: 2008 Number: 02 **June 5, 2008**

Risk Management Bureau publishes this newsletter to inform personnel of risk issues that have impacted or have the potential to impact the Sheriff's Department or its employees. The purpose is to provide information which will help employees make decisions that will protect them from personal injury or civil litigation and protect the interests of the Department.

THE "REAL COST" OF DRUNK DRIVING - YOU KEEP ON PAYING

Forty thousand dollars sounds like a lot to pay for a drink at a party or get together, but if that last cocktail puts you over the limit, that "one for the road" could easily cost you that or more.

One drink too many puts you at risk for not only an arrest, but also for fees, fines and costs that can run you thousands of dollars. While a DUI may be a misdemeanor charge, it's a matter that most judges and district attorneys take very seriously. The financial toll of a conviction will play out for years to come, and could add up to more than $40,000 before everything is over. This includes bail, fines, legal fees, increased auto insurance premiums, loss of work income, court-ordered alcohol education programs and more.

EXPENSE	NET COST RANGE	TOTAL COST
Bail	$250.00	$250.00
Impound fees	$100.00	2 days - $200.00
Court costs and DMV fees	$1,500.00	$1,500.00
Court-ordered programs	$1,000.00	$1,000.00
Legal fees	$5,000 to $ 20,000	$20,000.00
Insurance premiums[1] (Annual)	$6,500.00	3 years - $17,615.00
Lost Wages[2] - 7 to 15 days suspension	$2234.00 to $4,788.00	$4,788.00
Alternative trans. costs - monthly pass	$62.00	12 months - $744.00
Lost opportunity costs[3]	$1,034.40	3 years - $3103.20
TOTAL		**$46,097.00**
Interest (I = P x R x T)[4]	**$25,860.00**	
TOTAL - With Interest		**$71,957.00**

[1] Insurance premium based on a 25 year old driver, driving a 2004 BMW 325i 4dr. sedan with full coverage and a $500.00 deductible. Premium calculated with a ten percent reduction per year.

[2] Wages lost based on a Deputy (step IV) with an Intermediate Post certificate, suspended for 15 days.

[3] Refers to the amount of lost interest on a savings account if the total cost is invested at 3% simple interest.

[4] Amount of interest earned on funds, if invested, for 25 years

This newsletter is published by Risk Management Bureau, Corrective Action Unit, at (323) 890-5400

3-01/030.40 USE OF ALCOHOL

Under the influence of alcohol while on duty – 10 days suspension to discharge *(previously 10-15 days)*.

Under the influence of alcohol while on duty and belligerent/ uncooperative with law enforcement – 15 days suspension to discharge *(previously 10-15 days)*.

3-01/030.10 OBEDIENCE TO LAWS, REGULATIONS AND ORDERS

Off-duty drunk driving – 15 days to discharge *(previously 7-15 days)*.

Off-duty drunk driving with collision or belligerent/uncooperative with law enforcement – 20 suspension days to discharge *(previously 10-20 days*).

While the number of alcohol-related incidents in which deputies display particularly egregious and embarrassing behavior seems to be on the decline, serious career-ending incidents continue to occur. This past year, for instance, a deputy was charged with two felony counts of driving under the influence causing serious bodily injury. The deputy in the case consumed several mixed drinks at a bar before heading home with his girlfriend. Shortly after leaving the bar, the deputy was involved in a traffic collision with a vehicle which was legally parked on the side of the road. The deputy immediately called a friend after the accident and started to walk away from the collision. Before his friend arrived at the location, LASD investigators conducting an investigation in the area came upon the scene of the collision and contacted the deputy who was walking away. The deputy repeatedly told them he was not the driver of the vehicle involved in the collision. The investigators nonetheless detained him until deputies assigned to investigate the collision arrived. The deputy later admitted he had in fact been driving the vehicle. The deputy was given a breath test more than three hours after the collision and his blood alcohol content measured at .14 percent. The passenger in the vehicle suffered two broken vertebrae, pain to her right arm and fingers, and swelling to her cheek as a result of the collision. While the case was pending in criminal court, the deputy resigned in lieu of being discharged. He thereafter pled no contest to one felony count of driving under the influence of alcohol causing injury and was ordered to serve five days in jail as a condition of a five year term of probation.

New Policy on Alcohol and Firearms

In our last two annual reports, OIR discussed the Department's efforts to implement a policy in its Manual of Policies and Procedures (MPP) to address a problem it saw with deputies carrying their firearms when drinking alcohol off-duty. The effort was primarily spurred by an off-duty incident in which an intoxicated deputy accidentally shot and wounded his cousin. The need for a new policy was also supported by a number of other cases in which

off-duty deputies were drunk and either displayed or brandished their guns. The policy, as far as we know, was unprecedented in law enforcement. While the policy took longer than expected to implement, we are pleased to report that the Department's newly amended "Safety of Firearms" policy set forth below was implemented in August, 2010.

> **MPP 3-01/025.45 SAFETY OF FIREARMS**
>
> Sworn employees assume a significant responsibility in protecting and serving the public. As a result, they enjoy a considerable level of public trust. Consequently, high standards are placed upon their conduct. These high standards extend to both on and off duty conduct. This is particularly applicable when the off duty conduct involves the consumption of alcohol. In order to remain beneficiaries of the public trust, we must balance the rights of our sworn employees with the responsibility to maintain the highest standards of professional and personal conduct.
>
> Sworn employees and Security Officers carrying or handling any firearm while on or off duty shall not consume any intoxicating substance to the point where the employee is unable to or does not exercise reasonable care and/or control of the firearm.
>
> NOTE: For purposes of this section, intoxicating substance shall include alcoholic beverages, medication (both prescription and over-the-counter), and/or controlled substances.
>
> A violation of this section shall be determined upon the totality of the circumstances. It shall be presumed that an employee who has a 0.08 percent or more by weight of alcohol in his or her blood is unable to exercise reasonable care and/or control of a firearm. However, the fact that the employee acted reasonably and without negligence may rebut the presumption.

There was a long delay in implementation of this policy, due largely to the deputy unions' opposition to some of the proposed language. In particular, the unions chafed at the inclusion of a presumption that anyone whose blood-alcohol content was .08 percent or greater would be unable to exercise reasonable care and control of a firearm. The Department attempted to address the unions' concerns by making this presumption rebuttable with evidence that the employee acted reasonably, but otherwise stood firm on the .08 percent component. OIR supported the Department's steadfastness, because without the definitional language, the policy would have provided deputies little useful guidance as to what the Department intends to prohibit. Eventually, the unions withdrew their opposition to the proposed policy. They did not endorse the policy, but permitted the Department to unilaterally implement it without causing formal impasse procedures before

the Employee Relations Commission. The guidelines for discipline provide for a 15-day suspension to discharge for a violation of this policy. Prior to the implementation of this policy, the discipline generally imposed for an inappropriate display of a weapon was a 5 to 15-day suspension.

So far, two deputies have been investigated for violating the provisions of the new policy. One was arrested for DUI following a traffic collision and is alleged to have been carrying his weapon. The investigation and disposition of the case is still pending. In the second case, a deputy was at home enjoying a glass of wine when he heard someone banging on his front door. When no one responded to his inquiries, he armed himself with his backup revolver and went outside to investigate. He did not see anyone so he went back into his home. As he de-cocked his weapon, he accidentally fired a round into the ground. The deputy immediately reported the accidental discharge to a supervisor. A sergeant responded two hours later and believed the deputy was under the influence of alcohol. However, the deputy explained that, at the time of the incident, he had consumed no more than half a glass of wine, but said he had been drinking since the incident. The deputy's wife corroborated his statement. That, coupled with the fact he had not sounded intoxicated when reporting the incident, made it difficult to determine whether the accidental discharge was related to the deputy's alcohol consumption. The Department concluded the allegation that the deputy violated the Safety of Firearms policy was unresolved.

In the future, many possible scenarios may trigger application of the new policy. Each scenario will present new challenges to fair and effective interpretation of the rule. In the meantime, we believe that the Department, by implementing this policy, has sent a strong message to sworn employees that care and forethought must be used in anticipation of any situation that might mix alcohol and guns.

Increased Unit Commander Responsibilities

The Department expanded unit commanders' responsibilities upon being informed that an employee under their command is involved in an alcohol-related incident. If an employee is detained or arrested for an alcohol-related incident, the unit commander must immediately notify the Internal Affairs Bureau (IAB). The unit commander may respond to the employee's location if the employee is detained, but must immediately respond to the employee's location if the employee is arrested. In addition, if the employee is a sworn member of the Department, the unit commander responding to the employee's location is directed to place the deputy "on-duty" and order the employee to provide a blood, breath, or urine sample to obtain the employee's blood alcohol for administrative purposes. Refusal to provide a sample will result in being relieved of duty pending completion of an administrative investigation and could subject the employee to being charged with insubordination and suspended for ten or more days. An employee may also be relieved

of duty if the alcohol-related incident is accompanied by aggravating factors such as a traffic collision, criminal misconduct, uncooperative/belligerent conduct, or possession of a firearm.

Given the Department's focus on alcohol-related misconduct, a sergeant was recently disciplined for failing to properly address an allegation that a deputy reported to work intoxicated. In that case, the sergeant received information from an employee indicating a deputy who was on her way to work her assigned early morning shift was intoxicated. The sergeant met the deputy as she arrived to begin her shift. While the sergeant observed the deputy to be disheveled, after speaking with her and performing a field sobriety test, the sergeant did not believe the deputy was under the influence of alcohol. The deputy reported she had consumed one or two glasses of wine several hours before reporting to work, started crying, and became very upset when she learned someone had accused her of coming to work drunk. For this reason, the sergeant concluded she was not fit for a duty assignment that day and made arrangements for another deputy to drive her home. Department executives learned about the incident through an anonymous letter and initiated an Internal Affairs investigation.[1] The Department's concern was that the sergeant who sent the deputy home failed to notify anyone up her chain of command of the incident, particularly the unit commander empowered to order the involved deputy to submit to a blood-alcohol content analysis. The Department concluded the sergeant had not met its expectations for its supervisors and gave her a brief suspension on a founded charge of Performance to Standards.

In addition to implementation of the measures discussed above, the Undersheriff, in August 2008, started publishing a weekly bulletin describing the latest alcohol-related arrests of Department employees and urging Department members to "lead by example and don't become one." The thinking behind publishing the bulletin was that by informing all LASD employees about alcohol-related incidents for which co-workers had been arrested, it might deter others from making similar poor decisions which could lead to an arrest. At the end of 2009, the Undersheriff also started requiring all employees who are arrested for an alcohol-related crime to attend a personal meeting with him to discuss topics such as training, experience, career goals, and job satisfaction.

DUI Statistics and Update

Notwithstanding the Department's efforts, the number of DUI arrests once again increased by more than a third to 37 in 2008, but the number has remained fairly steady for three years and may be on the decline. The number of DUI arrests stayed at 37 in 2009 and climbed slightly to 40 in 2010. In the first six months of 2011, however, there were only 13 DUI arrests of personnel. If this trend continues, we may see a significant decrease in DUI arrests this year.

1 To its credit, the Department has a long standing policy of investigating anonymous complaints.

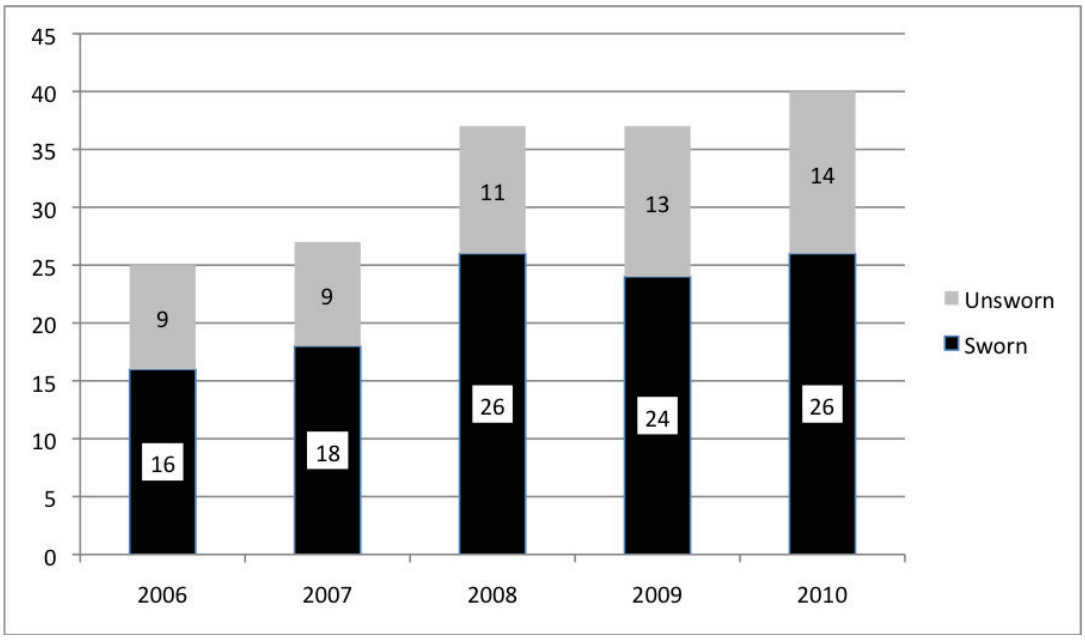


Figure 1 DUI Arrests of LASD Personnel 2006-2010

To place these numbers in context, OIR examined the total number of DUI arrests in California. While the number of total 2010 DUI arrests in California has not yet been published by the Department of Justice, Criminal Justice Statistics Center, the chart below shows the total number of DUI Arrests in California from 2005 through 2009.

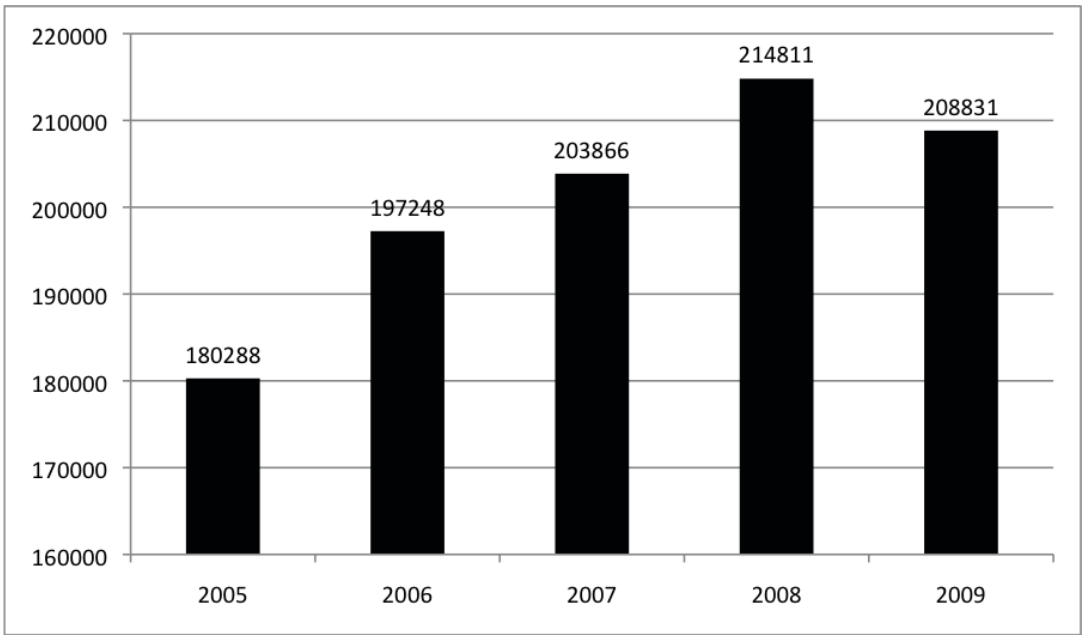


Figure 2 California DUI Arrests 2005-2009

The 48% increase in arrests of Department members seen from 2006 to 2008 is difficult to explain given that the total DUI arrests in California rose only 9% during the same time period. However, efforts by law enforcement agencies to arrest individuals for driving under the influence have increased in the past five years and may account for part of that upswing. Moreover, anecdotal evidence suggests law enforcement officers used to be driven home or provided other kinds of professional courtesies in the past. Law enforcement officers are now much more reluctant to allow Sheriff's employees they pull over for driving under the influence to be released without consequence. The California Highway Patrol in fact requires its officers to arrest all persons who violate the DUI statutes and does not permit discretionary releases.

As discussed above, the Department altered its guidelines to reflect increased discipline for personnel arrested for driving under the influence. Because the requisite burden of proof for the imposition of discipline is a preponderance of the evidence standard, rather than the beyond a reasonable doubt standard that is required for a criminal conviction, discipline may be imposed irrespective of whether the prosecution is able to secure a conviction.

OIR has access and is afforded input into all Department administrative investigations and disciplinary actions. Based on a thorough analysis of all of the cases since 2008, the length of discipline imposed upon personnel arrested for DUI has increased consistently. In 2008, for example, one lieutenant received a written reprimand; one deputy was suspended for four days; two deputies were suspended for seven days; six employees including sworn personnel were suspended for ten days; and the remainder who received suspensions and were not demoted or discharged[2] were suspended for 15-30 days. With respect to DUI arrests in 2009 and 2010, no deputies, sergeants, or lieutenants have received less than a 15-day suspension and a significant portion have received more due to the presence of the newly considered aggravating factors discussed above, i.e. belligerent/uncooperative with law enforcement, traffic collision, or possession of a firearm.

The Optimistic Conclusion

If the trend we have seen in the first part of 2011 holds, it is possible the Department's efforts to reduce the number of Department members arrested for DUIs have been successful at turning a corner. The accumulation of strategies employed by the Department in recent years amounts to a multipronged approach that may finally be showing results.

2 Personnel demoted or discharged for a DUI arrest typically have other prior discipline, prior DUI arrests, or serious aggravating factors such as making false statements during the investigation.

Select Controlled Substance Cases

Use of Illegal Steroids

A deputy sheriff and his live in girlfriend had a domestic dispute. The police responded and arrested the girlfriend, concluding she had been the dominant aggressor. In the course of her interaction with the police, the girlfriend told them the deputy had been taking illegal steroids to enhance his physique. The deputy reported the police contact to the Sheriff's Department, which obtained a copy of the local police agency report. The report included the girlfriend's steroid allegation. The captain of the custody facility where the deputy worked considered the steroid allegation in the context of the deputy's disciplinary history. In his six years on the Department, the deputy had been disciplined two times for becoming involved in off-duty fights at bars. He was also disciplined once for discourtesy and insubordinate behavior directed at a sergeant and a lieutenant. In addition to these angry conflicts, the captain had observed that the deputy appeared to have become visibly bulkier and more muscled in recent months and had been exhibiting increased hostility. On the strength of these indicators, the captain requested the Internal Affairs Bureau perform a "for cause" drug test on the deputy. IAB concurred that such a test was warranted and sent a team of investigators to the deputy's workplace. The analysis of the resulting urine test showed the deputy tested positive for three anabolic steroids classified as controlled substances and had an unusually high concentration of testosterone, a naturally occurring substance. The positive test results caused the captain to request a full internal affairs investigation to determine whether the deputy had violated the Department's drug policy.

Sheriff's Department policy prohibits employees from using illegal drugs, including illegal steroids, on or off-duty.[3] It is often referred to as one of the Department's "zero tolerance" policies because the standard discipline for a founded violation is discharge.

---

3 MPP 3-01/030.45 USE OF DRUGS OR NARCOTICS
Members shall not use any controlled substances, narcotics or hallucinogens except when prescribed by a physician for an illness or injury. Members shall not report to work or be on duty while under the influence of any such drugs. Whether on or off duty, members found under the influence of the mentioned drugs in a public place shall be subject to immediate relief of duty pending an investigation.
If reasonable suspicion exists that an employee is using or is under the influence of a drug or narcotic, the Unit Commander or higher may authorize a test of the employee. Once the test has been authorized, Internal Affairs Bureau shall be contacted. The employee shall be relieved of standard duty pending the result of the investigation. The investigators will order the employee to provide an appropriate sample for testing. The sample shall be delivered to Scientific Services Bureau for analysis. If an employee refuses to provide a sample, the employee shall be subject to discipline for violating section 3-01/030.10, (c) and (e).

When interviewed by internal affairs, the deputy denied taking illegal steroids and opined that the legal dietary supplements he took might have produced the laboratory results showing illegal substances. Investigators consulted the Department's crime lab expert who stated that legal supplements would not produce the type or concentration of steroid metabolites found in the subject deputy's system. As a result, the deputy was discharged for taking illegal steroids and for lying to internal affairs investigators about it.

The deputy appealed the discharge. During a lengthy civil service hearing, the Department's drug expert testified there was a remote possibility that legal supplements could produce some, but not all of the metabolic traces detected in the deputy's system. Additionally, the deputy's attorney argued the Department had failed to follow a sound procedure for administering the urine test. The civil service hearing officer concluded both of these factors created sufficient doubt to overturn the discharge. Mindful that the Department must only prove the violation by a preponderance of the evidence, one might ask how a remote possibility of another result would cause the hearing officer to conclude that the Department had not met its burden.

In any event, the recommended ruling by the hearing officer placed two important principles at risk for the Department: its ability to prohibit drug taking by employees and the reasonableness of its drug testing procedure. The latter principle had been successfully attacked in prior cases, causing Internal Affairs investigators to take extra care with the procedures in this case. Both the deputy's and the Department's representatives mounted vigorous defenses on both sides of these issues before the Civil Service Commission, which makes the final decision on each appealed case. At first, the Commission accepted the hearing officers' recommendation. Ultimately, however, the Commissioners were persuaded to reverse themselves and to overturn the hearing officer's decision and affirm the discharge of the deputy. At the time of this writing there remains one further opportunity for appeal before the Commission's decision will be final.

The Department is only called upon to administer a "for cause" drug test to one of its employees on rare occasions. This is a fortunate circumstance, but it means the procedures for administering such a test are not well practiced. Because a positive drug test will almost certainly result in a discharge and a civil service appeal, the stakes are very high for both the employee and the Department. In order to assure that its zero tolerance drug policy is enforceable, the Department must prepare for these rare events and continue to take extra care to administer drug tests in a consistent and unassailable manner.

Use and Cultivation of Marijuana

A professional employee was arrested after a traffic stop of her vehicle revealed she was cultivating marijuana. The employee stated she was legally cultivating medical marijuana

under California's Medical Marijuana Compassionate Use Act. However, a consensual search of her home revealed a number of marijuana plants which the arresting agency believed were in excess of the amount permitted under the Act. It was further discovered that the employee was stealing electricity from the power company to grow the marijuana plants by tampering with her meter. She was alleged to have stolen approximately $2,900 worth of electricity. The District Attorney did not file criminal charges stating the cultivated amount was "borderline legal under the medical marijuana compassionate use act." Moreover, the power company was non-desirous of prosecution for utilities theft because the employee had paid the majority of the amount due for the electricity she allegedly stole.

Upon conclusion of the criminal matter, the Department conducted its own internal investigation into the employee's conduct. During the investigation, the employee admitted to growing marijuana plants and selling them to medical marijuana dispensaries. She stated the cultivation of marijuana was her second job for which she had a valid medical marijuana card. She also admitted to using the marijuana for medical purposes, but she denied stealing electricity. At the conclusion of its internal investigation, the Department found the employee was in violation of its notification and obedience to laws policies for failing to notify the Department she had taken a second job, for possessing and using a controlled substance, and for stealing electricity. The Department discharged the employee for the policy violations. OIR concurred with the findings and discipline.

PART TWO

Force Incidents and Concerns

Unarmed Shootings: Development of New Policy and Protocols

The calendar year 2010 saw approximately the same number of deputy-involved shootings from the year before:

Year	2009	2010
Number of hit shootings	27	23
Number of non-hit shootings	15	20
Total Shootings	42	43

In addition to continuing to track the total number of shootings, the Department has paid special attention to hit shootings in which the suspect is found to be unarmed. This arose as a result of a series of controversial deputy-involved shootings that occurred in the summer of 2009 in which no weapon was located on the suspect. This confluence of unarmed suspect shootings in a three month period caused the Department to reexamine both its policy regarding the use of deadly force and its investigative protocols. With regard to investigative protocols, the Sheriff instructed that in cases in which an individual is hit and it is learned that the individual was not in possession of a weapon or facsimile weapon, the internal affairs investigation is to be completed within ninety days of the incident. This expedited handling of the "unarmed shooting" cases results in a greatly decreased turnaround time for purposes of fact gathering, analysis, and Departmental response to the

incident, including swift potential accountability and training. In addition to the three shootings that occurred in the summer, the Sheriff also instructed that all prior unarmed shooting investigations that had not yet been completed be similarly placed on a ninety day investigative time line.

This expedited handling of the "unarmed shooting" cases results in a greatly decreased turnaround time for purposes of fact gathering, analysis, and Departmental response to the incident, including swift potential accountability and training.

As a result of the Sheriff's directive, the Department has more closely tracked the unarmed shooting incidents. In 2009, there were four unarmed shooting incidents. In 2010, there were eight unarmed shooting incidents and for the first four months of 2011, there have been four additional unarmed shootings. In contrast, in 2009, 23 suspects were armed while in 2010, 15 suspects were armed. In 2009, there were seven incidents in which suspects actually fired on deputies while in 2010, there were two such incidents.

In addition, the Sheriff requested that his master training officers convene and discuss current training issues surrounding deputy-involved shootings. Because a number of the unarmed shooting incidents involved a suspect running from deputies, the Sheriff posed the question: "If a person who you believe is armed runs from you, what should you do?" The master training officers responded to the question by developing a training pamphlet entitled "Split Second Decision." In that pamphlet, eight scenarios are outlined and questions are posed to deputies who are asked to "make a decision" regarding best tactics. One common theme among the scenarios is the concept of whether it is tactically prudent to apprehend the suspect or contain him. Questions of communication, coordination, and officer safety are stressed throughout the training book.

Moreover, consistent with the tactical concepts illuminated in the Split Second Decision pamphlet, a new Sheriff's policy was developed. Entitled "High Risk or Armed Suspects," the policy reads as follows:

> The intent of this section is to increase deputy safety and minimize the potential for deputy-created jeopardy where deputies place themselves unnecessarily in harm's way.
>
> When dealing with a high risk or suspected armed suspect, sworn members shall be cautiously persistent in performing their duties. Consistent with this

philosophy, while every situation is not absolute, in many cases, it may be safer to chase to contain rather than chase to apprehend.

This policy shall be considered when assessing the tactical performance of deputies involved in deadly force situations. Moreover, the following specific tactical considerations should be utilized when a deputy is confronting high risk or armed suspects.

The policy proceeds to direct the deputy to important tactical considerations such as concealment, cover, designated shooter, field of fire, fire discipline, partner splitting, shooting backdrop, target acquisition and tactical positions of advantage.

In effectuating its review of the unarmed shooting cases, the Department determined tactical decision-making fell below performance expectations in some instances. The following are examples of cases wherein accountability and discipline were imposed:

Case One

Two deputies were checking an area in response to a call about an armed robbery. The deputies parked their radio car directly in front of two potential suspects. One of the suspects fled from the deputies. One deputy followed the suspect up a driveway. The deputy perceived the suspect begin to point what he believed to be a gun at him. The deputy fired three rounds. A cell phone was discovered near the suspect, but no weapon was located. The Department determined that the deputy's tactical decisions to park the radio car directly in front of the suspects and to immediately pursue the fleeing suspect, placed him and his partner in a vulnerable position. The deputy's failure to communicate with his partner or with the station about his actions, failure to use available illumination or cover, and failure to accurately assess the level of threat posed by the suspect, also deviated from Department training. The deputy received discipline for his violation of the Department's Performance to Standards policy.

Case Two

Two deputies responded to a possible robbery in progress of a commercial establishment. As the deputies approached, one of the suspects began to flee. One deputy pursued the suspect by foot. The deputy perceived the suspect to be reaching for his pocket

repeatedly. Believing the suspect was attempting to arm himself, the deputy fired at the suspect. After the shooting, the suspect was found to have possessed only a wallet. The deputy who pursued the suspect received discipline for unnecessarily placing himself and his partner in an unsafe position by failing to adequately communicate and coordinate with his partner when he approached the suspect; failing to communicate with the station and request backup when he decided to contact two suspects who were possibly involved in an armed robbery; failing to ensure the safety or check on the welfare of employees at the establishment that had been potentially robbed prior to chasing a suspect; leaving the employees to deal with a second suspect in the vicinity of the store; failing to draw his weapon prior to chasing a suspect believed to be armed; failing to use sound tactics when he chose to close the distance between himself and the suspect; failing to reassess the advisability of a foot pursuit designed to apprehend the suspect after repeatedly observing the suspect reaching for his pocket in a possible attempt to arm himself; choosing to retrieve his radio car after the shooting rather than ensure the safety of the possible robbery victims; and failing to adequately broadcast or confirm the existence of any outstanding suspects to responding units after the shooting.

Case Three

Three deputies encountered a potential narcotics suspect seated in his car. One of the deputies ran up to the driver's door. When the suspect noticed the deputy's presence, he became startled and reached down. Believing the suspect was holding a weapon, the deputy repositioned himself behind the suspect. The deputy observed the suspect then begin to move his hands to his chest area. The deputy fired his weapon, striking the suspect. No weapon was subsequently located in the suspect's vehicle. The deputy was found to have violated the Department's Performance to Standards policy as a result of the following tactical deficiencies: failing to develop a safe tactical plan by placing himself and other deputies at a tactical disadvantage; approaching the vehicle from the front while the suspect was seated inside and had the advantage of cover and concealment; failing to accurately assess the level of threat posed by the suspect; and failing to immediately communicate his perceived threat to his partners.

In other instances, the Department concluded that despite the fact that the suspect was eventually found to be unarmed, the deputies' tactics were tactically sound. The following is an example of a case wherein the deputies were found to have acted within policy:

Case Four

Two deputies received a dispatch of a domestic violence incident. The deputies observed the suspect and stopped their patrol vehicle behind him. The suspect got out of his car, failed to comply with the deputies' repeated commands, and ran away from the deputies. The deputies pursued the suspect into an alley by foot. In the alley, the suspect turned toward the deputies after grabbing at his waistband, extended his arm, and pointed a dark object at the deputies. Both deputies fired at the suspect who then ran into an alcove. The suspect again pointed the dark object at the deputies. The deputies fired at the suspect a second time, fatally injuring him. No weapon was found near the suspect, but a cell phone was located nearby. Civilian witnesses also reported observing the suspect point a dark object at the deputies prior to the shooting. In evaluating the tactics employed by the deputies, the Department found that prior to the shooting the deputies gave adequate and repeated warnings for the suspect to remain in his car, show his hands and get on the ground. The Department also found that the deputies maintained contact with each other and put out a prompt and detailed broadcast prior to the shooting; the deputies maintained good communication with each other and put out a prompt radio broadcast after the first shooting; and the deputies used available cover, communicated well with each other, and put out a prompt radio broadcast after the second shooting.

Despite having made sound tactical decisions, the deputies ended up fatally shooting an unarmed man as a result of the suspect pointing an object at the deputies which they could not discern was a cell phone and not a gun. While many unarmed shooting cases involve fact sets in which the tactical decision making leading up to the shooting may unnecessarily place a deputy in harm's way and result in a deadly force incident, the evidence in this case indicated that this particular shooting was not one of them. The station captain nonetheless commendably decided to send the involved deputies to tactical training to replenish a perishable skill.

And, in the following unarmed suspect shooting incident, there was disagreement between the Department and OIR about whether the tactics rose to the level of a policy violation:

Case Five

Two deputies in a residential area noticed three vehicles parked illegally in an alley. They stopped their marked patrol vehicle to speak with five to seven individuals standing in a garage near the parked vehicles. They smelled marijuana and decided to detain the individuals and search them. Most of the individuals were cooperative, but one suspect cursed at the deputies and refused to obey their commands. The deputies radioed for backup as they confronted the belligerent suspect.

Almost immediately, the deputies noticed an additional individual sitting in the corner of the garage. They recognized him as a parolee at large known to be armed and dangerous. One deputy escalated the backup request to an assistance request as deputies attempted to detain the suspect at gunpoint. The suspect advanced on the deputies and one deputy sprayed him with pepper spray to little effect. The suspect then ran toward the deputies, striking one on the shoulder as he attempted to run past him. The other deputy reached around and grabbed the suspect's shirt. As they struggled at the garage entrance, the suspect grabbed at the deputy's gun and then broke free. Now in the alley, the deputy reached out and grabbed the suspect as he continued to struggle. The suspect broke free again, swiped at the deputy's gun, and took several steps away from the deputy. The deputy took several steps toward the suspect before the suspect stopped and turned back toward the deputy. Believing the suspect had a weapon and was turning to fire, the deputy fired at the suspect. No weapon was found on the suspect. First aid to the suspect was delayed because responding supervisors believed it was not safe to render first aid until the residence was cleared.

All agreed the deputies quickly realized they had a potentially volatile situation on their hands, wisely called for backup when one suspect became uncooperative and then appropriately elevated the request when they realized they were dealing with a parolee at large. However, OIR believed there were tactical deficiencies with the deputy engaging the suspect at several points in the encounter. As the suspect pushed his way out of the garage and the deputy grabbed onto his shirt, the deputy still had his handgun drawn. This placed the deputy at a tactical disadvantage because it left the gun

vulnerable to the suspect's attempt to take it, while at the same time compromising the deputy's ability to win the hand-to-hand struggle because his dominant hand was engaged in protecting the gun. The suspect broke free and, even though he had already tried once to take the deputy's gun, the deputy again reached out to pull the suspect closer to him and continued the struggle. Finally, the suspect again broke free and rather than seek cover, the deputy advanced several steps toward the suspect.

While the Department expressed similar concerns about the tactical decision making of the deputy, it disagreed with OIR that those decisions rose to the level of a policy violation. All, however, agreed the on-scene supervisor's performance rose to the level of a policy violation because he failed to accurately assess the risk posed by the occupants of the house, he failed to consider logical alternatives, and he failed to effectively coordinate the delivery of prompt medical assistance to the suspect. Despite concluding that the shooter deputy's tactics did not rise to the level of a policy violation, the Department did order that the deputy be briefed by his station captain regarding the tactical concerns identified above.

Yet another reform emanating from the unarmed shooting incidents was the enlargement of commanders' responsibilities to a deputy-involved shooting incident. In several of the controversial shootings, tensions became additionally frayed when no information or, even worse, misinformation was conveyed to family members. When these shortcomings were made known to the Sheriff, he tasked one of his commanders with developing a checklist of responsibilities for on-scene commanders and to devise a deputy-involved shooting information and resources pamphlet. Under LASD protocols, the commander is usually the ranking officer who responds to deputy-involved shooting incidents. The resulting Deputy Involved Shooting Commander's Checklist sets out certain tasks required of the assigned commander who responds to the deputy-involved shooting incident. Among the on-scene responsibilities is to ensure compliance with the anti-huddling policy; ensure all response units are notified and responding; and participate in the "walk-through" briefing at the scene. The checklist further instructs the commander to ensure timely notification to the suspect's next of kin, including the suspect's condition and current whereabouts; to arrange transportation of cooperative family members to the hospital, if necessary; and to ensure distribution of the "Deputy Involved Shooting Information and Resources" pamphlet. The checklist further directs the commander to identify any community unrest, ensure contact is made with concerned community members to counter misinformation and ensure the use of intervention workers to counter significant community misconceptions about the incident. The checklist also tasks the commander with making sure an appropriate media briefing takes place as soon as practical; with consulting with the station captain

to monitor employee and community sentiment; with encouraging the unit commander to privately meet with the suspect's family to address any concerns about the incident; and with ensuring the unit commander schedules town hall meetings, as needed, to address widespread community concerns or questions about the shooting.

The Sheriff caused the Deputy Involved Shooting Information and Resources pamphlet distributed at deputy-involved shootings to be developed. The pamphlet is designed to provide information to the public about what occurs after a deputy-involved shooting. The pamphlet contains information regarding the investigative process for deputy-involved shootings and crisis counseling referrals.

The idea behind both the expanded responsibilities of commanders and the Information and Resources pamphlet is that by providing more information to the public about a deputy-involved shooting and how it is investigated, it will increase the public's understanding about the processes. Moreover, the expansion of commanders' responsibilities to include addressing concerns and needs of family members of persons shot, as well as the need to quell rumors, deflect tensions and ensure that current protocols are undertaken, is recognition that the impact of a deputy-involved shooting cannot be underestimated. In addition to collection of the facts, issues important to retaining the public's trust must be taken into consideration by the ranking Department member.

We are pleased to report that as a result of the Sheriff's intercession, the Training Bureau's traditional and important role in reviewing force and shooting incidents has been restored.

An unfortunate and significant step backward in deputy-involved shootings was the diminished role that the Training Bureau has assumed in the review process. For years, members of the Training Bureau were part of the regular roll-out team. The theory was that every deputy-involved shooting presented potential training issues and that it was critical that those responsible for identifying issues were able to observe the conditions first hand. For the past year, members of the Training Bureau have not been regularly rolling out to deputy-involved shootings.

In addition, LASD protocols call for the Training Bureau to prepare a training analysis for each force and shooting rollout. The rationale behind the training analysis was to provide the panel of commanders a recitation of how deputies are trained with respect to tactical issues that are presented in the incidents. Having knowledge of how the Department trains its deputies is important to know in determining whether the deputies performed consistent with training. However, in the past few years, the Training Bureau has ceased writing analyses of the force and shooting incidents.

OIR spoke to the Sheriff about the diminished role that the Training Bureau had assumed. The Sheriff immediately thereafter instructed the reinstatement of Training Bureau rollouts to deputy-involved shootings. In addition, the Sheriff instructed that Training Bureau resume preparing written analyses of deputy-involved shootings. We are pleased to report that as a result of the Sheriff's intercession, the Training Bureau's traditional and important role in reviewing force and shooting incidents has been restored. In OIR's view, any erosion to the comprehensive review process in which the Department has engaged in the past could have led to deleterious consequences and kept the Department from learning from and improving their decision making and response to these incidents. For the Department to continue to be one of the most progressive law enforcement agencies in reviewing these types of incidents, in OIR's view, LASD must resist any countervailing influences that might result in retrenchment of its current robust review protocols.

TASER Policy and Techniques: The Evolution Continues

In our *Seventh Annual Report* published in 2009, OIR discussed the modifications the Department made to its TASER (electronic immobilization device) policy and the issuance of a Training Bulletin in November of 2008 that described recommended strategies and tactics for use of TASER devices, also known as electro-muscular-disruption devices (EMD), or conducted energy devices (CED). OIR also reviewed two significant deployments of the TASER device, one led to serious injury and the other to a death. Since the issuance of the *Seventh Annual Report,* Department members deployed a TASER in three cases in which death subsequently occurred.[4] In addition, there have been further revisions to the Department's TASER policy. Below, we describe those significant events and the modification in Department policy. We also discuss the recent publication from the National Institute of Justice (NIJ) that sheds new light on possible risks associated with the use of electronic immobilization devices.

4 It is important to note that in cases in which a TASER was used and death subsequently occurred, it does not necessarily follow that the TASER use was a cause or even contributed to the death. That being said, it is important that the Department and OIR continue to review such cases to learn on a case by case basis to what degree, if any, the TASER use played a role in the arrestee's death.

Description of TASER Activation

A TASER electronic control device is activated by pulling its trigger. An electrical charge fires a small primer in the cartridge which forces a pressurized nitrogen capsule rearward into a hollow puncture pin. The nitrogen is released into two chambers that forces the cartridge blast doors, aluminum dart probes, and two insulated probe wires (25 feet in length) out of the cartridge. When the probes make successful contact into a conductive target such as a person, the circuit is completed and energy is delivered from the TASER to the target. Once the circuit is completed, the electrical charge contracts the muscle area between the two points and incapacitates the suspect by rendering him incapable of controlling those muscles. In many cases, when properly targeted, the person will be immobilized and fall down.

Cases Wherein a Death Occurred Subsequent to the Deployment of a Taser

Death Incident Number One

Deputies responded to a call that a naked male was fighting with people on a street. When the deputies arrived they found a naked male who was well over six feet tall and weighed about 350 pounds. He was screaming and banging on vehicles. Efforts to calm him down were fruitless. The man moved into the backyard of a residence where he tried to tackle one of the deputies. The deputies deployed pepper spray and a TASER with no apparent effect. (It was later learned that the TASER darts failed to make contact with the suspect.)

As more deputies arrived, the individual tried to break through the back door of the residence without success. Two other deputies also deployed their TASER devices, but it was later determined that neither device's darts successfully penetrated the suspect's skin. A fourth deputy then used his TASER and the man fell to the ground face down and refused to allow deputies to handcuff him. Another deputy, at the direction of a sergeant, used his TASER in "drive stun mode" (i.e. not firing the darts, but applying the TASER unit directly to the suspect at close range).[5] Deputies were then able to successfully handcuff the arrestee but because he was so large, three sets of handcuffs had to be strung together.

5 Whether the TASER is used by firing the darts or in drive-stun mode generally results in significant differences in how the human body is impacted. While an effective TASER deployment in which the darts are fired will cause muscles to contract and tends to immobilize the individual, using the TASER in drive stun mode usually only results in the infliction of pain.

Deputies also applied a hobble restraint[6] to the arrestee's ankles so that he would stop kicking. No impact weapons or other force was used to detain the arrestee. However, a baton was used to pry the arrestee's arms from underneath his body. Deputies then noticed that the arrestee had stopped breathing and immediately began administering cardiopulmonary resuscitation (CPR) until emergency medical personnel arrived. He was transported to a hospital where he was pronounced dead.

An autopsy revealed relatively minor injuries: three dart penetrations as well as small lacerations on the lower lip, right lower leg, the back, arms, and both knees. No controlled substances were found in his system, but a significant amount of alcohol was detected. The coroner also found that the suspect suffered from morbid obesity, cardiomegaly with left ventricular hypertrophy, and hypertensive cardiovascular disease. The coroner opined that the suspect's death was due to the "probable effect of hypertensive heart disease, agitated behavior requiring restraint/electromuscular incapacitation device application" with the contributing condition of "morbid obesity."

The Executive Force Review Committee (EFRC) determined that the TASER use was reasonable and within policy. OIR concurred but had concerns that the data from the TASER devices were not immediately downloaded. Also, the data of the device whose darts did successfully penetrate the suspect, did not record accurate dates for the activations and some of the information was nearly impossible to decipher. Based on those concerns the EFRC ordered that the other TASER devices have their data preserved for analysis and that the data that did exist be further evaluated.

Death Incident Number Two

Deputies encountered a man who had been involved in a traffic accident. The man weighed 440 pounds and was highly agitated as he sat in the driver's seat. He then abruptly exited the car and advanced on deputies with his arms raised and his fists clenched as if getting ready to fight. Deputies ordered him to stop and advised him that he would be tased if he walked any closer to them. However, the man refused to obey the commands made by the deputies at which point one of the deputies deployed his TASER probes into the man's chest and allowed the device to cycle for five seconds. The TASER deployment did not appear to have the desired effect of immobilizing the man, and instead caused him to turn around and walk back toward his vehicle. Deputies then attempted to handcuff the man, but he again became uncooperative and noncompliant. The deputy with the TASER cycled it again for another five seconds. Deputies were able to handcuff the man after the second cycling of the TASER

6 A hobble restraint is a one-inch wide polypropylene webbed belting device used to hold together an individual's ankles. A person is considered "hobbled" if he is handcuffed and his ankles are held together with a hobble restraint device, but the clip end of the device is not connected to the handcuffs. When the clip end of the device is connected to the handcuffs, the procedure is known as a TARP or total appendage restraint procedure.

and transported him to an ambulance. Still agitated, he attempted to kick paramedics, so deputies placed a hobble restraint on his ankles. He was then transported to a hospital where he died the following day. No impact weapons were used during the incident.

The finding of the coroner was that the arrestee died of complications from drug use and underlying contributing heart and liver disease. Toxicology tests revealed the presence of cocaine, opiates, alcohol, marijuana and phencyclidine (PCP). The direct cause of death was "excited delirium," which is well-recognized and is "one of several terms that describe a syndrome that is broadly characterized by aggitation, excitability, paranoia, aggression, great strength and unresponsiveness to pain." (NIJ, *Study of Deaths Following Electro Muscular Distruption*, at p. 21, May 2011.) Along with the aggravated behavior and elevated core body temperatures, there is an abnormal elevation and secretion of catecholamines[7] triggered by the stimulating effects of the drug(s) in the body. This can produce a potentially lethal condition in the normal functioning of the organs which can lead to death in spite of aggressive medical treatment.

The review of this incident by IAB was recently concluded and the case will soon be presented to the EFRC panel to determine whether the deputies' conduct and TASER use complied with Department policy and tactical standards. Per regular protocols, the case will be reviewed to determine whether further policy refinement or training is in order. OIR will continue to closely monitor this matter through its completion.

Death Incident Number Three

A solo deputy on foot patrol stopped a man for a minor infraction. The deputy asked the man several questions and noticed that he was sweating, unsteady on his feet and had a blank stare. As the deputy explained his options, the man charged at the deputy with his hands raised. The deputy side-stepped the charge and used his radio to call for backup. The deputy momentarily gained control of the man and was reaching to retrieve his handcuffs from his belt when he broke free. The deputy was unsuccessful in taking down the man before he turned on the deputy and began to swing his fists.

The deputy again called for backup and issued verbal commands instructing the man to get on the ground and place his hands behind his back. The man refused to comply with those commands. According to the deputy, when the man charged at him a second time, the deputy deployed his TASER at the suspect. The deputy believed the initial activation was for five seconds which is the standard cycle when the TASER device trigger is pulled and released. However, the downloaded TASER data indicated that the first activation was

7 "Catecholamines are hormones produced by the adrenal glands, which are found on top of the kidneys. They are released into the blood during times of physical or emotional stress. The major catecholamines are dopamine, norepinephrine, and epinephrine (which used to be called adrenalin)." (Medline Plus, U.S. National Library of Medicine, National Institute of Health, accessed July 5, 2011.)

13 seconds in length. This deployment caused the man to fall to the ground. When the activation ended, the man immediately attempted to stand up. The deputy reportedly then activated the TASER a second time. This again caused the suspect to fall to the ground.

As soon as the cycle ended, the man attempted to stand up and remove the wires from his body. The man ignored the deputy's commands to remain on the ground. According to the deputy, he activated the TASER for a third time. The man fell back down onto his right side, unsuccessfully tried to remove the wires from his chest, and then tried to get up once more. The deputy activated his TASER again. This allowed a security assistant who had arrived on the scene to move in and handcuff the man. According to the deputy, this was the fourth and final time that he activated his TASER.

After the man was subdued, the deputy and other law enforcement personnel who arrived on the scene checked his vital signs. Within a few minutes, emergency personnel arrived and transported the suspect to a hospital where he was pronounced dead after resuscitation efforts failed.

The autopsy revealed that the arrestee had methamphetamine and amphetamine in his system. During the confrontation, a glass smoking pipe used to ingest narcotics fell out of the man's pocket. The Homicide investigation revealed that the arrestee had been suffering from schizophrenia. Physically, unlike the other two deaths described above, the man was of an average physical build. The report from the Los Angeles Department of Coroner was unable to determine the cause of death, but noted the presence of methamphetamine in the decedent's system and the temporal relationship between the EMD use and his death.

While the involved deputy recalled activating the device four times and re-assessing the danger posed by the suspect before each activation, the data revealed a total of seven activations with a majority of those activations exceeding the usual five second cycle. The downloaded data recorded a total of 66 seconds of activation time over less than a 90 second period.

Activation #	**Duration**
One	13 seconds
Two	8 seconds
Three	5 seconds
Four	11 seconds
Five	9 seconds
Six	15 seconds
Seven	5 seconds
Total activation	**66 seconds**

An engineer from TASER International, the manufacturer of the device, inspected and tested the TASER used by the deputy in the incident and found that it was functioning properly. In addition, "the ECD [electronic control device] was also tested for proper data recording and accuracy of the data recording system." The engineer found that the unit recorded a series of test firings "both properly and accurately."

The engineer also analyzed the probes that were used during the incident. The report described the "physical changes" that the probes undergo when proper contact with a target is made and electrical conductivity is achieved between the two probes:

> If either probe does not make good contact with the target, then the TASER ECD will arc in front of the ECD with no TASER energy being transferred downrange and the target will likely not receive any of the TASER energy nor be incapacitated.
>
> If energy is transferred downrange to the target via a probe deployment, there will be physical changes to the probes' wire air gap that can be verified with a microscope. Where energy is transferred at the point where the wire attaches to the probe, there is an "air gap." When both probes make contact, the probes will have a carbon buildup or "scoring" at this air gap. As energy is transferred from the wire to the probe surface and then into the target, there will also be melting of the insulation of the wire attached to the probe.

The report concludes that the physical changes to the wire surface indicate the circuit/charge was completed through the probes, but that "[o]ften times clothing disconnects can occur during an event, which may cause the circuit to be broken. Although the ECD recorded 66 seconds of total duration for this event, *the physical changes are consistent with only a fraction of delivered electrical charge to the target*. An additional probe evaluation may be needed to determine a closer approximation of actual delivered charge time period." (Emphasis added.)

OIR believes it is important the Department obtain clarification from TASER International about what it means when it states that the probes are consistent with only a *fraction* of the delivered charge. If, as in this case, the device was found to be working properly and the evidence supports a conclusion that the probes properly penetrated the suspect's torso, it is unclear how the duration and gaps between activations did not occur exactly as recorded by the TASER device used by the deputy.

Moreover, OIR is concerned that the deputy's belief as to how many times and how long he activated his TASER was significantly different than what the data indicated. OIR is also concerned about whether the deputy had sufficient time to reassess whether the suspect still presented an immediate threat before reactivating the device, something that is required by Department policy and training. The EFRC panel found that the use of force was in policy.

Post-TASER Use Hospitalizations

In addition to the three deaths described above, there were two other force incidents where a TASER was used on inmates who were subsequently hospitalized.

Hospitalization Incident Number One

The first incident involved a a deputy who was conducting random searches of inmates in one of the jails. He ordered an inmate who was walking on the floor to stop and face the wall. The inmate allegedly complained about how he was being treated as the deputy began to search him. The inmate allegedly pushed back against the deputy and threw an elbow striking the deputy in the face. The deputy deployed his TASER. As a result, the inmate fell to the ground. After what the deputy reported as a five-second TASER cycle, the inmate allegedly attempted to push himself off the ground, rolled onto his back and kicked another deputy in the face. The initial deputy activated the TASER a second time from a distance and then moved in and made direct contact with his TASER device on the inmate's thigh in what the deputy described as a "three point contact." He believed that this second activation lasted five to seven seconds. At its conclusion, the inmate attempted to stand and also tried to grab the TASER from the deputy. The inmate's actions caused the cartridge to dislodge from the grip of the TASER. The second deputy struck the inmate in the legs with his flashlight. A third deputy punched the inmate several times in the rib cage and face. The deputy with the TASER then used it in drive stun mode, making contact with the inmate five to six times. A fourth deputy deployed pepper spray in the inmate's face. After the use of pepper spray, the inmate submitted to being handcuffed.

The data from the TASER showed a total of seven activations during this incident:

Activation #	**Duration**
One	60 seconds
Two	21 seconds
Three	5 seconds
Four	32 seconds
Five	5 seconds
Six	5 seconds
Seven	0 seconds
Total activation	**128 seconds**

It is not possible to determine which of those activations were through the probes or in drive stun mode, but they do show that the activation was of a far longer duration than the deputy stated.

Initially, the medical staff observed bruising to the left and right sides of the inmate's face, a bruised nose and forehead, scratches and contusions to his upper body, a chipped tooth and two puncture wounds from the TASER probes on his left tricep and back. After the initial clinic evaluation, the inmate was transferred to the Los Angeles County Medical Center (LCMC), diagnosed with the condition of rhabdomylosis[8] and hospitalized for several days. He was subsequently released from LCMC and returned to a jail facility.

The incident was reviewed by the EFRC panel which found the use of force in policy, but recommended that the deputies receive additional training for "cuffing under power," i.e. the technique of handcuffing a suspect while the TASER device is still activated.

Hospitalization Incident Number Two

Another recent incident occurred in a custodial facility after a fight broke out between two inmates. A deputy responded and reportedly saw one inmate continuously biting another inmate's ear. When the inmate failed to respond to verbal commands, the deputy deployed his TASER and reportedly activated the device in a single 54-second cycle. During that time, another deputy arrived to unlock and enter the cell and handcuff the assaultive inmate. That inmate was taken to the clinic and subsequently transferred to LCMC where he was diagnosed with rhabdomyolysis. The facts in this incident are still preliminary. Because this incident was a significant use of force resulting in hospitalization of the inmate, the review will be prepared by Internal Affairs investigators for presentation to the EFRC panel. The EFRC panel will review the incident and determine whether the deputies complied with Department policies and tactical standards. In addition, the incident will be cause for another examination of whether additional modifications to the Department's TASER policy are in order. OIR will continue to monitor the investigation and outcome of this incident throughout the process.

8 "Rhabdomyolysis" is the breakdown of muscle fibers resulting in the release of muscle fiber contents (myoglobin) into the bloodstream. Some of these are harmful to the kidney and frequently result in kidney damage. If not treated, the condition can be fatal. (See Medline Plus, U.S. National Library of Medicine, National Institute of Health, accessed July 5, 2011.)

Recent Developments in the Study of Deaths Following Electro Muscular Disruption

In May of 2011, the National Institute for Justice published a report, *Study of Deaths Following Electro Muscular Disruption* (NIJ Report). The convened panel included fourteen experts with experience in forensic and emergency medicine, applicable sciences and occupational health and safety.[9] In addition to receiving briefings from various interested parties, including researchers, use of force experts and a representative from TASER International, the panel also surveyed the most current research in the field on the relationship between injuries and deaths and the use of EMD devices.

One portion of the report looked specifically at respiratory and metabolic issues that have arisen in light of the relatively recent advent of the use of EMD devices by law enforcement. Metabolic acidosis is one condition that can result as a consequence of rhabdomyolysis. Metabolic acidosis occurs when the body produces too much acid or when the kidneys are not removing enough acid from the body. Severe metabolic acidosis can lead to shock or death. The NIJ Report describes the role that a conducted energy device can play on acid levels in the body:

> As with rigorous exercise, the CED causes muscle contractions that produce lactate in the blood. Lactate lowers the pH of blood, making it more acidic. Respiratory rates increase to counteract this effect by reducing the amount of carbon dioxide (CO_2) in the blood and thereby mitigating the effects of increased lactate. In extreme cases, the increase in blood acidity (referred to as "acidosis") could lead to cardiac arrest.

(NIJ Report, *supra*, at p. 15.)

The report's authors suggest that there still is plenty to learn regarding the relationship between EMD device use and its physiological impact. The report acknowledges that there is "very little research" on the placement of the darts and possible interruption with respiration, noting that probe placement on the back could interfere with the ability to breath. (NIJ Report, *supra,* at p. 15.) Thus, while the body is demanding increased respiration to counteract acid production and to compensate for the heavy exertion associated with a physical struggle, the activation of an EMD device *may* have just the opposite effect. The report states that "further study with objective measurement of breathing is needed to draw more definitive conclusions." (*Id.* at p. 16.) Because of the lack of understanding of a possible relationship between EMD device use and acidosis, the metabolic section of the NIJ Report concludes, "until the role of CEDs with respect to respiration has been researched fully, it would be appropriate for law enforcement

9 Notably, one of the panel members is the current Chief Medical Examiner-Coroner for Los Angeles County.

personnel, when possible, to refrain from continuous activations of longer than 15 seconds." (*Ibid.*)

Elsewhere, the NIJ Report also concludes that there is an increased risk of injury from EMD device use on "small children, those with diseased hearts, the elderly and pregnant women." The NIJ Report further notes individuals who become engaged in use of force incidents are more likely to be intoxicated, mentally ill, or have other serious underlying medical conditions than the general population. Each of the three deaths discussed above were preceded by a physical encounter between deputies and suspects who were under the influence of alcohol or a controlled substance, and at least one of the individuals had a history of mental illness. While the "relative risk of CED deployments appears to be lower than other use-of-force options," the NIJ authors pointed out that "further, extended CED exposure may not be effective in the subdual of some individuals with high levels of drug intoxication or mental illness." In such a situation, law enforcement personnel "should consider other options," not only because the device is ineffective in the particular situation, but because the risk to health of long-duration CED exposure (over 15 seconds) is not understood. (NIJ Report, *supra,* at p. 3.)

On several occasions, the NIJ Report emphasizes that "most adverse reactions and deaths associated with CED deployment appear to be associated with multiple or prolonged discharges of the weapons. There is limited research with regard to exposure of greater than 15 seconds." (NIJ Report, *supra,* at p. 3.) Thus, the authors put forth this warning:

> Caution is urged in using multiple or prolonged activations of CED as a means to accomplish subduing the individual. There may be circumstances where repeated or continuous exposure is required; law enforcement personnel should be aware that the associated risks are unknown and that most deaths associated with CED use involve multiple or prolonged discharges.

(*Id. at p. ix.*)

OIR will continue to closely monitor developments as researchers continue to explore the risks associated with particular population groups and the use of devices like the TASER. In particular, OIR is working with the Department to determine whether the cautionary message of the NIJ Report and analysis of actual incidents in which there has been prolonged and/or repeated TASER deployment suggests that further policy refinements on multiple or prolonged TASER use are in order.

Changes to the Department's Training and Policy

In the *Seventh Annual Report*, OIR noted that the Department was committed to completing a comprehensive training video to reinforce the principles of the new TASER policy. That video project was completed and made available to Department personnel through its intranet in December of 2009. The fourteen minute video covers various field and custodial scenarios, describes how the TASER works, and how the device is properly utilized. The video, however, does not emphasize one of the important revisions to the TASER policy made in November 2008, i.e. that "application of the TASER shall be discontinued once the suspect does not pose an immediate threat to themselves, Department personnel or the public." (MPP 5-06/040.95.) Rather, the presenter in the video specifically states that "the drive stun technique is approved for deputies to gain further compliance from the suspect, if required." This language could be interpreted to suggest that personnel may apply the taser solely for compliance purposes and not in response to an immediate threat as required by the policy.

The "immediate threat" language was incorporated into Department policy at the urging of OIR following constructive and considerable dialogue with personnel in the Field Operations Support Services unit. The language is consistent with recent federal case law which has held the TASER is "an intermediate level of force" weapon, the use of which must be justified by a strong government interest that compels the employment of such force. (*Bryan v. MacPherson* (9th Cir. 2010) 630 F.3d 805, 826.) Force used by law enforcement personnel must comply with the Fourth Amendment of the United States Constitution's prohibition against unreasonable seizures. (*Graham v. Connor* (1989) 490 U.S. 386.) While the federal courts have recognized the law enforcement value that electronic immobilization devices have, their use requires that "the suspect poses an immediate threat to the safety of the officers or others." (*Bryan, supra,* at p. 826.)

Also, while the presenter in the video states that there are "no lasting injuries or side effects when the TASER is properly used," personnel are advised to monitor the condition of suspects on whom a TASER was used without providing guidance as to what symptoms to look for. In addition, the video does not include a revision to policy made after the video's completion, and at OIR's behest, which requires that a "verbal warning of the intended use of the TASER shall precede activation of the device" unless it would compromise officer safety or is impractical under the circumstances. The verbal warning provides the involved individual an opportunity to comply with personnel's orders to submit and to also warn other personnel that the TASER may be activated. OIR will work with the Department to assure that its training materials and instructed techniques are consistent with policy, legal precedent, and current research on the effects of TASER usage on suspects and inmates.

5-06/040.95 ELECTRONIC IMMOBILIZATION DEVICE (TASER) PROCEDURES

The TASER is a less lethal hand held electronic immobilization device used for controlling assaultive/high risk persons. The purpose of this device is to facilitate a safe and effective response in order to minimize injury to suspects and deputies.

Use of the Electronic Immobilization Device (TASER)

The following policy guidelines shall be adhered to:

- Only a Departmentally approved TASER shall be utilized by personnel,
- A TASER shall be issued to and used only by those personnel who have completed the Department's TASER Training Program,
- Personnel authorized to carry a TASER on duty, may purchase a Departmentally approved TASER for on and off duty use,
- Prior to the use of the TASER, whenever practical, Department personnel shall request a supervisor,
- Any individual subjected to an application of the TASER, in either the "probe" or the "touch/drive stun" mode, shall be taken to a medical facility prior to booking, for appropriate medical treatment and/or removal of the probes,
- Application of the TASER shall be discontinued once the suspect does not pose an immediate threat to themselves, Department personnel or the public.

Except in emergent circumstances, the TASER should not be applied to the following or used in any other situation where there is a reasonably foreseeable likelihood of severe injury or death. In the extraordinary instance that Department personnel feel compelled to utilize the TASER in the following circumstances, the conduct of the involved personnel shall be evaluated in accordance to the Use of Force policy with sound tactical principles.

- Handcuffed persons,
- Persons detained in a police vehicle,
- Persons detained in any booking or holding cell,
- Persons in control of a motor vehicle,
- Persons in danger of falling or becoming entangled in machinery or heavy equipment which could result in death or serious bodily injury,
- Persons near flammable or combustible fumes,
- Persons near any body of water that may present a drowning risk,
- Persons known to have a pacemaker or known to be pregnant.

The Custody Division Manual may define criteria for a unique application of the TASER within a custodial setting.

Verbal Warning

Unless it would compromise officer safety or is impractical due to circumstances, a verbal warning of the intended use of the TASER shall precede the activation of the device in order to:

- Provide the individual with a reasonable opportunity to voluntarily comply.
- Provide other sworn personnel and individuals with a warning that a TASER may be activated.

The fact that a verbal and/or other warning was given or reasons it was not given shall be documented in any related reports.

Authorized Department personnel discharging a TASER shall request the response of a supervisor if not already en route or on-scene.

Reporting the Use of the Electronic Immobilization Device (TASER)

The use of the TASER, either by utilizing the probes or the touch/drive stun mode, shall be reported as a "significant" use of force as defined in the Department Manual of Policy and Procedures, section 5-09/430.00, "Use of Force Reporting and Review Procedures."

Whenever a use of a TASER requires force reporting, a download of the TASER stored data and video shall be conducted and submitted with the force package.

Personally Owned Electronic Immobilization Devices (TASER)

Authorized Department personnel shall only carry Department authorized Electronic Immobilization Devices (TASER) whether on or off-duty.

Personally owned TASERs shall be available for computer download upon the request of a supervisor. The device shall meet the specification of the Weapons Training Center, and shall only be used in accordance with this section.

Department personnel shall record all personally owned Department-authorized TASERs (carried on-duty and off-duty) with Personnel Administration when the devices are purchased or obtained, sold or disposed of, stolen or lost.

In February of 2011, the Department also published a new policy that formalized its situational use of force options by defining the four use of force categories that had been in existence for some time but had never been expressly defined. The options recommended by the Department are dependent on the conduct of the suspect, i.e. whether the suspect's conduct is considered "cooperative," "resistive," "assaultive/high-risk," or "life-threatening/serious bodily injury." The level of force options recommended differs for each category and ranges from verbal commands to lethal force. The Department's TASER policy limits its use to controlling "assaultive/high risk persons." However, until this year neither the "assaultive/high risk" category nor any of the other categories were specifically defined in the Department's Manual of Policies and Procedures. Current policy set forth in MPP 3-01/025.20 defines assaultive/high risk as follows:

> Behaviors/Situations that belong in the assaultive/high risk category include: An unlawful threat or unsuccessful attempt to do physical harm to another, causing a present fear of immediate harm; a violent physical attack; a situation in which the totality of articulated facts causes a reasonable officer to form the opinion that a significant credible threat of violence exists.
>
> The assaultive individual has crossed the line of resistance and is threatening an assault, attempting an assault, or physically assaulting the Department personnel or citizen. This category also deals with high-risk situations.
>
> In this category, the likelihood of injury is obvious due to deliberate assaultive actions or other significant threatened actions. These actions (or threatened actions) are so obvious as to make a reasonable person realize that they must do something to defend themself, or others.

OIR welcomes the inclusion of written policy clearly defining the use of force categories because it provides guidance for both personnel who may find themselves in a situation which requires the use force as well as for those charged with reviewing uses of force to determine whether the force used fell within the Department's policy.

Concerns Regarding Timeliness of Force Investigations

The Internal Affairs Bureau of the Sheriff's Department is responsible for investigating the more serious employee misconduct investigations, all deputy-involved shootings, and use of force incidents in which the arrestee suffers significant injuries as a result of the force.

The Department's Administrative Investigations Handbook is intended to serve as a guide for investigators from Internal Affairs. In the handbook, there is language that states Internal Affairs shooting and force investigations are to be completed in 30 calendar days. Elsewhere in the handbook, investigators are advised that all Internal Affairs investigations should be completed within 90 days. Based on OIR's experience in reviewing investigations, the 30 calendar day requirement for IAB shooting and force investigations is unrealistic. The general 90 day guideline is more feasible and, in OIR's view, should be the controlling language with regard to all IAB investigations. OIR has discussed this with IAB executives who have agreed that the 90 day guideline is more realistic. To avoid confusion and attempts to hold the Department to timelines that cannot be regularly met, OIR has recommended that the handbook be revised so that all investigations conducted by IAB have a 90 day deadline.

Unfortunately, with regard to the force and shooting investigations, the 90 day deadline for completion of investigations has been rarely met.

Unfortunately, with regard to the force and non-hit shooting investigations, the 90 day deadline for completion of investigations has been rarely met. With regard to "non-hit" deputy-involved shootings where a deputy fired his duty weapon but failed to hit the suspect(s), the timelines show that from 2007 through 2009, it took IAB on average five months (150 days) to complete their investigations. In only seven of 56 cases, was the 90 day deadline met. With regard to force investigations, the time for completion of investigations was even longer. A review of IAB investigations from 2007 through 2009 revealed it took approximately seven months (210 days) to complete the investigation of

these cases. During that time frame, the 90 day investigative time frame was met in only 28 of 195 cases.[10]

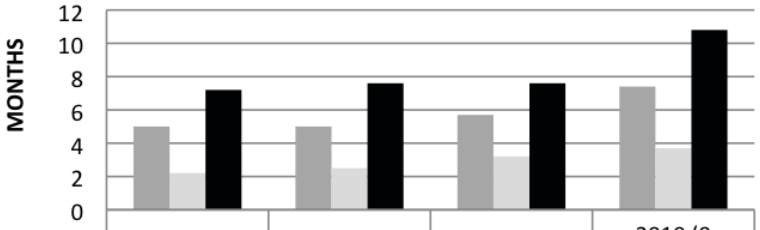
When completed, shooting and force investigations are forwarded to the Executive Force Review Committee for determinations regarding whether the actions of personnel were within policy and for review of potential training, supervision, and equipment issues. The Administrative Investigations Handbook provides for a 50 day time period for the review of the incidents. Regrettably, this 50 day time frame is also rarely met. For example, with regard to non-hit shootings from 2007 through 2009, it took an average of two and one half months (78 days) for both deputy-involved non-hit shootings and force cases to be scheduled and heard by the Executive Force Review Committee. In sum, for this three year time period, non-hit shooting investigations averaged seven and one half months from the time IAB received the case to the time the Committee reviewed the case. Force cases have an even more dismal record, on average they took over nine months from the receipt of the case by IAB to the review by the Committee.[11]

A review of the timelines of non-hit shootings heard by the EFRC panel from January 2011 to May of 2011, shows the time it took IAB to complete their investigations rose even higher than the previous three years to an average of seven and one half months (224 days). With regard to use of force investigations, IAB decreased its average time to complete their investigations to five months (150 days). The average time for non-hit shooting cases to be heard by the EFRC panel rose to just over three and one half months (112 days) and the average time for force cases to be heard rose to an average of five and one half months (162 days). Of the 31 cases heard by the EFRC panel between January and May 2011, 15 cases were heard in the eleventh month while 14 cases were heard in the tenth month of the one year statute of limitations period. That means that 29 of 31 cases were heard with less than two months to go before expiration of the one-year statute of limitations.

10 While not ideal, the IAB timelines for misconduct investigations were generally not as delayed as the force and shooting investigations. With regard to hit shootings, the computation of time frames is more complicated since IAB is significantly reliant on the Homicide investigation providing the framework for its administrative investigation.

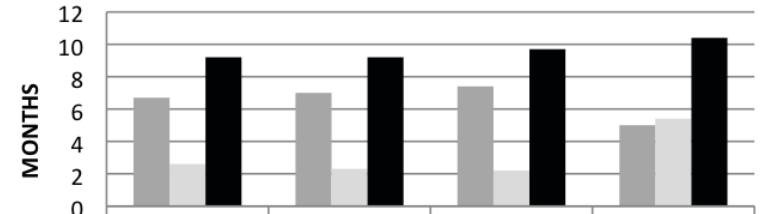
11 Under the Public Safety Officer's Procedural Bill of Rights Act, notice of any discipline resulting from investigation of officer misconduct must be provided to the officer "within one year of the public agency's discovery by a person authorized to initiate an investigation of the allegation." California Government Code Section 3304(d).

NON-HIT SHOOTING INVESTIGATIONS



	2007 (24 Cases)	2008 (18 Cases)	2009 (14 Cases)	2010 (9 Cases Heard by EFRC from Jan. to May 2011)
Length of IAB Investigation	5	5	5.7	7.4
Length Between Completion of Investigation by IAB and Hearing by EFRC	2.2	2.5	3.2	3.7
Total Time for Completion of Case	7.2	7.6	7.6	10.8

FORCE INVESTIGATIONS



	2007 (63 Cases)	2008 (67 Cases)	2009 (67 Cases)	2010 (22 Cases to date)
Length of IAB Investigation	6.7	7	7.4	5
Length Between Completion of IAB Investigation and Hearing by EFRC	2.6	2.3	2.2	5.4
Total time for Completion of Case	9.2	9.2	9.7	10.4

These timelines are not consistent with best practices for internal investigations and accountability. For the investigation and review process of these cases to take close to a year in the vast majority of cases is unfair for both the Department and the involved employees alike. A deputy who is involved in a deadly or significant force incident has to

wait months before being informed about whether his or her force was deemed to be reasonable or not and whether there were any tactical decision making errors or related policy violations. Likewise, Department managers are required to wait months before learning whether their employees will be subject to discipline or training requirements. Because the investigative and review process is so protracted, the universally accepted concept that for discipline and training to be effective, it should follow close in time to the incident has not been able to be followed in the Sheriff's Department. Whether there existed issues with the deputy's use of force or, at the other end of the spectrum, the deputy performed admirably, in the vast majority of cases neither deputy nor Department leaders will learn such until almost a year after the incident.

Because the investigative and review process is so protracted, the universally accepted concept that for discipline and training to be effective, it should follow close in time to the incident has not been able to be followed in the Sheriff's Department.

An additional problem with having the review process often bump up against the eleventh month is that such a protracted process eliminates certain options for the reviewing panel. Should the panel determine that there were gaps in the investigative process, one option that has generally been available is to send the case back for further investigation. This option is problematic however, when the case is up against the one year statutory deadline. Either the panel is obliged to forego the option of further investigation or the investigator must rush through the additional investigative tasks in a highly compressed time frame.

OIR has begun discussions with Department leaders who have agreed that the investigative and review time frames for force incidents need to be significantly compressed and consistent with Departmental expectations. We are hopeful that the Department's understanding of the concerns articulated here will cause the time frames to fall more frequently within the expectations articulated by the Department in its handbook, namely, the completion of investigations-within 90 days and the review process within 50 days thereafter.

Advising Deputies Against Reaching Into Vehicles

A traffic stop can change suddenly from being routine to potentially life-threatening when the driver fails to follow a deputy's commands and attempts to flee. A deputy's reaction to the situation will depend on the circumstances, and each tactical decision will carry with it advantages, shortcomings, and safety risks. OIR conducted a review of these types of cases and learned that it was not uncommon for a deputy to almost instinctively reach into an occupied vehicle and grab the driver's arms or keys to prevent the driver from fleeing. However, as demonstrated by the cases below, reaching into a vehicle is inherently dangerous and the risks generally outweigh any benefit that can be had from employing the tactic.

Case One

While patrolling, deputies approached a car parked in an isolated rural area. After running the license plate number, the deputies learned the driver was a felon at large who was possibly armed and dangerous. Deputy A approached the suspect's vehicle, opened the driver's side door, and grabbed the suspect's hands. Deputy B reached inside the passenger window to also grab the suspect. The suspect then started the engine, put the car in gear, and pulled away while Deputy B's torso was still inside the vehicle. Once Deputy B was able to free himself and land on his feet, he made a split-second decision to shoot at the moving vehicle.

The EFRC panel reviewed the case and found Deputy B committed a tactical error by reaching into the suspect's car, in violation of the Department's Performance to Standards policy. The deputy received a three-day suspension for the violation of policy. Deputy B appealed the discipline to Civil Service. With regard to reaching into the suspect's vehicle, one expert witness (retired LASD sergeant with 18 years of experience as a tactics instructor for the Department) testified on the deputy's behalf that the deputy used appropriate tactics. In contrast, a high-ranking Department member testified that the deputy should never have climbed through the window because he put himself at a tactical disadvantage. Because of the conflicting testimony and the fact that the Department did not have a specific policy prohibiting the technique, the hearing officer found

Deputy B's conduct did not violate any Department policy. As such, the discipline was rescinded.

Case Two

Two deputies responded to a radio call regarding a suspect shooting into an inhabited dwelling. While canvassing the area, Deputy A approached the driver's side of a parked vehicle and ordered the driver to show his hands. When the driver failed to comply, Deputy A opened the driver's door, reached into the vehicle, and grasped the suspect's wrists in an effort to extract him from the vehicle. During the struggle, Deputy A's flashlight fell to the ground. Deputy B then entered the rear passenger door on the driver's side and struck the suspect several times on the head with his flashlight. Deputy B's head strikes, however, were ineffective. The suspect was nonetheless able to free his right hand, start the vehicle, and put the vehicle in gear. Deputy A's lower body was dragged several hundred feet before he was ejected from the vehicle. Fearing for his life (and still inside the vehicle), Deputy B drew his handgun and prepared to execute a contact shot to the suspect's head when the vehicle collided with a parked car. The force of the collision propelled Deputy B into the dashboard. The deputies and the suspect suffered cuts, bruises and abrasions.

Despite the questionable tactical decision making made by the deputies, the EFRC panel determined that no Department policy had been violated. The EFRC panel did recommend, however, that the facts and risks associated with the incident be briefed to the unit, and that the deputies attend formal tactics training.

As this case demonstrates, the deputies were at a tactical disadvantage the moment they reached into the vehicle. Deputy A immediately lost control of his flashlight and limited his tactical and defensive options. He also put the suspect within arm's reach of his weapon. Moreover, Deputy B opined that his flashlight strikes were ineffective because he was unable get a full swing inside the vehicle. Because of his limited options, Deputy B was prepared to shoot the "unarmed" suspect in the head. Although the use of deadly force may have been justified under the circumstances, it is clear that the deputies' decisions to reach into the vehicle precipitated a sequence of events that could have led to the use of deadly force. Had Deputy B been required to shoot the suspect, the incident may have hailed a firestorm of criticism from the community and left the Department vulnerable to liability.

Case Three

Deputies approached an occupant of a parked vehicle who they believed was involved in a drug transaction. When contacted, the driver (sole occupant of the vehicle) placed what appeared to be a handgun underneath his legs and attempted to start the vehicle. Instead of backing away from the vehicle and taking cover, Deputy A reached into the open driver's side window and grabbed the keys from the ignition. Deputy A then attempted to open the driver's door but he was prevented from doing so because it was locked. After a brief struggle, deputies were able to open the door and extract the suspect from the vehicle.

Although the facts, i.e. potentially armed suspect who attempts to start his vehicle, required immediate safety precautions, Deputy A reached into the vehicle for the suspect's keys out of concern that the suspect would flee. By doing so, Deputy A placed himself in a vulnerable position where his weapon could be grasped by the suspect. Reaching into the vehicle also increased the risk that the deputy might be dragged by the vehicle, seriously injured, or killed. However, the EFRC panel nonetheless found Deputy A's conduct did not rise to the level of a violation of any Department policy.

Case Four

Two deputies initiated a traffic stop of a vehicle driving erratically at a high rate of speed. Deputies ordered the suspect to exit the vehicle. The suspect claimed he was unable to comply because the driver's side door was broken. Deputy A attempted to open the door but was unsuccessful. Deputies then asked the suspect to exit through the passenger door. Deputy B opened the passenger door and leaned inside the vehicle, placing his knee on the front passenger seat. As the suspect exited, he struck Deputy B on the chest and chin, causing the deputy to fall against the passenger door. The suspect was eventually extracted from the vehicle and arrested.

In this case, instructing the suspect to exit through the passenger door may not have been the safest way to get him out of the vehicle since he was in a position to easily start the ignition and quickly put it into gear. Under the circumstances, however, it may have been the only practical option. Deputy B nonetheless increased the threat potential by leaning into the vehicle and putting himself in a position where he could be struck by the suspect and potentially dragged by

the vehicle. The deputy also created a situation that could have led to the use of deadly force. The EFRC panel reviewed the case and determined that no Department policy had been violated.

Case Five

Two deputies conducted a traffic stop of an individual with an outstanding arrest warrant for a narcotics violation. When the suspect was asked to exit his car, he started the vehicle. As Deputy A reached to unlock the driver's side door, the suspect grabbed the Deputy's arm and began to drive away. Deputy B, seeing his partner being dragged down the street, fired four rounds from his Department-authorized weapon. The suspect eventually released Deputy A, who fell to the ground after being dragged about 30 feet. The deputy sustained head and arm abrasions.

The EFRC panel reviewed this last case and determined that, because there was no specific Department policy prohibiting deputies from reaching into vehicles, the involved personnel did not violate Department standards. At OIR's suggestion, however, the deputies' unit commander drafted a training bulletin that addresses the dangers of "reaching into a vehicle." OIR worked closely with the station on developing the training bulletin which also discusses how deputies can maintain tactical advantage when dealing with a suspect occupied vehicle. For instance, as outlined here, the bulletin advises deputies to scan for potential weapons or threats, give clear commands which verbally control the driver's hands, and call for back up if necessary.

In addition to alerting deputies to the inherent dangers of the practice and providing alternative tactical responses, the bulletin also holds deputies accountable for their actions. Specifically, it states that the risk factors described in the bulletin "will be considered when the Station is called upon to make an evaluation of Deputy acts that result in the Deputy reaching into an occupied vehicle." The training bulletin is a step in the right direction but its enforcement is limited to deputies assigned to that specific station.

Should the tactic of reaching into cars continue to cause problems for deputies, OIR will advocate more strongly for the Department to consider creating a Department-wide policy on the tactic. The existence of a specific Department policy would further educate deputies about the officer safety issues and risks of reaching into vehicles -- guidance that would have clearly assisted the deputies who were discussed in the above cases. Certainly, without a Department-wide policy advising against the tactic, deputies may run the risk of continuing to put themselves and others in danger.

West Hollywood Station Training Bulletin

January 21, 2010

SUBJECT: REACHING INTO VEHICLES

PURPOSE: **The purpose of this Training Bulletin is to discuss the potential dangers and hazards that may arise when reaching into a suspect occupied vehicle. Additionally, the bulletin will discuss potential options to increase and/or keep your tactical advantage when dealing with a suspect occupied vehicle.**

TACTICAL APPROACH AND CONTACT: Upon contacting a driver or suspect during an unknown risk traffic stop, deputy personnel should attempt to keep a position of advantage. This could be accomplished by any of the following but not limited to:

-Determine whether the vehicle's engine is running
-Staying on balance with gun side back
-Never crossing the front door threshold
-Appropriate spot lighting
-Direct and clear verbal commands (i.e. have driver turn off vehicle and place the keys on the dashboard)
-Scanning for potential weapons or threats
-Verbally controlling the driver's/suspect's hands
-Paying attention to possible "red flag" warnings the driver and other occupants are exhibiting
-Closely monitoring your surroundings
-Not breaching the window plane
-Call for "back up" is necessary

POTENTIAL HAZARDS: The dangers or hazards in reaching into a driver occupied vehicle may outweigh the benefit that can be had from employing the tactic. As a general guideline, reaching inside a suspect occupied vehicle may present the following tactical disadvantages:

Unit Commander Signature:

West Hollywood Station Training Bulletin

January 21, 2010

SUBJECT: REACHING INTO VEHICLES

1-You expose your hand/body to being pulled inside the vehicle
2-If pulled inside, the suspect may "drive off" and expose the deputy to great bodily injury from being dragged or possibly run over
3-If pulled inside, your firearm retention would be compromised
4-By reaching inside you may be exposing yourself to potential battery
5-Reaching into a vehicle may expose you to attack by unknown weapons

CONSEQUENCES OF REACHING INTO A SUSPECT OCCUPIED VEHICLE: Based on the above potential hazards, deputy personnel may be exposing themselves to injury ranging from minor to great bodily injury. Additionally, placing yourself in this potential tactical disadvantage could result in using deadly force against the driver/suspect. This deadly force in turn could expose the surrounding community to potential risk of injury or loss of life.

CONCLUSION: This training bulletin is designed to be an informational tool only. Prior to contacting any driver or suspect, formulate your tactical plan and maintain your position of advantage at all times. Do not let the driver or suspect compromise it.

Deputy personnel should always evaluate each individual scenario they are exposed to and attempt to use the most tactical position of advantage while making these unknown risk contacts. Be conscious of the above, whenever contemplating reaching inside an occupied vehicle and making life threatening decisions.

The risk factors above will be considered when the Station is called upon to make an evaluation of Deputy acts that result in the Deputy reaching into an occupied vehicle.

Unit Commander Signature: _____

Homicide's Handling of Force Complaints By Suspects In Deputy-Involved Shootings

When a deputy is shot by a suspect, detectives from the Homicide Bureau conduct an investigation into the shooting and submit the case to the District Attorney's Office for a filing decision. If the deputy used force against the suspect, Internal Affairs will conduct a separate investigation after the homicide investigation is concluded. This additional investigation is conducted even if the homicide investigation revealed that the injured deputy fired his weapon in self-defense after he was injured. The EFRC and OIR then review the investigations prepared by both Homicide and Internal Affairs. While the EFRC's review first and foremost evaluates whether the shooting by the deputy was within policy, consideration is also given to the thoroughness of the investigation as well as potential tactical and training issues.

OIR's review of a recent shooting wherein a deputy was shot disclosed a potential glitch in how information regarding force allegations which surface during the Homicide Bureau's investigation is handled. In the case, the suspect shot at the officer multiple times when the officer asked him to approach his patrol vehicle. The officer was hit in the shoulder, but was able to seek cover behind his patrol car and return fire in the suspect's direction. The suspect was able to avoid being shot, ran to a nearby vehicle, and fled. Other deputies immediately responded to the shooting. After a short vehicle and foot pursuit, deputies located the suspect lying face down in the bathroom of a house nearby. The arrest report indicated the suspect was arrested without incident, but he was taken to the hospital where he was treated for a broken nose, a laceration to his right eyelid, and an abrasion to his lower abdomen. The next day, the suspect told Homicide detectives that he had been beat up by arresting officers. This information, however, was not communicated by Homicide to either Internal Affairs or the unit commander where the arresting deputies were assigned. Homicide's completed investigation was provided to Internal Affairs about six months later. The Internal Affairs sergeant assigned to the case did not have an opportunity to read the transcript of the suspect's interview alleging he had been beaten by arresting officers until three months later. To the sergeant's credit, he immediately picked up the phone and informed the unit commander about the allegations once he read the suspect's statement. A unit level investigation into the suspect's allegations of improper force was thereafter conducted.

The investigation, however, was inconclusive. The lapse in time between the shooting and the notification of the alleged misconduct to the unit compromised the unit's ability to conduct a fair and thorough investigation. While the deputies were all interviewed and denied using any force against the suspect during the arrest, it was believed to be too late to scour the neighborhood for witnesses who may have seen the suspect prior to entering the residence where he was arrested. Said witnesses may have been able to shed light on whether the suspect suffered his injuries during the foot pursuit prior to encountering deputies inside the residence.

OIR brought this issue to the attention of the EFRC panel. The panel agreed the delayed reporting of misconduct allegations was an issue that should be brought to the attention of the Homicide Bureau. OIR discussed the issue with the captain of the Homicide Bureau. He was previously unaware of the problem, but promptly communicated to his detectives that in any future cases where a suspect alleges misconduct by deputies, the information should be immediately communicated to either Internal Affairs or the unit commander where the deputies are assigned in order to allow for a timely and thorough investigation into the allegations. OIR is hopeful and expectant that this verbal admonition will resolve the issue, but should further similar incidents occur, it may suggest a more formal unit directive be prepared.

Select Force Cases

Shooting at Fleeing Vehicle After Altercation in Parking Lot

An off-duty probationary deputy[12] was in a fast food restaurant just prior to the beginning of his shift at a jail facility. He heard his car alarm and went to the parking lot where he learned his car had been struck by another patron. The driver of the other car stopped, and he and the deputy initially exchanged information. The driver then drove to another part of the parking lot, and the deputy followed him. The two then engaged in an argument about whether they needed to call the police to take a report about the incident. According to the other driver, the deputy displayed his gun and identified himself as a "cop." The man later said he did not believe the deputy was really a police officer, so he got back into his car and fled. The deputy initially ran alongside the car and then, as it pulled away, he fired several

12 Deputies and other Department employees generally have probationary status during their first year of employment, meaning that their permanent employment is still under review and employment may be terminated at will.

rounds at the car as it exited the parking lot. One round struck the wall of a business across the street and four rounds struck the vehicle. Investigators eventually located the other driver and concluded he was intoxicated at the time of the incident. The man was not hit by any of the deputies' bullets. The entire incident was captured on video by a restaurant surveillance camera.

When responding units arrived, the deputy initially stated he reached into the vehicle as the other driver was trying to flee and was dragged approximately 15 feet before he could disengage. He said he then fired at the rear of the car. He declined to give any further statements or submit to an administrative interview, citing the possibility of criminal charges and his Fifth Amendment right to remain silent. Based on the information available, the Department was sufficiently troubled by the deputy's actions – shooting at a fleeing vehicle with a backdrop of a well-trafficked street and parking lot – that it made the decision to terminate his probation and discharge him.

Failure to Report Deputy-Involved Shooting

A deputy was on patrol searching for a residential burglary suspect when she saw a man matching the description of the suspect walking on the sidewalk. As she pulled her patrol vehicle over to contact the man, she removed her firearm and exited the vehicle pointing her weapon at the suspect. In the midst of questioning the suspect, he took off running. The deputy pursued the suspect and radioed in that she was in foot pursuit of a possible burglary suspect. The suspect was eventually contained and detained by assisting units. At the conclusion of the incident, the deputy was asked to write a report on the incident. She included the information detailed above. However, while the suspect was being detained at the station, the watch commander asked him about his injuries to ensure he did not require medical attention. During the conversation, the suspect asked if, "a deputy could shoot at him if he wasn't carrying a gun?" This prompted the watch commander to inquire into a possible deputy-involved shooting and to notify IAB.

Prior to the arrival of Internal Affairs investigators, the watch commander sent a sergeant out to the scene of the foot pursuit to locate witnesses who may have heard a gunshot. Several witnesses were located who had heard a gunshot. The Department immediately opened a criminal investigation into the alleged use of unreported deadly force. They seized the deputy's duty weapon for testing and determined it had been fired. Furthermore, investigators were able to locate a bullet in the area. Prior to the deputy's scheduled interview with criminal investigators, she resigned from her position and refused to make any statements in the criminal case.

The District Attorney was presented with the ballistics evidence mentioned above as well as statements from approximately 10 witnesses in a nearby building who heard a gunshot and

then ran to a window where they saw the deputy with a gun in her hand chasing the suspect. The District Attorney declined to file criminal charges against the deputy, citing insufficient evidence of either intentional use of deadly force or negligent use of deadly force. The deputy never made any statements regarding the discharge of her weapon, but the District Attorney surmised that she may have accidentally discharged her weapon.

Unreasonable Force Against a Juvenile

During a juvenile proceeding, a deputy advised a minor who was dressed inappropriately to go out into the hallway and adjust his attire. The minor complied with the deputy's request. After re-entering the courtroom, the deputy approached the minor again, placed his hand on the minor's shoulder, and re-advised him to appear in court properly dressed in the future. The minor became agitated and told the deputy not to touch him. During the court proceedings which followed, the minor was convicted of a misdemeanor battery charge. The deputy believed the minor's agitated state of mind coupled with his conviction might cause him to become hostile towards his family or his attorney. The deputy therefore followed the minor out into the hallway and advised him to leave the court building. The minor questioned the deputy as to why he had to leave the building. The minor's attorney interjected and advised the minor it would be best if he left. As the minor walked down the stairway, the deputy followed behind and placed the minor in a headlock as he escorted him down the stairs. The deputy said he did so to prevent a physical altercation which he believed was forthcoming because the minor had taken a combative stance. The minor's attorney, however, said the deputy pushed the minor and then dragged him down the stairs in a headlock. No significant injuries were suffered by the minor as a result of the deputy's actions. The deputy was found to have used excessive force on the minor and to have violated the Department's Performance to Standards policy by failing to notify a supervisor prior to contacting an uncooperative or emotional person. The deputy had no prior discipline and was suspended for three days. However, during the grievance process, the discipline was reduced to two days.

PART THREE

Custody Issues and Concerns

In our *Eighth Annual Report,* we indicated approximately 19,000 inmates were housed in the Los Angeles County Jail system. This past year, however, the number of inmates have averaged about 16,600, and in the first six months of 2011 the number of inmates housed in county jail has further decreased to about 14,400, with the number falling below 14,000 in both April, May and June. The last time the jail population in Los Angeles County was below 14,000 was in 1984. This reduction in the volume of inmates in the jail system is largely attributed to a shortfall in the Sheriff's budget which was met with the virtual closure of several jails, the institution of an early release program for non-violent offenders, and the faster transfer of sentenced prisoners to state prison. The number of inmates housed in county jails, however, is scheduled to start increasing in October of this year due to the passage of legislation which will permit defendants sentenced on non-violent, non-serious, non-sex offenses to be housed in county jails. The bill was passed by the Governor in an attempt to comply with a recent federal court order requiring the State to reduce its prison population by 40,000 inmates in order to relieve overcrowding and improve conditions in its state correctional facilities. It is currently anticipated that Los Angeles County will be able to house up to 8,300 state prisoners. However, it will require opening up all of the jails and sections of jails which were previously closed and long-term funding for the program is currently uncertain. OIR will closely monitor the situation as the influx of state prisoners into the county jail system is certain to pose additional challenges for the Department.

Notwithstanding the decrease in the number of inmates housed in county jails, a number of systemic issues concerning the jails presented themselves since our last report. This section will discuss the following three issues: (1) the Mexican Consulate's concerns regarding three significant cases involving Mexican nationals and the Department's response to those concerns; (2) the unfortunate deportation of a mentally disabled United States Citizen; and (3) the use by jail deputies of sheets of paper with scanner codes to circumvent physical checks on inmates.

Interaction With The Consulate Of Mexico

The Consulate General of Mexico in Los Angeles presented the Sheriff with his concerns regarding three cases involving Mexican nationals that occurred in 2009 and 2010. Two of the cases involved in-custody deaths of Mexican nationals and the third involved an allegation by a Mexican national that he had been beaten by law enforcement officers and was sexually assaulted by fellow inmates with the assistance of jail personnel. The Consulate's concerns were twofold with respect to the in-custody deaths: (1) that Department members may have caused or contributed to the inmates' deaths; and (2) that the Department did not notify the Mexican Consulate of the deaths. With respect to the inmate who alleged he was physically abused and sexually assaulted, the Consulate was simply concerned that a full investigation into the allegations be made. In response, the Sheriff requested OIR's assistance in reviewing the incidents and addressing the Consulate's concerns.

OIR attorneys independently reviewed the three investigations and examined jail records, medical documents and coroner reports. OIR attorneys also worked collaboratively with Department personnel and in some instances recommended additional investigation before reporting their observations and conclusions. The following are detailed descriptions of the three cases and their outcomes.

In-Custody Death Deemed a Suicide

In 2009, a Mexican national and inmate at Men's Central Jail was found hanging in his cell while in the custody of the Los Angeles County Sheriff's Department. As per OIR protocol, an OIR attorney immediately rolled out to the scene and began actively monitoring the Department's investigation. Shortly after the inmate's death, his family contacted the Mexican Consulate and raised several concerns. Among the family's

concerns, was a belief that the inmate had not been given proper emergency medical aid. The family also had questions about bruising found on the decedent's head and seven broken ribs.

As discussed in further detail below, based on a review of all the relevant material and information, as well as discussions with the inmate's family,[13] the Consulate staff, Department members, the County medical examiner, and an independent forensic pathologist, OIR determined there was no evidence the inmate's death was the result of foul play or anything but a suicide. OIR further found that Department personnel did not violate any polices or procedures, and that the Department conducted a thorough investigation into the death.

Background

As per Department protocol, during the intake process at LASD's Inmate Reception Center, personnel conducted a medical and psychological screening of the inmate in question. At that time, the inmate did not report that he was mentally ill, nor was there any indication that he suffered from a mental illness or was suicidal.

Approximately nine months after being incarcerated, the inmate was discovered alive but lying on the floor of his cell with a telephone cord tied around his neck.[14] When interviewed, the inmate stated he wanted to kill himself because he believed his wife was having an affair. After five days of monitoring the inmate, he was re-evaluated and declassified from his suicidal status.

Approximately five months later, the inmate (housed in a single-man cell) was discovered lying on the floor. The inmate had tied two knee-high tube socks together, wrapped them around his neck, and affixed one end to a cell bar above the cell door.[15] Deputy personnel and nursing staff arrived and immediately initiated CPR and rescue breathing. All efforts by personnel to revive the inmate were unsuccessful.

---

13 OIR also coordinated and facilitated a two-hour meeting with the County medical examiner and the decedent's family members so that the family could have an opportunity to get clarification about the death. The entire meeting was conducted in Spanish, as per the family's request. Both the OIR attorney and the medical examiner are fluent Spanish speakers.

14 The Department is aware that continual access to telephones (and telephone cords) may pose a risk for inmates with suicidal ideations. In this case, however, there was no evidence that the inmate was suicidal when he was placed in a cell with a telephone.

15 The socks the inmate used were a pair the inmate purchased through a Department-approved vendor. Shortly after this suicide, the Department commendably decided to end the availability of these knee-high tube socks to inmates.

Concerns Raised by the Inmate's Family

One of the main concerns raised by the family was the belief that the decedent was denied medical attention. This belief was spurred, in part, by the independent autopsy report commissioned by the family which states "[r]esuscitative marks are not present over the precordium." Even according to the independent forensic pathologist, however, that finding was not intended to suggest that lifesaving efforts were not conducted. Instead, the finding was intended to indicate no burn marks from cardiac paddles were evident on the decedent's chest. The pathologist explained that cardiac paddles -- which typically contain a high voltage – occasionally leave burn marks on the skin. Here, the record showed an external defibrillator was affixed to the inmate's chest. Medical personnel, however, did not apply the shock because the defibrillator -- which prompts usage based on heart rhythms -- did not "advise" for a shock to be conducted. In fact, there was significant evidence that medical attention was promptly summoned and administered. When Department personnel learned the inmate was unresponsive and not breathing, personnel immediately called for paramedics and medical staff. Deputies and medical staff responded to the cell without delay and began CPR. Additional medical staff arrived shortly thereafter with a gurney and emergency equipment, and they applied oxygen and an IV. Indeed, there is evidence that there were two small punctures on the decedent's left forearm which, according to the medical examiner, is indicative of an IV insertion.

The decedent's family had received several phone calls from inmates who claimed to have observed Department personnel preventing paramedics from entering the cell and administering aid. However, there are no cells located across from the decedent's cell and the neighboring inmates -- located on either side of the decedent's cell -- were interviewed and stated they did not hear or observe what was occurring inside the cell. Also, based on the investigative record, city paramedics arrived approximately one minute after the inmate was pronounced dead and were not prevented or delayed from entering the cell.

The family was also troubled by a notation in the independent autopsy report that indicated the decedent had bruising over the forehead. According to the forensic pathologist, the bruising appeared to be pre-mortem and may have occurred a long time before the inmate's successful suicide. The forensic pathologist, however, made no conclusions about the exact timing and cause of the bruises. The County medical examiner surmised that the "abrasions" may have been caused by a strike to one of the protruding horizontal cell bars which were adjacent to where the inmate was hanging. Based on a review of the investigation, there was no evidence to support a finding that the head abrasions/bruising were the result of any pre or post-mortem conduct on the part of any third party, i.e. LASD personnel, medical staff, or other inmates. Additionally, both autopsies concluded that the direct cause of death was asphyxia by "self-inflicted" hanging and specifically found the head abrasions/bruising did not cause or contribute to the inmate's death.

What appeared to be bruising on the decedent's fingertips was also of concern to the decedent's family. According to the medical examiner, however, the decedent's fingertips were not bruised. Instead, the inmate's fingertips had residual ink after the Coroner obtained his fingerprints for identification purposes.

The family also believed that the decedent's broken ribs (noted in the independent autopsy report) were evidence that the inmate had been beaten by Department personnel. However, based on OIR's review, there was no evidence that the decedent suffered any bodily trauma inflicted by a third party (i.e. Department personnel). Further, as learned from discussions with the County medical examiner and the independent forensic pathologist, broken ribs are typically caused during an autopsy when the chest cavity is opened.

The family also expressed their disbelief that the decedent could fashion a noose from a pair of socks. This impression was based on their mistaken belief that inmates wear ankle-high socks. As mentioned earlier in this report, the socks the inmate used as a ligature were knee-high length.

Finally, the family did not believe the inmate was depressed or that he was capable of taking his own life. As mentioned above, during the intake process, the inmate did not report he suffered from a mental illness. However, distraught over the belief his wife was cheating on him, he had in fact, previously attempted suicide. After he was declassified from suicide status, the inmate remained in custody without any outward indication that he was suffering from mental health issues. A review of the case did reveal that there was no follow-up care by the Department of Mental Health (DMH) personnel after the inmate was declassified. Although OIR understands policy requires mental health personnel to follow-up with declassified inmates within a week of the declassification decision, OIR continues to recommend that the Department work with DMH to find additional ways to ensure that inmates who have expressed suicidal ideation continue to receive special attention while in custody even when it appears the mental health crisis is behind the inmate. Clearly, one who has seriously attempted suicide presents a greater risk of future suicide attempts. After the inmate's completed suicide, investigators learned from one of the inmate's family members that he had a history of "several other suicide attempts."

In-Custody Death Deemed an Accidental Overdose

A second Mexican national died in the custody of the Los Angeles County Sheriff's Department in late 2009. The on-call OIR attorney rolled to MCJ and began actively monitoring the investigation into and review of the circumstances surrounding his death. The County medical examiner concluded the cause of death was heroin intoxication, and the manner of death was accidental. Shortly after the inmate's death, however, the

Consulate raised concerns that the inmate's death could be related to an incident he had allegedly observed involving the fatal beating of another inmate by deputies. The Homicide Bureau conducted the primary investigation into the inmate's death, and the Internal Affairs Bureau, Custody Support Services, and the Risk Management Unit conducted secondary internal investigations, reviews, and assessments to determine whether any MCJ personnel violated Department policies, procedures or training, and to determine whether any reform of Department policies, procedures or training were required to minimize such deaths.

All Department personnel who investigated or reviewed the circumstances of the death worked in collaboration with each other, and kept the OIR attorney fully informed of their investigatory activities and findings. Moreover, each investigative unit was receptive to OIR's recommendations regarding their work on the case. The investigation revealed that the incident the inmate had allegedly witnessed did not result in the death of an inmate. In fact, the force incident referred to by the decedent involved deputies responding to one inmate stabbing another inmate, and their efforts to stop the assault and bring the aggressor under control. As a result of the stabbing, the inmate on whom force was used was charged with attempted murder. OIR conducted an independent review of the Department's force investigation as well as the circumstances surrounding the death of the inmate and concluded the investigations were thoroughly and expeditiously conducted, Department personnel did not violate any policies or procedures, and there was no evidence the inmate's death was caused by deputies in retaliation for his possibly witnessing a beating death of another inmate.

Background

In the summer of 2008, the inmate had been arrested for murder. Since then, the inmate had been in the county jail system awaiting trial on the murder charge. The night before he died, he attempted to make a number of telephone calls to family members. However, there were not enough available minutes on the family members' calling cards to complete the calls. His cellmates stated he appeared despondent after attempting to make the telephone calls; and before going to sleep, he ingested a brownish liquid. The next morning, the inmate was found lying in bed, unresponsive and not breathing. As a deputy conducted security checks in the module and approached the inmate, cellmates alerted the deputy that the inmate was unresponsive and not breathing. Jail personnel called for paramedics. Paramedics arrived at the cell and unsuccessfully tried to revive the inmate. The inmate was pronounced dead on scene a few minutes later. At the time of the inmate's death, he shared a four-person cell with three cellmates. Pending the arrival of homicide detectives, MCJ personnel had properly removed the cellmates and secured the cell in which the inmate had been housed.

The initial investigation of the scene showed medical debris, vomit and blood on the inmate's mattress, but no visible trauma or markings on the decedent's body that would indicate any type of physical violence. This impression was confirmed by the medical examiner. During his 16-month stay in the county jail system, the inmate had been medically and psychologically screened, and medical and psychiatric personnel found him suitable for housing in the general population. Hence, while the medical examiner who conducted the autopsy concluded the death was caused by a heroin overdose, he could not conclude the death was a suicide as opposed to an accidental overdose.

Concerns Raised by Consulate Regarding Possible Retaliation

A civilian working as a volunteer in the jail informed the consulate that she had interviewed the inmate about two months before his death and he had expressed concern for his safety because he had allegedly witnessed a murder committed by prison guards. The civilian told the Consulate she was concerned the inmate's death may have been caused by deputies in retaliation for witnessing their fatal beating of an inmate. In addition, the inmate's mother informed the Consulate that a fellow inmate had called her to inform her that on the night her son died, he had heard noises coming from his cell which sounded as if he was being beaten. After receiving this information, Internal Affairs investigators interviewed witnesses and reviewed use of force incidents that occurred within the relevant timeframe. As a result, investigators were able to identify a use of force incident that the inmate may have witnessed. This incident occurred in a module in which he was housed at the time. The incident involved an inmate who possessed a shank and attacked another inmate. The inmate stabbed the victim inmate several times in the head and upper torso. When the armed inmate refused to comply with deputies' commands to drop the shank, deputies conducted a takedown of the inmate. On the floor, the armed inmate began kicking and punching deputies. Deputies deployed a number of force options to stop the aggression including a Taser, O.C. spray, and punches. Deputies were eventually able to gain control of the armed inmate and handcuff him. The inmate was transported to a local hospital for medical treatment. The force used by deputies in this incident did not result in the death of any inmate.

When interviewed about this incident, the inmate with the shank did not complain about the force used upon him. Because the decedent is not alive, there cannot be any absolute certainty that this force incident was the one related by him to the civilian volunteer. However, the similarities between what the decedent had described regarding the circumstances surrounding the force, the timeframe, and the fact that it occurred in the module in which he was then housed, all strongly suggest that this was the incident the inmate had talked about prior to his death. Moreover, a review of all inmate deaths during

the described timeframe did not reveal any deaths resulting from injuries of the type one would sustain as a result of blunt force trauma.

Notification Issue

Pursuant to the 1969 Vienna Convention on Consular Relations Treaty, Article 37 and other agreements and laws, the Department is required to notify Consulates (from nations that are party to these reciprocal agreements/laws) about the arrests or deaths of citizens who are in the United States as foreign nationals. In the two in-custody deaths discussed above, the investigative record revealed the Department authorities failed to notify the Mexican Consulate of the inmates' in-custody deaths. When OIR notified the Sheriff of this issue, the Department promptly responded by conducting trainings and disseminating relevant bulletins reminding Department members of its notification responsibilities. OIR continues to work with the Department to develop a more robust system in an effort to ensure timely notification when foreign nationals have the misfortune to expire in the county jails.

Alleged Physical Abuse and Sexual Assault

A Mexican national who is currently serving a sentence at a California state prison was an inmate in Los Angeles County jails in 2009 and 2010. Towards the end of his county jail detention, he told ACLU jail monitors and representatives from his consulate that he had been beaten by law enforcement officers and sexually assaulted by fellow inmates. The ACLU and the Mexican Consulate notified OIR of these allegations. In response, an OIR attorney examined jail records concerning the inmate, talked to jail personnel and met briefly with the inmate. Jail records documented medical care the inmate had received but did not reference any uses of force by deputies or inmate-on-inmate violence. Additionally, when the inmate had been sentenced in court, his counsel had requested protective custody for his client, explaining that the inmate said he had been beaten up by jail deputies acting on instructions of a Los Angeles City Councilman. The OIR attorney requested and the Department agreed to conduct an investigation into the inmate's allegations.

The inmate was transported to state prison the next day, but one day later, Custody Division detectives traveled to the prison and interviewed him in Spanish. During the interview, the inmate said that when he was originally arrested for trying to register a stolen vehicle, a Highway patrolman threw him to the ground and handcuffed him. He also said three other CHP officers beat him, causing his face to be swollen and bloody. He stated all of this was done at the direction of the councilman. The detectives contacted the deputy who monitored the group of trusties that included the inmate. The deputy said the inmate never complained of being attacked sexually. Moreover, jail records showed no reports of medical attention for any physical or sexual assault. The inmate did have numerous treatments during this time, but they were for seizures for which he took medication, an

ear infection, a pre-existing arm injury, and a pre-existing eye problem. He had made no mention of assaults to any of the medical personnel.

The alleged beatings, sexual assaults and deputy collusion appear to be inconsistent with his trusty status, a privilege conferred on inmates that allows them greater freedom of movement. The inmate may also have had psychological concerns. He told detectives that, among the complaints he had made to his consulate, he requested psychological treatment.

OIR reviewed the investigation, the underlying jail records, and listened to the detectives' interview of the inmate in prison. The investigation was extensive but failed to produce any evidence that corroborated the inmate's dramatic claims of victimization. OIR agreed that there was no basis to name specific subjects or to make any finding other than "unsubstantiated." OIR informed the Mexican Consulate of the status of the investigation and its concurrence with the Department's findings.

United States Citizen Deported From County Jail

In May 2007, an inmate was processed out of MCJ through its Inmate Reception Center (IRC). As part of the Department's "287(g) program,"[16] the inmate was interviewed by a custody assistant and disclosed he was born in Mexico and had crossed the border into the United States 18 years earlier. This contradicted the information he provided when he was arrested and booked, at which time he stated he had been born in California. Nonetheless, a federal immigration hold was placed on the inmate and the Department transferred him to Immigration and Customs Enforcement (ICE) custody. Shortly thereafter, he was deported voluntarily to Mexico.[17]

The Department quickly learned that the former inmate was, in fact, a United States citizen and, according to his family, was developmentally disabled. He was lost and unaccounted for in Mexico for a period of 89 days. He was returned to custody after trying to cross the

16 Section 287(g) of the Immigration and Nationality Act allows a state and local law enforcement entity to enter into a partnership with ICE so that the state or local entity receives delegated authority for immigration enforcement within their jurisdictions. The Sheriff's Department first entered into a Memorandum of Understanding with ICE in 2005 pursuant to which convicted inmates being released from the jail are screened to determine their immigration status.

17 The inmate signed a voluntary departure order rather than challenge ICE's action and assert a right to a deportation hearing. In general, from the perspective of an undocumented immigrant, voluntary departure is preferable to deportation because it creates fewer limitations on an individual's future opportunities to apply for legal status.

border back into the United States, and eventually reunited with his family. The incident drew widespread media attention and led to a lawsuit against the LASD and ICE. The lawsuit was resolved by a settlement that imposed no liability on the LASD.

With regard to the Department's role in the inmate's deportation, the incident raised two important issues. The first is the Department's process for screening inmates coming into its custody for mental health or developmental issues. Here, the inmate was never identified as someone with a developmental disability who may need extra help in custody or may not understand interview questions or written documents.

The IRC is the point of entry and exit for all male inmates coming into or leaving the county jails. Inmates coming into the system arrive at booking, and then make their way through various stages of processing and classification. After inmates are showered and have changed out of street clothes into jail uniforms, they go to medical screening. There, a custody assistant asks a series of screening questions and makes observations of each inmate. A nurse is available to assist the custody assistant, if requested. The screening questions call for the inmate to self-identify any medical or mental health issues, asking "Have you ever been in a 'Special Education' class, considered developmentally disabled, or a client of a Regional Center?" The IRC custody assistant indicated the inmate responded "no" to this question.

In this case, the inmate also had been assessed by a station jailer at the time of booking.[18] The questionnaire used there likewise asks a series of questions, but also asks the jailer to make independent assessments. For example, the form asks, "Does the arrestee appear to be under the influence of alcohol and/or drugs?" And, more specific to this matter, "Does the arrestee's behavior suggest a mental disorder (disordered social behavior, hallucinations, profound depression, confusion)?" The form also asks, "Does the arrestee appear to be developmentally disabled/retarded?" In this case, the station jailer answered these questions in the negative.

If the inmate has no identified medical or mental health issues, he continues through the intake process and staff assigns him to a housing location, usually within 12 hours of his arrival at IRC. If an urgent medical issue is identified, the inmate remains in the IRC clinic and is seen by a doctor quickly. If the condition is not an emergency, the inmate is sent to a part of the Twin Towers Correctional Facility operated by IRC. There, the inmate may have to wait 24 hours or more to see a nurse, doctor, or mental health practitioner, but he spends that time in a cell with a bed and receives the same hot meals as any other inmate in custody. Following the medical or mental health assessment, IRC and Medical Service Bureau staff determines the most appropriate housing location for the inmate.

18 Inmates who are arrested by the LASD are sometimes housed initially at a station jail, until they are arraigned. Some initial screening is done at those facilities and inmates with mental health or medical issues are quickly sent to IRC, where more specialized staff is available to address those issues.

The inmate who was deported in this case was not identified as developmentally delayed at any stage of this multi-level screening process. He also went to court several times while in custody, and neither his attorney nor the judge ever told the Department that the inmate needed any special handling or accommodation. According to jail records, he functioned capably while in custody and apparently gave personnel no reason to believe he was at a different developmental level than other inmates.

If the inmate had been identified as developmentally disabled – either by a self-report or staff observation – he could have been placed in mental health housing or in special housing for inmates considered "soft," meaning they are unable to manage the dynamics of jail for one reason or another. Perhaps most importantly, if identified as developmentally delayed while in custody, the inmate more likely would have received special attention from mental health staff at the time of his release. He may nonetheless have been sent to ICE custody, but there is a greater chance officials would have contacted his family before deporting him.

Though the scenario played out differently here, the Department has steadfastly asserted it did nothing wrong in this case, and points to the settlement of the lawsuit as the best evidence of this. The plaintiff received a confidential amount from the federal government, but dismissed the case against the LASD with no liability to the County. Certainly, in a perfect world, this inmate would not have found himself in custody without the help he obviously needed to manage his release. But in an environment with thousands of inmates, developmental delay can be difficult to assess. An inmate may have very limited intellectual capacity but be able to eat, shower, and follow directions sufficiently so as not to draw attention to himself. This is particularly so because jail staff is accustomed to dealing with inmates who are suffering through drug withdrawal, stress, or damage from extended drug use, all of which share some characteristics with developmental delay. While the Department strives to do a better job of identifying inmates with disabilities and matching them with appropriate care, resources, and protection while in custody, this case does not clearly demonstrate any particular area where the Department's performance was deficient.

The second issue relates to the Department's partnership with ICE and how it functions in its role of identifying soon-to-be-released inmates who may warrant further inquiry by federal immigration officials. At the time of this incident, IRC had eight custody assistants trained by ICE, only six of whom were responsible for conducting interviews of released inmates. The trained custody assistants interviewed inmates whose names appeared on a list of those who were identified as foreign born at the time of booking. For those inmates interviewed who could not produce proof of citizenship, the custody assistant would initiate an immigration hold and, instead of being released, the inmate would be transferred to ICE custody. When not engaged in those interviews, the ICE-trained custody assistants would conduct random screening of inmates in IRC's release area. The process, as described to

OIR, had the custody assistants simply walk down the line of soon-to-be-released inmates, asking, "Where were you born?" Inmates who stated they were born in the United States were permitted to continue through the release process. Those who stated they were born elsewhere were pulled out of the line to be interviewed and, depending on the outcome of that interview, transferred to ICE custody.

The inmate in this case was not on the foreign born list, but was identified during a random screening. The custody assistant who questioned the inmate said the inmate told her he was a citizen of Mexico. He provided a birthplace, as well as a day and place at which he crossed the border into the United States. According to the custody assistant, the inmate never claimed to have been born in California and did not appear to be mentally disabled or confused. She completed the appropriate paperwork, placed the immigration hold on the inmate, and made him available for transport to ICE custody. Neither the custody assistant nor any other Department member had further contact with the inmate prior to his voluntary departure.

In 2007, the 287(g) program was relatively new. The custody assistants involved were in many ways still learning how to conduct their new jobs, and ICE agents were largely absent from the jail. Subsequent and probably unrelated to this case, the federal Office of Inspector General (OIG) audited 287(g) programs nationwide. The resulting report was critical of these programs because, among other things, ICE did not properly train and supervise local staff. LASD custody assistants working the 287(g) program have, since its inception, attended a four-week training class at the Federal Law Enforcement Training Center in South Carolina. Following the OIG audit, they now also receive periodic recurrent training and have more ready access to ICE supervisors who can answer their questions and review their work.

In addition to improved training, another distinction between the way the 287(g) program operates today compares to 2007, is the shift away from random screening. The priority of the program is to work the foreign born list, and to focus particularly on interviewing those convicted of serious crimes or identified as gang affiliated. With current resources, custody assistants have a difficult time completing this task. To the extent there is time to conduct any random screening, custody assistants – some of whom were those originally selected for the program in 2005 – are now sufficiently experienced to spot potential issues. Suspicious driver's license or Social Security numbers, for instance, can be identified by reviewing the inmate's paperwork, without the need to walk the line and question inmates.

The story of the United States citizen deported in this case is tragic and could have had even more dire consequences. While it is impossible to point to specific shortcomings by the LASD, it is undeniable the system failed him at a number of levels. We are hopeful that his ordeal serves as a powerful lesson learned so that, with more sophisticated training of

staff involved in the 287(g) program and increased awareness by ICE, such a situation will never again occur.

Jail Suicide, Deputy Vigilance and Corrective Action

There are suicides in the County jail system almost every year. Last year there were four successful suicides, down from a recent peak of eight the previous year. Between January and April of 2011, there has only been one suicide. Each of these events has its own particular tragic circumstances, and they often reveal shortcomings large and small in the various systems designed to keep inmates safe and healthy. They can also reveal employee failures to comply with those systems. For this reason, OIR attorneys roll out to the scene of every jail suicide. Internal Affairs investigators, at OIR's recommendation, now also roll out to these events, as do Homicide investigators. We highlight below a recent suicide where the Homicide and Internal Affairs investigations revealed both weaknesses in the system and intentional malfeasance. The subsequent corrective actions taken by the Department have revised many aspects of custody deputy and supervisor responsibilities for inmate welfare.

To put the following incident in context, we asked the Department to collect data on unsuccessful suicide attempts as well. Custody figures show that in 2010 there were 174 suicide attempts that were prevented. The figures show that a significant number of those attempts were thwarted by vigilant deputy behavior, either through security checks, pill call, count, or searches. The suicide attempts at the Twin Towers facility, not surprisingly, account for over one third of all attempts, since many inmates in the system receiving mental health treatment are housed there. While the suicide attempt data provide an important source of information relative to inmate behavior, the data also demonstrate the vigilance of deputies who have prevented inmates from ending their own lives.

Revelations from a Jail Suicide Investigation

A deputy was performing mandatory inmate welfare checks in the very early morning hours on the short cell row of a "discipline module," housing high security inmates for whom he was responsible. This part of his job consisted of a walk down the row twice per hour so that the deputy could look into each cell and confirm that each inmate in the one-man cells was breathing and not in distress. When the deputy looked into a cell near the beginning of the row, he noticed that the inmate was sitting on his bunk facing away from the bars in the

same position he had been in the last time the deputy had checked. He looked closer and recognized that something was amiss. The inmate had a ligature around his neck attached to a grate in the back wall of the cell, suspending him in a partial sitting position just above the end of his bunk, with his hands bound. The deputy sought help immediately and medical staff was called. The inmate was cut down from the ligature and CPR was attempted but to no avail. The inmate was declared dead at the scene.

The inmate's limbs were already quite stiff when he was removed from his cell for life-saving efforts. This observation raised immediate questions about whether the welfare check logs maintained by the discipline module deputy that night were accurate. Further investigation and interviews revealed that the hand written entries documenting half-hourly checks of the entire row were not at all accurate and many of them had been filled in by the discipline module deputy long after the appropriate check time.[19]

The discipline module deputy admitted to investigators that he had faked the hand-written records of some of his row checks. Internal Affairs investigators, however, discovered even more disconcerting information in the early hours of the investigation.

Because of this and other anomalies, the Department's Custody executives had the Internal Affairs review stepped up to an immediate formal Internal Affairs investigation. The investigation eventually revealed that the discipline module deputy had performed only a fraction of his required inmate welfare checks in the hours prior to the discovery of the suicide, and had performed no checks for the last hour and forty minutes before he discovered the inmate hanging in his cell. Each of the row checks that the deputy

19 There were other significant issues presented to jail authorities that were learned by the Homicide investigation into this suicide. For example, as noted above, the inmate's hands were bound with the same ligature made from torn linens. The autopsy also showed internal bruising from injuries incurred before the hanging. These were cause for concern and scrutiny. But, other evidence, including fellow inmates and a deputy who noted the inmate's depressed state, strongly pointed to suicide as the cause of death. Moreover, as a result of a breakdown of the notification protocols between the Coroner's office and the Sheriff's Homicide Bureau, no one from Homicide was present when the autopsy was performed, a significant divergence from ordinary procedures. Additionally, the investigation revealed that the Coroner's office inadvertently released the ligatures to the family instead of retaining them as evidence for Homicide investigators. Finally, as a result of the despondency noticed by a custody deputy a day before the suicide, the inmate was placed on a list so that he could be visited by a specially trained mental health team. The team had not yet received the notice at the time of the suicide. All of these issues call out for systemic study and potential reform; and with varying degrees of speed and efficacy, the Sheriff's Department has been responding to them.

had performed had been accomplished in less than 35 seconds, calling into question the thoroughness of the few row checks that the deputy had undertaken. Jail rules specific to the discipline module require the constant presence of at least one deputy on the row or in the booth adjacent to the row. However, during his shift, the deputy had left on one occasion to go to the staff gym to work out and shower, and on another to go outside of the facility for a "chow run" to a nearby restaurant. The investigation revealed that the module deputy was away from the module for an estimated total of three hours during the first five and a half hours of his shift.

The investigation further revealed that the discipline module deputy's immediate supervisor, the floor sergeant, condoned the chow run, though he may have presumed that the deputy had arranged for a substitute to patrol the module. The deputy in fact had not. The floor sergeant had visited the discipline module once during the shift and had even done a brief check down the row, but he had neglected to notice that the module deputy had failed to perform his welfare checks for long periods of time.

The discipline module deputy admitted to investigators that he had faked the hand-written records of some of his row checks. Internal Affairs investigators, however, discovered even more disconcerting information in the early hours of the investigation. Contained in the module booth was a single photocopied sheet of paper. It was covered with bar codes,[20] each labeled with the name of one of the rows of jail cells on that floor of the jail, including the discipline row. The meaning of the sheet of paper was obvious to anyone who knew the basic procedure for performing inmate welfare checks in the jail. Since 2007, many of these checks have been documented through the use of hand held bar code scanners. Permanent bar code plaques are mounted at each end of every cell row in the facility. Module deputies are supposed to scan each of the plaques as they walk the rows performing their checks. The scanner's memory records each bar code and the time interval between scans. In essence, the data are gathered to document precisely when a deputy performs the row checks, as well as to determine how quickly the row checks are performed. The scanning system was promoted as an effective way to ensure that the welfare checks were being timely conducted. More importantly, the scanning system was seen as an effective deterrent to any after the fact efforts to doctor welfare check logs after something "bad" such as a suicide had occurred.

The presence of photocopied replicas of the jail bar codes in the module, however, pointed to a deliberate effort to circumvent the scanning system entirely.

20 These bar codes are similar to the bar codes found on grocery products which are scanned by employees at checkout to calculate the prices of the products.

The presence of photocopied replicas of the jail bar codes in the module, however, pointed to a deliberate effort to circumvent the scanning system entirely. Investigators looked for additional bar code sheets and found them. They also examined the downloaded scanner records for that night and found that one of the "completed" discipline module row checks had been scanned in by a deputy from another module on the floor. When interviewed, this deputy admitted using a bar code cheat sheet he had received from a work partner and explained how the fraudulent row scanning was accomplished from the comfort of his desk without having to actually walk the rows. He also stated that he had accidentally scanned the wrong bar code while scanning his own cheat sheet in order to fake his own row checks. This explained why the deputy's identification number appeared as someone who had performed a row check for the discipline module.

By the end of the inquiry, jail authorities had initiated four separate internal investigations related to the scanner cheating phenomenon. A total of ten subjects were disciplined.

Investigators learned that jail authorities had previously suspected some module deputies might be cheating with the bar codes, but as a result of this investigation, the Department now had concrete proof.[21] After conferring with jail authorities and with OIR, Internal Affairs investigators attempted to gauge the full extent of habitual row check scanner fraud throughout the facility. They searched computer memories for digital copies of the bar codes as well as e-mailed copies of the bar code sheets. This search yielded several jail employees who were then interviewed as spin-off investigations. Two of these deputies admitted to sharing the cheat sheets with other deputies in the jail and one deputy claimed to know who had developed the cheat sheet to begin with, but he declined to name the cheat sheet inventor. The investigation stopped there until Internal Affairs investigators met with the Custody Operations Chief, who refused to accept the impasse. Investigators were instructed to re-interview the subject and apprise him of the consequences of insubordination and any failure to fully cooperate in internal investigations as well as the Department's expectation that he tell the complete truth. During the subsequent interview, the deputy did reveal the cheat sheet inventor's identity.

Once confronted, the inventor deputy candidly explained how he had created the cheat sheet system. He found that the scanner contained the data necessary to identify each unique bar code. He found widely available bar code replication software, brought it into the jail, programmed in the bar code identifiers for the desired bar codes, and printed out

21 There have also been other problems with misuse of the scanner system. For example, jail authorities have learned that deputies have downloaded messages into the scanners and used them to transmit messages to one another.

perfect replicas. By arranging them all on one sheet of paper, he could provide an effortless way for deputies to scan the "beginning" and "end" of each row without leaving their seats. Because of this convenience, investigators found that deputies who engaged in fraudulent scanning often tended to pause only momentarily between scans. As a result, the deputies who were using the cheat sheet created a telltale pattern in the scanner memory download records that investigators used. These records along with other corroborative evidence, such as the presence of cheat sheets and statements by other deputies, served to build a strong evidentiary case against the offending deputies.

By the end of the inquiry, jail authorities had initiated four separate internal investigations related to the scanner cheating phenomenon. A total of ten subjects were disciplined. Two deputies were discharged -- the discipline module deputy who had skipped welfare checks of the inmate who committed suicide, and the deputy who invented the cheat sheet. Three deputies received high level suspensions, and four deputies and one custody assistant received medium level suspensions. Additionally, the floor sergeant who had failed to adequately supervise the discipline module deputy received the maximum suspension available under County ordinance.

In addition to discipline and individual accountability, Custody authorities recognized that this severe defect in the system needed to be addressed in other ways. The corrective actions included immediate fixes and longer term fixes. The immediate fixes included a modification to the scanner software to make it more secure, and replacing all of the bar code plaques with new ones. Additionally, the facility captain issued a series of briefings and a unit order to make it clear to all employees that further cheating would not be tolerated.

Nevertheless, the Department's decisive reaction to this potentially massive system failure was commendable. The Department turned over all rocks necessary to evaluate the breadth of the problem and to fashion meaningful corrective actions.

Jail authorities also set out to design a longer term solution to the problems revealed by the suicide investigation – failure to do timely row checks and failure to supervise those doing the checks. Jail managers have focused their systemic remedial action on the floor sergeant role. Computer screens have been placed in each floor sergeant's office. This allows the sergeant to monitor the use of the scanner by jail staff in real time. The sergeants have also been encouraged to "walk the floor" more frequently and are now required to perform periodic audits of scanner record printouts to

look for telltale patterns indicating corner cutting or possible fraudulent activity. We believe this focus on the supervisors is appropriate and will provide the most durable solutions.

The scanner cheating cases revealed a disappointing lapse in integrity on the part of the involved deputies. Their actions were overt and premeditated, demonstrating a wholesale failure to recognize one of the most important responsibilities of a custody deputy, namely to diligently watch over and provide safety and security for the inmates under his or her supervision.[22]

Sadly, most of the offending deputies were at the beginning of their law enforcement careers. Nevertheless, the Department's decisive reaction to this potentially massive system failure was commendable. The Department turned over all rocks necessary to evaluate the breadth of the problem and to fashion meaningful corrective actions. The custody system is now able to use the scanner technology with greater confidence. Moreover, jail supervisors have more tools to help manage their staffs and to enforce the rules that keep the Department in compliance with State mandates. This is unlikely to be the last time that the unintended consequences of technological innovation cause problems for the custody system. This unfortunate episode provides a path for the Department to follow when it needs to react to similar future challenges.

22 The longstanding jail Unit Order on "Safety, Security and Fire Prevention Checks," for instance, begins, "[t]he primary objective of all personnel assigned to [the] Jail is to ensure the safety and security of all inmates housed at [the] Jail."

PART FOUR

Misconduct Cases Involving Sworn Personnel

Most Department policies govern the behavior of employees during work hours. However, particularly with respect to sworn personnel, many policies also extend to off-duty private and public behavior. The Department has a long standing tradition of holding deputies accountable for their off-duty actions based on the principle that their behavior can affect the Department's reputation and effectiveness within the community as well as the deputy's integrity and character. OIR consults with Department executives on misconduct cases ranging from the failure to wear a seat belt to the commission of a felony offense. OIR continues to monitor cases through the appellate process before the Civil Service Commission. Currently, OIR is monitoring just over 800 cases. Approximately two-thirds of the monitored cases involve allegations of LASD personnel misconduct unrelated to the significant use of force and shooting cases OIR also reviews. The following is a sampling of misconduct cases involving sworn personnel wherein discipline ranging from a written reprimand to discharge was imposed.

Off-Duty Misconduct

Deputies' Entanglement in Financial Crimes During Economic Downturn

Since OIR's inception, we have closely monitored all off-duty misconduct cases involving the commission of crimes by deputies including the commission of financial crimes. Although there have been notable exceptions, financial crimes in the past 10 years have primarily consisted of minor theft-type allegations. This past year, however, the level of financial crimes we have observed has risen to more serious and deliberate allegations of misconduct. OIR has no definitive explanation for the reasons behind this sudden increase in the level of financial crimes allegedly committed by deputies. While ultimately, the criminal justice system and the Department's disciplinary system cannot excuse such significant lapses of judgment by peace officers, the financial pressure that may have been faced by the involved deputies due to the Global Financial Crisis could well have played a role in their alleged decisions to violate the law and their oaths of office. Deputies were among the many borrowers who financed their homes with adjustable-rate mortgages, but had difficulty making their payments or refinancing once interest rates reset and market values declined. Deputies have also been affected by an increase in unemployment among their spouses as well as unexpected increases in he cost of gasoline and college tuition for themselves and their children.

Moreover, four or five years ago, most deputies who wanted to work overtime to earn extra money on a regular or occasional basis could generally do so quite easily. Overtime was generally available to any deputy who sought it. While some deputies worked overtime on occasion to earn extra money to save for leaner times or pay for a particular item they wanted to purchase, other deputies may have adopted a lifestyle beyond that which their regular salary afforded. Last year, the Sheriff was faced with substantially over a hundred million dollar cut from his budget. In order to keep from having to lay off deputies, the Sheriff outlined a plan to save money which included having deputies with administrative duties work schedules that would otherwise be filled by deputies accruing overtime and having command staff work patrol or fill in at the jails or the courts. The reduction in overtime in itself has accounted for most of the savings – an estimated $58 million. Regrettably, the reduction in available overtime may also have contributed to the rise in poor decision making by deputies who appear to have, at times, resorted to unfortunate measures in order to get out from under debt possibly caused by living beyond their means. In essence, vehicles and other luxury goods may have been acquired when overtime was readily available, and those deputies who no longer have overtime as readily available may not have been able to keep up the payments on those luxury goods.

The following three cases involve deputies who engaged in or attempted to engage in insurance fraud.

Case One

A citizen informant called the police to report a vehicle was on fire in a field adjacent to this residence. Arson investigators responded and determined the vehicle was owned by a deputy who had only been out on patrol for 14 months. When they contacted the deputy they were informed the vehicle must have been stolen from the deputy's residence. The next day, the deputy filed a claim with his insurance company. Arson investigators for the Department later determined the fire was caused intentionally by applying an open flame to vapors of an ignitable liquid that was poured into the vehicle. A few months later, the deputy became a suspect because an expert hired by his insurance company tested the vehicle's ignition and determined the car could not be driven without a transponder key due to an anti-theft system which had been installed in the vehicle. Investigators thereafter secured a search warrant for the deputy's cell phone records and determined he had been in the area where the vehicle was abandoned and torched, rather than at his father's home in another city where he had previously told investigators he was during the relevant time period. In addition to the three vehicles he owned, the deputy had a home with a substantial mortgage and three credit cards with balances of over $1,000 each. The District Attorney's Office filed six felony counts including arson, insurance fraud, perjury, and filing a false report. The deputy pled no contest to two felony counts: possession of flammable material with intent to set fire to property; and insurance fraud. The remaining counts were dismissed and the deputy was sentenced to 180 days in custody, ordered to pay restitution to the insurance company, and prohibited from owning or possessing any dangerous or deadly weapons as conditions of a three-year term of probation. Faced with a discharge notice, the deputy elected to resign.

Case Two

A probationary deputy contacted a friend who works for another law enforcement agency to report that the deputy's house had been burglarized a day earlier. The friend – also a relatively inexperienced peace officer – initially told the deputy he would send a unit to the

deputy's house to take a report because the deputy's home was within the jurisdiction of the friend's police agency. The deputy said it would not be necessary to take a report because he already cleaned up the house following the burglary. The deputy provided a list of stolen items totaling over $10,000 and told his friend he needed a crime report because he was going to file an insurance claim. The friend/officer taking the report became suspicious based on the value of the stolen items and the fact that the deputy had failed to immediately report the crime and had cleaned the house prior to calling police. The officer notified his supervisor, who visited the deputy's home with another officer. They spoke with members of the deputy's family who knew nothing about an alleged burglary of their property. When questioned, the deputy changed his story and claimed it was the garage that had been broken into and that the home was undisturbed, a story that seemed implausible to the investigating officers for a number of reasons.

Upon learning that the outside law enforcement agency was investigating the deputy for filing a false police report, the Department moved quickly to terminate his probationary status and then permitted the deputy to resign. The deputy subsequently pled no contest to a misdemeanor count of filing a false police report.

Case Three

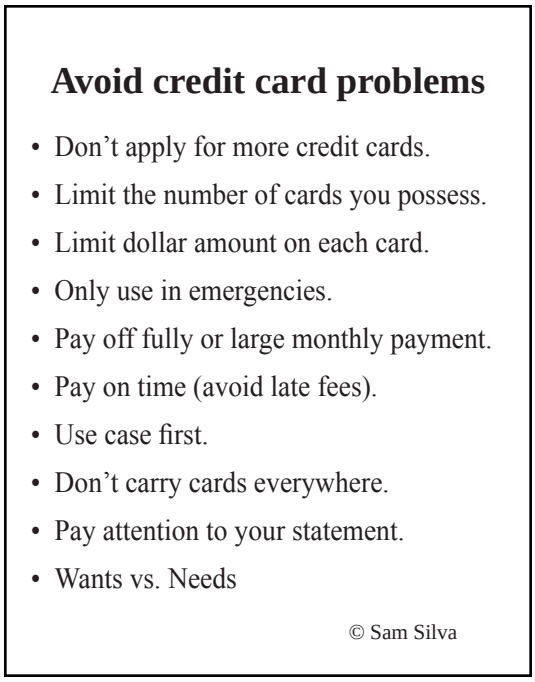
A deputy reported to police his vehicle was stolen from his residence, and filed a loss claim with his insurance provider. A few days after the initial theft report, the vehicle was located in Mexico. An American law enforcement agency took control of the vehicle and notified the insurance company of its recovery. The vehicle was then towed to an auto body shop chosen by the deputy and he placed pieces of tape on the areas of the vehicle allegedly damaged from the theft. Once the insurance adjuster was able to view the car, she became suspicious because there was little to no damage to the vehicle and the taped areas appeared to be pre-existing. The adjuster spoke to the owner of the body shop and was informed the deputy had received an estimate to repair the areas marked by tape three months prior to the alleged theft. Further raising suspicion were the facts that the deputy had all the keys to the vehicle in his possession at the time of the alleged theft and he was not cooperating with the insurance company's investigation into the theft.

As a result of raised suspicion, the insurance company forwarded the case to the District Attorney's Office for consideration. The District Attorney conducted its own investigation and discovered, through cellular phone records, that the deputy and a friend who worked as a law enforcement official from another agency called one another as they drove from Southern California to the Mexican border on the night the vehicle was allegedly stolen. Based on this information, the District Attorney filed three felony counts: perjury; filing a false insurance claim; and providing false information for an insurance claim. The deputy pled no contest to a misdemeanor charge of accessory to a felony. The administrative investigation is complete and the deputy has been discharged.

The fraudulent conduct described in the above three cases is not unique to the Sheriff's Department. A search of media accounts revealed recent guilty pleas to insurance fraud charges by officers employed by other law enforcement agencies in Los Angeles County.

Moreover, two LASD deputies are currently under federal indictment for engaging in an alleged mortgage fraud scheme. The deputies are alleged to have purchased homes and obtained loans in amounts which exceeded the actual sales prices of the homes. According to the indictment, the homes were then sold and the deputies received a portion of the difference between the sales prices and the inflated loan amounts. If convicted, one deputy is facing up to 45 years in prison and the other deputy is facing up to 105 years in prison.

These cases should serve as a cautionary tale for deputies to take measures to learn financial skills that ensure they live within their means. To assist deputies in this regard, the Department began to offer a life skills class in January 2010. The class was formulated and is taught by a retired LASD lieutenant, Sam Silva, who spent part of his 35-year career working as an internal affairs investigator and who has written a book on life skills for peace officers because he saw what he described as "nice people making bad decisions." Since its inception, 350 deputies, 221 custody assistants, and 184 professional staff including security officers and security guards have taken the class. In addition, the Department intends to add this course to the list of mandatory courses taken by new recruits at the academy and is working on scheduling two financial planning workshops open to all employees before the end of the year and is rolling out a poster campaign to encourage deputies facing financial hardships to reach out to Employee Support Services for guidance. OIR commends LASD for its proactive addressing of this issue to help reduce the likelihood that additional deputies will fall prey to these career-ending tragic episodes with deleterious life-changing consequences.



Deputy Engages in Relationship with a Convicted Felon

In October 2007, Deputies were dispatched to a 9-1-1 hang-up call made from the home of a Custody Division deputy on temporary leave from the Department. When the responding deputies arrived, the subject deputy met them outside the home, holding her young infant. Deputies observed some injuries to the subject deputy that, together with the 9-1-1 call, made them suspect a possible domestic violence incident. The subject deputy was uncooperative and evasive in response to the deputies' questions. She informed responding deputies that her boyfriend had left the home, but they suspected she was being untruthful. Responding deputies persisted in their investigation and the subject deputy's boyfriend eventually came out of the house. Deputies arrested him on domestic violence charges and later learned he had a long criminal history, including arrests for kidnapping, robbery, and weapons violations.

The Internal Affairs investigation originally focused on the allegation that the subject deputy had obstructed an investigation and placed responding patrol deputies in a dangerous situation by exposing them to a potential ambush by the suspect. With OIR's encouragement, the investigation was expanded to examine whether the subject deputy's relationship with the suspect violated the Department's Fraternization and/or Prohibited Association policies. In the end, the investigation determined that the subject deputy knew

of the suspect's criminal background at the time she began a relationship with him, and that her conduct violated the Prohibited Association policy.

While the investigation was pending, the subject deputy was involved in an off-duty shooting during which she shot and wounded her boyfriend, the suspect in the scenario described above. That incident, which occurred in February 2008, is still being reviewed by the District Attorney's office for potential prosecution of the subject deputy. Following a decision by the District Attorney, the Department will conduct an administrative investigation into that shooting incident.

Because the statute of limitations on the first case prevented it from waiting for an outcome of the investigation into the shooting incident, the Department decided to discharge the deputy for Prohibited Association, obstructing an investigation, and making false statements during the course of the administrative investigation.

The case was recently heard by the Civil Service Commission but a decision on whether to sustain the Department's discharge decision has not yet been rendered.

Sergeant Commits Multiple Thefts

Disturbing allegations about a sergeant surfaced in early 2009. When not working for the Department, the sergeant was employed as a private security guard at a large estate. During one of the sergeant's shifts, an office on the property was burglarized and a safe alleged to contain a significant amount of cash was stolen. A number of factors led the owner of the security company who employed the sergeant to believe the theft had to be an "inside job" and the sergeant was the most likely suspect. ICIB investigated and, while circumstantial evidence suggested the security company owner might have been correct, no conclusive evidence was found to implicate the sergeant in the burglary. Nonetheless, the investigation revealed the sergeant had not sought the required approval from the Sheriff's Department before engaging in outside employment and had submitted time sheets to the Department indicating he was working for LASD during some of the same times he was receiving payment for working as a private security guard.

While the burglary investigation was pending, the Department learned the sergeant had been arrested for shoplifting at a department store, and had been accused of using his young children to assist him in the crime. He was prosecuted for grand theft and child endangerment. While released on bail for these charges, he was arrested yet again on suspicion of another burglary after being caught on video stealing from another department store. The Department also learned about other possible shoplifting charges and an allegation that the sergeant may have stolen Department property. In the original grand theft and child endangerment case, the sergeant was convicted of two felonies which were later reduced to misdemeanors. The remaining cases are still pending.

The Department waited some time for the criminal cases to be resolved, but ultimately discharged the sergeant based on the evidence gathered in the grand theft investigation, as well as the evidence that he had falsified official time records.

On-Duty Misconduct

Massage Break

A deputy working a specialized assignment as a detective took a break in the middle of his work day to go to a day spa for a massage. He did not notify his supervisor or make arrangements to adjust his work schedule to accommodate the massage, but he properly secured his weapon and other uniform tools in his county vehicle while at the day spa. During his massage, members of the Department's Vice and Licensing detail entered the massage parlor to conduct a business license compliance check. The detail's purpose was to simply check licenses, but its operation was in response to city complaints about the number of massage parlors that appear to be fronting illegal prostitution operations. The license detail members encountered the detective while he was receiving a massage and asked for identification. The detective became belligerent with investigators and eventually left.

When confronted by supervisors and during the administrative investigation, the detective stated the massage was treatment for a prior work-related back injury. He also asserted general practice in the unit made it acceptable for him to handle personal matters while on-duty, provided he remained available to handle calls. The deputy's supervisor disagreed about the extent to which detectives could conduct personal business on-duty, i.e. he indicated a banking errand might be acceptable while a doctor's appointment required notification to a supervisor. The Department concluded the detective's behavior was worthy of a short suspension for his unprofessional conduct toward the Vice and Licensing detail investigators and for engaging in personal business while on duty.

Failure to Report Striking Pedestrian with Patrol Vehicle

As a deputy driving a patrol vehicle neared an intersection, a pedestrian who was under the influence of alcohol suddenly stepped off the curb and into the vehicle's path. When the deputy saw the pedestrian, he immediately applied the brakes but was unable to make a complete stop before striking him. The pedestrian attempted to brace himself by placing

his hands on the hood of the car but lost his balance and fell to the ground. The deputy immediately exited his vehicle to assess the situation. The pedestrian stated his knee was "a little sore." Despite the pedestrian stating he was in pain, the deputy failed to request medical aid in violation of Department policy. According to the deputy, he did not request medical aid because the pedestrian stated he was "fine" and just wanted to go home. The deputy also failed to report the incident to a supervisor that night as required by policy, claiming that it was a "real busy" night.

The deputy drove the pedestrian home and claimed to have explained to the father (whose primary language was Spanish) that his son was struck by the patrol vehicle. The deputy also counseled the father that his underage son should not be consuming alcohol and provided his business card. Approximately a week later, the pedestrian's father came to the deputy's assigned station to file an in-person citizen complaint alleging he had just learned his son was struck by the patrol vehicle when he asked his son why he was limping. According to the father, the deputy had only communicated to him that his son was "almost" struck the by the patrol vehicle. The father was also upset that the deputy did not summon medical personnel to the scene. The father indicated he had not taken his son to seek medical treatment and declined the station's offer to provide his son with immediate medical care.

The unit commander and OIR agreed the deputy's misconduct warranted a ten-day suspension. At grievance, the unit commander reduced the discipline to a seven-day suspension and included an alternative disciplinary plan which, in part, required the employee to attend a course that reinforces good judgment and decision making.

Inappropriate Comments to Jail Visitor

After visiting her inmate boyfriend at a jail facility, a female complainant reported a deputy mouthed the words "call me" to her while she was speaking on the visiting phone, through the glass, with her boyfriend. As the deputy mouthed words to her, he simultaneously made hand gestures such as taking his hand and blading it across his throat, then pointing to the inmate as if to suggest she "end the relationship with the inmate." In addition, the inmate and other witnesses in the visiting area said they heard the deputy say, "Have your girlfriend show me her tits" when the inmate turned around to look at the deputy. The inmate did not respond and the deputy then quickly stated he was joking. After the visit was over and several inmates were filing out of the visiting area, the deputy asked the boyfriend of the complainant to "stay back." The inmate alleged that while alone in the visiting area, the deputy asked him personal questions about his girlfriend and what dorm he was being housed in. The deputy also learned that the inmate was working as a trusty in the kitchen. Shortly thereafter, the inmate boyfriend's working privileges were revoked and

he was moved from the trusty dorm he was housed in where he enjoyed many privileges to a crowded general population dorm.

The Department investigated all of the allegations made by the inmate and his girlfriend. During the investigation, the deputy denied he acted inappropriately toward the female or had the inmate transferred in retaliation for the filing of their complaint. After a thorough investigation, the Department concluded the deputy lied to his supervisor and exhibited discourteous and inappropriate behavior toward the female. The evidence, however, was insufficient to support the retaliation allegation, in part because the inmate was moved by someone other than the deputy. The Department imposed a 15-day suspension on the deputy for a number of policy violations including Making False Statements to a Supervisor, General Behavior, and Derogatory Language. OIR concurred with the findings and discipline. The deputy's appeal of the discipline is currently pending before Civil Service.

Locking of Co-worker in Back Seat of Patrol Vehicle

A deputy was dispatched to a hospital to relieve deputies providing security for an inmate. Upon arrival, she was informed by another deputy that her services were no longer needed so she returned to her unit of assignment. Unbeknownst to the deputy, Bonus Deputy A and Deputy B expected her to give them a ride back to their unit and were upset to learn she left without them. They made two attempts to contact her via her personal cell phone, but the deputy did not answer her phone. Dispatch later contacted the deputy via radio and directed her to return to the hospital to pick up the deputies. When she arrived at the hospital, both Bonus Deputy A and Deputy B appeared to be visibly upset because they had to wait an extra 35 minutes for the deputy to return. Bonus Deputy A insisted on driving and had the deputy get in the backseat of the patrol car. Deputy B sat in the front passenger seat. Upon arriving at their unit of assignment, Bonus Deputy A and Deputy B got out of the car and retrieved their equipment from the trunk, but neither of them opened the locked rear passenger door to let the deputy out. According to the deputy in the backseat, Bonus Deputy A believed she left the hospital without them intentionally and said "leave her in the car" on her way out of the patrol vehicle. Deputy B denies hearing the statement and claimed not to notice that the deputy remained in the backseat of the patrol car. The deputy was locked in the backseat of the patrol car for about 20 minutes before she was able to contact someone with her cellphone who could let her out.

The Department found Bonus Deputy A violated the Department's Relationship with Subordinates, Conduct Toward Others, and Performance to Standards polices. A 15-day suspension was deemed appropriate with OIR's concurrence because, while Bonus Deputy A admitted to intentionally leaving the deputy locked in the backseat to punish her, she

was not remorseful for her actions and said she would do it again. The Department found that Deputy B violated the Performance to Standards policy because she should have been aware of the fact that the deputy was left in the backseat of the patrol car and could not let herself out. With OIR's concurrence, Deputy B was initially served with the Department's intent to suspend her for two days. However, during the grievance process (and without OIR consultation), her discipline was reduced to a written reprimand.

Failure to Book Robbery Suspect

Deputy A observed a female he believed resembled the photograph of a suspect in a recent robbery bulletin. A supervisor was called to the scene and took a picture of the female. The supervisor sent the photograph to the detective investigating the robbery. The detective viewed the photograph of the female detained and told the supervisor he strongly believed she was the suspect in his robbery. The supervisor then relayed this information to Deputies A and B, and directed them to arrest and book the female for robbery. The supervisor further provided the deputies with a booking packet and his patrol car to transport her to the women's jail for booking. Instead, however, the deputies transported the female to the men's jail complex where they attempted to fingerprint her to determine her true identity. They were informed females were not permitted to enter their facility for the sole purpose of being fingerprinted. Nearing the end of their shift, the deputies decided to fill out a Field Interview Card with her information and release her rather than transport her to the women's jail. During the Internal Affairs investigation, both deputies said they did not remember being told to arrest and book the female. Both deputies also said they tried to confirm her identity because they did not believe they had probable cause to arrest her. The Department found both deputies in violation of multiple policies, including but not limited to Performance to Standards, Duties of Deputy Personnel, Obedience to Laws, Regulations and Orders, and Making False Statements During a Departmental Internal Investigation. Deputy A was suspended for 25 days and Deputy B was discharged. Both deputies had a history of being disciplined for policy violations.

Failure to Report Damage Caused During Service of Search Warrant

When LASD conducted a search of a residence during a planned probation or parole search, or unexpectedly when exigent circumstances justify a search, LASD's policy regarding residential searches guided the deputies' conduct. Among other requirements, the policy directs the field supervisor to determine whether any property damage has resulted from the search. If property damage has resulted, the supervisor must document the damage by videotaping it and preparing specific documentation.

In one case, a deputy joined a group of other deputies at a residence in order to assist in conducting a protective sweep of a home. A protective sweep is the warrantless search of a residence for the purpose of locating a suspect the officer believes may be a danger to the residents or may be harbored inside the residence. The need to conduct a protective sweep arose in this case when deputies chased a suspect with a handgun into a residential area. A man was located in a garage behind a residence and detained pending further investigation. Because it was unclear whether the man detained was the suspect with the gun, deputies determined they needed to conduct a protective sweep of the residence. The deputies formed a team and cleared the home by searching it for the suspect they had seen with the gun.

Shortly after the protective sweep was finished, the resident of the home called LASD alleging a deputy had damaged a door inside her home during the search. The sergeant who acted as the field supervisor requested all involved deputies respond back to the residence so he could conduct a prompt investigation into the resident's allegations. An unidentified deputy responded that he was "98" over the radio and did not return to the residence. It took two days for the station to determine which deputy had responded "98" over the radio and which deputy had caused damage to the door, but it turned out to be the same deputy. When asked about the door damage, the deputy responded that he kicked the door open during the protective sweep because someone had told him to. The deputy also said he reported the door damage to two deputies and said he thought that was "good enough" to satisfy his reporting requirements. However, he could not name the deputies and no deputies matched the description given by the deputy. At OIR's recommendation, the deputies were re-interviewed and asked whether anyone ordered the deputy to kick the door open. They all denied giving any such instruction and further denied being advised of the damage to the door by the deputy.

At the conclusion of the investigation, the deputy was charged with numerous policy violations, including Making False Statements for lying during the investigation, Responsibility for Documentation for failing to document his actions during the protective sweep, and Professional Conduct for making disrespectful comments to the sergeant. The Department imposed a 25-day suspension. OIR concurred with the findings and discipline.

Inadequate Response to Service Call

A patrol deputy was assigned to handle a call regarding construction noise. The deputy did not respond to the call until an hour later. When the deputy responded, he drove past the location, failed to make contact with the informant, and cleared the call as "unable to locate the source of the noise." When he was later asked about the call by a supervisor, the deputy refused to acknowledge that the call may not have been handled properly. Furthermore, the deputy assumed a defensive stance and raised his voice when addressing his supervisor.

The deputy's conduct in failing to properly handle the call was held to violate the Department's Performance to Standards and General Behavior policies. In addition, the deputy's attitude when being questioned by his supervisor about the call was held to violate the Department's Conduct Toward Others policy. The deputy's prior discipline consisted only of a written reprimand. The Department's intent was to impose a three-day suspension for the violations. Prior to imposition of the three-day suspension, however, the deputy retired from the Department after a 30-year career in law enforcement.

PART FIVE

Review of LASD's Investigation into Ruben Salazar's Death

Introduction

On August 29, 1970, Ruben Salazar died after being struck in the head by a tear gas canister fired by a Los Angeles County Sheriff's deputy. Within the past several years, the Sheriff's Department received multiple Public Records Act requests seeking access to the investigative files related to Mr. Salazar's death. The County and the Department denied those requests for legal reasons. The issue arose most recently as surviving family members, the media and public marked the fortieth anniversary of Mr. Salazar's death last fall. Before making a decision about whether to release the documents publicly, the Sheriff requested that OIR take possession of the documents, review them, and prepare a report regarding their contents. We did so, and issued the following as a stand-alone report in February of this year.

Mr. Salazar, a Los Angeles Times columnist and news director for KMEX-TV, was one of the most prominent Hispanic reporters at the time of his death. At least in part because of a well-publicized dispute with then-Los Angeles Police Department Chief Ed Davis regarding Mr. Salazar's reporting on allegations of police abuses in the Hispanic community, some suspected his death may have been an intentional killing, aimed at silencing Mr. Salazar.

On the day of his death, Mr. Salazar was attending the National Chicano Moratorium and March in East Los Angeles, organized to protest the disproportionate number of Hispanic soldiers killed in the Vietnam War. Violence broke out during the March and subsequent rally. The Sheriff's Department called in additional deputies to address the rioting and looting, and to assist the approximately 100 deputies, reserve deputies, and Training Academy cadets initially deployed to provide security during the event. In the midst of the ensuing chaos, deputies received a report of a man with a gun entering the Silver Dollar Café. Shortly before that report, Mr. Salazar had gone into the bar with a colleague and two acquaintances. Accounts vary regarding the responding deputies' actions, but at least eight

Sheriff's Department personnel responded to the Silver Dollar Café, and two – an acting sergeant and a sergeant – independently fired tear gas projectiles into the bar in an attempt to clear it out. The evidence suggests it was the first of these projectiles that struck Mr. Salazar in the head, killing him instantly.

The Sheriff's Department's Homicide Bureau conducted an investigation into the shooting, and the Coroner's Office convened a publicly televised inquest in September, 1970. Following the inquest, District Attorney Evelle Younger issued a statement in which he declined to file a criminal complaint against the involved deputy, because there was no evidence of malice (required for a murder charge) and insufficient evidence to establish beyond a reasonable doubt that the deputy's conduct was criminally negligent (required for an involuntary manslaughter charge). The District Attorney further stated that he was not in a position to moralize, examine training, or determine the validity of the allegations made in civil litigation.

Following the District Attorney's decision, the Sheriff's Department considered the matter closed. Sheriff Peter Pitchess issued a statement that there was "absolutely no misconduct" on the part of the deputies involved and asserted deputies responded properly in the midst of a riotous situation. No further internal investigation or review was conducted by the Department. After reviewing the Sheriff's Homicide investigative reports and the inquest transcripts, the federal Office of the United States Attorney and the United States Department of Justice, Civil Rights Division, decided not to conduct a federal grand jury investigation into the matter and closed their case. The Salazar family filed a lawsuit against the County and Sheriff's Department. That case was settled for $700,000 before it went to trial.

The Los Angeles County Sheriff's Department would handle its investigation and review of this incident much differently today than it did in 1970.

The Los Angeles County Sheriff's Department would handle its investigation and review of this incident much differently today than it did in 1970. In addition to the Homicide investigation conducted and forwarded to the District Attorney for review of potential criminal charges, under current protocol, in every instance when a deputy fires his or her weapon or uses force that results in death or serious injury, the Department's Internal Affairs Bureau conducts a review of the incident and presents its finding to a panel of commanders referred to as the Executive Force Review Committee. That panel determines whether the level of force used was justified and, as importantly, evaluates the entire incident to determine whether the involved deputies violated any Department policies, performed at a level below the Department's

expectations, or used sound tactics. In cases where tactical decision making falls below Department expectations, the Committee recommends either discipline and/or retraining for the involved personnel. Additionally, the Committee can and does make recommendations for department-wide training, policy revisions, and equipment reviews depending on what is learned during the deadly force reviews.

Certainly through the prism of current best police practices, it cannot be disputed that the deputies who responded to the Silver Dollar Café on August 29, 1970, employed poor tactics and made mistakes that resulted in Mr. Salazar's death. That being said, the evidence gathered during the Homicide investigation provides no evidence that Mr. Salazar was either targeted on the date of the incident or intentionally killed by the deputy who fired the fatal tear gas projectile.

Scope of Review

We reviewed the eight boxes of documents that have been maintained by LASD's Homicide Bureau regarding Mr. Salazar's death. The majority of these documents pertain to the Moratorium that created the backdrop for but do not directly relate to the events involving the Silver Dollar Café. Consequently, our review did not focus on these documents but rather on the Homicide investigation and all of the witness statements provided to detectives. This report is not intended to be a summary of the entire Sheriff's Department record in this case, nor is it an exhaustive review of all of the events that transpired on August 29, 1970. Rather, our report is a summary account of the documentary evidence of the factors that led to Mr. Salazar's death with commentary and conclusions about the performance of Department members on that day made through the prism of current police practices.

To the degree we reach conclusions about tactics and other decision-making, we are mindful that policing in 1970 was vastly different than policing is today. Technological advances have provided today's officers with better communication options (such as multiple-frequency handheld radios), safer equipment (such as bulletproof vests), and quicker access to data, allowing them to more easily and safely respond tactically to quickly-evolving incidents. Law enforcement has also evolved in the way it trains for and responds to critical situations, including changes in ways in which tear gas is deployed, presenting safer alternatives both to the officer and the public. Officer training has vastly improved, stressing tactics and officer safety and exposing officers to realistic scenarios in training settings before they encounter them in the field. We are also mindful of the unique circumstances presented to the responding deputies on August 29, 1970 – a riotous situation in which they were responding to burning buildings and looting while they were being assailed with rocks and bottles. We also, of course, have little knowledge of what

Departmental expectations were in 1970 with regard to how deputies should respond to this incident.

For these reasons, to the degree that we view the decision making of the deputies through the precepts of today's best policing practices, we do so not to criticize the actions of the deputies who were operating under a different set of expectations, equipment, and training, but rather to demonstrate how far policing has come and how a similar incident today would be examined and reviewed. For those former peace officers who served the Department well during this era, we are hopeful that our comments on performance examined through today's lens will be received in the spirit in which they are given.

Description of Documents

Of the eight boxes that comprise the Sheriff Department's file in this case, two pertain to the Moratorium March. These two boxes include permit requests and memoranda regarding the Department's planning for the event. It is clear from a review of these materials that the Sheriff's Department grossly underestimated the potential for violence that occurred on August 29, 1970. This could have deleteriously impacted the deployment of deputies and other tactical planning for that day, leaving LASD with too few resources to effectively deal with the situation. In addition, it includes reports prepared after the March detailing, among other things, the participation by militant groups in the riot and background information on those thought to be responsible for inciting violence.

It is clear from a review of these materials that the Sheriff's Department grossly underestimated the potential for violence that occurred on August 29, 1970.

Two other boxes contain witness folders, in which all the statements and testimony given and reports written by the 61 witnesses in the case are compiled. All of these reports and witness statements are contained elsewhere in the investigative materials. Another box contains photographic evidence and reel-to-reel tapes of witness interviews. One box contains the transcript of the 16-day Coroner's inquest.

A seventh box mainly consists of materials pertaining to the investigations of other riot-related incidents, including the death of a 15-year old boy as a result of burns sustained following the explosion of a trash bin, a deputy-involved shooting resulting in the death of the suspect who allegedly drove his vehicle directly at deputies, and an assault and attempted murder of a deputy by rioters in Laguna Park. This box also contains verification regarding documents and other evidence provided

to the United States Attorney General and United States Attorney's Office as part of the federal government's inquiry into Mr. Salazar's death.

The Homicide investigation file is contained in an eighth box which includes all of the reports written by Homicide detectives and those prepared by involved or witness deputies. The box also contains the Coroner's autopsy report and summaries of the inquest proceedings.

In general, the documents are voluminous but not particularly well-organized. They contain many duplicates, incomplete parts of documents, mislabeled and unlabeled folders, and handwritten notes in a form that made thoroughly reviewing without disturbing or re-organizing the documents a difficult and time-consuming task.

The Moratorium March and Surrounding Chaos

The Congress of Mexican-American Unity planned the August 29, 1970 Moratorium to begin with a parade from Belvedere Park on Third Street in East Los Angeles, down Atlantic Boulevard to Whittier Boulevard to Laguna Park (now named Ruben F. Salazar Park), where organizers planned to hold a rally protesting the Vietnam War and the disproportionate number of Hispanic casualties. Witnesses described the presence of more radical groups inserting themselves into the March and promoting violence. The day started to descend into chaos as the parade moved down Atlantic Boulevard and grew to occupy the entire boulevard rather than just the two lanes approved on the permit. As deputies assigned to fixed posts along the parade route tried to keep the roadway clear, some marchers allegedly began spitting and throwing bottles at the deputies.

One flashpoint was a liquor store along the parade route near Laguna Park where, according to reports we reviewed, people began stealing beverages. In response, the owners locked the doors, trapping some inside, and called the Sheriff's Department. Responding deputies clashed with demonstrators, and the violence spread. All along Whittier Boulevard, protesters started fires, broke windows, and looted buildings. The event turned into a full-scale riot and deputies eventually cleared Laguna Park by force.

In all, 44 buildings were looted; 17 buildings incurred major damage and 172 buildings incurred minor damage; six buildings were damaged by fires worth an estimated $561,000 in losses; 95 County vehicles were damaged, along with 15 vehicles from other agencies; 75 deputies were injured; and three firefighters were hit and injured by rocks and bottles. It is not clear how many civilians were injured, but two civilians other than Mr. Salazar were killed – a 15-year old boy who was burned in the explosion of a trash bin, and a man who was shot by deputies as he allegedly tried to run over them with his vehicle. There were

also many accounts of brutality and unnecessary force used by deputies handling the crowd and clearing the park. If the Department made any effort to investigate these allegations or hold any deputies accountable for using excessive force, it is not reflected in the documents we reviewed.

In the immediate vicinity of the Silver Dollar Café, at 4945 East Whittier Boulevard, two buildings were burned, at least two buildings were looted, and several others incurred minor damage. The scene outside the bar was total chaos. Investigative photographs of the locations corroborate the damage reported to buildings and police vehicles.

Events at the Silver Dollar Café

Mr. Salazar was at the March with a KMEX reporter and two other companions. At the end of the March, as violence broke out in Laguna Park, the four of them walked back up Whittier Boulevard to La Verne Avenue, where they stopped to observe a large fire burning at a furniture store across the street from the Silver Dollar Café. The group decided to enter the bar to use the restroom and get something to drink. Mr. Salazar and his KMEX colleague took seats at the bar near the front entrance to the bar while the other two went outside to make phone calls.

Several groups of deputies were dispatched to Whittier Boulevard and La Verne Avenue in the area near the bar to deal with a crowd gathering there. People were smashing windows, looting nearby businesses, and throwing rocks and bottles at deputies. An acting sergeant on scene, Deputy Thomas Wilson,[23] deployed tear gas canisters to move the crowd back off of Whittier. As the deputies moved back onto Whittier from La Verne, one deputy was told by an individual in the street who was directing traffic and wearing a red vest[24] that he had seen two men with guns (a rifle and a handgun) enter the Silver Dollar. At around 4:30 p.m., that deputy initiated a radio broadcast relaying this information.[25] The deputy who had received the information about armed persons entering the Silver Dollar also notified Deputy Wilson of that information.

---

23 Consistent with state law mandates, OIR's general practice is to not disclose the identity of any individual member of the Sheriff's Department in our reports. This report is unique, however, in that the events at issue happened more than 40 years ago, prior to the enactment of current peace officer privacy statutes; none of the involved personnel are currently still working in law enforcement; and the names of those involved are part of the public record, were widely reported in the media at the time, and are easily accessed via the internet today.

24 This individual was later identified and testified to his observations. During the subsequent litigation, the Department learned he had once been an LAPD Reserve Officer, but had been terminated from that position following his arrest for disturbing the peace.

25 The existence and substance of the radio call was corroborated by checking the radio logs and transmissions that day which are included in the boxes of documents.

Detectives later located the individual who had provided the information to the deputies. He remained adamant that he saw individuals with guns, including one with a rifle, going into the Silver Dollar, and provided a detailed account during his testimony at the Coroner's inquest. Several civilian witnesses overheard this individual, identified by his red vest, reporting to the deputy that armed persons were inside the Silver Dollar.

Witness accounts of what happened next are inconsistent and sometimes at odds with others. Given the number of witnesses, the limitations of eyewitnesses, and the chaos surrounding the entire incident, this is understandable and to be expected. Indeed, we would look suspiciously at an investigative report of an incident such as this in which the witness statements were all consistent, neatly aligned and seemingly choreographed. Moreover, to the Homicide Bureau's credit, most of the witnesses were interviewed on tape and their statements were then transcribed.

According to the deputies' accounts, Deputy Wilson and four other deputies positioned themselves outside the doorway of the Silver Dollar and yelled commands for people to throw out their weapons and come out of the bar. Numerous witnesses from neighboring businesses and firefighters reported hearing deputies ordering the people in the bar to come out, though it is not clear whether they heard commands given by the deputies with Wilson or those given later by Sergeant Laughlin. With perhaps one exception, witnesses inside the bar reported they did not hear any such commands. Based on the chaos unfolding on Whittier Boulevard, it could well be that deputies gave commands but that those inside the bar did not hear them.

Several people described being outside the bar when deputies ordered them to get inside shortly before the shooting. Some people inside the bar reported seeing several men come into the bar shortly before the shooting. No one inside saw anyone with a gun enter the bar. According to one deputy stationed outside the Silver Dollar, civilians on the outside of the building were urging those inside to shoot the deputies.

Based on the forensic evidence, the Coroner concluded that the first round fired by Deputy Wilson was the Flite-Rite that struck Mr. Salazar in the head, killing him instantly.

Deputy Wilson took a position on the right side of the doorway, which at the time was only covered by a curtain, crouched down and looked under the curtain into the bar, where he could see people moving about. He then moved across the doorway, simultaneously firing one tear gas canister into the bar. Deputy Wilson stated he believed this action was necessary because no one had responded to deputies' commands to come out of the bar. He said he intended to fire the missile

high so that it would strike the ceiling and bounce to the rear of the bar, driving persons out the front entrance. He loaded a second round and also fired this one into the bar. The first round was known as a "Flite-Rite" projectile and was designed to penetrate windows, doors, and other light structures in situations where suspects were barricaded behind or within a structure. Because they have fins and a weighted nose, they were intended to be fired with some accuracy at a target. They were designed with a high muzzle velocity to enable them to penetrate structures. It was for this reason that they were not intended to be fired at persons. The second round was a "Spedeheat" projectile, sometimes referred to as a "tumbler" because it is designed to turn end-over-end to minimize the chance that the nose will strike anyone or penetrate anything. It travels more slowly and emits gas in flight.

In his interview with Homicide detectives following the shooting, Deputy Wilson said both the rounds fired were red. In fact, the only red cartridge found was the Flite-Rite determined to have killed Mr. Salazar. The type of "Spedeheat" round Deputy Wilson fired was blue.[26] Deputy Wilson testified at the inquest[27] that, at the time he first fired into the Silver Dollar, he was not sure which type of canister was loaded in his gun. Just prior to responding to the Silver Dollar, Deputy Wilson was controlling the crowd at Whittier and La Verne where he had fired at least two rounds of tear gas projectiles, which he referred to as either "duster" or "tumbler" rounds. He loaded another round while still on the street maintaining a crowd control position. He did not check his weapon after leaving Whittier and La Verne to respond to the reported threat at the Silver Dollar, but he believed it contained another of the duster or tumbler rounds. While at the time he did not believe he was firing a Flite-Rite into the bar, he nonetheless maintained during his inquest testimony that it did not really matter which projectile he used because the important thing was to quickly get gas into the building. He further testified that he did not learn until several days after the incident that he had fired a Flite-Rite, when Homicide investigators informed him of their determination. Until that time, he believed he had fired two duster rounds into the bar. Despite the fact he did not fire it intentionally, Deputy Wilson defended his use of the Flite-Rite as the most appropriate projectile for the job.

Based on the forensic evidence, the Coroner concluded that the first round fired by Deputy Wilson was the Flite-Rite that struck Mr. Salazar in the head, killing him instantly. While one witness inside the bar described hearing a sound like a gunshot and then communicating with Mr. Salazar and not seeing him drop until after the second gunshot sound, the other witnesses in the Silver Dollar reported seeing Mr. Salazar fall immediately

26 The color of the canister indicates which type of gas it contains and is not related to the type of projectile. The blue projectiles contained C.S. gas, which in 1970 was a newer type of more potent yet less toxic gas. The red projectiles carried C.N. gas. The Department's tear gas training expert testified at the Coroner's inquest that most of the Department's inventory was the red C.N. gas but that it was gradually being replaced with the blue C.S. gas canisters.

27 Deputy Wilson testified voluntarily at the inquest, despite the fact he was facing a possibility of criminal prosecution and had a Fifth Amendment right not to testify.

after the first shot. Whether it was fired first or second, it is apparent that the Flite-Rite round fired by Deputy Wilson was the fatal round. The remaining patrons all exited the bar through the rear as or immediately after Deputy Wilson fired his two rounds.

One witness inside the bar indicated that prior to the shooting, he saw the muzzle of a rifle poke through the curtain covering the doorway. He said he yelled that he believed the deputy was about to fire and a shot immediately rang out. The witness said he then ran out the back.

After firing the second round, Deputy Wilson recognized there may have been no deputies covering the rear of the location. Deputy Wilson then moved to the rear of the bar himself and realized people from the bar had exited from a back door. He apprehended two men who were standing near a car in the back parking lot, one of whom had an automatic pistol and claimed to be the owner. The other man was carrying ammunition for the pistol. One of the deputies accompanying Deputy Wilson stated he knew the man with the gun and believed him to be the owner of the bar. It was later discovered this individual was not, in fact, the owner of the bar. Deputy Wilson kept the gun but did not get any identification from the men before he released them. He never determined conclusively whether those men had ever been inside the bar, though he stated he believed they had been because he noticed their eyes were red and watery, indicating exposure to tear gas. Deputy Wilson then returned to the front of the building and turned his attention again to controlling the crowd. He never entered the bar but said he assumed someone else had cleared the interior.

As Deputy Wilson and the others moved to the rear of the location, Sergeant Robert Laughlin arrived on scene with three other deputies, responding to the radio call reporting men with guns entering the Silver Dollar. He did not communicate with Deputy Wilson or anyone else already at the scene, but began to broadcast over his vehicle's public address system orders for those inside the bar to throw out their weapons and come out. When no one emerged, Sergeant Laughlin fired a total of three Flite-Rite projectiles from a position of concealment behind the door of his radio car, approximately 70 feet from the entrance to the bar. The first round struck the doorframe and did not enter the bar, but the two subsequent rounds did enter.

Within several minutes after firing these rounds, Sergeant Laughlin heard a "Code 4" come out, meaning that the location had been secured. He considered sending a search team into the location, but it was dark inside and he stated no one with him had a flashlight. In addition, there were only two gas masks on scene, and Sergeant Laughlin decided the visibility out of these masks was so poor and the gas inside the building so thick that a search would be ineffective. He then received an emergency assistance request near La Verne Avenue and left the Silver Dollar to respond to the request.

Shortly after the incident, the actual owner of the bar came to the scene. He reported to deputies he had a rifle inside the bar that he wanted to secure. Deputies allowed him to

enter. The owner said he moved in and out quickly because the gas was still very thick. He then handed the rifle over to the deputies, who documented the collection of the rifle. He said he saw no one inside the bar.[28]

LASD's Post-Shooting Response

A colleague of Mr. Salazar who was in the Silver Dollar at the time of the shooting stated he repeatedly and immediately informed deputies on scene that Mr. Salazar was injured and still inside the bar. He said his pleas were ignored by deputies.[29] The investigation did not learn the identification of any deputy who this individual may have talked to, perhaps due in part to the fact that the Homicide investigation was not focused on this issue.

At approximately 5:30 p.m., a Sheriff's Information Bureau sergeant responded to the Silver Dollar Café in response to reports called in from KMEX that Mr. Salazar was in the bar. He saw that the location was secured and assumed the handling deputies had cleared the location, so he left.

Deputy Wilson stated he remained in the area of Whittier and La Verne performing crowd control functions, and then returned to the Silver Dollar later in the evening, around 7:30 p.m., at which point two deputies approached him to report that a citizen told them there was someone injured in the bar. In his interview with Homicide, Deputy Wilson said he did not believe he had enough deputies to safely enter the bar, so he told the deputies to tell the citizen to go in and bring the injured person out. One responding deputy reported that the Department did not initially send personnel into the bar and asked the citizen to go in because of fear that it was a "set up." Deputy Wilson then received information that the person inside the bar was seriously injured, perhaps even dead. Deputy Wilson stated he then put out an emergency broadcast for a unit with a gas mask to respond and requested an ambulance.[30]

---

28 Presumably, but not definitively, this rifle and the gun discovered outside the back entrance to the Silver Dollar were not the weapons allegedly observed by the civilian who reported seeing two men carrying guns into the bar.

29 Documents show that an ambulance was dispatched to LaVerne and Whittier at 4:40 p.m. It arrived at 5:03 p.m., but left at 5:09 p.m. without picking anyone up after the driver stated he spoke with a deputy who had no knowledge of a request for an ambulance. It is not clear who called for this ambulance or why, but it is possible it was intended for Mr. Salazar and that deputies failed to coordinate with the responding paramedics. The timing of this seems early for an ambulance to have been called for Mr. Salazar, but because the Homicide investigation did not establish a precise time line, it is impossible to determine with any certainty.

30 The Department's administrative control file indicated that at 7:30 p.m., the Department was notified there was a person "injured" inside the bar.

Deputy Wilson reported that deputies did respond with gas masks and he believed they entered the bar, but he could not identify these deputies by name. At approximately 7:45 p.m., Special Enforcement Bureau (SEB) personnel – two sergeants and a deputy – responded to the Silver Dollar pursuant to a request for a unit with gas masks to search the location (presumably Wilson's request). When they arrived, they reported there were no other Sheriff's Department personnel in the immediate area and that the door to the bar was locked. They forced the door open and located Mr. Salazar inside. They immediately notified Homicide.

The Sheriff's Information Bureau sergeant who had earlier been to the scene reported that at around 7:00 p.m., he heard SEB had found a deceased person at the Silver Dollar and returned to identify Mr. Salazar, who he knew personally.

The KMEX manager indicated he had made numerous phone calls throughout the evening to the Sheriff's Department to inform them that Mr. Salazar was inside the bar and to get confirmation about Mr. Salazar's condition. He stated the Department was not responsive to his concerns.

Homicide Investigation and LASD Review

As soon as SEB located Mr. Salazar inside the Silver Dollar and confirmed he was dead, personnel notified the Homicide Bureau, whose investigators promptly took control of the scene. Detectives interviewed all the witnesses they could identify, took measures to identify and locate witnesses who did not come forward voluntarily, and made extensive use of a Department criminalist to sort through and interpret the forensic evidence.

Some witnesses refused to identify themselves to LASD officials but contacted KMEX. Detectives cooperated with KMEX officials and the Salazar family's lawyer to gain access to these witnesses and conducted interviews at the attorney's office.[31] Several other witnesses who initially gave statements to Homicide, including the individual in the red vest who alerted deputies that armed men had entered the Silver Dollar, later expressed concerns about testifying because of threats they received. The Department provided protection to those individuals to ensure their cooperation during the Coroner's inquest. Even so, several witnesses declined protection and refused to testify before the inquest.

The Homicide investigation did not show signs of bias. The interview transcripts we reviewed, while not always optimally thorough, did not contain leading questions or reveal a particular agenda being promoted by detectives. As illustrative of this orientation,

31 Homicide detectives were apparently frustrated by the presence of the attorneys when interviewing the witnesses. One homicide note candidly indicates that during the interview, controversial points could not be explored with the witnesses because of the polite "question and answer" atmosphere, and because the attorneys would lead the witnesses.

the investigative report contains one notation about a witness who called the handling detective three weeks after the incident while the inquest was ongoing. The witness stated he was inside the bar and heard deputies give warnings prior to firing the gas projectiles. Detectives questioned his account, and then the witness stated he would be anywhere detectives wanted him to be and say anything they wanted him to say if it would assist the Department. To their credit, detectives documented this contact and, obviously, did not use the witness in their investigation.

The failure to focus on any aspects of the incident beyond the immediate question of how Mr. Salazar died and the lack of any subsequent internal review by the Department, however, left many questions unanswered and opened the door for decades of speculation about what the Department may have been trying to hide. Detectives asked few questions relating to the most obvious and pressing tactical issues presented – why deputies did not contain the rear of the location before firing gas into the bar; why deputies using tear gas were not equipped with gas masks to prevent contaminating themselves and to then be able, if need be, to enter the location after the introduction of the gas; why responding units failed to communicate with each other; and why deputies did not clear the location after firing the gas to check for any injured persons or suspects who may have remained inside. Detectives also asked no questions about the more sinister theory being expounded, namely, that Mr. Salazar was targeted. As a result, responding deputies were not asked if they knew or had heard of Mr. Salazar, whether they knew he had been observing the March earlier, whether they had been assigned to follow him, and whether they knew he was inside the Silver Dollar at the time of the incident.

. . . unlike with the protocols of today, no one in the Department was ever held administratively accountable for the poor response of personnel to concerns that there was someone injured inside the bar.

Because the incident was not subjected to any sort of internal administrative review, issues regarding the hasty and poorly coordinated deployment of gas, the decision to deploy the Flite-Rite missile, and the lack of coordination after the gas was deployed were not internally scrutinized and no one was held accountable for performance that did not meet Department expectations. That outcome was not unusual or unexpected given the standards of the day. It is unclear whether detectives were aware of community concerns that Mr. Salazar may have been targeted in the immediate aftermath of the incident, and, in any event, Homicide's role was limited to investigating the death of Mr. Salazar and not the tactical issues surrounding it.

If a similar incident occurred today, the internal review following the Homicide investigation would fully explore each of these issues from an administrative perspective, and the fact that the prosecutor declined to file charges would not be seen as absolving the Department from exploring each decision more thoroughly. A wider and deeper investigation into the circumstances surrounding Mr. Salazar's death undoubtedly would have revealed more facts, better answered lingering questions relating to this incident, and likely would have held persons accountable for poor performance through the disciplinary process.

Another issue that was not a focus of the Homicide investigation was the confusion and lack of coordination and communication regarding the length of time it took to recover Mr. Salazar's body from the Silver Dollar. Certainly, there was plenty of "ball dropping" with regard to this part of the episode, resulting in a several hour delay before anyone attended to Mr. Salazar. Yet the Homicide investigation made little discernable effort to identify which deputy or deputies received the report from Mr. Salazar's colleague about Mr. Salazar still being inside the bar. Neither was the investigation focused on other poor assessments and decision making that led to the delay in locating Mr. Salazar. Further, unlike with the protocols of today, no one in the Department was ever held administratively accountable for the poor response of personnel to concerns that there was someone injured inside the bar.[32]

These issues, arguably, were not central to Homicide's mission, and were apparently not vital, in the eyes of the District Attorney, to the decision whether to file criminal charges. Some of these issues were tangentially addressed during the inquest, but not typically answered to full satisfaction. For members of the public, a number of important questions remained when the Sheriff, the Coroner, the District Attorney, and the United States Department of Justice closed their files on Mr. Salazar's death.

Tactical and Training Issues

Failure to Coordinate Tactical Response

When Deputy Wilson heard reports of men with guns having gone into the Silver Dollar Café, he moved quickly to clear the bar. However, he did not communicate much with assisting deputies, and took no time to coordinate any kind of tactical response to the situation – including the positioning of deputies at the rear of the bar. He stated during his inquest testimony that he did not believe he had enough deputies to safely cover both the front and the rear of the location. His primary concern was keeping himself and others safe in the face of a hostile crowd on the street in front of the bar. He said he was less concerned

32 For example, last year a lieutenant was disciplined for the failure to coordinate a tactical response to timely provide aid to an injured individual subsequent to a deputy-involved shooting. The Training Bureau also responded by developing a scenario intended to address the issue.

with actually apprehending any suspects. Under principles of current day policing, this was a tactical blunder. The only real point in clearing the location was to locate the men with guns, including a rifle, who reportedly went into the bar. Those individuals may have posed a greater threat to deputies and others barricaded inside a building with potential hostages. But having these guns on the street during a riot also would have created a danger that deputies should have viewed as a priority.

The failure to cover the rear of the bar also presented challenges to the ensuing investigation because Homicide detectives had little information as to who actually was in the bar when the gas was introduced. Because the back exit was not secured, it is quite possible some witnesses who subsequently claimed they had been in the bar at the time were not actually there, and some who were in the bar were never identified or interviewed.

If Deputy Wilson believed he had insufficient resources to address the situation properly, he should have used the radio to request additional units.[33] Had he done so, he would have learned that Sergeant Laughlin was minutes away. The two should have coordinated a plan to address the threat in the Silver Dollar. Instead, Wilson fired gas into the bar and then moved to the rear as Laughlin approached. Laughlin, unaware that anyone else had responded to the weapons report or made any attempt to clear the bar, fired more gas into the bar and then left the location without ever speaking to Deputy Wilson.

At the rear of the bar, Deputy Wilson detained two men standing near a vehicle. He did not confirm that they had been inside the Silver Dollar, but noted their eyes were red and watering, suggesting they had been in the bar at the time the tear gas was introduced. One of the men stated he was the owner and that he had a gun in his pocket. The other man had a box of ammunition for the automatic pistol. An assisting deputy then approached and told Deputy Wilson he knew the man with the gun, suggesting he was in fact the owner of the bar. While he did secure the gun and ammunition, Deputy Wilson released both men without asking for identification.

Neither Deputy Wilson nor Sergeant Laughlin took responsibility for clearing the inside of the Silver Dollar to ensure that no injured persons, suspects, or guns remained. In his statement to Homicide, Deputy Wilson stated he did not go into the bar because he and the other deputies needed to attend to the crowd moving up Whittier Boulevard which was interfering with the firefighters working there and because he assumed the other

33 We are mindful of the fact that, in 1970, patrol deputies did not carry handheld radios, and the only means they had to communicate with dispatch was in a patrol car. In addition, they had only one radio frequency, so that, in order to communicate with another car, deputies would have to request the assistance of dispatch. Today, every deputy is equipped with a handheld radio fastened to their uniform, there are a multitude of frequencies available for use, and deputies can talk directly to each other over the radio.

deputy he saw firing gas into the bar (Sergeant Laughlin) had checked the interior.[34] In his inquest testimony, Wilson added that he did not believe anyone would be able to withstand the effects of the tear gas and remain in the building,[35] and he had no reason to believe anyone was dead or injured inside. This was a faulty assumption that could have had dire consequences had Mr. Salazar not been instantly killed by the first tear gas missile.

Sergeant Laughlin stated he did not go into the location because, even though he and one other deputy with him had gas masks, they were a type with small lenses that allowed for poor visibility. Because no one had a flashlight, he decided it would be unwise to enter the bar. He also took into account the report that someone had been apprehended with a gun when he decided to respond to another assistance call rather than take any further action at the Silver Dollar.

This and other equipment issues certainly played a role in the Department's failure to locate Mr. Salazar's body for over two hours. Looking through today's lens, it is difficult to believe that the LASD would have issued deputies tear gas guns and the authority to use them, but not issue or require them to carry gas masks. Deputy Wilson's failure to clear the interior of the Silver Dollar is understandable because he did not have the proper equipment to do so. What is not so understandable is his decision to deploy gas into the structure knowing full well that he did not have the proper equipment to enter the building if necessary. Sergeant Laughlin had a mask, but claimed it was insufficient because of poor visibility and neither he nor any of the deputies with him had a flashlight. Despite these equipment deficiencies, neither Wilson nor Laughlin saw or understood the importance of clearing the location they had just flushed with tear gas, pointing to even greater deficiencies in strategic planning, tactical training and decision making under today's policing standards. While we recognize the chaotic, riotous situation presented many challenges to the Department that its deputies may not have been sufficiently trained to diffuse, there is no complete justification for the tactical deficiencies that were employed.

Reports that Deputies Ordered People into the Silver Dollar Prior to the Shooting

One of the most puzzling aspects of this incident stems from the numerous reports that deputies ordered several people on the street to go into the Silver Dollar Café just prior to the deputies' use of tear gas to clear the building. One of the men with Mr. Salazar that day

34 The fact that Deputy Wilson observed a second volley of gas being introduced into the location by Sergeant Laughlin and yet apparently did not notify him that he had also introduced gas into the bar is yet another example of the extremely poor coordination and communication by the on-scene units. This shortcoming is exacerbated by the fact that the two Departmental protagonists noted here were acting in a supervisory capacity.

35 Several deputies stationed outside of the Silver Dollar claimed to have been overcome by the fumes of the tear gas after it was deployed.

reported he tried to leave the bar to watch the events unfolding outside but was ordered by a deputy with a shotgun to go back in. It would have been completely illogical for Deputy Wilson or any of the other deputies responding to reports of men with guns in the bar to encourage anyone to go into the bar at the same time they were intending to clear it. No deputies admit giving such commands, but none were pressed for an explanation of these reports. It is possible that other deputies, unaware of the account of the men with guns entering the bar, had encouraged people to get into the bar and off of the street as part of a crowd control effort. But no deputies ever came forward to acknowledge having done so, and photographic evidence published by the media shows unarmed men near the doorway of the bar as a deputy who appears to be holding a tear gas gun approaches. The documents we reviewed do not resolve this mystery.

Training Issues

At the inquest, the parties spent considerable time examining LASD training on the use of tear gas and tear gas weapons. With regard to the tactical coordination issues discussed above, there is no discussion in any of the materials as to whether or not deputy personnel performed in accordance with their training. By today's standards, the failure to communicate, contain the bar, and then clear it would not meet the Department's expectations.

The Department's expert on tear gas and firearms, Deputy Robert Hawkins, testified at the inquest about LASD training on tear gas and tear gas munitions. Deputy Hawkins was an instructor at the LASD Academy who also trained numerous other police agencies in Southern California. He gave lengthy descriptions of the various types of tear gas projectiles and their uses. He opined that the Flite-Rite used by Deputy Wilson was the appropriate projectile for the job of clearing the Silver Dollar Café.

By today's standards, the failure to communicate, contain the bar, and then clear it would not meet the Department's expectations.

From a training standpoint, the critical distinction was whether Deputy Wilson was firing into a crowd or a barricade. The Department training was clear that Flite-Rites were to be used to drive out barricaded suspects but were never to be fired into a crowd. Deputy Hawkins testified that it would never be acceptable practice to fire a Flite-Rite directly at someone. All of the personnel who were asked to address the question – Wilson, Laughlin, and Hawkins – stated they believed the armed gunmen reported to be inside the bar presented a barricaded suspect situation. In that situation, the expert concluded that aiming a Flite-Rite for the back of the room was the best way to get the gas in and the suspects out. While it may be true that those inside the

Silver Dollar were "barricaded," this logic focuses too much on semantics and not enough on practicalities. The reason the Flite-Rite was to be deployed against barricaded suspects is that it could penetrate doors and windows. Without any structure beyond the curtain to slow the projectile's velocity and absorb its impact, firing the round into the Silver Dollar was equivalent to firing it at a crowd, contrary to the manufacturer's warnings and Department training.

The obvious follow-up question about whether it was appropriate to fire into a darkened building through a door blocked by nothing more than a curtain was never asked. Deputy Hawkins did state he would want to know what was behind the curtain. All the witnesses accepted as true Deputy Wilson's statement that he intended to fire the Flite-Rite high, aiming for the ceiling, expecting it to bounce to the rear of the bar. Deputy Hawkins offered two possible explanations for why the projectile did not go high, but instead struck Mr. Salazar. First, he noted the Flite-Rite does not right itself immediately after leaving the weapon but may take as much as a hundred yards to stabilize if it does not penetrate a structure. It will not tumble like the Spedeheat, but because it is fired from a short-barreled rifle, it leaves the weapon with little guidance and has a "definite pitch and yawl." By this very explanation, Deputy Hawkins undermined his own conclusion about the appropriateness of firing the Flite-Rite into a darkened bar through nothing more than a curtain, as one cannot accurately anticipate the projectile's flight path. The better assessment of Deputy Wilson's actions was that he used the wrong projectile under the circumstances presented, resulting in tragic consequences.

Deputy Hawkins also opined, in response to a question from the Hearing Officer, that the curtain over the doorway could have deflected the flight of the projectile. The day before Deputy Hawkins (the last witness to testify) gave this opinion to the inquest jury, the LASD criminalist performed some tests to determine to what extent a curtain like the one at the Silver Dollar would deflect the path of a Flite-Rite. He found that any deflection of the projectile by the curtain fabric was insignificant. His findings were not documented until much later, when County Counsel's office asked him to prepare a memo for purposes of litigation. The findings that contravened Deputy Hawkins' theory were not presented during the inquest.

None of the subtleties of how the Flite-Rite projectiles fly or how the weapon handled could have been known to Deputy Wilson or Sergeant Laughlin because, before August 29, 1970, they had never actually fired those projectiles. Deputy Hawkins testified that during tear gas training, the class only observed a demonstration of the weapon being fired because the Flite-Rite projectile cost more than 10 dollars each, a prohibitive expense at the time.[36] Sheriff Pitchess ordered the Flite-Rite projectiles to be removed from LASD stations after this incident.

36 Efforts by the media to obtain the Department's manual on the use of tear gas projectiles were refused, reportedly because the manufacturer indicated the materials were confidential.

Alleged Surveillance of Mr. Salazar and other Intelligence Concerns

Much of the public's concern about Mr. Salazar's death – at the time and continuing today – has been around the theory that he was killed intentionally, not accidentally or negligently. The theory centers on Mr. Salazar's frequent criticism of law enforcement and his concern that he may become the subject of a police set-up in an effort to discredit him. He told officials with the United States Commission on Civil Rights in the weeks before his death that he was being tailed because his coverage of police brutality had angered law enforcement officials. When he died at the hands of police shortly thereafter, it was understandably difficult for his family, friends, and supporters to accept that Mr. Salazar might have simply been in the wrong place at the wrong time.[37]

If Mr. Salazar was under surveillance, either the LASD did not know, or did not maintain any record of its knowledge.

It was not an era of openness and public transparency. The Sheriff's Department had no choice but to admit the facts of the shooting but otherwise circled the wagons around its deputies, offered few explanations and no apologies. That posture fueled the skeptics.

The Department's investigation did not give any credence to the intentional killing theory and so did not ask questions that might have quelled some of the suspicion. For example, did Deputy Wilson have any knowledge of who Ruben Salazar was? If he had known Mr. Salazar was in the bar, would that have meant anything to him? Were any government agents, LASD or otherwise, following Mr. Salazar on the day of his death?

If Mr. Salazar was under surveillance, either the LASD did not know, or did not maintain any record of its knowledge. Because the Homicide investigation was not scoped to address this concern, it becomes difficult 40 years later to address whether the alternative theory has any credence whatsoever. There is nothing in the documents we reviewed, however, to suggest anyone was following Mr. Salazar or that this was a targeted killing. In fact, the series of tactical errors detailed in this report rather definitively point to a hashed up operation in a sea of chaos that resulted in the tragic death of Mr. Salazar rather than a deftly designed assassination.

There was one bit of intelligence information-gathering we found – a handwritten note dated July 22 [no year] indicating that a sergeant in "Intelligence" called to request a copy

37 In addition, one witness reported that on the day of the March, Mr. Salazar "joked" about "who would be had" that day.

of the complete press credential on Mr. Salazar because it "appears that [liar][38] Ruben is spreading bad rumors about us in ELA." Mr. Salazar's press pass application is with this note, but there is no evidence to suggest anything came of the request to review the application. There is no evidence of any effort by the Department to remove Mr. Salazar's press pass. As with so many of the documents in the files we reviewed, this information is not stored in any organized manner, but is simply stuck amidst other unrelated documents.

After Mr. Salazar's death, the Department searched for any criminal history, along with the records of his companions that day, information routinely gathered as part of the Department's protocols after every deputy-involved shooting or death. There is a supplementary report dated six days after his death noting that Mr. Salazar's car was parked at the KMEX lot and another car is parked at his home. The import of this report is not at all clear, though it may have been in response to media reports that the car had been found at the East Los Angeles Sheriff's station.

The files contain a series of requests made by the County Attorney defending the civil lawsuit. These requests for documents and investigative follow up occurred well after the conclusion of the inquest, declination by the District Attorney, and the closing of the Homicide investigation. One of these requests from the County Attorney included a request to learn more about Mr. Salazar's family background and alleged expulsion from Mexico. There is no substantive follow up on this request from the Department located in the files.

The Department's files on Mr. Salazar also contain a large amount of material on the Moratorium March that was the backdrop for Mr. Salazar's death, as well as literature and intelligence files on those thought to have been instigators of violence that day, including the Brown Berets[39] and a group associated with Angela Davis. This does not appear to be part of the Homicide Bureau's file, and it is unclear who compiled this information or for what purpose.

Conversation with Former Deputy

In addition to reviewing the eight boxes of materials retained by the Homicide Bureau, OIR had the opportunity to talk with former Deputy Wilson, the deputy who fired the Flite-Rite missile that killed Mr. Salazar. The primary import of that discussion was to question the former deputy about areas of inquiry that were not addressed by the Homicide investigation. As detailed elsewhere, the 1970 investigation was not designed to assess

38 This is a handwritten note that appears to say "liar" but could conceivably instead say "dear." Neither is a particularly favorable interpretation.

39 A group first organized by young Mexican-Americans in East L.A. in the late 1960's, initially with a focus on community organizing against police brutality and for educational equality. It grew into a national organization with a broader focus on Latino equality.

whether, as some suspected, the LASD had targeted, followed, and intentionally killed Mr. Salazar because of his criticism of police tactics. As a result, former Deputy Wilson was not asked whether on the date of the incident he knew or had heard of Mr. Salazar, nor whether he had been ordered to target him or follow him on the date of the incident.

In 2011, over 40 years later, those questions were posed by OIR to former Deputy Wilson. He indicated in no uncertain terms that until after the incident occurred, he had absolutely no knowledge of who Mr. Salazar was or what he looked like. His account of the incident is consistent with the statements and testimony he gave 40 years ago. One interesting fact that gained more significance when related by former Deputy Wilson was that on the date of the incident, his permanent unit of assignment was Montrose (now Crescenta Valley) Station, but when reports of the riot began to surface he volunteered to assist East Los Angeles Station. Upon arrival, he immediately began the process of crowd control. This apparent last minute assignment of Deputy Wilson to assist in crowd control does not support the theory suggested above that he had been specially chosen to target, follow, and kill Mr. Salazar.

Another interesting fact not illuminated in the 1970 investigation was former Deputy Wilson's response when he first learned someone had died in the Silver Dollar. Consistent with what he told Homicide, he returned to the bar at some point more than an hour after he had fired the tear gas. At that point, he was approached by a man who said there was an injured person inside the Silver Dollar. Deputy Wilson initially believed the injured person was in the alley behind the Silver Dollar.[40] The man was instructed to pull the injured person out so that first aid could be rendered. Shortly thereafter, the man reappeared and shouted "Muerto! Muerto!" which Wilson interpreted to mean the man was dead. It was at that point he realized a dead man was inside the Silver Dollar. Former Deputy Wilson said his immediate thought upon hearing this was that the man with the gun in the back of the Silver Dollar had killed someone in the bar and he anguished at the idea that he had let that man go. It was not until hours later that the former deputy was informed the man identified as Ruben Salazar had been killed inside the bar as a result of being struck by the Flite-Rite missile he had deployed.

Conclusion

Ruben Salazar was a powerful advocate for the Latino community who became an icon for journalists and for those interested in advancing the cause of civil rights through exposure of injustices. His untimely and tragic death by means of a tear gas projectile fired by a Sheriff's deputy led to a diminishment of trust between some in the Latino community and

40 During the 1970 investigation, Deputy Wilson stated that a deputy was contacted in the alley behind the bar about an injured man inside the bar. It is not surprising to have two different statements taken forty years apart.

the Sheriff's Department. We have detailed in this report how the lack of transparency by the Sheriff's Department in 1970 and a number of questions left unanswered by the Homicide investigation continue to cause some to challenge the official results and question why those involved were never prosecuted for their roles in Mr. Salazar's death. To the degree the eight boxes of documents retained by the Homicide Bureau shed additional light on Mr. Salazar's death over 40 years ago, this report is intended to provide a narrative of those materials. However, the insight provided by these documents is lacking in that the Homicide investigation did not attempt to directly address the question that lingers – namely, the suspicion by some that Mr. Salazar was targeted that day by law enforcement. Moreover, because the scope of the Department's investigation and subsequent inquest was limited to reviewing whether a crime had been committed, a more exacting review of tactical flaws, poor decision making, and other potential performance deficiencies did not occur. With those limitations, we are hopeful this account of the materials that do exist will provide a fuller explanation of the events that day; an account that is long overdue.

APPENDIX A

Summary Of Systemic Changes

Year Nine

OIR Identification of Systemic Issue	OIR Recommendation	LASD Response	Implementation of Recommendation
Consistently high number of alcohol-related incidents	Increase discipline for alcohol-related misconduct	Increased discipline for alcohol-related misconduct.	Yes, see pages 2-4
Consistently high number of alcohol-related incidents	Implement policy that prohibits carrying of firearm when under the influence of alcohol	Policy created that prohibits carrying of firearm when under the influence of alcohol	Yes, see pages 4-6
Consistently high number of alcohol-related incidents	Increase unit commander responsibilities	Increased unit commander responsibilities relating to notifications, responding to incident, and requiring blood-alcohol test	Yes, see pages 6-7
Insufficient guidance to deputies dealing with armed suspects	Develop policy providing further guidance to deputies on dealing with armed suspects	Policy implemented providing further guidance to deputies on dealing with armed suspects and Split Second decision book outlining potential hazards of dealing with armed suspects developed	Yes, see pages 14-15
Training Bureau stopped rolling out to deputy-involved shootings	Training Bureau resume rolling out to deputy-involved shootings	Training Bureau to resume regular rollouts to deputy-involved shootings	Yes, see pages 20-21

OIR Identification of Systemic Issue	OIR Recommendation	LASD Response	Implementation of Recommendation
Training Bureau stopped writing training analyses	Training Bureau resume writing training analyses	Training Bureau to resume writing training analyses	Yes, see pages 20-21
Repeated and prolonged TASER use	Evaluate current TASER use policy and training to see if modifications are appropriate in light of current studies on the effects of TASER use	Training Bureau Commander in discussions with OIR on an evaluation of force incidents that fall into this category	In progress, see pages 24-30
Insufficient guidance to deputies regarding TASER use	Revise TASER policy to require verbal warning following guidance provided by courts	Policy revised to require verbal warning unless it would compromise officer safety	Yes, see pages 31-33
Lack of formal policy defining use of force categories	Define use of force categories	Policy adopted defining use of force categories	Yes, see page 34
Deadline for completion of force and shooting investigations is rarely met	Complete force and shooting investigations within time limits set forth in existing policy	Agreed time frames for force incidents need to be significantly compressed	In progress, see pages 35-38
Dangers of reaching into suspect vehicles	Develop Department-wide policy discouraging or prohibiting tactic	Unit level training bulletin alerting deputies to the dangers of reaching into vehicles	Partial, see pages 39-44
Lack of procedure for handling of suspect's complaint of force (unrelated to deputy-involved shooting) when Homicide Bureau is investigating deputy-involved shootings	Ensure complaints of force communicated to Homicide Bureau which are unrelated to Homicide's investigation are immediately communicated to unit or IAB for investigation	Homicide Captain issued oral directive instructing Homicide detectives to immediately communicate any force allegations made by suspect that they do not intend to investigate to the unit or IAB	Yes, see pages 45-46
Failure to notify consulate regarding in custody deaths	Provide more training on consulate notifications requirements	More exacting training provided regarding consulate notification requirements	Yes, see page 56

OIR Identification of Systemic Issue	OIR Recommendation	LASD Response	Implementation of Recommendation
Jail row check scanner was vulnerable to manipulation by jail staff using fabricated bar codes	Investigate full extent of problem in custody system and consider technical and disciplinary solutions	Software change made scanner more robust and employees who used fabricated bar codes were held accountable	Yes, see pages 61-66
Deputies failing to do cell row inmate welfare checks in compliance with Department policy	Increase sergeant's responsibility for monitoring deputies conducting welfare checks	Floor sergeants given capability and responsibility for real time monitoring and surveying of deputy performance of cell row checks	Yes, see pages 61-66
Allegations of retaliation by jail staff against inmates received insufficient level of investigative follow-up	Develop investigative protocol to more thoroughly address allegations of retaliation.	New "hybrid" investigative protocol developed by Custody under supervision of a Custody commander to apply higher level of scrutiny to allegations of this nature	Yes, see pages 61-66
Deputies committing financial crimes	Develop educational programs designed to prevent deputies taking on too much debt and mismanaging their finances	Financial skills course to be mandatory course for new Academy recruits and scheduling of financial planning workshops	Yes, see pages 68-72