Fourth Office of Independent Review Annual Report

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Foreword

by Michael J. Gennaco
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One morning in July of this year, a sergeant from Internal Affairs came up to my office to discuss an investigation I had been monitoring for several months. What he wanted to talk about first, though, was a deputy-involved shooting in the Antelope Valley that he and one of my colleagues had both rolled to the previous week. According to the earliest information and eye-witness reports, deputies had learned of an armed man who had chased his former girlfriend into a restaurant, ordered everyone else out at gunpoint, and then forced her to sit next to him in a corner booth as he brandished the gun. Deputies had rushed in, confronted the suspect, and then fired after he allegedly pointed his weapon at them. The deputies killed the man; meanwhile, the frightened hostage—still seated next to the man who had kidnapped her as the shooting began — was unharmed.

It seemed like a daring and dangerous rescue, yet the story received only a couple of paragraphs' worth of attention in the Los Angeles Times. The sergeant was quick to emphasize the disparity between this coverage and the waves of attention that had followed the Compton SUV shooting in May. After that incident, with its barrage of shots captured on video, the Department had spent weeks enduring harsh criticism and an unflattering national spotlight. Now, the more recent incident had barely registered with the media or public. For the sergeant, it was a typical example of the thankless job of a peace officer: every mistake is met with harsh scrutiny while saving the day merits only a shrug.

Around that same time, my office was receiving an unusually high number of inquiries from the public about a variety of individual cases or complaints. Several callers had become familiar with OIR due to our involvement in the Compton case and the Department's investigation of it. They hoped that we would be able to address some of their needs, or vindicate the rights they claimed that deputies had violated in one way or another. Predictably, they tended to see the Department in a very different light than the sergeant. They felt frustrated by the way they had been treated, and powerless in the face of the Department's subsequent response to their allegations.

The range of conversations that I had in those busy weeks was, in many respects, representative of OIR's unique vantage point and mission as we complete our fourth year as independent monitors of the Los Angeles Sheriff's Department. At its best, OIR's role allows us to serve as a bridge between law enforcement and the public it serves. Our access allows us to assess the Department's actions based on all the available facts, while our independence allows us to keep a critical distance and to appreciate the validity of people's criticisms or concerns. The effort to accommodate all perspectives, promote thorough fact-gathering and principled decision-making by LASD, and enhance transparency on behalf of both sides of the issues, is central to OIR's effectiveness as an oversight entity.

In our four years of oversight, we have repeatedly witnessed the value of good communication and the pitfalls of its absence. Accordingly, we make it a priority to listen intently and to speak constructively whenever possible. I'm always pleased by a day of conversations in which a spirited defense of the Department from a captain or chief in the morning is followed by a similarly spirited challenge from a concerned community activist in the afternoon. When that dialogue teaches me something, or offers me the opportunity to add to the other person's understanding, it reinforces my belief in the positive potential of oversight.

The Compton shooting case, which we discuss at length in Part One of this year's Report, illustrates two of the concepts that have made the strongest impression on me this year: the reality of differing perspectives, and the vital importance of transparency. Both of them relate directly to one of OIR's overriding goals, which is to promote greater public confidence in the Sheriff's Department.

One of the lesser-noted features of the Compton videotape was the clip in which one of the non-shooting deputies could be seen (and heard) yelling at the cameraman and various residents to get away from the scene. He had his gun extended and used profanity freely in the process, and some of the residents responded in kind. Here was a classic example of the "differing perspectives" phenomenon that OIR sees in countless incidents, although often less starkly. To the deputy, understandably anxious about the safety of his partners and the bystanders, and recognizing that the situation was far from stable, the encroaching videographer and neighbors were at best a complication and at worst a danger to the deputies or themselves. The neighbors, on the other hand, were equally justified in their own reactions: curiosity about what had happened, suspicion as to what the deputies had done already and intended to do now, and indignation over being verbally abused as they stood on their own property.

As is often the case, there was potential legitimacy to both views of those frightening few moments. This is the reality that OIR attempts to incorporate into its assessment of any particular case. When there is a clash over who is "right," and even when there is conflict over what specifically happened in a given event, OIR reviews the Department's efforts to answer those questions appropriately. We do so from a starting point that recognizes not only that each side might be right, but also that all parties might genuinely *believe* they are. Our mandate is to help ensure that the results of an investigation are principled and supported by the evidence. Beyond that, though, we look for opportunities to help the Department and the public communicate better, understand each other more, and find more constructive ways to encounter each other.

OIR also has an abiding commitment to transparency. My colleagues and I believe strongly that heightened transparency changes the culture of law enforcement for the better, and benefits both the public and the Department itself. LASD undoubtedly would have appreciated fewer airings of the Compton shooting videotape. However, the existence of the images and the public interest in them gave the investigation a momentum that was, in the end, constructive. The videotape was the centerpiece of the investigators' attempts to determine what happened, and why. When the Department received demands to explain and account for all that occurred, and chose to do so in a thorough and comprehensive way, that pressure resulted in enhanced accountability. Furthermore, LASD, unlike law enforcement agencies who have found themselves facing similar crises, chose to fully report the results of its investigation and has accepted OIR as an oversight entity designed to ensure that the public gets the facts. This approach left most observers satisfied that justice had been served by the resulting discipline and reforms.

The vast majority of cases do not come supplied with a video, but OIR endeavors to promote that same level of careful scrutiny. We also seek to offer a window into the LASD discipline system and its results. We continue to publish a quarterly discipline chart that sets forth the status of various pending cases involving allegations of misconduct. This year, we have expanded our website (www.laoir.com) to include other features as well. We have published articles and columns by the OIR attorneys on a range of issues related to LASD and our oversight role, and we now post the results of Civil Service Commission hearings in which deputies challenge the significant discipline they have received. Finally, this Report continues to be the cornerstone of our attempts to communicate our assessment of the way in which the Department has dealt with systemic issues and includes matters that, in our view, reached a principled outcome as well as cases that have not been treated quite as well. Our Report also notes our occasional frustrations in dealing with LASD each day.

All of these steps are intended to foster a greater awareness of how, and how well—or not—LASD works. Most of the time, we have found that the Department is proud of the good work it does, serious about addressing misconduct, and committed to making improvements where needed. And we have found that the public, for its part, appreciates the Department's efforts, values being heard, and has information or insight that the Department's executives and deputies would do well to consider. OIR is cognizant of its place in this important and engaging interaction.

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One frustration that continues to bedevil us is the failure of Department executives, at times, to consult with us at the end of the disciplinary process before agreeing to modify a disciplinary decision. Our oversight model is heavily reliant on our interaction with Department managers—that ability has been put to the greatest test at the end of the disciplinary process. Too many times we have been chagrined to learn that a Department executive has modified a disciplinary decision without engaging in dialogue from us. As we have repeatedly explained to LASD's decision-makers, we respect and endorse the notion that the ultimate decision regarding discipline rests with the Department. However, it is imperative to the viability of our model that we have an opportunity to provide our perspective on any impending modification before the Department changes its decision.

We do not consider the occasions when there has been no consultation with OIR to be part of a sinister or deliberate attempt to exclude us. Instead, the problem lies with the nature of decision-making at the end of the process, which tends to be needlessly rushed. A certain momentum often develops to "settle" a case that can result in the executive forgetting to contact OIR in the "heat of the moment." We understand this dynamic, but we still find it frustrating—particularly when months of careful investigation and thoughtful analysis are seemingly undone on the fly.

As is detailed in this Report, we have created additional constructs and notification requirements in an effort to ameliorate this situation. We have even brought the issue to the Sheriff's personal attention and he has personally reiterated to his command staff the need to consult with us. The problem, however, continues to recur. While we are hopeful that our continued vigilance (and public reporting each time LASD has failed to consult with us) will result in the elimination of this phenomenon, we are prepared to take any necessary steps to reinforce the importance of our consultation protocols with the Department. Not to do so would be to relinquish our responsibility to make oversight a meaningful factor at all stages of critica internal investigations.

PART ONE The May 9, 2005 Compton Shooting: Insights and Updates

On May 9, 2005 on a residential street in Compton, California deputies fired 120 rounds at a vehicle and its driver at the termination of a vehicle pursuit. The videotape of the pursuit and shooting brought international attention to the behavior of the deputies. It also sparked concerns from members of the community, LASD, and OIR.

Sheriff Baca quickly set the tone for the Department's response by accepting responsibility and acknowledging the apparent problems in the handling of the incident. Remarkably, the deputies themselves soon followed suit. Rather than simply disappearing from view or adopting a defensive posture, nine of them appeared at a press conference within days of the shooting. They expressed their regrets for the unintended danger that their high volume of shots had caused the surrounding neighborhood. In doing so, they showed a welcome regard for the community they serve; moreover, by providing insight into the danger they had perceived, they broadened the public's understanding of the event.

The prompt and progressive approach that was evident in the immediate aftermath of the shooting carried over into the Department's actions of the next several weeks. LASD met with members of the community on multiple occasions in an effort to promote dialogue and defuse the understandable tensions. Meanwhile, it conducted a rigorous and wide-ranging internal investigation. It scrutinized not only the deputies' actions but also the policies, training, and equipment with which the deputies were expected to do their jobs. In a month's time, LASD completed its investigation of the incident, imposed discipline, developed a new policy regarding shooting at cars, and planned the training for it.

OIR's model successfully allowed it to play a role in the various components of the LASD response. An OIR attorney rolled-out to the shooting scene that night, and had input from the outset of the investigation. She made recommendations and specifically articulated a standard for thoroughness and completeness that OIR hoped would be met. OIR's continuing access to the investigators then helped ensure that its suggestions could be heard and accommodated in a practical, efficient way — without slowing the demanding pace that LASD had set for itself.

Additionally, because OIR had been involved consistently with oversight of all shootings in the preceding 3 1/2 years, OIR was already aware of potential deficiencies in LASD's shooting at cars policy and was ready with a proposed policy change when LASD indicated it was interested in altering its policy.[1] OIR's access allowed it to work directly with LASD executives in shaping that policy and the training that is currently ongoing. Finally, the fact that OIR is a permanent fixture at LASD allows it to follow-up with the Department to monitor the implementation of the new policy and training.

In mid-July of 2005, OIR issued a public report describing the Compton shooting incident moment by moment, evaluating the internal investigation and its outcome, detailing LASD's modifications to policy and training in response to the incident, and discussing how previous deficiencies in training and equipment impacted on the incident. That report is available on the OIR website: www.laoir.com.

The July public report is meant to be comprehensive, but the ensuing months have brought further developments and additional time for reflection. Accordingly, what follows is both a summary of key facts about the case and a supplement to OIR's earlier public statements about it.

A. Synopsis of the Events on May 8-9, 2005[2]

On May 8 and 9, 2005 deputies from the Compton Sheriff Station responded to a call for service from a resident on the 800 block of Butler Avenue who reported that

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1 In fact, OIR's Third Annual Report discussed some of OIR's concerns in this area and OIR's and LASD's early discussions towards implementing a change in policy. (Third Report at pp. 22-24.)

2 This synopsis is based on the information and evidence gathered during the LASD investigations, including interviews of civilian and sworn witnesses, review of forensic evidence, review of radio traffic and other LASD transmissions, and review of two videotapes recorded by local news stringers.

he had heard gunshots being fired. They attempted to contact a suspect in a vehicle. When he drove away from them, the deputies initiated a vehicle pursuit of the suspect. The deputies contacted an LASD helicopter that immediately headed towards the pursuit, but was more than 9 1/2 minutes away.

The vehicle pursuit lasted for more than 10 minutes. Five LASD vehicles participated in the pursuit: the original two-deputy unit assigned the call, another two-deputy unit, two one-deputy units, and the Field Sergeant. There were also a number of patrol units that monitored the pursuit over the radio and drove to the area, but did not become involved in the pursuit.

The original assigned unit provided information about the pursuit over the radio. The Lieutenant/Watch Commander monitored this broadcast and provided some direction to the units in the pursuit and to units not in the pursuit. During the pursuit, the Lieutenant requested that a deputy drive to the location of the original call where the gunshots were heard to determine whether there were any victims of an assault. The Lieutenant also told other units to not get involved in the pursuit and to set up a perimeter.

During the pursuit, the suspect was reported by deputies as driving erratically, at high rates of speed, and almost hitting parked cars. The suspect also reportedly slowed to a stop on a couple of occasions and the deputies indicated their belief that he was going to end the pursuit. But, each time the suspect began driving again. A couple of times, deputies indicated that the suspect drove at and nearly hit deputies. The deputies who had initiated the pursuit broadcast this information over the radio.

During the pursuit, the suspect repeatedly drove on the same streets through the same neighborhood. He drove on Butler Avenue a number of times. The deputies therefore attempted to deploy spike strips to puncture the suspect's tires and end the pursuit. Numerous requests were made for spike strips to be deployed, and eventually the Watch Deputy along with a deputy trainee brought a spike strip from the station. The spike strip was deployed and the suspect's SUV passed over it, but the strip did not fully activate and the SUV's tires were reportedly unaffected. A second attempt was made to use the spike strip, but the pursuit terminated before the suspect drove over the strip again.

The LASD helicopter arrived over the pursuit a couple of minutes before it terminated and took over the radio broadcast of the pursuit. The Lieutenant then terminated the pursuit and told the radio cars to begin a surveillance mode. The deputies turned off their lights and sirens and stopped at the corner of Butler Avenue and East Myrrh Street. Over the radio, deputies were requested to deploy themselves at least two or three streets on each side of Butler Avenue and Myrrh Street. Seconds later the LASD helicopter observer broadcast over the radio that the suspect was stopped on Butler Avenue and then stated it looked like the suspect was getting out of his car.

After this broadcast, deputies who were involved in the pursuit and deputies who were in the area monitoring the pursuit converged on the suspect's SUV on Butler Avenue. The suspect, rather than get out of his car, started to drive again, erratically driving back and forth and up and down Butler Avenue, and the lawns adjacent to it. While this was occurring, the deputies all exited their radio cars and were on foot. On foot they placed themselves on both the east and west sides of Butler Avenue and both north and south of the area where the SUV was driving. At several points deputies moved to avoid being hit by the suspect's SUV. Ultimately, the suspect's SUV stopped to the north of most of the deputies on Butler Avenue. It was then perceived by deputies that the suspect drove in a southwesterly direction towards several deputies who were on a sidewalk and then in a southerly direction towards a deputy near a patrol car.

Based on the videotape, it appears that the shooting began just after a squeal of tires and as the SUV moves forward in a southwesterly and then southern direction, ultimately coming to rest against a radio car. Ten deputies fired a total of 120 shots. Two hit the suspect, injuring him seriously but not fatally. Several hit the suspect's car and surrounding patrol cars. Some rounds went into nearby homes – fortunately injuring no one.

Some deputies fired because of a perceived threat to themselves, some because of a perceived threat to another deputy. Some deputies fired while attempting to move out of the path of the SUV. As the videotape shows, some deputies fired when it appears other deputies might be in their line of fire. And ultimately a deputy was hit by one round of crossfire (though not seriously injured).

LASD immediately initiated two investigations, one by the Homicide Bureau and one by the Internal Affairs Bureau (IAB). Per its usual protocols for a deputy-involved shooting in which the suspect is hit, Homicide's investigation was intended to gather evidence as to the legality of the force used by the deputies, for assessment by the District Attorney's Office. The IAB investigation, on the other hand, reviewed the whole of the deputies' performance with an eye toward possible policy violations and training issues.

B. Assessment of Performance and Accountability of Involved Personnel

After the completion of the IAB investigation, the Executive Force Review Committee (EFRC) reviewed the shooting. [3] Per standard practice, OIR attorneys attended the EFRC meeting and asked questions, offered input, and weighed in on the eventual recommendations coming out of the committee meeting. The EFRC panel received a copy of the IAB investigation to review before the panel met. In addition, the IAB investigators presented the results of the investigation in detail and were available to respond to any questions the panel had about the information gathered in the investigation.

The EFRC panel reviewed not only the actual shooting, but also all employee conduct relating to the incident, from the initiation of the pursuit, through taking the suspect into custody. The panel determined that the initiation of the pursuit and its continuation until terminated were within policy, and that no deputies involved in the pursuit violated the Code 3 policy in their responses to the incident. But the panel determined that one deputy's participation in the pursuit violated policy in that the Watch Commander had limited the pursuing vehicles to three radio cars and the Sergeant. The panel determined that some of the deputies' conduct at the termination of the pursuit and their approach of the suspect vehicle on Butler Avenue violated LASD policies and failed to conform

[3] The EFRC is a committee comprised of Commanders. These Commanders review all shooting incidents to determine whether the force used was within policy, and also whether the other conduct of the involved personnel during the incident complied with LASD training and policy. For policy violations, the EFRC can recommend discipline, which then must be approved by the Chief under whose command the employees work. In addition and apart from violations of policy, the EFRC can recommend that the involved personnel receive training including attending specific LASD courses and de-briefing the incident within their command or with experts from the Training Bureau.

to the standard of performance expected of employees. The panel also concluded that the performance of the on-scene supervisor was below the level expected of a supervisor. The panel found that the conduct during the shooting itself and the tactics leading up to the shooting were below the standards of performance expected. Finally, it concluded that the procedures used to extract the suspect from his vehicle were within policy.

EFRC recommended that deputies be found to have violated policies and that discipline be imposed. These recommendations were forward to the Chief of Field Operations Region II (the region in which Compton is located) for his review. After this review, it was determined that all force used by the involved deputies complied with LASD's current use of force policies. However, deficiencies in other conduct, including tactics, resulted in discipline being imposed.

While each of the deputies' conduct was assessed individually, several general and common threads emanated from the investigative results. First, there was no evidence, whatsoever, of any willful intent on behalf of any of the deputies who discharged their weapons to violate the rights of the driver or anyone else in this case. The evidence, rather, revealed performance by the deputies that did not rise to the standards of performance expected of them.

Perhaps foremost among these performance issues is the failure of the field supervisor or any of the deputies to develop a coordinated and safe plan to deal with the driver of the SUV. Once the pursuit was terminated, the deputies in the pursuit were instructed to go into surveillance mode, and the watch lieutenant advised the participants to set up a perimeter. The deputies did not set up a perimeter and demonstrated a complete disregard of the rationale behind surveillance mode.

While some of the units who were not involved in the pursuit did make some preliminary gestures towards containment, once they received information that the suspect might be exiting his vehicle, those that ultimately were involved in the shooting abandoned all such efforts and converged on the SUV. The failure of the field supervisor and the deputies to develop a tactically sound plan, the failure of the pursuing deputies to go into a true containment mode, the wholesale abandonment of any attempts at containment once the suspect stopped his SUV, and the uncoordinated response by all shooter deputies directly to the SUV on Butler set the wheels in motion for the eventual unfortunate shooting episode.

As a result of the poor tactical approach by the deputies, they found themselves in possible harm's way by the suspect who remained in the SUV. At too-close quarters to the SUV with insufficient consideration for cover, the deputies had limited their options with which to safely deal with the suspect when he began maneuvering the SUV on Butler. Unsure of where fellow deputies had deployed, with no tactical or strategic plan, each deputy was forced to individually come up with his own course of action or reaction when he perceived a threat to himself or a fellow deputy. These ten uncoordinated decisions that were then made while deploying deadly force caused the deputies to make poor choices in concern for background, regard for cross fire, abandonment of cover, control of gunfire, and reassessment of the threat presented. The unfortunate result was a deputy and suspect being shot, 120 deadly rounds being expended, numerous bullets going into houses in the community, a radio car being shot up, and the potential, fortunately not realized, for further injury or loss of lives by both the deputies and the residents of the community.

C. Reevaluating Training and Policy

LASD determined that while the tactics employed fell below expected standards, the shooting itself was within policy. Nonetheless, LASD recognized that while the shooting was within policy, having 120 shots fired in a neighborhood, and one of them hitting a fellow officer, was indicia of a poor tactical response. Therefore LASD, to its benefit, reexamined both its training and its policy.

Prior to this shooting, and as set out in our Third Annual Report, OIR had been discussing with LASD the advisability of a revised policy instructing and goveming when deputies could shoot in response to a threat posed by a car. (Third Report, at pp. 22-24.) While OIR believed that LASD's then-current policy was actually sound, OIR concluded that an improved policy could better emphasize the tactics deputies should use to avoid a deadly threat from a vehicle in the first place, and to escape that threat if it did arise despite use of good tactics. LASD had agreed that a change would be beneficial, but, as is too often the case when improved policies are being developed by LASD, deciding on the appropriate policy was a slow process.

As a result of this incident and Sheriff Baca's concerns, the interest in refining current policy was pushed to the forefront. Within days of the shooting, OIR met personally with the Sheriff and presented its draft policy for consideration. The policy eventually adopted (which contains significant input from OIR) clearly states that shooting must be the last resort, and that all actions by all involved personnel both prior to and during the shooting will be evaluated for compliance with specified basic tactical principles.

The new policy has several critical attributes. First, where the sole deadly threat is from the vehicle itself, it prohibits shooting unless there is no reasonable alternative. Second, the policy specifically identifies the tactical principles that will be used to evaluate the conduct of all department employees – not just those who shoot – who are on scene when a shooting occurs.

In addition to modifications to the policy governing shooting at vehicles, two other significant modifications were made to LASD policy. First, the policy regarding use of deadly force in general was modified to emphasize the need for each department member to individually assess the threat and the principle that a deputy cannot fire his or her weapon simply because other deputies are firing. Second, the pursuit policy was modified to instruct deputies that if a suspect is noncompliant at the termination of a pursuit and refuses to exit his vehicle, he shall be treated as a barricaded suspect, and if armed, an appropriate special weapons team response should be requested

What is significant here is that LASD was not content simply to examine the behavior of the deputies, and lay all responsibility for the incident at their feet. Rather, LASD recognized that it and its policy might bear some of the responsibility for the events. LASD ultimately determined that a revised policy might assist other deputies to avoid the unfortunate series of events that occurred in Compton. To their credit, the unions recognized the Department's intent on adopting revised policies to address the issues identified in the Compton shooting and readily agreed to "meet and confer" so that implementation could occur quickly.

Similarly, LASD examined its training in general and its training of the involved deputies in particular to determine whether some responsibility lay there as well. Five of the ten shooting deputies had not received their Continual Patrol Training (“CPT”) in the preceding two years. CPT is intended to refresh deputies on all their perishable skills, including providing weapons tactical training. It is LASD’s goal that every deputy attend CPT once every two years. This lack of training clearly had an effect on the outcome of the encounter. LASD immediately provided training, and not just to the involved deputies. It also sent a mobile training unit to Compton station for all deputies to undergo shooting scenario training. LASD is also examining its training practices department-wide. OIR sees much to be done here, including insulating training from LASD's budget vagaries.

In addition, LASD had already been examining the content of its training, but after this incident it quickly modified the content to address certain areas of concern. For instance, in May 2005, LASD's Use of Force and Tactics training added a scenario on shooting at vehicles. In addition, deputies attending Patrol School prior to their transition from custody assignments to patrol assignments now are trained on reacting to drivers who use vehicles as weapons.

Finally, LASD recognized that it needed to train deputies on the new policy itself. As LASD and other law enforcement departments have learned in the past, announcing a new policy, without accompanying training on that policy, often proves ineffective. LASD therefore created a training video to be used to introduce the revised policy to all Department personnel. LASD has already held several training sessions to introduce the video to supervisors. Those supervisors are now taking the video and the training back to the units to explain the new policy.

D. Equipment Review

LASD also recognized that the availability, or lack of availability, of certain equipment may have contributed to the less than ideal results in Compton. In particular, there were concerns about the spike strip deployed that evening and its apparent malfunction. A review determined that Compton had not followed policy for deploying spike strips in the field, but that might be explained by the fact that none of Compton's spike strips functioned properly. LASD then expanded its examination of the issue department-wide. This audit revealed that LASD has a shortage of functioning spike strips. Repairs are not possible because of litigation involving the company that supplied LASD with the strips. LASD has currently redistributed some working strips in an effort to have working strips available everywhere. It is also looking into alternate sources for new strips.

3-01/025.40 ASSAULTS BY MOVING VEHICLES - FIREARMS POLICY

This section reinforces the Department's Core Values and underscores the reverence for human life.

The use of firearms against moving motor vehicles is inherently dangerous and almost always ineffective.

For the purposes of this section, an assaultive motor vehicle shall not presumptively justify a Department member's use of deadly force. A Department member threatened by an oncoming motor vehicle shall move out of its path instead of discharging a firearm at it or its occupant(s), allow the vehicle to pass, and utilize other tactical or investigative means to apprehend the suspect. If Department members decide to engage the vehicle in a pursuit, that pursuit shall be governed by the Department's pursuit policy (section 5-09/210.00 et seq.).

When on foot, Department members, except as required for fixed-point traffic control, shall not position themselves or remain in the path of a moving motor vehicle. Additionally, they shall not stop in a position directly in front of or behind a driver-occupied, stationary motor vehicle. Such positions are inherently unsafe.

A Department member shall not discharge a firearm at a motor vehicle or its occupant(s) in response to a threat posed solely by the vehicle unless the member has an objectively reasonable belief that:

- The vehicle or suspect poses an immediate threat of death or serious physical injury to the Department member or another person, AND
- The Department member has no reasonable alternative course of action to prevent the death or serious physical injury.

In the extraordinary instance that a Department member feels compelled to fire at a motor vehicle or its occupant(s), the conduct of the involved personnel shall be evaluated in accordance with sound tactical principles including the following:

- Cover and/or tactical relocation,
- Safe distance,
- Incident command and tactical leadership,
- Coordinated personnel placement,
- Tactical approach,
- Regard for viable target acquisition,
- Due regard for background, including the location, other traffic, and innocent persons,
- Due regard for crossfire,
- Controlled fire and management of ammunition.

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E. Unique Features and Lasting Impressions

1. *The Value of an Expedited Investigation Must Be Balanced Against the Challenges It Poses— and Illustrates the Need for Sufficient Resource Dedication to Internal Affairs.*

A typical investigation of a deputy-involved shooting where the suspect has been hit by the deputies' gunfire may not be completed for more than a year after the incident. In this case, LASD completed its investigation within one month in response to the Sheriff's mandate for expedited handling – and in keeping with the Sheriff's recognition that the public's concerns warranted a timely result. Despite the expedited nature of the investigation, neither its thoroughness nor its fairness to the officers was compromised. From this, OIR and LASD, and the community at large, learned that a thorough investigation can be completed in a shorter time frame than we have traditionally come to expect.

In this case, the results have suggested to OIR and others that the intense effort involved in completing this investigation quickly provided important dividends. The public, LASD, and the involved deputies and supervisors all benefited from a speedy resolution. First, LASD showed a commitment to the community of Compton to address performance issues with dispatch. Second, the fact-gathering process was improved because witnesses were asked about their observations and actions within days of the event rather than months or years later. Third, because the discipline and training were imposed soon after the event, their remedial impact was greater. Finally, the speedy resolution avoided employees operating "under a cloud" for an extended period of time and provided them the ability to receive the Department's efforts at correction and progress with their careers.

However, completing the investigation in the targeted time frame was not facile. There were ten shooting deputies, plus two additional deputies that needed to be interviewed, as well as two supervisors and other witnesses. There was physical evidence that needed to be processed, third-party videotapes to be tracked down, and crime scene processing to be completed to create accurate depictions of the scene. To meet the goal imposed by the Sheriff while adhering to the standards for thoroughness that OIR expected, LASD needed to commit significant extra resources to the investigation. Homicide detectives worked long hours to compile their reports of their interviews, to process evidence, and to pass information to

IAB. Normally, IAB would assign two investigators to a shooting review. Here, there were the two assigned investigators, but many more pitched in to help in summarizing deputy interviews and gathering information. And again, investigators were working around the clock, seven days a week.

There is a clear cost – in overtime, stress, and neglect of other pending matters – to such an intense dedication to one case. OIR recognizes that investigators cannot be asked to expend the necessary level of energy every day non-stop and still maintain high quality – let alone their health. And of course, the two investigators involved in this case had other investigations on their desks that were delayed by their need to give their full attention to this one.

Therefore, in order to continue this practice of expedited investigations in high profile and significant cases such as this one, LASD needs to devote adequate resources to IAB in the form of investigators and supervisors. With a full contingent of investigators, IAB would not be limited to two dedicated investigators for a case receiving expedited review. Interviews, gathering evidence, and processing material could proceed on multiple tracks with additional investigators assisting full time. In addition, with sufficient investigators, other investigations could be transferred to investigators not involved in the expedited review, so as not to delay or compromise other pending cases.

That said, the IAB group is still lacking a full contingent of investigator positions that were unfilled during the departmental downsizing that occurred the past few years as a result of the budgetary challenges. For example, for the past several months, IAB has had a vacant lieutenant's position unfilled. In addition, IAB could benefit from a creation of an additional roll-out team. As it currently stands, the rollout teams are too often being required to respond to critical events, at the risk of their other case responsibilities. In fact, the two investigators assigned to the Compton shooting, had several days of rollout responsibilities befall them when they were working to finish this case within the thirty day deadline.

2. *The Deputies' Cooperation with the Investigation Was Crucial to Its Speed, and Gives the Department Reason To Review Its Usual Protocols.*

It is also critical to note that this expedited review may not have occurred without the voluntary cooperation of the involved deputies and supervisors. LASD's standard practice is to allow the District Attorney to first review all shootings where a suspect is struck by gunfire before LASD then evaluates the deputies' conduct. That said, in this case, the ten shooter deputies decided, with advice of counsel, not to rely on any possible legal challenge they might be able to mount to delay their administrative interviews for several months or even years and instead agreed to submit to compelled interviews before the District Attorney finished his review.

The benefits of prompt review that emerge from this case are, regrettably, no guarantee that future deputies or their counsel will follow in the footsteps of their Compton predecessors by waiving the usual delay before administrative interviews. Accordingly, LASD should address the potential legal challenges that a deputy may be able assert to delay LASD's investigation until after the District Attorney has completed his review. OIR intends to work with LASD to reexamine the settlement agreement it entered into in the "Gates and Johnson" litigation in which LASD may have limited its ability to undertake certain internal investigations of deputy conduct while criminal investigations are pending against the deputy. Ignoring this issue may impair the Department's ability to expeditiously complete an investigation the next time a critical event occurs.

3. *By "Breaking the Mold" of Conventional Law Enforcement Response, the Sheriff and Involved Deputies Contributed Greatly to the Constructive Tenor of the Shooting's Aftermath.*

This incident was certainly unique in the outreach to the community by Sheriff Baca and the involved deputies. Within days of the shooting, Sheriff Baca addressed the community and listened to its concerns – including walking the street where the incident had happened and apologizing to residents there. He also quickly admitted what was apparent to everyone: that the result of the incident – 120 rounds fired – was problematic and needed a thorough and timely investigation. To any outside observer who saw the video, these concessions about potential deficiencies may have seemed like nothing more than an expression of the obvious. However, given law enforcement's traditional reluctance to admit fault, his statements were certainly progressive. OIR witnessed and participated in these community meetings, and the community clearly appreciated his candor as well as his willingness to listen to their concerns.

No less progressive and refreshing was the apology offered by nine of the involved deputies. Again, their acknowledgment that it was less than ideal to fire 120 rounds in a residential neighborhood was, to some observers, merely a statement of the obvious. But we at OIR are not aware of any other incident in which the involved officers publicly apologized to the community in this fashion. The symbolic value alone was significant — it showed the public that, in the traditionally insular and defensive world of law enforcement, people's concern and anger were being heard, understood and largely accepted. Moreover, the street of understanding presumably runs both ways. At the same press conference, the community had the opportunity to see that these officers were not ruthless, faceless rogue cops, but instead were individuals who cared about the city of Compton and had a number of legitimate concerns about the dangers posed by the suspect.

Subsequently, some have doubted the sincerity of their apology, given that they have exercised their rights to challenge the discipline that LASD imposed. OIR does not share this view. We do not see inherent inconsistency between the deputies' expression of regret for what occurred and their individual choices to question particular findings or the amount of discipline that they received.[4] Perhaps the ultimate test of the deputies' attitudes toward the event will be found in their future performance with the Department. For now, though, their forward-thinking decision to appear and express regret about the incident at the press conference merits admiration.

4. *OIR's Model — and the Department's Continued Cooperation with It — Allowed for Civilian Oversight To Be a Major Component of the Response to This Event.*

The OIR model is premised on real-time review of LASD, including its investigations. Through timely and direct discussions with investigators, OIR attempts to identify any deficiencies in an investigation before it is completed, so that they may be remedied. The goal has always been to improve the finished product rather than criticize its flaws after the fact. This type of review, however, becomes more difficult when the investigation schedule is expedited.

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[4] We do, however, disagree with their position that the amount of discipline was inappropriate.

In essence, OIR too had to expedite its review. OIR's protocols and its established relationship with the Department facilitated this process considerably. Because an OIR attorney was at the scene of the shooting the night it occurred as the investigation commenced, that attorney was able to provide immediate input into the investigation. As interviews were completed, OIR received the tapes, summaries, and transcripts and reviewed those. As evidence was processed, OIR obtained copies of it. As videotapes were obtained and analyzed, OIR reviewed them. This allowed OIR to stay abreast of the investigation and provide meaningful input when investigative decisions were made. This also allowed OIR to make its own recommendations and suggestions about the evidence-gathering process. Because OIR is located in the same building as IAB, OIR was able to do all this on a rolling and efficient basis, rather than stalling the process with cumbersome meetings.

OIR's model also provided it the flexibility to fashion an arrangement whereby ten of the involved deputies agreed to allow OIR to attend their interviews with IAB. This opportunity greatly enhanced OIR's ability to provide guidance on a quickly moving investigation. The OIR attorneys were able to ask questions at the end of the interview. Under ordinary procedures, OIR would have received a tape or transcript of the interview after it was completed, and only after reviewing those would OIR have been able to raise any ambiguities or suggest follow-up questions with the IAB investigator. In this investigation, OIR's immediate presence helped ensure that important information was captured without a need for cumbersome re-interviews. In fact, OIR's questions occasionally gave the deputies an opportunity to clarify their statements and make their viewpoints better understood.

OIR's model brought similar advantages to its participation in the policy review phase of the project. Because OIR is not an ad hoc review committee gathered to address one incident, but an established monitoring body, OIR was able to utilize its past experiences and efforts in order to provide timely and meaningful input as LASD rapidly revised its policy on shooting at vehicles.

In fact, OIR already had a draft policy it had been working on with LASD, and therefore was able to present that document to the Sheriff personally. This draft formed the framework for the revised policy and led to the renewed discussions on revision. In contrast, had OIR been a one-time review group, it would have taken several weeks, at least, to get up to speed on the relevant issues in order to provide meaningful input. In short, OIR's institutional knowledge of the issue allowed the promulgation of a new policy in a timely fashion.

In addition, rather than suggest a policy that narrowly addressed only the issues in this one shooting, because OIR was familiar with other shootings involving vehicles, OIR was able to remind LASD of these other scenarios and help formulate a policy with much broader application. Too often agencies adopt reform in a piecemeal fashion in response to the latest high-profile incident. LASD's new policy, however, incorporates lessons learned by LASD and OIR over several years, from a number of incidents.

Finally, on a going-forward basis, OIR's continued involvement with LASD will greatly facilitate its ability to monitor LASD's implementation of its new policy. LASD has established a training program for the new policy. OIR has put LASD on notice that it will audit units to determine how many deputies have received the training. In addition, the new policy will be applied to future shootings. OIR, through its attendance at EFRC and discussions with LASD decision-makers, will scrutinize how LASD applies the new policy and make recommendations in an effort to ensure its consistent and uniform application.

PART TWO

Developments in the LASD Discipline Process

Guidelines for Discipline

In OIR's Third Annual Report, OIR reported on the delay in the implementation of certain policy changes, and in particular the Guidelines for Discipline. (Third Annual Report, pp. 69-73.) For years preceding OIR's creation, there was a movement in LASD to update the Guidelines for Discipline. LASD felt that revisions were necessary to bring recommended discipline in line with current values. In addition, the format of the Guidelines for Discipline was confusing to some and there was a desire to have the guidelines directly track the potential policy violations in the Manual of Policies and Procedures. OIR participated in discussions of the revisions, but this was an LASD motivated project.

During the Summer of 2003, LASD Executives agreed to the revisions to the Guidelines for Discipline. LASD then approached the employee associations to meet regarding the changes. As we previously reported, the first meeting did not occur until mid-2004, nearly a year after LASD Executives had agreed to the revisions. As of our last report and based on this glacial pace, OIR was pessimistic that the revised Guidelines for Discipline would be implemented anytime soon. Finally, on August 1, 2005, the new Guidelines were implemented. While LASD did meet on several occasions with the employee associations, ultimately one association did not concur with the revisions. After repeated discussions with the one outstanding association, LASD implemented the revised Guidelines for Discipline.

The revisions are progressive and are intended to fulfill LASD's vision to make the guidelines more user-friendly and to recommend ranges of discipline consistent with contemporary values. For instance, the new guidelines stiffen the penalties for violence. Under the old guidelines, assaultive behavior off duty had a discipline range of a 3-7 day suspension. Under the new guidelines, assaultive behavior has a discipline range of 10 days to discharge. Similarly, under the old guidelines, the penalty for domestic violence did not include discharge unless the victim required medical treatment. Under the new guidelines, any domestic violence, regardless of whether medical treatment is required, could result in discharge. The new guidelines also increase the penalty range for false statements. Under the old guidelines, the range for false statements alone, did not include discharge. Under the new guidelines, the recommended range for a false or misleading statement includes the potential for discharge.

While the revisions should be helpful, unfortunately the process was too attenuated from start to finish. However, LASD has been working to speed up the process for making these types of changes – which in this case took two years. OIR hopes that future reforms will receive more prompt attention and implementation. LASD management seems to share this goal: in this case, the Department took decisive action to implement the Guidelines.[1] The approach bears repeating – LASD's mission is too important for vital reforms to become bogged down in unnecessary delay.

Reductions in Discipline During and After Grievance or Skelly Hearings

As OIR reported in the Second Annual Report, at pp. 56-62, once LASD announces its intended discipline, there are various opportunities for that discipline to be changed before it becomes final and is imposed. Often this occurs during or after the grievance process or a Skelly hearing. Sometimes there is a reasoned basis for the reduction, such as relevant new information being provided. Other times, the change is seemingly without a reasoned support— there is no new information to justify a departure from the original decision. OIR's goal is to limit and ultimately eliminate the instances where discipline is reduced without a reasoned basis to support the reduction. To that end, LASD and OIR instituted a protocol, also found in the Second Annual Report, establishing a procedure for consultation with OIR in certain situations when a reduction in discipline is being considered.

In addition to repeatedly reminding new and existing executives of the protocol, OIR has recently established a procedure whereby it is given notice when a grievance or Skelly hearing is scheduled. This awareness promotes efficiency. In the midst of an often protracted process, the notification provides the OIR attorney an ability to touch base with the Department's decision makers at an opportune time. So far, this new procedure appears to be working as a means of promoting communication and enhancing OIR's ability to provide input at the end of the disciplinary process.

[1] As a further example of the Department's new found resolve, we note in Part One of this Report the speedy implementation of the "shooting at cars" policy after meeting with employee associations.

In many instances, this protocol has served its purpose well. Prior to modifying discipline, executives have consulted with OIR. OIR has discussed the reason for the change with those executives in an attempt to assess whether there is a reasoned basis for it. Often, the justifications make sense, and OIR readily concurs. On other occasions, OIR recommends against the change and sometimes even takes its position up the chain of command. The key to the protocol is not that OIR always gets its way, but that it has an opportunity to be aware of developments in the case, to continue to present its perspective meaningfully, and to cause LASD executives to carefully examine their reasons for proposing a change.

Unfortunately, over the past year OIR has encountered a number of instances where LASD executives reduced discipline without consultation with OIR. Each time this has happened, OIR has raised the issue with the involved executive. In one case, the problem arose with a newly promoted executive who was unaware of the protocol. As soon as OIR became aware of the problem, OIR forwarded a copy of the protocol to the involved Chief. In subsequent cases, that Chief followed the protocol and consulted with OIR before changing discipline. Because promotions occur and new executives may not be aware of the protocol, OIR has, when the opportunity arose, reminded executives of the protocol.

In more disturbing cases, executives who were aware of the protocol have nonetheless failed to abide by it. Some of these instances were isolated examples of simple forgetfulness or miscommunication. However, when the problem persists within the same Division or with the same individual, it obviously becomes an even greater cause for concern. In fact, it goes to the heart of OIR's relationship with the Department.

Without the ability to know what is happening and to offer its views at each critical moment in the process, OIR loses some of the strength and legitimacy of its monitoring role. Cases not only come to disappointing conclusions, but they erode all of the principled analysis and decision-making that initially occurred in the case. As a result, OIR is mandated to report to the public that it cannot endorse the ultimate disciplinary decision. Accordingly, when OIR experienced a run of poor communication with a particular executive this year, it took the step of expressing its dismay to that person's supervisor – one of the highest-ranking people in the Department. The situation has improved in recent months, though OIR will continue to be vigilant in the future.

OIR Is Provided a Window into the Grievance Process

As the preceding sections suggest, the appellate rights of the deputies can result in a substantial amount of additional process. If the deputies decide to exhaust their right to challenge any imposition of discipline, the case can end up as the subject of a Civil Service Commission or Employee Relations Commission hearing. The adversarial proceedings are intended to proceed much like court cases in which lawyers for the respective sides present evidence and argument in support of their positions. The hearing officer then makes findings that are ratified (or altered) by the Commission itself.

Prior to that step, however, the subject deputy and the Department attempt to (and often are able to) resolve any disagreements through a grievance process. The deputy who wishes to challenge his discipline meets with the Captain and/or Chief of his division and other interested parties (including his counsel and/or peer representatives) to state his case and explain why the findings and/or amount of discipline should be reduced or completely overturned. The deputy will often present a perspective or actual evidence that had not been previously considered. When the presentation in a grievance hearing (which often involves questions or extended dialogue with other participants) is complete, the Captain or Chief will clear the room and discuss the case again with peer representatives with an eye toward making appropriate alterations to the initial decision. Often, the result will be a settlement that changes some component of the discipline (holding part or all of the suspension in abeyance is a common example) in exchange for the deputy's waiving of additional appellate rights.

OIR has long been interested in having access to these grievances, since they often result in the altering of decisions that OIR has monitored, endorsed, and often influenced. However, the union has been reluctant to support OIR's presence at these meetings.[2] OIR has nonetheless attended grievances and Skelly hearings on a few occasions. One of these occurred recently, when a deputy with sincere concerns about his case invited OIR to witness his grievance proceeding.

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[2] OIR does not concede that the union has the right to exclude it from any grievance or Skelly hearings. To date, however, because of the risk of impacting negatively on any disciplinary matter, and because attendance at these post-disciplinary hearings has not been absolutely essential to the effective role of OIR, we have not formally challenged the union's objection. As we have relayed to the union, however, there may come a time when OIR will assert a challenge to the union's position on this issue.

The case involved a three-day suspension for the alleged mishandling of an encounter with a deputy district attorney by a Court Services deputy. The incident began in the attorney's visiting section of the court lockup, when an inmate became disruptive and demanded to be returned to the holding tank from which he had been summoned by the prosecutor in a criminal case. The deputy district attorney wanted his cooperation as a witness, but the inmate did not wish to assist her, and angrily insisted on terminating his discussion with her.

The Court Services deputy sought to defuse the situation by returning the inmate to the holding tank. When the prosecutor asked that the inmate be brought back for more questioning in spite of his reluctance, and then involved the deputy's supervisor in her request, a clash resulted. The deputy, who was admittedly frustrated with the prosecutor's actions, allegedly raised his voice and made his points in a fashion she found condescending and highly offensive. She later filed a complaint against the deputy, and the Department initiated an internal investigation.

As a result of a unit-level investigation, the Department determined that the deputy had violated policy in three distinct, if minor, ways, and expressed its intent to suspend him for three days as a result. The thrust of the discipline revolved around the finding that the deputy's concerns, while legitimate, had not been raised or handled in an appropriate way. (OIR agreed with this result in terms of both findings and discipline.)

It was at this point that the deputy contacted OIR and requested its involvement in monitoring the grievance process. This was unprecedented. However, the deputy's challenges were not only deeply felt, but also turned on legal arguments as to the legitimacy of the prosecutor's initial request, and the potential pitfalls to the Department of essentially forcing an angry and uncooperative inmate to submit to a witness interview. He believed that the presence of OIR's lawyers could potentially clarify the issues.

The Department eventually agreed to this arrangement, and OIR attended the grievance along with the deputy, his union representative, two peer representatives, the Chief of Court Services, and the deputy's Captain. The meeting lasted a full two hours, and the deputy had every opportunity to present his side of the story and respond to the Department's concerns. He did so thoughtfully and respectfully, and did succeed in softening the Department's position – slightly. However, he was unwilling to accept the compromise offer made by the Department, and expressed his intention to appeal the discipline to the county's Employment Relations Committee.

The outcome – or rather the failure to resolve the case – seemed regrettable. One of OIR's biggest concerns about the discipline process is how lengthy it can often be, with the exercise of rights coming at the expense of closure in a way that undoubtedly puts strains on both sides. At the grievance attended by OIR, the deputy received due process in a way that reflected well on the care and patience of everyone involved. OIR also believed the Department's position to be reasonable, but the deputy believed otherwise, and will now apparently exercise his rights at the next level.

OIR certainly recognizes the legitimacy of the deputy's continued desire to pursue the principles of his appeal. Moreover, and more important than the specifics of the final result, OIR appreciates the deputy's willingness to break from usual practice and include OIR at this important but previously (and still typically) cloistered stage of the discipline process.[3]

Settlement Agreements

In our Second Annual Report, we discussed LASD's lack of ability to track and enforce agreements entered into to settle disciplinary actions that, as part of the settlement, imposed conditions such as counseling or substance abuse treatment. (Second Annual Report, at pp. 62-67.) We identified several reforms that OIR suggested, and LASD agreed to implement. These included a central unit to act as a repository for all agreements requiring such remedial measures, a tickler calendar system to monitor compliance and provide periodic reminders to supervisors to check on compliance, and a unit responsible for contacting supervisors when an employee is not in compliance with a remedial settlement agreement. These were all implemented.

LASD also agreed to implement standardized language in the settlement agreements requiring the employee to provide proof of compliance with the remedial measures. This past year, OIR discovered that this reform was not fully implemented. Some agreements had the proposed language, but others did not. This made some of the settlements potentially more difficult to enforce because this

[3] While OIR does not regularly attend Skelly or grievance hearings, the presiding LASD Captain or Chief does routinely contact OIR with an account of what occurred. This allows OIR to stay abreast of important developments in each case, albeit indirectly.

placed the burden on LASD to prove non-compliance with the agreement. Also, some of the agreements lacked the waiver of confidentiality necessary for LASD to verify compliance with requirements of attendance at counseling sessions and other programs. These agreements therefore continued the previously identified problem of imposing remedial measures on employees, but leaving LASD without the ability to verify whether those remedial measures were completed.

OIR followed-up with the interested parties in the LASD. This culminated in a meeting with all relevant LASD units to hammer out final, standardized language. Ultimately, LASD created clear, standardized language upon which to base its settlements. This form both places the burden on the employee to show completion of the remedial measures, and allows LASD the access it needs to verify that completion.

This experience highlighted the importance of OIR's ability to follow-up on the implementation of promised reforms. Those familiar with other forms of law enforcement oversight are also likely familiar with situations where reforms have been recommended, and even accepted by the agency, but there is no method to determine whether they have actually been implemented, and once implemented are continuing to be followed. Constantly shifting personnel in an organization as large as LASD, sometimes hinders efforts to make a change and have it stick.

One of OIR's critical functions is to monitor whether reforms are actually implemented, and whether the implementation becomes institutionalized. Therefore, in the case of the settlement language, as in others, even though there is an agreement on the language, OIR will continue to monitor settlements to check for the inclusion of the agreed upon language.

Progressive Disciplinary Remedial Measures: The Apology

As stated in Part One of this Report, the deputies' public apology in the Compton shooting case was a development that OIR and many other observers applauded. OIR is pleased to note that, since last year's Report, other cases have produced statements of regret or efforts to correct the record in the wake of misconduct or poor performance. This effort to incorporate an "apology component" into the resolution of discipline cases is one that OIR will continue to promote and lobby the Department to use as an effective disciplinary measure.

C A S E

In one off-duty incident, a deputy drove while under the influence of alcohol and collided with a parked car. To compound matters, the deputy was uncooperative with the responding police officers from another department and when transported to the hospital for examination of minor injuries, was similarly uncooperative with hospital staff. The deputy received a thirty-day suspension as a result of this off-duty conduct. In addition to the suspension, the deputy agreed to author letters of apology to the police agency involved in his arrest and to the hospital staff for his poor conduct. In those letters, the deputy accepted full responsibility for his unprofessional behavior and commented about the "extreme professionalism" with which he had been treated by both groups.

C A S E

In another off-duty incident, a deputy was embroiled in a custody dispute with his wife. During that dispute, the deputy used his peace officer position to improperly access DMV information about two persons involved in the dispute. An internal investigation was initiated and it was learned that the deputy had improperly accessed the DMV information. It was further learned during the investigation that at one of the custody court hearings, the deputy had testified that he had not recalled running the DMV information for one of the persons. During the investigation, the deputy admitted to improperly accessing the DMV information and conceded that he had been mistaken when he testified that he did not recall running the information. In addition to a suspension, the deputy agreed to correct his earlier testimony about not having run the DMV records. In a written declaration submitted to the judge, the deputy "corrected the record" regarding his running of the DMV information.

These two cases are exemplary of remedial measures that better address misconduct than the typical measures used by LASD. Unfortunately, the vast amount of discipline imparted by LASD consists solely of suspensions or "fines" for the misconduct. Little or no thought is given to whether a remedial measure should be imposed in addition to – or even instead of – the suspension. While these fines may have a deterrent effect for similar misconduct from the deputy upon which it is imposed or other deputies who may otherwise be so inclined to stray from the core values of the organization, the suspensions are not tailored to the policy violation in any meaningful way. Moreover, such suspensions from work impact deleteriously on pure innocents of the policy violation, namely, the family members of the employee. Finally, the imposition of a suspension does little to remedy the root conduct that formed the basis for the violation of policy.

Rather than bureaucratically handling the above two cases by imposing suspensions, LASD (upon OIR's suggestion) agreed to focus more particularly on the "harm" caused by the misconduct and then tailored a remedy (agreed to by the employee) that more precisely remedied the harm. In the first case, the deputy recognized that the police and hospital staff that were required to deal with his inappropriate behavior deserved an apology from him. In the second case, the deputy similarly recognized that the judicial proceedings needed to be "set straight" as a result of inaccurate information he had provided.

By "accepting responsibility" for those actions and acknowledging that others were deleteriously impacted by their misconduct, the deputies accomplished a number of objectives. First, the police personnel, hospital staff, and participants in the judicial proceeding received what many wronged parties would most like to have: a simple statement of apology. Second, the willingness to accept responsibility and to apologize is an often difficult but invaluable admission from an individual and provides evidence that the person is truly understanding of the impact his inappropriate behavior may have had on others. Finally, such a statement enhances the reputation of the department as a whole — the fact that a peace officer had the decency and courage to admit he erred and apologize for his human fallibility is exemplary of a law enforcement organization consisting of persons of ultimate good will. OIR resolves to continue promoting this positive trend in applicable future cases.

LASD Personnel Who Plead "No Contest" to Serious Criminal Offenses Sometimes Escape Discipline

Years ago the California legislature passed a statute that allows state employees to be disciplined where they have been convicted of certain offenses. Government Code Section 19572(k) provides that all state employees, including law enforcement officers such as state corrections officers and California Highway Patrol officers, can be disciplined for convictions involving crimes of moral turpitude. These crimes generally involve dishonesty, moral depravity, or a willingness to do harm to others, including child molestation. The California legislature believed that the seriousness of such crimes necessitated discipline for state employees who suffered such convictions, even if the employee pleaded "no contest" to the charges.

Importantly, under this approach, it is the conviction itself that establishes the basis for discipline, thus eliminating the employing agency's need to prove separately that the misconduct occurred. The state statute allows for discipline even in cases where the employee pleaded no contest to a misdemeanor. For example, in a case where a state employee pleaded no contest to misdemeanor fraud, citing this Government Code Section, a state disciplinary board allowed this conviction to be used as a basis to discipline the employee.

Employees of the County of Los Angeles, including LASD personnel, are not covered by this statute, which applies only to state, not county, employees. Regrettably, no similar statute exists that permits a no contest plea to form the basis of disciplining a deputy sheriff, a county employee. The California Court of Appeal has lamented this unusual void in the law, and suggested that elected officials remedy this by legislation:

> The failure of the Legislature to act in this area has created an anomalous situation. A conviction based on a nolo contendere plea can lead to the revocation of a chiropractor's license or the disciplining of a state employee but such conviction cannot be used to discipline a deputy sheriff. Since a public safety officer occupies a position of public trust and is therefore held to a higher standard than other employees, the Legislature may wish to consider permitting the disciplinary authority to consider the fact that an officer has been convicted based upon entry of a nolo contendere plea.

County of Los Angeles v. Civil Service Commission, 39 Cal.App. 4th 620, 629 n. 9 (2nd Dist. 1995).

Due to this loophole in the law, when LASD sworn personnel plead "no contest" to serious offenses, such as child abuse, these no contest pleas cannot be considered for purposes of discipline. Instead, if LASD seeks to move forward in addressing the misconduct through its disciplinary process, it must prove the allegations as if that plea had never occurred. Because the deputy is not bound by the plea, he can assert his innocence and put the burden of proof on the Department. As a result, a deputy can agree not to contest the evidence against him in a criminal proceeding and accept a conviction yet then vigorously contest that same evidence in a subsequent disciplinary proceeding. This anomaly seems inefficient at best and at worst a corruption of the judicial process.

This past year offered an extreme example of this phenomenon, when a deputy who had pled "no contest" to charges involving child abuse was able to challenge the Department's subsequent attempt to fire him – and prevail.

A deputy was charged with felony corporal injury to a child resulting in a traumatic condition, a felony offense. He plea-bargained and was allowed to plead "nolo contendere"[4] to a misdemeanor version of the offense. He was sentenced to 3-years probation, ordered to complete a 52-week child abuse treatment program, and was ordered to stay away from the 3-year-old girl he was convicted of abusing. However, the no contest plea meant that the Department did not have an automatic basis for firing him. Instead, it was forced to undertake an administrative investigation of the incident, in which, unlike in the criminal proceeding, the deputy defended himself vigorously.

LASD assessed the evidence from the criminal investigation and its own further work and decided to discharge the deputy. The deputy appealed his termination to a Civil Service Commission hearing officer. At his disciplinary hearing, due to the present state of the law, LASD was unable to use the deputy's conviction to support the discipline. Taking advantage of the inadmissibility of his no contest child abuse conviction, and taking an entirely different approach than he had in the criminal case, the deputy presented evidence to exculpate himself. The deputy hired experts, who never personally examined the child's injuries, which were burst blood vessels on her face. The deputy's experts testified that the injuries were not caused by abuse, but by the child's crying, sneezing, or an infection. LASD countered this evidence by calling physicians who had personally examined the child's injuries. These physicians stated they believed the injuries were most likely caused by an adult covering the 3-year-old child's mouth and asphyxiating the child. The child had alleged that the deputy had covered her mouth. Nonetheless, the hearing officer found that LASD had not met its burden to establish child abuse, and the deputy got his job back.

Ironically, if the deputy had been employed by the state and not the county, his conviction would have been admissible, and the hearing officer would have been able to consider it. We cannot predict what the outcome would have been had the hearing officer been able to consider the deputy's conviction; however, there is no doubt that the deputy was in a much better position because he did not have to admit the fact that he had been convicted, and this advantage may have affected the outcome. More importantly, the ability of the deputy to accept the evidence against him in the criminal case and then to deny that he committed any misconduct in the administrative arena, resulting in inconsistent results, indicates two systems that are not in synch with each other. This is a discrepancy that probably merits legislative attention. In the meantime, though, participants in both the

[4] "Nolo contendere" is a Latin term which literally means "I do not contest it." Legally, it means that the defendant does not contest that the evidence presented against him would establish his guilt.

criminal justice system and the disciplinary system should be alerted to the potential for inconsistent results in an effort to devise resolutions that will not be anomalous.

Drug Testing Case

In late 2004, a civil service hearing officer suppressed evidence of a Narcotics detectives positive urine test for methamphetamine, resulting in the detective, who had been discharged because of the positive test, getting his job back. The hearing officers suppressed the positive urine test because he found that the department had failed to abide by procedures to safeguard urine specimens according to the Memorandum of Understanding ("MOU") between the deputies' union and the department. Although there was no evidence that the urine sample belonged to anyone other than the detective, the hearing officer believed that he had no choice but to exclude the test, citing a provision of the MOU, Article 28, Section VI, paragraph F, which states that "Drug testing results are inadmissible without audit trail showing compliance with each aspect of procedure. Burden of showing compliance is on the LASD or the Bureau." Because the MOU does not define "audit trail," or "procedure," or explain which "aspect(s)" of procedure that required compliance, this provision was somewhat ambiguous, and the hearing officer acknowledged this. In the end, though, he found on behalf of the officer nonetheless, and the Civil Service Commission upheld the ruling.

Needless to say, each employee working in the drug testing program or the lab should become familiar with the provisions of Article 28 of the MOU, the Random Drug Testing Program, which sets forth the procedures to collect and test urine samples, and ensure that the program complies with each aspect of this provision.[5] The department's failure to follow the procedures concerning handling urine samples in this case resulted in a detective who had apparently been under the influence of methamphetamine getting his job back.[6]

[5] One other disappointing aspect of this case is that each department member involved in the drug testing program, including a commander, testified that he had never even read Article 28. At any rate, it would also behoove the Department to revisit the MOU, which is outdated and should be revised to reflect more reliable tests and advances in technology since the agreement was first adopted.

[6] In fairness, we note that the detective's claim was that any ingestion of methamphetemene was job-related and accidental; however, this contention was never adjudicated by the hearing officer, who before even hearing this issue suppressed the evidence of the positive test.

Courtroom Security and Violence

An examination of one case regarding courtroom violence on which the media reported earlier this year provided a window into the security issues that LASD's Court Services deputies face as they provide a law enforcement presence for the entire county court system. In March 2005, a "high security" inmate who was housed in one of the county jails appeared in a Superior Court room at the San Fernando Superior Courthouse regarding his double murder jury trial. During the trial, the defendant inmate inflicted a two and one-half inch cut to the arm of the alternate public defender with a razor blade. The inmate then tossed the blade, and deputies took control of him and escorted him from the courtroom without further incident.

Certainly, the episode raised questions about whether LASD deputies, who had responsibility for the inmate at his jail facility, during his trip to court, and throughout his stay in the courthouse, had followed the appropriate protocols to prevent such an attack. However, the subsequent inquiry established that the Department had shown due diligence at all of the potentially relevant points. LASD personnel had conducted the appropriate searches and, based on their previous assessment of the inmate as a security risk, made the appropriate requests of the presiding judge for full restraint of the inmate during trial.

It appears that the razor blade used in the assault had been removed from the razors distributed within a jail facility. Pursuant to Title 15, Article 12, Section 1265 and Department policy, all inmates are allowed to have razors for shaving purposes; however, once a razor blade is removed from the razor, the razor blade becomes contraband.

Historically, there was little information which foretold of the inmate's attack in the courthouse. From 2003 through March 2005, the inmate had made 35 court appearances at the San Fernando Courthouse, and during that time, he had never displayed any violent or assaultive conduct within the courthouse toward deputy personnel. On several occasions, the inmate had tried to escape from custody both at Men's Central Jail and the San Fernando Courthouse; however, on none of those escape attempts was violent.

Prior to the start of the trial, LASD personnel reviewed the inmate's jail history and, based on the inmate's prior assaultive behavior toward LAPD officers and escape attempts, they made a request to the presiding judge that the inmate be handcuffed and leg chained during the jury trial. However, at a hearing where the inmate was represented by the alternate public defender who advocated against the use of such devices, the judge declined LASD's request.

When the inmate arrived at the courthouse on the day of the attack, he wore a "black box" and ankle chains that limited the movement of his arms and legs. The inmate did not walk through the metal detector because his chains would activate the alarms. For safety reasons, the inmate was temporary placed in a cell until LASD personnel could search him. Prior to placing the inmate in the cell, LASD personnel searched the cell, and after placing the inmate in the cell, LASD personnel thoroughly searched his person. After this search of the inmate, LASD personnel handcuffed one of his wrists to the waist-chain, allowed the other hand to remain free and left the inmate alone in the cell.

Shortly, before escorting the inmate into the courtroom for the beginning of trial, LASD personnel transported the inmate un-handcuffed from the cell to a glass-enclosed attorney interview room, and the inmate remained alone there for several minutes. Before the inmate entered the attorney interview room, LASD personnel searched the room. When the inmate appeared in court for trial, two LASD deputies were present in court for additional security. At one point during trial, the inmate stood up, and a deputy placed a hand on the inmate's shoulder and guided him back into his seat.

During a morning recess, the two deputies present in court renewed LASD's request that the inmate be handcuffed and leg chained. In response to the request, the judge held a formal hearing and during the hearing, approved the use of a "stealth belt." During the hearing, the presiding judge ordered the application of the least visible restraint to keep the inmate in his chair. The judge stated: "There would be no shackling, and just a strap to keep [the inmate] connected to the chair." LASD personnel and the inmate returned to the attorney interview room, and in that room deputies fastened the stealth belt around the inmate's waist. After LASD personnel fastened the stealth belt to the inmate, they returned him to the courtroom. While the inmate wore the stealth belt, his hands remained free.

Within 60 minutes after returning to court, the inmate cut his alternate public defender's upper right arm with the razor blade. The inmate immediately tossed the razor blade onto the floor, and the deputies immediately restrained and handcuffed him and then, without further incident, escorted him out of the courtroom. At the beginning of the next session of trial, the presiding judge conducted a hearing and ordered LASD personnel to fully restrain the inmate for the remainder of the trial and the use of the safety chair.

This case highlights the inherent tensions between maintaining court room security and ensuring that the defendant's right to a fair trial is not prejudiced by the jury viewing him manacled and in chains. (Ironically, because of the configuration of a courtroom, it is the defense attorney who is the most vulnerable to attacks by his or her client.) It also offers insight into the complexity of the inmate classification system and the coordination between divisions of LASD in order to maintain proper security. In this case, as evidenced by the expressed appreciation by the alternate public defender to courtroom deputies, LASD personnel performed to the standards expected of them.

PART THREE Issues in the Jails

Inmate Escapes

In the typical day, fifteen to twenty thousand inmates reside in the county jail system, and each day a large percentage of them are on the move: in and out of the system itself as new arrivals or releases; back and forth from courts across the county for appearances in pending cases; and to and from the different jail facilities themselves due to transfers, medical or mental health issues, or space considerations. There is also extensive daily movement within each facility, as inmate workers perform their assigned tasks, and other inmates travel to meet visitors, see their attorneys, attend classes or receive counseling. In some limited circumstances, inmate crews actually work outside the confines of the jail buildings themselves. They perform routine maintenance of the grounds around the downtown jail complex, for example, and are largely responsible for staffing the massive laundry operation at the north county Pitchess Detention Center complex. They are regularly "loaned out" to courtroom facilities for the day to serve as workers there, and have considerable latitude to move around the grounds without direct monitoring or supervision. They also serve as trustees at individual patrol stations.

Not incidentally to all this movement and activity, they also escape – at least temporarily. In a recent ten-month period (November 1, 2004 through September 30), there were nineteen incidents classified by the Department as "escapes." Some of these occurred during the booking process with new arrestees, and many involved inmate workers at patrol stations who simply walked away from their posts. Seventeen of the nineteen were re-captured – most within a day (or even minutes) of their attempt. Many of the episodes were straightforward and easily resolved – such as the newly arrested suspect who escaped after kicking out the window of a patrol car, and was immediately apprehended by the handling deputies. However, in OIR's view, each escape should receive close scrutiny from the Department in terms of both accountability for personnel and possible weaknesses in the relevant systems or protocols.

What follows is a look at some of the incidents that OIR followed with special interest, and the outcomes of those cases.

Laundry Worker Escapes

North Facility is one of the three separate jails currently operating in the Department's large ranch near Santa Clarita. This July, it experienced two escapes within a week when inmates assigned as laundry workers walked "off the job" and attempted to make it off the sprawling grounds toward freedom in the surrounding communities. One was re-captured within hours; the other remains at large.

Reviews of the incidents are not yet final, but the early results of investigations conducted by both Internal Affairs and Custody Division have not led to allegations of misconduct on the part of individual officers. Instead, the system worked as it was supposed to, and still did not prevent the inmates from escaping.

This is because the electronic monitoring system at the North Facility, designed in light of the inmate workers' extensive freedom of movement on the grounds of the complex, had limited goals. It is meant to alert deputies when an inmate damages his electronic bracelet or breaches the perimeter while wearing it. It gives notice, but at best is meant to promote a speedy response and perhaps serve as a deterrent. It does not, however, physically stop a determined inmate from running at an opportune moment. At best, it limits the extent of the inmate's "head start." And even this is compromised by the need to go through procedures that eliminate the possibility of false positives and help the deputies determine who specifically has gone missing.

LASD executives explain that, in an earlier era, this was an appropriate level of security that balanced the risks of escape against the formidable staffing requirements of the laundry – an operation that processes thousands of pounds of county bedding, towels, and clothing per day. A substantial portion of the inmates were, by nature of the crimes they had committed or the charges they faced, considered negligible flight risks, and not particularly dangerous to society even if they did decide to flee. Budgetary constraints and other variables have made that category of inmate more of a rarity in the county jail system. Now, LASD must lower its eligibility requirements and accept an "edgier," potentially more dangerous class of inmates as laundry workers in order to continue to fill the inmate worker staffing needs. As a result of these changed circumstances, the premises upon which the adequacy of electronic monitoring once rested are no longer fully applicable.

Accordingly, LASD executives made the decision to install fences that will surround the laundry operation at a height of twelve feet. It is a step that makes obvious common sense, and should reduce the small number of annual laundry escapes at North.

Escape from Court (Classification Issues)

In May of 2005, an inmate with an extensive criminal history – escaped from the Clara Shortridge Foltz Criminal Justice Center in downtown Los Angeles. He had left North County Correctional Facility at approximately 6:00 AM that day on a Sheriff's Department bus in order to appear in court at the Foltz building. As is a regular practice with inmates in the courthouse – whose hearings might occupy only a small portion of the day before return trips to the jail facilities begin, LASD personnel in the courts apparently utilized him as a worker performing light janitorial duties. Taking advantage of this relative freedom of movement, the inmate found a way to leave the courthouse without detection.[1]

Interestingly, it was not until after 8:00 the next morning that the responsible personnel finally determined that the inmate was physically gone. Such is the scope and complexity of the daily LASD movement of inmates that his failure to return from court on the last bus – which did not reach NCCF until approximately 11:00 PM – had provoked interest but not alarm. It was not uncommon for paperwork to trail the actual movement of the inmates within the system, and the personnel at NCCF realized that several benign explanations (such as a medical issue) could explain inmate's absence. Deputies did, however, begin making inquiries and conducting counts within the facility in an attempt to find him, and were obviously unsuccessful.

At that point, a two-pronged investigation began. Detectives from the Major Crimes Bureau led the effort to re-capture the inmate, who faced a variety of erious charges including kidnapping and car theft. Investigators and search teams took a variety of approaches and worked on a round-the-clock basis. They eventually tracked Taylor to the Atlanta, Georgia area, where a team arrested him less than three weeks after the escape.[2]

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1 The inmate's specific method of escape continues to be subject of investigation, but at least two plausible theories have emerged: that he obtained clothing from a storage closet that allowed him to blend in with the line of inmates slated for release, or that he secreted himself somewhere in the building until it was closed for the night and he could leave at his leisure.

2 OIR did not actively monitor this investigation, but did learn subsequently about some of its components. While the operation's success speaks for itself, the energy, creativity, and determination of the Major Crimes Bureau in apprehending the escapee deserve separate acknowledgment.

In the meantime, investigators from Internal Affairs (as well as supervisors within the Custody Division) sought to unravel the circumstances of the escape for evidence of systemic failure and/or personnel lapses. Their inquiry, which is still ongoing, eventually developed two main focal points:

> *At NCCF:* Given the severity of the inmate's alleged crimes, and his high bail at the time of escape, why was he eligible to serve as an inmate worker at the court rather than subject to a higher level of security?
>
> *At the Foltz Building:* Even though the inmate was serving (perhaps improperly) as an inmate worker, with accompanying freedom of movement, should other safeguards have prevented the escape from occurring?

OIR will report the outcomes of these investigations after their completion. In the meantime, the response illustrates causes for concern and the value of LASD's holistic assessment of incidents such as this.

Deputy Negligence

In October of last year, a nineteen year-old inmate went to Henry Mayo Hospital for treatment of injuries he received in an attack by other inmates at one of the Pitchess Detention Center facilities. In keeping with normal procedure, the facility assigned one deputy the sole responsibility of monitoring that inmate in his hospital room. Nonetheless, the inmate escaped. Deputies from nearby Santa Clarita station apprehended him later that same day, but not before he had assaulted and seriously injured a homeowner in one of the adjoining neighborhoods.

According to the deputy's account, the inmate had been in the bathroom in the middle of the day, and upon emerging had surprised the deputy by shoving a walker in his direction and then fleeing out the door of the hospital room. The deputy claimed to have made an effort to follow him before communicating the situation to others and requesting assistance.

The inmate, however, told a different story after being re-captured. He claimed that upon leaving the bathroom he observed that the deputy was preoccupied with a computer that was in the room. He took the opportunity to gather some of his own effects and slip out without the deputy even noticing. Then he fled out of the hospital through an alarmed door.

In the ensuing Internal Affairs investigation, the nursing staff at the hospital corroborated the inmate's account. They said that the alarm alerted them, but that they entered the room to find the deputy at the computer, looking confused and unsure of what had happened. Investigators subsequently performed an analysis of the computer's activity for the day, and found that the timing and content of that activity suggested a distracted, preoccupied officer who was still "logged on" when the escape occurred, in spite of his assertions to the contrary.[3]

OIR monitored the investigation in keeping with its usual protocols. The evidence-gathering and interviews were particularly thoughtful and effective, and the finished case proved that the deputy had been negligent in watching over the inmate and had compounded that mistake through a false account of his actions. OIR concurred with the Department's decision to discharge the deputy.

Force and Integrity Issues in the Jails

Though shootings almost never occur in the jails (in fact, for safety purposes in the jail environment, custody deputies do not even carry guns), significant force is common and often results in injuries. Deputies routinely are required to use pepper spray, physical holds, or personal weapons (hands and feet) in order to subdue individual inmates who attack LASD personnel or each other. Occasionally, a large-scale dorm disturbance leads to the deployment of gas, pepper balls, "flash bang" devices, and other less-than-lethal ordnance. Tactics, training, risk management, and sometimes discipline are all potential focal points of Department concern when such force occurs.

The Department has extensive protocols for reporting and reviewing all force, including force used in the jail facilities. The custody context adds to the complexity of this analysis: the inmates, as a group, can obviously be more dangerous and hostile to the deputies than the community at large. Antagonisms and conflicts with the deputies are inherent. At the same time, the inmates are more vulnerable than the average person – locked away, often discredited in the claims or allegations they make, and very much subject to the control of the deputies who guard them.

[3] The computer analysis that occurred in conjunction with the investigation also revealed that much of the deputy's on-line activity involved sexual content prohibited by Department policy. A separate investigation involving separate conduct by the same deputy established that, on another occasion, he had inappropriately stored pornographic content on his Department computer.

Each year, OIR reviews a number of force incidents from the jails as part of its regular protocols. When injuries to the inmates are sufficiently serious (broken bones, flashlight strikes to the head) to warrant a roll-out from Internal Affairs, OIR receives notification and has the opportunity to respond to the scene and track the ensuing investigation. Force incidents sometimes lead to administrative investigations as well, out of concern about the necessity of the force or the propriety of the deputies' tactics. Additionally, OIR receives requests from the ACLU or other outside contacts that it monitor specific force investigations, based on allegations of impropriety from the involved inmates. These cases give OIR the opportunity to audit the regular LASD force packages for thoroughness and completeness – and sometimes to push for additional inquiry.

What follows is a discussion of two cases that represented some of the issues involved in custody force analysis.

CASE

In July of 2004, an inmate at one of the Pitchess Detention Center facilities was walking in the corridor and allegedly flashed gang signs at the inmates in one of the large dorms. Told to stop by one of the deputies, the inmate ended up punching the deputy in the face and injuring his eye. This began an extended fight in which several responding deputies used force while the inmate continued to struggle. Meanwhile, the commotion incited a major disturbance in the adjoining dorm, as inmates pelted the deputies with whatever materials they could reach. The inmate received a broken leg in the skirmish, and was transferred to another facility. Though he admitted punching the deputy, he claimed that he had been provoked, and alleged that much of the force took place after he had stopped resisting.

LASD (and OIR) reviewed the force extensively, making sure that the many deputies involved had justification and sound tactics for the kicks, punches, and flashlight strikes that were used in subduing the inmate. Conflicting information in the supplemental reports prompted an Internal Affairs investigation. The additional interviews and scrutiny of involved personnel did not succeed in clarifying a problematic discrepancy, but also found no definitive evidence that the mistakes in reporting were intentional or a sign of wrongdoing.

Several weeks after the fight, the deputy who was punched went, in uniform, to the inmate's new location. A partner who had not been involved in the force incident accompanied him. The two took pains to locate the inmate and engage in a brief exchange with him, the contents of which remain in dispute.

To reviewers of the case, however, the subtext of the visit was clear – an effort at intimidating an inmate whose own force had injured the deputy, and who had made allegations against that deputy and others for improper treatment relating to the incident. At worst, it was the sort of "old school" bullying that LASD has worked hard to eliminate. At best it was a gross error in judgment: an unprofessional and unnecessary act of curiosity that gave the inmate ammunition for his various claims. Though the serious false statements and obstruction charges were not proven, the deputies each received a 20-day suspension for placing themselves in a situation where inappropriate attempts at coercion could be credibly alleged.

CASE

In one significant case in 2005, a deputy in a custody facility kicked a handcuffed and hobbled inmate. (Hobbling is where deputies place a cord, known as a rip hobble, around an inmate's legs to prevent the inmate from kicking.) The incident began when the inmate was found wandering unescorted inside a jail clinic, which was a violation of procedures. Deputies escorted the inmate to a bench, where they were going to secure him to prevent his wandering. The inmate began struggling, kicking and swinging his arms at the deputies, who handcuffed and hobbled the inmate.

While the deputies were escorting the inmate to an isolation cell, the inmate placed his legs against the doorframe to prevent the deputies from taking him into the cell. The inmate fell to the floor. While other deputies attempted to carry him into the cell, the subject deputy began to kick and kicked at one deputy, who blocked the kick with his foot. A sergeant at the scene ordered him to stop, but the deputy continued kicking until ordered to stop a second time. He kicked the inmate a total of four to six times. The incident was witnessed by a second sergeant, who at OIR's suggestion, was also interviewed. Each sergeant was of the opinion that the deputy's kicking was unreasonable and unnecessary. The deputies' kicks were described as full, wind-up, soccer-style kicks. The force caused contusions to the inmate from his hip to his upper back. One sergeant stated that he believed the deputy used unreasonable force because he lost control of his emotions.

In recounting the incident over a short period of time, the deputy altered his statement, further worsening the situation. At first, the deputy reported he only kicked the inmate once. Later, the deputy reported he kicked the inmate two or three times. In his last report, the deputy stated that the force he used was two to three "quick jabs" with the top of his foot, suggesting that he did not really kick the inmate at all, but only pushed him. In light of the two sergeants' statements, which corroborated each other, and contrasted significantly with the deputy's version, the deputy was found to be in violation of department policies – unreasonable force, false statements, general behavior (conduct unbecoming an officer), and obstructing an investigation – and was disciplined.

Dealing with "Recalcitrant Inmates" at NCCF

In the last several months, supervisory personnel from the captain down to senior deputies at NCCF have made a concerted effort to promote adherence to a "unit order" from 1998 that is designed to defuse tense situations before they escalate into serious violence. The order guides the response of deputies who are contending with a "potentially violent inmate," which the order defines as "any inmate who refuses to comply with orders from personnel, demonstrates hostile behavior, or has been diagnosed or is believed to have a mental disorder." It obligates the deputies, time permitting, to wait for the presence of a supervisor and a video camera and then move the inmate to a designated disciplinary module.

The order is meant to ensure a "planned and coordinated resolution." It also seeks to limit instances of deputies acting spontaneously and attempting to pull inmates aside for "counseling sessions" or other informal intervention that too often ends in a fight. (In fact, OIR has reviewed more than one case in which the inmate claims that he only began to resist when brought into a dayroom because he "knew what was coming.") Because inmates are very capable of sudden recalcitrance, anger, and refusal to cooperate, it is important for the deputies to step back when possible rather than following an impulse to engage and address the problem right away.

Allowing additional personnel to arrive and following a calm and orderly protocol does not eliminate the possibility or necessity of force in all situations. It does, however, improve the odds of a smooth and successful outcome. And it makes a great deal of sense from the perspective of both officer safety and risk management.

While the order has been in existence since 1998, high turnover among the deputies and some ambiguities in the language have led to stretches when it was not a prominent part of the facility's strategy. That has recently changed. In an effort to reduce the amount of force and prevent abuses of authority, the order's language is being broadly interpreted and supervisors are communicating their expectations through briefings and strict enforcement of it.

CASE

As meals were being distributed for his dorm, an inmate refused to get off his bunk and join the line. A deputy entered the dorm to investigate and decided after a brief conversation to remove him to a dayroom – without notifying a supervisor. A fight ensued in *the dayroom, and the inmate ultimately received a broken leg before deputies were able to subdue him.*

In the investigation of the incident, the deputy maintained that he did not consider the inmate "potentially violent," but that he instead seemed medically or mentally impaired. The deputy claimed he was just re-locating the inmate until he could devote more attention to him. However, in the immediate aftermath of the force, he had told a responding sergeant that his intent was to "counsel" the inmate, and other aspects of his conduct seemed more consistent with an informal attempt to handle a recalcitrant inmate.

The Executive Force Review Committee determined that, while the force was in-policy as justified by the inmate's actions, the deputy had violated the facility unit order. He received a five-day suspension.

CASE

When deputies entered a dorm to perform an early morning count, one inmate woke up suddenly and verbally lashed out at the deputies. The deputies later decided to "roll up" the inmate and send him to disciplinary housing in response to his outburst. However, after getting approval to do this, the deputies then entered the dorm and got into a struggle with the inmate, who refused to leave his bunk. Without adjusting their plan or fully implementing the requirements of the "recalcitrant inmate" unit order, the deputies then took the inmate to an adjoining day room, where a serious fight ensued. The inmate's jaw was broken.

The Executive Force Review Committee determined that, while the force was in-policy based on the inmate's resistance, the deputies had failed to meet the standard of the unit order and had used poor tactics, "thereby escalating the situation." Two deputies received minor suspensions, and a senior deputy, who observed the incident and failed to appropriately intervene, was also disciplined.

These were not the only instances in which NCCF personnel received discipline or were subject to investigation in conjunction with the unit order. Ideally, however, there will be fewer such investigations in the coming months – and fewer force incidents – as the emphasis on the unit order continues to pay dividends. The unit order makes sense and stresses fundamental principles of deliberation, organization, and supervision. OIR applauds the renewed commitment to it.

PART FOUR OIR Issues: Updates and Further Developments

Update on LASD: Response to the Jail Homicides of 2003/2004

In the OIR Third Annual Report, we reported about a series of five inmate- on-inmate homicides that occurred in Men's Central Jail and the Inmate Reception Center between October 2003 and April 2004. We also published a lengthier special report on the topic in October of 2004 entitled "OIR Evaluation and Recommendations Concerning Sheriff's Department Investigations of Five Custody Homicides." It details the LASD investigations of the jail events and the circumstances that surrounded them, the administrative discipline that resulted and the active OIR oversight of this process. Following its evaluation of the systemic shortcomings that may have contributed to the inmate homicides, OIR also presented specific proposals for procedural and policy reforms to the Custody Division executives. The proposals represent a pragmatic approach to preventive maintenance. Many were developed in consultation with Custody Division personnel.

OIR can report that, in the 16 months since this series of homicides, there have been two inmate-on-inmate homicides at Central Jail. Neither of them had the sinister quality of nor exposed the systems failures identified in the previous five killings. One resulted from a spur of the moment pushing match between two trustees when one fell backwards over an object and struck his head. The other was the result of a very minor fist fight which apparently aggravated the extremely severe pre-existing head injury of one of the participants.

In the months since first publication of this special report, much of the related discipline of Department personnel has run through the grievance or appeal process. Many jail policy and procedural reforms have been planned or implemented. This section is intended to provide an update on the systemic reforms recommended at the conclusion of the investigations involving the five inmate homicides.

Discipline

Twenty-five employees of the Sheriff's Department originally received a notice of intent to discipline from the Department in connection with these investigations. They ranged in job title from Custody Assistant to Lieutenant. The initial discipline ranged from 3 days suspension to 15 days. After the process of grievance, appeal and sometimes settlement, the factual finding as to three Deputies was modified to unresolved or unfounded and the initial discipline was rescinded. The findings as to the remaining employees remained mostly intact, but in several of the cases, the length of the suspension was significantly reduced.

OIR viewed some of these reductions as appropriate and conferred with Custody executives about them. Others however did not seem consistent with the facts and OIR did not concur with these reductions in discipline, as reflected in our case tracking charts for the last quarter of 2004 and the first two quarters of 2005. Overall however, OIR can report that the LASD held firm to the basic principle of imposing discipline for negligent handling of work duties in the custody setting.

It is also relevant to the safe operation of the jails in the future that the Homicide Bureau's investigations of the suspected perpetrators of the homicides resulted in the District Attorney's Office filing murder charges against six defendants involved in three of the five killings. These three cases are currently pending trial in the criminal courts.

Policy and Procedures

The following are the major "Systemic Recommendations" made by OIR in 2004, with notes about progress made.

1. *Provide feasible objective criteria for the selection of inmate workers in the modules. Require supervisory approval of inmate worker selection and require documentation of selection and disqualification.*

Guidelines were developed and implemented for Men's Central Jail that include all three of the components in the above proposal. For the first time, the guidelines formally recognize the existence of informal inmate workers selected at the module level as distinct from the formal and segregated trustees, and provide workable limits on their selection. OIR recently requested that this policy be applied system-wide to all custody facilities. This has been done. {The policy is attached below.}

2. *Make permanent the practice of not using dayrooms for housing.*

5-01/025.00 HOUSING AREA INMATE WORKERS

Inmate workers assigned to housing areas shall be screened by housing area personnel and shall require final approval from the floor sergeant prior to being permitted to work. This screening shall consist of a review of the inmate's current security level and discipline history in the Incident Report Tracking System (IRTS) during the time of his/her current incarceration period. The following shall be disqualifying factors for candidates being considered for inmate workers:

- Previous discipline for assaults against staff and/or inmates,
- Previous discipline for serious acts of insubordination,
- Security level of 8 or 9.

Housing area personnel shall note the inmate(s) selected to work in their assigned housing area in the Title 15 Uniform Daily Activity Log (UDAL). This information shall be noted under each shift and shall include the inmate's name, booking number, and security level.

Variations from the above guidelines shall have Watch Commander approval at the permanent rank of sergeant or above. Unit Commanders shall have the discretion to be more restrictive, however the above criteria shall not be made less restrictive.

Following the jail homicides, one of which occurred in a crowded Men's Central Jail ("MCJ") dayroom, jail authorities reduced the number of inmates in all dayrooms, then quickly phased them out as a housing location. This is an important preventive step since the large MCJ dayrooms, most equipped with only one toilet and sink, had become the default repository for as many as 70 inmates at a time. The dayrooms were also difficult for jail staff to monitor because they were not designed with observation booths. For over a year, MCJ has kept the dayrooms clear of inmates except for small numbers during the daytime, however, recently, as a result of the Department's push to eliminate "floor sleepers", OIR has observed an intent to reopen several day rooms for limited housing. This phenomenon is exemplary of the continued pressure faced by LASD jail executives who have too few beds for the inmates in its custody. No ideal solution emanates from this situation -- there is a potential harm to society with early releases yet no inmate should be required to sleep on the floor, and the day rooms were not designed as sleeping cells. Currently, the Captain's order puts a twenty-Inmate cap on dayroom populations. Because of the potential creep in population that occurred in dayrooms in the past, OIR intends to continue to monitor the dayroom population. While it may be safe to house a small number of inmates in day rooms, the limited abilities of jail staff to observe day room activity mandates careful watch of that number.

To be fair, the response by LASD to attempt to reduce or eliminate "floor sleeping" (inmates who are housed in the jails but do not have a bunk assignment and sleep on a mattress placed on the floor) has been motivated by ongoing litigation by inmate plaintiffs challenging the practice. Whatever the Department's motivation, OIR supports a jail housing system in which there are sufficient beds for inmates to be up off of the floor of the jails and in housing which can be appropriately monitored

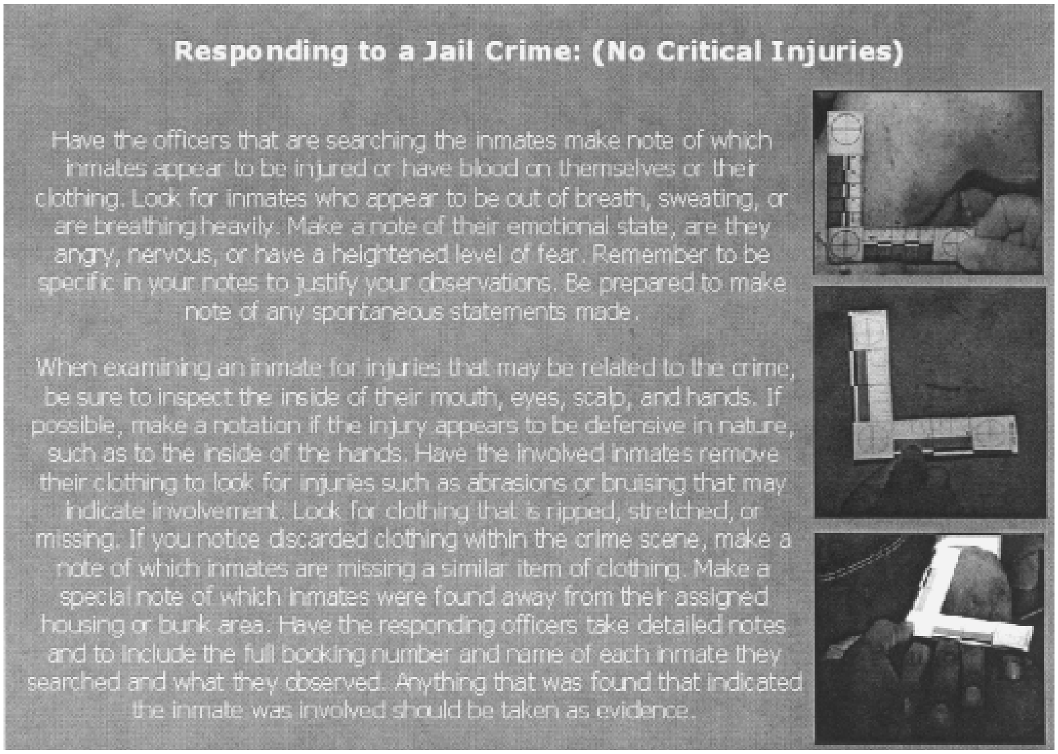
3. *Ensure compliance with the new search matrix by placing responsibility on supervisors.*

Contraband weapons and jail-made alcohol were involved in four of the five homicides. Evidence showed that searches of many of the modules were too infrequent and that there was no coherent system to insure comprehensive searching. MCJ developed a matrix so that supervisors could actively track and plan searches. To date this system appears to have reduced the “neglected” areas and increased the number of searches in general. Cumulative statistics are frequently compiled and made available to all supervisors. OIR has recommended that the matrix be implemented throughout the Custody system, and the Division has agreed in principle. Some facilities already use a similar approach, but the Department has yet to standardize its method for insuring that no housing area goes unsearched for long periods of time.

OIR has observed that the matrix-based search method appears to work reasonably well for MCJ. OIR selected a random, unscientific sample of 12 cells and four dormitories throughout the facility. Approximately half of the housing locations had been searched within the previous two weeks. Half of the remaining locations had been searched within the previous 3 weeks. The remaining six cells had been searched within the previous eight weeks.

4. *Establish a protocol with the Department of Mental Health whereby an inmate who expresses a request or behavior that would trigger a referral to mental health should be reevaluated regardless of when they were last evaluated.*

Correctional Services and DMH executives agree that there is no rule or practice that requires or justifies a waiting period between mental health evaluations, but there has been no formal protocol. LASD had made no movement on this suggestion, but Custody executives report that their level of communication with DMH has improved greatly.



5. *Ensure that custody personnel receive adequate training in crime scene preservation.*

Correctional Services and Training Division have developed an extensive training module focusing on the responsibilities of deputies and supervisors to preserve evidence after jail assaults and other crimes. The training has been made available by computer to all personnel and the Custody Training Unit has incorporated it into their on site training. {See the attached excerpt from this training program.}

6. *Develop an effective notification procedure regarding release of inmates under investigation for other crimes.*

OIR is not aware of any new procedures to provide extra quality control in this area.

7. *Apply recent captain's order to follow LASD's hourly safety check procedure as a formal unit policy in IRC.*

This has been implemented as a formal unit order. {See attached order below.}

8. Require TSB deputies to check every part of the IRC holding cells when they enter to remove inmates for transport.

This has been reiterated as a required practice by IRC and inmate transportation unit supervisors, but not codified as a formal policy. OIR made this suggestion several months ago and there has been no adoption of a formal policy by Custody officials.

9. Make the recent IRC captain's order limiting the number of inmates in the holding cells into a unit directive that complies with the rated capacities of the cells.

The captain's order requires that a sergeant give approval before any holding cell population exceeds 20, but the maximum capacities of each cell have not been codified as a unit directive yet. Because Custody officials come and go, OIR believes it is important to formally adopt this directive on the number of inmates at the IRC holding units. OIR will continue to monitor this issue.

10. Execute long-considered plans to install a wire mesh screen between the two tiers of the MCJ module where one of the fatal stabbings took place during an inmate disturbance.

This repair job, aimed at reducing the possibility of large inmate disturbances on this module, has been recently completed.

11. Create a clear policy that holds module officers accountable for violations of the security level mixing rules.

Unfortunately, no policy has yet been drafted.

12. Require formal documentation procedures when the MCJ inmate housing assignment office issues instructions to rectify improper security mixing in a cell or module.

The housing office has developed its own informal practice of documenting instructions it issues by telephone. While this informal practice of documentation is certainly better than the situation ante when there was no documentation of these instructions at all, the jail would be better served by development of a consistent documentation procedure. OIR will continue to press on this issue.

COUNTY OF LOS ANGELES

SHERIFF'S DEPARTMENT

A Tradition of Service

DATE: July 11, 2005

OFFICE CORRESPONDENCE

FILE NO.

FROM: ANTHONY ARGOTT, CAPTAIN
INMATE RECEPTION CENTER

TO: CONCERNED PERSONNEL
INMATE RECEPTION CENTER

SUBJECT: INMATE RECEPTION CENTER UNIT ORDER # 76
HOURLY SAFETY CHECKS

This Unit Order establishes policy and procedures for the performance of hourly safety checks.

EFFECTIVE IMMEDIATELY:

Per Section 4-11/030.00, Inmate Safety Checks of the Custody Division Manual, all inmates in our custody shall be visually checked at least once each hour to ensure their safety and welfare. This includes all areas of security where inmates are held or detained. Checks may be required more frequently as directed by Medical / Mental Health Staff.

Per Title 15 Minimum Standards for Local Detention Facilities, Article 3, Section 1027, safety checks requires documented direct visual supervision of all inmates at least hourly. Safety checks are intended to provide for the health and welfare of inmates. Staff members must be able to see each inmate without the aid of audiovisual equipment to assure that he/she is alive and not experiencing any trauma.

Henceforth, hourly safety checks shall be conducted and documented by the designated Title 15 Compliance Officer or in their absence their designee assigned to each area of security. A supervisor, no lower than the rank of Senior Deputy, shall ensure these checks are completed and documented on each shift in the Uniform Daily Activity Log Books. In no case shall more than 60 minutes elapse between the hourly checks.

The locations where these security checks are to be documented include all holding areas of the New Side of the Inmate Reception Center, Old Side of the Inmate Reception Center and 231/232. The only exception to this procedure shall be in the instance the holding area is closed. In this case the time of closure and time of reopening shall be noted in the Uniform Daily Activity Log Book for the specific area.

Related Policy
Inmate Reception Center Unit Order # 73, Title 15 Compliance Officer
Custody Division Manual Section 4-11/020.00 Uniform Daily Activity Log
Custody Division Manual Section 4-11/030.00 Inmate Safety Checks
Title 15 - Crime Prevention And Corrections - Division I, Minimum Standards for Local Detention Facilities, Article 3. Training, Personnel and Management, 1027 Number of Personnel

AA:JMF:jmf

13. Deploy adequate personnel to ensure compliance with the spirit and the letter of Title 15 safety requirements.

State law requires an hourly check on the basic well being of each inmate and, for some inmates, greater frequency. In 2005, largely in response to additional appropriations from the Board of Supervisors to address this issue, Custody established dedicated "Title 15 Officers" for each module to make sure that this function receives adequate priority. Currently, the Department has approved 96 new posts (76 deputies and 20 non sworn custody assistants) to fulfill the Title 15 mission. The program appears to address an important need. Custody management has repeatedly expressed the belief that it has exceeded expectations. One noticeable benefit is the early interruption of inmate suicide attempts. Custody Support Services calculates that Title 15 Officers interrupted 23 attempted suicides in Mens Central Jail, Twin Towers, and the three North facilities in the first seven months of the program. OIR has observed that there has been only one successful suicide in 2005. This may point to a welcome reduction from the 4.5 suicides per annum average in recent years. LASD should certainly expand the Title Program Officer program accordingly as it reopens previously closed facilities.

In addition to the Title 15 personnel, the Department has pursued some promising technological means to improve inmate security. Custody Division has installed a new generation of video surveillance cameras in the inmate dormitories in one of its five north county facilities. The cameras are able to swivel and zoom and store all data for long periods of time. This pilot program should test the utility of the system to detect inmate assaults and other misconduct, assist in investigations, enhance inmate welfare, and deter future misconduct. The system has been operating for only a few weeks, but appears to show clear utility to assist investigations. In one instance, jail personnel studied surveillance tapes after discovering a severely stabbed inmate. The video showed evidence of inmates preparing for the assault, assaulting the victim, then cleaning up the blood and provided the basis for identifying all of the participants. The District Attorney's Office subsequently filed charges against six suspects in the assault.

Currently, Custody is also experimenting with hand-held electronic scanners to document inmate welfare checks performed hourly by jail personnel on the cell rows. If perfected, this tool may prove to be a cost-effective way to improve the documentation of many types of mandatory inmate welfare events in addition to hourly checks, such as showers and outdoor exercise, and to make the records very difficult to fabricate.

14. Increase the response to inmates caught roaming within the facility, particularly in expressly restricted areas.

The assignment of the additional Title 15 officers and the implementation of several additional electronic wristband scanner check points throughout MCJ appear to have achieved some benefits to inmate and staff safety. A comparison of MCJ inmate discipline statistics for the first six months of 2003 (just before the inmate homicides), with those for the first six months of 2004 and 2005 show a 30% decline in confirmed inmate roaming incidents. The number of inmates disciplined for fighting – either with each other or with staff – is similarly down 27%.[1]

15. Locate resources so that inmates seeking medical attention and housing in the jail do not languish in the holding areas of IRC.

LASD has addressed the most acute aspect of this problem by opening up a floor of the Twin Towers jail facility for exclusive use as a clinic serving IRC. Additionally, the total number of inmate beds available in the downtown jail complex (MCJ, IRC and Twin Towers) has been increased slightly. IRC personnel also report that improved communication with MCJ on inmate movement issues has further helped alleviate bottlenecks in IRC. The cumulative result is that the number of inmates at IRC waiting to be housed after intake has been significantly reduced.

16. Improve the wristband identification system to guard against inmate theft and tampering; provide sanctions against inmates who discard or tamper with wristbands.

After considerable experimentation with forms of inmate identification, Correctional Services Division has designed a scannable picture identification card to be worn by all inmates throughout the system. The identification card will contain a bar code and other coded information that should help jail staff recognize, at a glance, inmates who are tampering, assuming a false identity or roaming outside their authorized area. Wristbands will be retained as a cross-reference, but the new system should eliminate some of the vulnerabilities of the old wristband system. Inmates who lose or discard their picture identification card will have a fee deducted from their commissary accounts.

[1] Based on calculations derived from data provided by the MCJ Legal Office.

LASD has begun implementing the picture identification card system with all new inmates. As with any new system, adjustment snafus are to be expected. For example, upon implementation of the identification card system, LASD staff at the courts confiscated some of the inmate identification cards as "contraband," because they had not been informed of the development of the new system. This occurrence is exemplary of the continued need for a Department as large and varied as LASD to continue to effectively communicate with each other.

17. Provide information about LASD's jail classification system to judges, prosecutors, defense attorneys and other participants in the criminal justice system.

One of the jail homicide investigations pointed to the lack of a commonly understood inmate classification vocabulary among officers of the court. Jail authorities have recently begun to act to fill this void by compiling a concise glossary of key terms defining the classification or special handling designation of inmates so that all parties in the courtroom will have a common understanding of how a judge's orders will affect the security and separation of inmates involved in court cases. The more important step, yet undone, is to communicate this information effectively to the involved parties.

18. Examine and alleviate gaps and bottlenecks in the inmate classification system.

It has been a longstanding practice that new inmates receive a security level number and any appropriate special handling designation (such as "keep away" or protective custody status) from a processing unit in the Inmate Reception Center ("IRC"). Classification and special handling designation affect an inmate's mobility within his facility and his vulnerability to assault by other inmates. Inmates are reclassified on a periodic basis by IRC or by their own housing facility. They are also sometimes reclassified between cycles because of important new information, such as a conviction or sentencing event in court or an attempt to escape or other disciplinary incident in jail. The jail homicide investigations helped bring to light the flaws, mistakes and generally slow information flow characteristic of this system. Custody executives have agreed in principle that many aspects of the system need attention, but have preferred to work toward a more distant global solution than to devote resources to short-term solutions. The leading proposal would centralize all classification and reclassification decisions within one unit and combine that function with all inmate housing placements throughout the system. This could greatly reduce the kind of mistakes and information gaps that have led to inmate assaults. OIR applauds a bold redesign of the current system, but we confess frustration with the LASD's slow pace in concretely addressing this complex problem in the here and now.

That the problem continues to exist will likely be made clear in ongoing investigations involving inmate assaults and escapes. While OIR will report out those matters upon the conclusion of the investigation, the preliminary information already indicates that failure in timely reclassification likely contributed to these unfortunate events.

LASD's Catch-Up on Outstanding WCSCRs and Claims Responses

In OIR's First Report, we reported on deficiencies in the quality and timeliness of LASD's responses to civil claims filed in preparation for litigation. In each subsequent report, we have provided updates on LASD's progress. LASD adopted new guidelines to improve the quality of its investigations into civil claims. OIR continues to monitor the claims responses prepared by LASD. While the quality may vary from claim to claim and unit to unit, for the most part, the responses are sufficient, and much improved over LASD's previous practice.

In addition, the timeliness of claims responses is much improved. LASD had a huge backlog, some 800 claims, when OIR first identified the problem. LASD monitors the outstanding claims on a quarterly basis. LASD units are required to review claims and provide a response within 20 days. The most recent review of outstanding claims that had been at the unit for 30 days or longer, showed that many units are completely caught up, and some have only a few outstanding reviews pending. This is a significant improvement. In addition, OIR is no longer seeing large numbers of claims that are several years old and have not yet received an investigation and/or a response.

In OIR's Third Annual Report (at pp. 47-48), OIR reported about another disturbing backlog at LASD. LASD's computer-based tracking system showed more than 2300 pending citizen complaints and commendations, or Watch Commander Citizen Comment Reports ("WCSCRs"), that covered the time period September 1999 to December 2003. This meant that either these citizen complaints and commendations had never been investigated, or that after being investigated they had somehow been misplaced and never entered into the computer system. Either situation was unacceptable. While the fact that both commendations and complaints were left pending allayed OIR's fears that this was an intentional whitewash, the failure to complete these reviews and enter them into the system was a major concern because it undermined the ability of LASD to monitor for potential "red flag" behavior or patterns of behavior by employees.

In the past year, LASD has made significant progress in reducing the number of WCSCRs that are outstanding. It has located or investigated more than 1000 of those tardy WCSCRs, while continuing to receive and investigate new WCSCRs. There is still, however, much to do. LASD has set a goal and timetable, in conjunction with OIR, within which to clean up the backlog over the next several months. Given the progress to date, the groundwork that has been lain, and the experience with claims responses, OIR is expectant that LASD will be able to reach that goal. Either way, as LASD's independent review entity, OIR will report to the public on the Department's continued response to this significant situation.

Risk Management Bureau's Continuing Progress

The OIR Third Annual Report described efforts undertaken by the LASD Risk Management Bureau ("RMB") to pro-actively manage LASD's civil litigation (at pp. 66-68). OIR has continued to be impressed with Risk Management's efforts and the results they have obtained.

OIR reported last year that through Risk Management, LASD had put more effort into resolving litigation at the civil claim phase, resulting in slightly higher civil claim payouts, but significantly lowered lawsuit payouts. Risk Management had seen lawsuit payments drop more than $13 million over three years. Fiscal year 2004-2005 continued this trend. Total payouts, for both claims and lawsuits combined, decreased again. In 2003-2004, payouts for both lawsuits and claims were slightly more than $6 million. In 2004-2005, payouts for both lawsuits and claims were slightly more than $5.3 million.

Risk Management continues to hold, and OIR continues to regularly attend, the Critical Incident Analysis meetings (CIA's), which were described in OIR's Third Annual Report. These meetings bring together investigators, County Counsel, and supervisors to share information, examine the incidents underlying litigation, and decide whether a case warrants an early settlement. Where OIR has prior knowledge of the incident, OIR shares any information it has. OIR also uses these meetings to evaluate the sufficiency of any LASD response to the allegation. CIAs have proven to be a useful tool for Risk Management to quickly gather information about the events underlying a lawsuit.

Recently, for example, OIR attended a CIA arising from a force incident in which a suspect fought with deputies who had come to his home to inquire about a confrontation he had just had with a neighbor. A few weeks after the arrest, one of the involved deputies worked an overtime shift at a jail facility. While reviewing his own recent cases at a computer terminal, he learned that the suspect was currently housed in that very jail. Allegedly, the deputy decided to go visit the suspect, waking him in the early morning hours and pulling him out of his dormitory to have a discussion in the adjoining dayroom. Though the deputy later maintained he had just done some informal counseling with the inmate, and with good intentions, the inmate's lawyer contacted the Department with a very different version of the encounter.

At the CIA, the deputy's operations lieutenant spoke about obvious concerns raised by the incident, but indicated that it might be handled as a citizen complaint and not a formal administrative investigation. OIR was able to alert the supervisor of another incident where deputies had been disciplined in a case involving comparable allegations. OIR strongly recommended an investigation, and the Department concurred. The investigation is pending.

OIR's regular communication with Risk Management has been productive in other specific instances as well, helping to insure that the policy, training, and accountability components of the Department are well-coordinated. The following examples are from the past year:

- RMB brought an incident to OIR's attention that was described in a civil suit. An inmate worker had attacked another inmate with a razor while serving him dinner through the bars of his cell. The inmate worker should not have been allowed to serve without escort because of the high security nature of the module. The module deputy was apparently preoccupied by a personal matter at the time and failed to observe the attack. The incident had been noted by a supervisor, but never investigated. Because what little was known about the incident pointed to a possible failure on the part of custody employees to attend to the welfare of inmates in their care, OIR requested that the captain of the custody facility instigate an administrative investigation. The captain assigned the investigation to an experienced lieutenant. The OIR attorney conferred with the lieutenant regarding investigation strategy given the unusual time constraints on the investigation. There were only a few weeks remaining in the one-year time period required to bring administrative discipline. The lieutenant completed a thorough investigation within the required deadline and the facts established by the investigation resulted in a 15-day suspension without pay for performance below the professional standards of the Department.

- An OIR attorney noticed troubling allegations in a civil suit and brought them to the attention of the Risk Management Bureau ("RMB"). The lawsuit asserted that months ago a man had been arrested and accused of molesting a child. He was sent to jail and placed in a general population module. He was promptly beaten and severely injured by other inmates who allegedly suspected or were told of the nature of his charges. These allegations, if true would be a sharp departure from the customary jail practice to isolate suspected child molesters. OIR and RMB conferred with other units and agreed that virtually nothing was known or had been investigated at the time regarding the alleged incident. The jail facility was asked to assemble any pertinent documentation on the inmate. OIR reviewed these materials and determined that they raised more questions than they answered. OIR urged that a broad-based investigation was necessary despite the fact that the one year administrative discipline time limit had expired. LASD has agreed that an investigation of the matter would be valuable and might reveal ways in which the Department could avoid a similar event in the future. RMB is currently coordinating that investigation and OIR will continue to monitor it.

- After perusing operations logs, OIR noticed that two inmates had recently attempted suicide on different occasions using court lock-up telephone cords. OIR informed the Risk Management Bureau about this possible hazard. RMB did further research on the issue and found that two other similar incidents had occurred in recent years in court lock-ups. RMB then agreed with OIR that, even though state statutes governing living conditions in custody did not require any change in the telephones, it would be a prudent and reasonable preventive measure to seek a simple redesign of custody telephones, particularly in the courthouse lock-up areas. LASD approved a relatively inexpensive rearrangement of the telephone cord and receiver latch that would reduce the hazard and has begun to implement this retrofit throughout the county.

RMB and New Taser Policy

OIR also coordinated with RMB on a project to clear up the backlog in force package processing, with a special emphasis on taser use data. The project began when OIR was recently asked to review some data gathered by the LASD on the use of the taser by sworn personnel against suspects and inmates. Based on OIR's experience of reviewing force cases throughout the Department, the data looked incomplete. An OIR attorney did a brief survey of a representative sample of stations and custody facilities and concluded that the taser data had severely undercounted the actual use of the taser by personnel at these units. OIR took its findings to RMB, which serves as the repository for use-of-force documentation.

RMB was able to determine which units had undercounted their taser use and why. The main problem was a bottleneck in the processing of "force packages," by many units. A force package is the collection of reports and documents that every unit must complete after an incident where deputies have used physical force in an encounter with the public. The package is then forwarded to RMB for input into the Departmental database in which force incidents are tracked. Additionally there was widespread noncompliance with a 1995 field operations directive requiring each unit to complete a form and send it to Training Division every time a taser is used. In order to avoid a recurrence of this problem, the preliminary data entry ("PDE") process, whereby a field supervisor or watch commander must make a terse computer entry within hours of the incident, will be reprogrammed to include an entry field that lists what specific type of force or weapon was used. The supervisor will not be able to complete the PDE without filling in that field.

This programming modification will mean that any use of a weapon will be input into PPI at the earliest opportunity. It also ensures that the database will be easily searchable by weapon — e.g., taser. Before, an interested party would typically have to read through the description of every incident to locate specific weapons use. The change will provide an automatic cross check for taser and other weapons use data derived from force packages down the line. Finally, RMB will place more emphasis on its own data input backlog. Better performance from the units will be encouraged through the preparation of a monthly diagnostic report by RMB to be forwarded to all Chiefs, indicating what units have delinquent force packages and how many. This new process devised by RMB should simplify a complicated and ponderous process and will provide LASD with useful data about weapons use.

During this period, OIR also became aware that the Department had no detailed department-wide policy on taser use, despite a widespread distribution of tasers to deputies over the past year and a large number of times the taser was being deployed. OIR was aware that administrative discipline cases involving tasers were multiplying predictably, yet deputies had very little policy guidance as to how and under what circumstances to use the taser. Official policy only told them that the taser constitutes "less lethal" force appropriate for use against "assaultive/ high risk" suspects. OIR found that, in fact, a comprehensive taser use policy had been drafted by a recently-retired expert in the field training unit and vetted by other experts within the Department. The policy had moved through the entire approval process, but had been stalled for a long period by a last-minute concern over possible conflict between the direction given to field deputies and those for custody deputies.

OIR conferred with the Leadership and Training command staff who agreed that the need to provide clear guidance to deputies on taser use had become increasingly urgent. They also agreed that the appropriate policy development and approval process, including conferring with employee unions, was complete and that only bureaucratic barriers stood in the way of implementation. A minor wording change allowing Custody Division to further develop more specific rules of engagement readily solved the log jam that had stalled the issuance of the policy. The new policy was implemented and distributed in August 2005. It is reprinted below.

OIR followed up with the training staff to insure that a broad training plan accompanied the first ever Department-wide taser policy. This process will commence with a four-hour Taser Instructor Update course to be given in October of 2005.

OIR had no direct input on the original substance of the policy but feels that it provides some overdue guidance to sworn personnel and is a significant improvement over the virtual absence of policy that has prevailed until now. OIR will continue to monitor both the collection of taser use data and the effectiveness of the new taser policy.

Videotaping by Supervisors

In our Third Annual Report, we discussed in detail a case in which the tactics deployed in apprehending a suspect in the San Gabriel River were less than ideal. One particular decision that we noted was the decision by the tactical supervisor to videotape the apprehension attempt himself rather than delegate the task to a subordinate. As we stated, such a decision undermined the supervisor's ability to assess the event as it unfolded and make adjustments along the way.[1]

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[1] The concerns discussed here do not in any way alter OIR's view that there should be as much videotaping or otherwise permanent recording of events involving LASD as practicable. The concern raised here is who is the appropriate LASD employee to undertake that responsibility.

Since then, we have observed yet another instance of a supervisor videotaping a dynamic situation, which may have undermined his effectiveness as the on-scene commander. In this case, the supervisor was attempting to communicate with the suspect and ensure a proper deployment of the tactical plan. The supervisor's decision also to personally videotape the incident resulted in a dilution of his observational abilities in a dynamic situation and a videotape that did not capture a significant part of the event. Whenever a supervisor is serving as videographer, his observational abilities will be limited to whatever he or she sees through the viewfinder. In our discussions with LASD about this phenomena, they have agreed that supervisors who are the on-scene commander should delegate any videotaping to a deputy so that supervisors can fully perform their role in ensuring an effective tactical plan is implemented.

As a first step toward addressing this situation, a revised policy has been proposed that sets out the responsibilities of the incident commander in dynamic situations. The proposed policy makes clear that the incident commander is responsible for the overall control and coordination of the operation. Accordingly, the policy then instructs that the incident commander shall consider avoiding specific tasks and instead delegate such tasks to other personnel. This new policy begins to officially recognize that the more important responsibilities of the supervisor is to "supervise" and that in order to effectively do so, it is incumbent upon that supervisor to delegate tasks such as video photography to others.

More recently, an area commander was tasked with visiting each of the patrol stations, ensuring that each unit had working video cameras, and reminding supervisory and unit personnel of the advantages of videotaping dynamic events. As part of that briefing, a department-wide commander, who was privy to the details of the above described event, indicated his intent to emphasize the preferred practice of delegating the actual videotaping of those events to deputy personnel so that the supervisors were free to assume their responsibilities as scene commanders.[2]

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[2] There are probably a couple reasons that explain the tendency of supervisors to grab the camera rather than delegate the task to a deputy. First, usually the video camera is located in the supervisor's car and thus it is perhaps subconsciously thought of as strictly a supervisory tool. Second, supervisors often use the video camera appropriately after force events, traffic accidents involving LASD personnel, and other significant events to document evidence after an event such as injuries to an arrestee, damage to a vehicle, or on-scene interviews of witnesses to an event.

5-09/175.05 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 and minimize injury to suspects and deputies.

Use of the Electronic Immobilization Device

The following policy guidelines shall be adhered to at all times:

- Only Departmentally approved Tasers shall be utilized by personnel,
- Tasers shall be issued to and used only by those who have completed the Department's Taser Training Program,
- 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,
- The Taser shall not be applied to gain compliance over persons whom personnel reasonably believe are not presenting an immediate, credible threat to the safety of Department personnel or the public,
- Application of the Taser shall be discontinued once the suspect is controlled,
- Personnel may demonstrate a "sparking" of the weapon in an effort to gain voluntary compliance of the suspect. In the event of such a demonstration, personnel shall include a notation in their Mobile Digital Log (MDT) fully explaining the necessity of their actions. In the event the Taser is "sparked" by personnel who do not complete an MDT log, personnel utilizing the Taser in this manner shall submit a memorandum to their direct supervisor fully justifying their actions,
- Except in emergent circumstances, the Taser shall not be applied to the following without notification of the Field Sergeant of the intention to use the Taser, and the approval of the Watch Commander:
  - Civil demonstrators,
  - Handcuffed persons,
  - Persons detained in a police vehicle,
  - Persons detained in any custodial setting,
  - 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.

Reporting the Use of the Electronic Immobilization Device

- Authorized Department personnel discharging a Taser shall request the response of a supervisor if not already en route or on-scene,
- 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,"
- Department personnel utilizing the Taser shall include a notation in their Mobile Digital (MDT) log fully explaining the necessity of their actions. In the event the Taser is "sparked" by personnel who do not complete an MDT log, personnel utilizing the Taser in this manner shall submit a memorandum to their direct supervisor fully justifying their actions,

Unit Commanders shall ensure that random audits documenting the usage of Tasers are conducted each month.

Revised 08/10/05

The training and direction being provided LASD personnel regarding this issue will hopefully ameliorate this situation and supervisors will consistently delegate videotaping of dynamic events to deputies so that they can perform their vital incident command responsibilities. If, however, there persist continued incidents wherein either task is potentially compromised by a supervisor attempting to accomplish both simultaneously, further policy or accountability may be called for.

OIR's Continued Commitment to Increasing Transparency: New Website Features

As we have indicated in the past and state elsewhere in our report, an indispensable component of our mission is to provide transparency about the way LASD handles allegations of misconduct and critical events on both a case by case and systemic basis, and our evaluation of the Department's response. We see one of our core responsibilities as serving as a conduit so that information can flow to members of the public so they can assess for themselves how LASD handles these matters. In addition to the posting of basic information about OIR, electronic copies of our annual reports, and the quarterly case charts (which include detailed summary information of every case we monitor and include specific information regarding the misconduct allegation, an evaluation of the investigation, and our recommendations regarding the investigative outcomes and discipline) we have added several new features to our website to increase the information flow about related matters.

Special Reports

Occasionally a critical incident or series of incidents will generate significant interest among members of the public. For example, in 2004, the five inmate murders that occurred over a six month period in the jails and, this year, the controversial Compton shooting case in which 120 rounds were fired both warranted special treatment and a special report. Rather than awaiting the release of our annual report, we determined to immediately post these reports on our website upon their completion.

OIR Columns

Over the past year, we have also included columns on our website that report to the public in a new way. These essays are usually less formal than other public reports that OIR generates and are written by a particular OIR attorney rather than as a group project. To give the reader of this report a flavor of those articles we have included a couple of examples as "Appendix B." "Core Values for Overseers" provides a beginning discussion suggesting certain principles with which oversight entities might be guided in conducting their important work. "The Myth of the Ruthless Investigator" is intended to dispel misconceptions about the orientation and mind sets of those peace officers entrusted with the sensitive and critical responsibilities of investigating allegations of misconduct by their colleagues. In addition to these two articles, the following pieces have also been posted on our website over the past year:

- "*Questioning Assumptions: An Evidence-Based Approach to Allegations of Policy Violations*"
  This article cautions against investigators and reviewers using predetermined assumptions about what may have occurred in an incident, which could improperly shade the fact-gathering process.

- "*The Lying Dilemmas*"
  This article discusses the difficult task of addressing the too common phenomenon in which peace officers compound a rather minor transgression by making false statements subsequent to those acts and offers recommendations to reduce it from occurring.

- "*Toward Increased Transparency in the Jails and Prisons: Some Optimistic Signs*"
  This article was originally presented in conjunction with a conference sponsored by the Commission on Safety and Abuse in Prisons, a Commission that is currently holding a series of conferences throughout the country on current issues impacting on penal institutions. This article comments favorably about an increased trend in LASD to open up its jail doors to outside inspection and evaluation.

- "*The Harm to Public Service Standard in Police Misconduct Cases*"
  This article, originally published in the Los Angeles Lawyer magazine addresses how peace officers' special responsibilities and authority create a greater potential for harm to the public and that this greater impact on the public should be considered in determining the level of accountability to be assessed a police officer who abuses the public's trust.

Results from the Civil Service Commission

When LASD determines to impose significant discipline on any of its employees, the employee may appeal that result to the Civil Service Commission. Usually, upon appeal, the Commission assigns the appeal to a Hearing Officer who then hears evidence and testimony about the acts that led to the imposition of discipline. The Hearing Officer then writes a report that is forwarded to the Commission for review. At that point, the Commission may either adopt, reject, or modify the Hearing Officer's report. No effort to increase knowledge about the LASD discipline process would be complete without a reference to the findings of the Commission regarding cases appealed by LASD employees. For that reason, OIR has begun posting on its website the Final Reports of the Commission – which are public documents – for cases involving LASD employees.

Communications to LASD Employees

Occasionally, there will be references to OIR or matters involving the disciplinary system or related matters in employee association publications. At times, OIR has found that those references contain incomplete or inaccurate information regarding its position on matters. In each of those cases, OIR has provided written responses to those publications in order to clarify its position and to prevent LASD employees who might read the publications from receiving an incomplete or inaccurate view of OIR. However, because, of course, the choice of whether to publish our responses lies entirely with the editors of those publications, we also post our response on our website so that a full and accurate rendition of our perspective is available to those readers.

PART FIVE Force and Shootings: Trends and Case Studies

Update on EFRC Review of Uses of Force

The Executive Force Review Committee ("EFRC") panel has continued to critically examine the entire incident surrounding a use of force to determine not only whether the use of force was within policy, but also whether the conduct leading up to and subsequent to the use of force was within policy. During this examination, EFRC often is called upon to review tactical decisions and must decide whether poor tactics are a matter for training, or whether they are so egregious as to merit a finding of failure to perform to expected standards and imposition of discipline. In making this determination the EFRC panel is often guided by factors such as the context of the behavior, the employee's history of similar incidents, and the training the employee has already received. The EFRC panel turns to discipline when the facts cause a particularly high level of concern or when there is a belief that the discipline will be necessary to convince the employee to alter his or her behavior.

For most of the incidents it reviewed this past year, EFRC determined that the use of force was within policy. EFRC did find several uses of force outside policy and recommended discipline in a number of incidents.

CASE

Deputies contacted three individuals in a parked car. The occupants of the car were non-cooperative when ordered to show their hands. In response to their non-cooperation, a deputy sprayed the occupants of the vehicle with pepper spray. EFRC determined that the use of pepper spray under those circumstances was an unreasonable use of force. The deputy who used the pepper spray received a six-day suspension. His partner received a four-day suspension.

CASE

Deputy A was escorting an inmate when the inmate began to struggle. Deputy A and the inmate ended up on the floor fighting. With the assistance of two other deputies, *Deputy A was able to handcuff the inmate while the inmate lay face down on the floor with Deputy A straddling him. The inmate appeared at that point to have calmed down. As Deputy A stood up to get off the inmate, the inmate kicked him and the deputy fell over back onto the inmate who was still laying face down on the ground. Deputy A then struck the inmate 2-3 times in the face. Deputy A then stood up the inmate and began to walk him to the clinic for medical treatment. The two assisting deputies began to leave in another direction. Deputy A and the inmate rounded a corner and then the two assisting deputies heard a loud sound like a body smacking the floor and ran around the corner to see what had occurred. They saw the inmate on the floor again. One of the assisting deputies then escorted the inmate to the clinic. Deputy A claimed that after he rounded the corner, he realized he had blood on his hands and therefore stopped with the inmate standing near, but not against, the wall. He intended to pass the inmate to one of the assisting deputies so that he could wash up. He was surprised to see that neither assisting deputy was with him. The inmate then began to fall towards the ground on his own. Deputy A, who had a hand on the inmate, said he did not stop the inmate's fall, but the inmate fell gently. There was blood smeared on the wall that was inconsistent with Deputy A's statement that he had placed the inmate near, but not against the wall. The sounds the assisting deputies heard were also inconsistent with the inmate having "gently" fallen. Deputy A never reported any of the force he used. He stated that he assumed one of the assisting deputies made the report. EFRC recommended that Deputy A be found to have used unnecessary force for both the punches to the inmate's head and the subsequent events that occurred en route to the clinic. EFRC also recommended a founded charge for failure to report the use of force in both incidents. In addition, EFRC recommended a founded charge for false statements for the deputy's statements regarding the second incident that occurred en route to the clinic. EFRC recommended that Deputy A receive a 15-day suspension. Department executives adopted this length of discipline*

On several occasions over the past year, EFRC has also found that conduct other than the use of force itself violated policies. For instance, in several incidents arising out of custody and discussed in more detail at pp. 40-41, EFRC examined closely whether the deputies had followed the "recalcitrant inmate" protocol for the facility. In patrol, EFRC continues to look at the conduct of deputies and supervisors both before and after the use of force. In particular, EFRC examines whether any poor tactics placed deputies in the situation that required the use of force. Also, EFRC closely examines reporting requirements to ensure deputies and their supervisors are properly reporting incidents.

C A S E

Deputies established a containment when a suspect ran on foot at the end of a vehicle pursuit. Several of the deputies on the containment saw a family rapidly exiting a nearby home. The family told the deputies that the suspect was in their house. There was confusion about whether all family members had exited the house, and thus whether there was an immediate danger to innocent bystanders. Rather than ask a question to clarify that fact, a deputy ran into the house after the suspect, and to clear it of family members he erroneously believed had been left behind. There were, in fact, no family members in the house. Had the deputy clarified that, proper procedure would have been to treat the suspect as a barricaded suspect, and to not enter the house, particularly in light of the fact that there already was a containment established and plenty of resources in the area. To the credit of the involved deputies, in their interviews they readily admitted the deficiencies in their tactics and recognized how they could perform better. As a result, EFRC found that the first deputy who rushed into the house had performed below the standards expected of a deputy sheriff. His discipline, however, was mitigated by his acceptance of responsibility.

C A S E

A suspect drove away from two deputies who attempted to contact him. The deputies, and two assisting deputies, followed the suspect a short distance, at which point the suspect turned his truck into a parking lot, but continued driving at a slowed rate of speed. When the suspect turned into the parking lot, three of the deputies jumped out of their vehicles and ran up to the suspect's vehicle, which was still moving. A deputy, with his gun drawn, ordered the suspect to stop his truck. The suspect complied, but was not cooperative in exiting the vehicle. He had a gun holster on the seat next to him and appeared to reach for it. The deputies did not know whether there was a gun in the holster, but assumed there was. However, they had a crossfire situation and could not fire their guns, so their only option was to distance the suspect from the potential gun. They therefore used force to pull the suspect from the vehicle. Significant force was used, including striking or jabbing the suspect in the ribs with a flashlight. The suspect also hit his face on a portion of the truck during the struggle. Once the suspect was in handcuffs, the deputies requested that a Sergeant come to the scene. The deputies reported to the Sergeant the force that was used and the Sergeant interviewed the suspect on videotape. When the Sergeant reported the incident to his Watch Commander, however, his description did not fully capture the extent of the injuries to the suspect. The suspect was bleeding profusely because of his broken nose, but the impression conveyed was that his injuries were not that serious. In addition, the initial report by the Sergeant did not mention that a deputy had struck the suspect with a flashlight. The Sergeant stated that he only learned of the flashlight strike after he spoke with the Watch Commander and never updated the Watch Commander with the new information.

While the force was within policy, EFRC recommended that the deputies be found to have failed to perform to the standards expected because of their poor tactics in approaching the suspect while he was still in the vehicle. In addition, EFRC concluded that the Sergeant had failed to perform his supervisor responsibilities. Even accepting that the Sergeant was not initially aware of the flashlight strikes, EFRC concluded that he had an obligation to update his report to the Watch Commander when he eventually learned about them. EFRC recommended that the deputies be suspended for 3 days each and the sergeant for 5 days.

CASE

Two deputies drove alongside a suspect and began questioning him about the car he was driving. When the suspect drove away, the deputies went into pursuit. Eventually, the suspect alighted from his car and a foot pursuit began. When the deputies caught up to the suspect, he resisted and force was used to bring him into custody. One of the initial deputies wrote in his incident report that he had observed the suspect vehicle to have missing lug nuts, bald tires, and no gear shift knob. While investigating the force incident, IA investigators observed photographs taken of the suspect vehicle at the time of the incident and noted that the vehicle did not have bald tires, missing lug nuts, and a missing gear shift knob. EFRC reviewed the matter and concluded that the deputy had prepared a false report about the observations of the vehicle in order to bolster his justification for going into pursuit. The EFRC also found policy violations in the way in which the deputies pulled alongside the vehicle, and false statements made by the reporting deputy to investigators, as well as false statements regarding that deputy's involvement in the force incident. EFRC recommended that the reporting deputy be discharged. That discipline was later reduced pursuant to a settlement agreement with the deputy.

The willingness of EFRC to closely examine the tactics of deputies, and recommend training, debriefings, and discipline when appropriate, is important to improving the manner in which LASD encounters the public, and also in improving deputy safety and conduct. OIR will continue to monitor the work of the panel to determine whether this positive development continues.

Update on EFRC Review of Shootings

As we reported in our 2004 annual report, there had been a recent upward trend in LASD deputy-involved shootings, and this upward trend has continued through August 2005. From January through August 2005, there were a total of 53 deputy-involved shootings. Of those 53 shootings, 20 were non-hit shootings and 33 were hit shootings. This represents an increase over last year's numbers. In our 2004 annual report, we reported that from January through August 2004, LASD deputies were involved in a total of 46 shootings.

Previously, we stated that OIR has two areas of particular concern related to deputy-involved shootings and has explored each of these areas vigorously:

- *Disciplinary scrutiny of the circumstances surrounding a shooting and not simply the moment of pulling the trigger.* Even though a deputy's actions at the moment he or she discharges the firearm may be thoroughly justifiable, the decisions – made by the involved LASD employees – that led up to that moment or immediately following it may be ill-conceived or unsafe.

- *Decisions by deputies to shoot at drivers of vehicles based on the belief that the vehicle presents a deadly threat.*

In 2005, these two areas, among others, continued to hold particular interest for OIR and LASD. This year, as with last year, OIR has continued to urge LASD to examine shooting incidents broadly, and impose discipline for serious tactical shortcomings even if the shooting itself proved to be necessary and in-policy. The EFRC has shown a willingness to conduct this rigorous scrutiny. Recent cases have caused the panel to call for discipline and/or enhanced training based on the following issues:

- Failure to communicate with a partner.
- Splitting from a partner during a foot pursuit.
- Unnecessarily placing oneself in an unsafe position in the path of a suspect vehicle.
- Failure to control fire.
- Failure to identify a target prior to shooting.

OIR commends this approach and will continue its own protocol of close involvement with the force and shooting review process.

Re-Creation to Aid Review of Deputy-Involved Fatal Shooting of Two Suspects

In May 2005, a case came before the Executive Force Review Committee that arose out of a deputy-involved shooting that had resulted in the deaths of two suspects. Deputies had located the suspects in a parked car after a family member called the station and said the two men had threatened him with a gun. Eight deputies assembled outside their patrol cars behind the suspects' car and prepared to arrest them. One person in the car complied with the deputies' directions and was taken into custody without the use of any force. Two suspects remained in the vehicle. The vehicle then began to back up toward the patrol cars and deputies opened fire. It collided with the one of the patrol cars then drove forward into a metal security door and stopped. Both suspects were fatally wounded. A handgun was found on the back seat.

An OIR attorney rolled out to the scene on the night of the shooting and monitored the investigations of the Homicide and Internal Affairs Bureaus. OIR focused particular scrutiny on this incident because it had resulted in two deaths and involved a high number of rounds fired at a moving vehicle. OIR continued to confer with the IA investigator who was completing the "force review" of this case, a preliminary investigation of major uses of force to help executives determine whether an incident merits further investigation.

After a lengthy and vigorous Executive Force Review of the deputy-involved shooting, OIR asked the panel to instigate a formal internal affairs investigation. OIR was concerned that without the more extensive investigation entailed by a "formal IA," the panel would not have a sufficient basis to judge fairly the key issues of deputy tactics and judgment in the case. An accurate sense of the physical aspects of the incident scene was particularly hard to develop because of the unusually small strip mall parking lot, crowded with cars, where the shooting took place. The panel agreed that it had significant concerns about the danger of cross-fire, poor visibility, contagious fire and the initial justification for the use of firearms.

The panel agreed to extend and enlarge the review investigation. As part of that extended review, EFRC requested that IA "recreate" the incident. This proved to be a very enlightening approach. The re-creation of the physical scene provided helpful context to the witness interviews. Based on witness statements and careful review of the original photos of the scene, Internal Affairs investigators meticulously re-created the exact arrangement of vehicles and people at the outset of the incident, then moved them repeatedly through the events of the shooting.

All EFRC panel members viewed the re-creation at the location with similar late night lighting conditions. Each panel member, as well as the OIR attorney, was able to view the scene from the vantage point of each of the shooters and evaluate that deputy's visibility, field of fire and plausible perceptions. During and after the re-creation, panel members stated that they found this experimental technique extremely helpful in forming clear opinions about the tactics and decision-making used by deputies during the incident, and agreed that it was a worth-while use of Department resources given a case of this magnitude.

When the panel convened a second time to evaluate the case, they were able to conclude that each of the deputies possessed a plausible independent basis for shooting based on what appeared to have been rapid, erratic backing movement of the vehicle or, in some cases, on the appearance of an extended arm with a gun within the vehicle. The re-creation established that the cross-fire problems were not severe and it became apparent that some parts of the interior of the vehicle, despite tinted glass, would have been visible to some of the deputies. OIR concurred with these conclusions. Moreover, it also found both intrinsic value in the results of the re-creation, and symbolic value in the Department's willingness to undertake the additional steps in assessing this incident.

Other Notable Shooting Reviews

EFRC has reviewed a number of other deputy-involved shootings since OIR's last Annual Report. Most result in a finding that the force and tactics were in policy, and in some of the cases the Committee has reason to be impressed with the deputies' valor and sound performance. All cases, however, still receive close scrutiny, and shootings sometimes fall below Department standards – even when legally justified. Below are some of the notable cases that EFRC recently assessed while OIR actively monitored the process and offered its own input.

CASE

During a drug surveillance, deputies, detectives and a sergeant attempted to initiate a traffic stop on a suspected drug dealer's vehicle. When the suspect tried to escape in his vehicle, LASD members fired several rounds at the suspect's vehicle. These shootings failed to disable the suspect or his vehicle and occurred after Department personnel either placed themselves in a vulnerable position, i.e., at the rear of the suspect's vehicle and in the space between the suspect's vehicle and a parked car, or jumped out of the vehicle's path. A vehicle pursuit commenced, and the suspect's vehicle struck several LASD vehicles. During a later vehicle pursuit, LASD members fired additional rounds at the suspect and his vehicle. Again, these additional rounds failed to disable the suspect or his vehicle and occurred after Department personnel either placed themselves in a vulnerable position, i.e., the middle of the street, or jumped out of the vehicle's path. During the vehicle pursuit, there was ineffective radio communication among *the involved personnel and LASD's Communications Center. The vehicle pursuit ended when the suspect's vehicle crashed into a fence. At the conclusion of this vehicle pursuit, Department personnel fired several additional rounds.*

EFRC initially heard the case in March. After concluding that the shooting itself was within policy, the panel elevated the case to an IAB investigation to examine whether three of the involved LASD personnel violated policy. EFRC found that three Department members violated policy by failing either to communicate the vehicle pursuit in a timely manner, to supervise or assume adequate control over the incident, to take a tactically safe position, to use cover or concealment and to fire numerous rounds appropriately. LASD recommended discipline in the range of a written reprimand to a 15-day suspension. While OIR concurred with EFRC regarding the range of discipline recommended, it disagreed with EFRC's finding that only three Department members violated policy. OIR believed that deputies who had placed themselves in harm's way with regard to the suspect's vehicle, and/or had shot at the vehicle after the threat had passed, should also have received discipline. EFRC, after considering these issues, concluded that the actions did not rise to the level of policy violations.

CASE

A sergeant and deputy observed a suspected shoplifter leave a store and proceed to a parked car. After the shoplifter entered his vehicle, the sergeant ran up to the vehicle, pounded on the window and tried to open the driver's door. As the shoplifter pulled away, the sergeant released his grip on the door and fired one shot. The bullet fragmented, with one of the fragments striking the suspect. As the suspect drove away, the deputy proceeded to follow him on foot, without a radio or vest. EFRC found the shooting out of policy and recommended a 15-day suspension for the sergeant. EFRC found the deputy to have engaged in faulty tactics and recommended a 10-day suspension.

CASE

Two deputies responded to a domestic violence call. When the deputies sought to speak with the man who was allegedly involved in the domestic violence, he jumped from a second story window and ran away from the deputies. The deputies chased the man to the porch of a nearby residence, where the man told deputies that he was armed and that he would shoot them if they approached the residence. A standoff ensued, and as additional LASD personnel arrived at the scene, they sought to negotiate with the man regarding his surrender. During the standoff, the man repeatedly told deputies that if they released a canine or used any other type of force, he would shoot them.

During the standoff, there were about ten LASD personnel within the inner containment. This personnel included K-9 handlers and patrol deputies and sergeants. After a lengthy negotiation process, an LASD canine was released, and as the canine approached the man, the man stood up with something dark in his hand and made a throwing motion. Numerous LASD personnel within the inner containment fired their weapons, killing both the man and the canine. The dark object turned out to be a slipper.

Top executives in the Department heard a presentation of this shooting incident shortly after its occurrence, and ordered the immediate commencement of an IAB investigation. During 2003 and much of 2004, the IAB investigation was held largely in abeyance while the LASD Homicide Bureau completed its investigation and then the Los Angeles County District Attorney's office reviewed the Homicide Bureau investigation. As a result, approximately twelve months lapsed before the IAB investigation began in earnest.

When that investigation was finished, EFRC heard the presentation of this case. While there was substantial discussion regarding the facts of the case, EFRC requested further investigation to determine whether the involved personnel violated any Department policies. Areas for further investigation consisted of issues related to communication among the several LASD personnel, control of the incident and scene and the appropriateness of firing a weapon during the incident. Every LASD member who either took action within the inner containment or made a decision from the command post regarding the events that occurred was investigated as a subject.

Upon completion of the additional investigation, the Executive Force Review Committee reconvened. After further scrutiny, EFRC found a number of involved personnel had violated policy by failing to meet Department performance standards The Committee found that the most grievous performance failure was the lack of communication between the dog handler's supervisor and the perimeter deputies prior to the release of the dog. EFRC also faulted the deputies who fired their weapons who had not been chosen by the on-scene sergeant as "designated shooters". The recommended discipline for the policy violations ranged from two- to five-day suspensions. OIR concurred in part with the Committee's findings. There were three individuals whom the Committee found had not violated Department policy, and OIR did not concur with those findings. These individuals were a lieutenant (whom OIR believed should have communicated more proactively with Special Enforcement and Crisis Negotiation personnel), a sergeant (who OIR believed should have exercised better control over negotiations at the scene), and a deputy (who OIR believed had been in a poor tactical position when firing several rounds). While this matter continues to wend its way through the grievance process, OIR will continue to monitor it.

C A S E

Several civilians and a bus driver flagged down a deputy, who was by himself on routine patrol. When the deputy pulled next to the bus, the driver advised the deputy that he had seen a man with a gun, wearing blue clothing and walking east on a street. A civilian also advised the deputy that before walking away, the same man had pointed the gun at several people and pointed at a man on a street east of the deputy's location. The deputy drove his marked patrol car down the street where he observed the man walking. While driving toward the man, the deputy issued verbal commands for the man to stop and show his hands. The deputy saw nothing in the man's right hand; however, he could not see his left hand. The man ignored the deputy's commands and continued to walk away from the deputy.

The deputy stopped the patrol car, and with his service weapon drawn, the deputy got out of the patrol car. With the man about 10 to 15 feet away, the deputy continued to give commands to stop and show his hands. The man put his hands in the air and began to walk backwards directly toward the deputy. When the man was approximately five feet away, he turned and rushed toward the deputy. The deputy moved backwards to create distance between himself and the man. The man then attacked the deputy and grabbed the barrel of the deputy's service weapon. The man and the deputy fought over control of the deputy's service weapon. The man lost his grip on the deputy's gun, and as the man again grabbed for the deputy's gun, the deputy who held the gun's handle pulled back and fired five rounds. When the deputy fired his weapon, the man had grabbed the deputy's shirt and pulled the deputy toward him. The wounded man eventually fell to the ground and died. While no gun was recovered from the man, witnesses indicated that before walking down the street, the man dropped the gun.

During its initial review of this matter, EFRC determined that the shooting itself was within policy; however, because there were issues relating to communication and leaving cover and concealment, the Committee elevated the case to a formal administrative investigation to resolve those issues. After the additional investigation was completed, the EFRC concluded that the deputy violated policy by failing to communicate his position and situation in a timely manner and by leaving cover and concealment when he confronted a non-cooperative man who may have been armed. EFRC recommended a written reprimand and specific and relevant training for the deputy. OIR concurred with both the finding of a policy violation and the recommended discipline and training plan.

C A S E

A deputy and his trainee were in a vehicle pursuit in a residential neighborhood when the suspect's car became disabled and he pulled to the side of the road. The suspect then ran from the vehicle. The deputy began to follow on foot after instructing his trainee to stay with the female passenger in the suspect car. After a brief chase, the deputy saw the suspect attempting to scramble over a fence by climbing onto a parked car. With his gun drawn, the deputy closed the distance. Then the suspect slipped from the car and spun to confront the deputy, who was now right behind him. The deputy, fearing that the suspect was reaching for his gun in an effort to take it and use it against him, fired once, striking the suspect in the torso and killing him. The suspect was unarmed.

EFRC determined that the use of deadly force was in policy under the circumstances. However, it also found that the deputy's decision to separate himself from his trainee, and place himself so close to the suspect with his weapon accessible, had fallen below the Department's standards for safety and tactical efficiency. The panel recommended a five-day suspension, which was later reduced to two days with OIR concurrence.

C A S E

Four deputies were involved in the fatal shooting of an armed man. Near midnight, Deputies A and B were partners and observed a group of persons milling on a sidewalk or in or near two parked cars. As the deputies stopped their patrol car to investigate, two of the men in the group reached for their waistbands, pulled out guns and began to run away from the deputies. The two men split from each other, and Deputies A and B continued to chase one of the men. During the foot pursuit, Deputy A turned a corner first and saw the man pointing a handgun at him. The armed man pulled the trigger; however, his gun jammed without firing a round. Believing the man was going to shoot him, Deputy A fired several rounds. After hearing a shot, Deputy B turned the corner, and, without taking cover, also fired several rounds. The armed man was hit and fell to the ground

While awaiting the arrival of back-up units, Deputies A and B held the armed man at gunpoint. A back-up unit consisting of Deputies C and D arrived. Without taking cover, Deputy C joined Deputies A and B and trained his weapon on the armed man, who was ignoring orders to remain still. When the armed man reached for his weapon, Deputies A, B and C fired again.

During close scrutiny of this shooting incident, EFRC determined that the shooting itself was within policy. After making that determination, EFRC members recommended an IAB investigation that covered the involved personnel's tactics just before the shooting *and also whether one deputy's ammunition was authorized. The review of the tactics included such issues as whether the initial responding deputies should have turned their backs on the group of persons on the sidewalk and chased the armed men and whether the deputies had taken adequate cover before firing their weapons. EFRC's findings were as follows: (1) a founded policy violation on the use of unauthorized ammunition; (2) an unfounded allegation of a policy violation with respect to the foot pursuit decision; and (3) an unresolved determination regarding whether Deputy A had taken adequate cover. In addition, EFRC recommended specific relevant training for Deputy C. OIR concurred*

EFRC Statistics: October 2004 through September 2005

Total Reviews Closed	**90** [1]	
Hit Shootings	21	
Non-Hit Shootings	24	
Uses of Force	46	
Referrals to Training [2]	**27 reviews** [3]	**78 employees**
Hit Shootings	4	22
Non-Hit Shootings	10	16
Uses of Force	14	42
Discipline	**18 reviews**	**43 employees**
Hit Shootings	3	16
Non-Hit Shootings	6	8
Uses of Force	9	19

[1] One review involved both a Use of Force and a Non-Hit Shooting and therefore is counted in both categories below, but only once in this total number.

[2] Training includes formal training, including Laser Village and CPT, as well as mandatory unit-level debriefings. This also includes two cases where the training EFRC would have requested had already been completed.

[3] Eleven reviews resulted in both discipline and training. Those reviews are included in the numbers for both categories.

only with EFRC's finding with regard to the unauthorized ammunition. OIR believed that Deputies A and B had violated policy regarding their foot pursuit decision, and that Deputies A, B, and C had violated policy by failing to take adequate cover. In OIR's view, the deputies' need to fire was prompted in part by these tactical lapses. EFRC assessed these issues but concluded that the conduct had not been substandard to the point of violating policy. On the founded violation of policy, EFRC recommended a written reprimand. OIR concurred with this recommended discipline.

PART SIX Policy and Training Initiatives

LASD Redesign of Its Field Training Officer Program

In late 2005, the Department proposed to implement a new Field Training Officer (FTO) Program. FTO's are generally experienced deputies, still working patrol, who are entrusted with providing direct supervision and training to young deputies who are moving from their custody assignments to police work "in the field" for the first time. Fewer jobs in the Department are more significant in their influence over career formation. For a new deputy, the development and reinforcement of basic patrol skills and the real world application of Department policy and training all occur under the watchful eye of the FTO. The mentoring typically lasts six months, and has the potential to shape years of subsequent policing – for better or worse.

An excellent FTO, accordingly, is an enormously valuable asset to the Department and the community as a whole. He or she must possess not only a wealth of knowledge and tactical skill, but also the ability to impart that material effectively. But while it stands to reason that the cultivation and retention of deputies who fit this demanding profile would be a Departmental priority, to date there have been too few incentives provided to those who agree to serve as teachers in the "classroom" of the streets.

Recently, though, LASD has proposed a revamping of its FTO program with the goal of attracting the "best and brightest" to this important role. It would create three new FTO positions with salary incentives to attract and retain the best possible candidates. The plan merits both attention and support.

The three-tier FTO positions would work as follows. The first tier would be new FTO's who would be in a Bonus I position. (Bonus I is a salary position above a regular deputy, but below a sergeant). After one year of proven service, a current Bonus I FTO would acquire an additional two salary schedules and the new title of Senior FTO, the second tier. The third tier would be a Master FTO position, to be filled by the person who would serve as the lead training officer in each patrol station. The Master FTO would be compensated at 4 salary schedules higher than the Senior FTO. The Master FTO would mentor and train station FTOs and deputy trainees, and assist the station Training Sergeant. The Master FTO would periodically ride with the new trainees in a patrol car, passing on valuable training and experience. The Master FTO would also set up remedial training where necessary, provide input regarding FTO selection, assist in the maintenance of trainee records, assist in the development of the Department's training program, and ensure that all directives outlined in the Training Officer's Manual and Field Trainee's Manual are followed.

At the same time, LASD intends to develop selection criteria that will further ensure the quality of the candidates. Each new position would require the applicants to pass certain background criteria, to be worked out in the future, possibly (and hopefully) with pending administrative cases or use of force inquiries and certain serious founded administrative histories to be considered as disqualifying. FTO's would be required to prepare a Core Values exercise designed to demonstrate their commitment to ethics, and would incorporate ethics into their daily interactions with patrol deputies and trainees. Additionally, the program proposes that, after their selection, the FTO's would meet with their section Chiefs and the Sheriff periodically to update them on the progress of their efforts.

The stereotype of the gruff FTO who tells new patrol deputies to "forget everything you learned in the Academy" is based in part on an important truth: there is a gap between theory and practice, and between the ideal and the real. Nonetheless, the Department's values and ethics are very much meant to translate into everyday policing. The FTO's who can model those principles and impart them to others deserve the respect, the status, and the compensation that the new program intends to offer. In addition, by providing such incentives, LASD will be able to develop selection criteria to ensure that only those deputies with an exemplary performance history will be eligible for these important positions.

New Workers' Compensation Fraud Unit

In July 2005, the Department announced it would hire ten private investigators to probe cases of potential workers' compensation fraud. The Department expects that the $1.5 million workers' compensation fraud unit will save money by deterring fraudulent claims, and by encouraging deputies who have filed claims to return to work promptly once they have recovered.

Since the late 1990's, the Departments' worker's compensation costs have steadily increased. About 4,000 industrial-injury claims are filed by department employees every year. During the fiscal year that ended June 30, 2005, the department paid approximately $85 million in workers' compensation claims. Recently, the Board of Supervisors also brought attention to the increase in the number of Department personnel who file for disability pensions.

While the increases in claims may not necessarily be explained or accompanied by an increase in fraud, it appears that the Department's relatively small investment in the new unit (as compared to the overall workers' compensation costs) is a wise risk management decision. Even if the unit reduces costs by mere percentage points, it will likely pay for itself.

The following example comes from a case monitored by OIR within the past year. It preceded (and partially inspired) the formation of the new unit, and was investigated by a sergeant in the Internal Affairs Bureau. It highlights the type of alleged misconduct this new anti-fraud unit is designed to address.

CASE

In 2004, a deputy sheriff was prosecuted by the Los Angeles County District Attorney's Office for workers' compensation fraud and related offenses. The case was contentiously litigated, and the jury acquitted him of most counts, and hung on one count. After the criminal case was over, as is the usual course, the case became an administrative investigation. The administrative investigation revealed the deputy had allegedly violated certain policies by a preponderance of evidence. During a deposition in his worker's compensation case, the deputy allegedly made several false statements, including (among other things) that he had never been a witness or litigant in a deposition before; that he had not driven any motorcycles or off-road/all-terrain vehicles, boats, or jet skis after his alleged injury; and that he had not engaged in any outside employment activities after his alleged injury. The evidence also revealed that the deputy allegedly failed to remain at home as required by department policy after his claimed injury. In addition, the deputy allegedly engaged in outside employment, for which he had not obtained Department approval as required, including (among other things) working as a private investigator. The deputy was found to have violated several Department policies, including general behavior, obstructing an investigation, obedience to regulations, prohibited employment, and failure to secure approval of outside employment. The Department discharged him, and the case is currently awaiting hearing before a civil service hearing officer.

Changes to LASD Youth Programs

The Department runs programs for at-risk youth as part of its community outreach and holistic approach to crime prevention. Prominent among these is the "Vital Intervention and Directional Alternatives" program ("VIDA"). VIDA is a 16-week program that seeks to teach young people to make better life choices and prepare for their future. Part of the program revolves around physical fitness and training.

A few years ago, the Department allowed a significant number of military personnel to volunteer and assist in the physical training. At the time, conventional wisdom held that grueling boot camp-like exercises, e.g. push-ups and long distance running, could help at-risk teenagers develop discipline, and build self-esteem. Having been through actual military boot camps themselves, some of these new volunteers adopted an approach that was more aggressive and intense than was perhaps appropriate for each of the young program members. Some of the Marines screamed at the children like drill sergeants, and pushed them to their physical limits. It failed to be successful or constructive for some of the participants, who already had issues with authority figures. It was a case where good intentions and a plausible theory did not always correspond to a successful outcome in practice.[1]

In 2002, a significant incident occurred where a Marine was accused of assaulting a young boy. Three deputies assigned to the VIDA program were present, and used force on the boy, consisting of grabbing his arms and legs to control him. Soon after the incident, an LASD chief ordered a comprehensive review of VIDA. OIR monitored the review, and the internal investigation of the three deputies. In mid-2004, each deputy received discipline for failing to report the force they used. (Immediately after the incident, the Marine was excused from the program). Using information gathered from the investigation and review of the program, OIR met with VIDA supervisors to discuss new policies and training to help prevent similar incidents from occurring in the future. Recently, the department revised its VIDA Policy Manual incorporating OIR's recommendations in full or in part, including:

Limiting the Participation of Military Volunteers: Under the revised policy manual military personnel will not be approved as volunteers solely on their military expertise. Because some military personnel appeared to treat participants too harshly,

[1] This is not to say that the VIDA program overall did not benefit the attendees. In particular, the classroom element of the program generated a great deal of positive feedback. In addition, the vast majority of the parents who enrolled their children in the VIDA program were extremely complimentary of its impact.

e.g. using foul language, or forcing participants to do push-ups in mud, OIR recommended that they not be used as volunteers. The Department, however, did not adopt this recommendation; instead it chose to make military experience a non-factor in accepting volunteers. Nevertheless, the Department did make it clear that the boot camp atmosphere of VIDA was a thing of the past: "The VIDA Program's intent is not to create a military boot camp atmosphere, such as making physical contact with the students, use of profanity, discipline without a purpose, the demeaning of students, and other similar practices." The Department also prohibited the wearing of military uniforms. OIR is hopeful that these new policies will result in a clear understanding that any military personnel accepted as volunteers should not act like drill sergeants, or treat participants like military recruits.

Use of Force and Citizen Complaint Reporting Requirements: Under the new policy manual any VIDA staff who either use or witness force shall immediately report the incident to a VIDA sergeant and lieutenant, who will be responsible for conducting a force investigation and preparing a force package according to already existing Department use of force protocols. Because OIR found that force reporting practices in VIDA were either lax, inconsistent, or non-existent (as in the case involving the three deputies), OIR recommended the above policy change, which the Department adopted. The Department, to its credit, went a step further. The new policy makes it clear that use of force against participants should be avoided if at all possible: "Use of force in the VIDA Program shall only occur under the most compelling circumstances . . . Every effort shall be taken to avoid the use of physical force on a student." In addition, the new manual requires that any citizen complaints (concerning use of force or other misconduct) be reported to the VIDA sergeant and lieutenant, who shall follow Department guidelines to investigate such complaints.

Student Walk-Aways — Prohibition of Use of Force: In monitoring the review of VIDA, OIR found some instances where disgruntled participants attempted to walk away from the program site without permission, and deputies used minimal force, e.g. control holds, to prevent them from doing so. OIR recommended that the Department address this area, and come up with a solution that did not involve force. The Department did so, and came up with a laudable alternative. The new policy provides that force shall not be used to prevent a student from leaving a program site. Instead, the deputy shall advise the participant to remain until a parent can be notified, and if a parent is unavailable, a deputy will offer to transport the participant home. The policy also provides that the incident will be documented, which will allow for appropriate supervisory review.

Limitation on Handcuffing: The Department's review of VIDA also revealed a number of allegations that handcuffs were used on participants to punish them.

As a result, OIR recommended that VIDA staff be prohibited from punitive handcuffing of participants. The Department adopted this recommendation. The new manual states, "Handcuffs shall not be used to punish a student." OIR has also become aware that some contract cities have contracted with the Department to have personnel of their choosing at certain stations run informal programs for at-risk youth. Such programs are loosely modeled after VIDA, and are sometimes even mistakenly referred to as VIDA programs, however, they are not run or supervised by VIDA personnel. Even a structured program like VIDA that has been around for decades can have its problems, as the VIDA incident involving the marine and three deputies demonstrates. The difference with VIDA, however, is that it has a newly revised policy manual, which clearly sets forth procedures for reporting significant incidents, and supervisorial duties regarding such incidents. Other non-VIDA informal at-risk youth programs may not, or if they do, their policies may conflict with those of VIDA. Indeed, even if these informal programs were to use VIDA's new manual, to do so in a vacuum (without training or a network of experienced supervisors, for example) would still leave them susceptible to procedural weaknesses.

In 2005, one of these non-VIDA informal at-risk youth programs at a contract city station had an incident where a young girl suffered serious heat exhaustion during physical exercise. The girl had to be hospitalized, but fortunately she did not suffer permanent injury. OIR is monitoring the investigation, which is pending. Apart from the accountability issues that have yet to be resolved, the case seems to speak to the advisability of a uniform approach to youth programming. Such an approach would make the protocols and procedures more consistent, and presumably easier to enforce.

The Explorer Program: Revising an Outdated Policy Manual with an Eye Toward Risk Management

For many years the Department has offered a Law Enforcement Explorer Program, which is designed to interest youth in, and provide a basic understanding of, law enforcement. Young people, ages 14 to 21, may participate as Deputy Explorers in the program. Deputy Explorers are allowed to perform certain law enforcement-related activities under the supervision of sworn Department members, including assisting with traffic control, Color Guard activities, assisting station record keeping, and participating as observers in ride-alongs. In 2002 and 2003, OIR monitored a number of internal investigations involving allegations of (consensual) sexual misconduct committed by Department members against youth program participants, including one Deputy Explorer. In 2003, the media reported on a growing number of allegations of sexual misconduct in Explorer Programs nationwide. With an eye toward risk management, the Department and OIR began reviewing the Department's Explorer Program Manual of Policy and Procedure, which had not been revised since 1986. In 2005, the Department revised its Explorer Manual, adopting some of OIR's recommendations in the process:

Unit Commander Notification of Off-Site Activity and After-Action Report: The new Explorer Manual requires Department members to notify their unit commander, e.g. their station captain, of off-site field trips or social activities. Such activities may take place only with the concurrence of the unit commander. Immediately following the event, the department member must prepare a detailed memorandum describing the event, the program participants, and any circumstance that should be brought to the attention of the department. This policy was inspired by a 2004 incident where it was alleged that underage minor Explorers consumed alcohol and engaged in consensual sexual activity during a field trip . When the deputy supervising the Explorers became aware of the incident, he allegedly suggested to the Explorers that no one needed to know what happened. The incident, which parents of an Explorer brought to light, was subsequently investigated, and the deputy was disciplined. Hopefully, this newly required after-action report will encourage supervising deputies to document any significant incident that occurs during off-site Explorer activities so that an appropriate investigation may occur without delay.

Limiting Ride-Alongs with the Same Deputy: Because it was alleged in one Department internal investigation that a deputy had taken a female Explorer on numerous ride-alongs, and developed an inappropriate sexual relationship with her, and as a result of similar allegations in other departments nationwide, the Department instituted a policy requiring unit commander approval of all ride-alongs, and limits on ride-alongs with the same deputy. Further, Explorers are limited to no more than two ride-alongs with the same deputy in a calendar month. OIR had recommended that the department ban Explorers from participating by themselves in ride-alongs with a single deputy. The Department, however, believed that this restriction would interfere with the learning experience of the Explorers, so rather than prohibit single deputy ride-alongs, it limited the number of ride-alongs with the same deputy to two per month, and OIR concurred with this decision.

> *Inappropriate Relationships between Deputies and Explorers:* One of OIR's most important recommendations was to implement a policy prohibiting inappropriate sexual or dating relationships between Department members and any youth program participants, including Explorers. Along these lines, the department has revised its Explorer manual to prohibit unprofessional and inappropriate relationships and off-duty contacts between deputies and Explorers.

Currently, the Department is in the process of implementing a department-wide Policy Manual provision that would prohibit relationships of a dating, intimate or sexual nature between Department members and all youth program participants, (not just Explorers), including Youth Athletic League participants, VIDA participants, etc. The Chief of the Leadership and Training Division was the first department chief to support this idea. Risk Management worked with OIR to draft the policy. If implemented as currently drafted, the policy would also prohibit off-duty unplanned contact between department personnel and youth program members, inappropriate touching, comments, or conversations, the presence of inappropriate materials, and sexual harassment. It would also require separate accommodations for department personnel and youth group members on field trips, and would require prior unit commander approval and after-action reports for all youth program field trips. OIR encourages the Department to follow through on its good work in this area and implement the draft Policy Manual section Guidelines Governing Youth Group Programs, Manual of Policies and Procedures Section 3-01/050.87.

OIR Training Update

Throughout the past year, OIR made several presentations to LASD personnel and others. Some involved training on issues related to effective investigations, while others offered more general information about OIR's role in the LASD review process. OIR welcomes all of these opportunities. If the training blocks offer a useful perspective to investigators, or the information-sharing enhances people's understanding of OIR's approach, then the presentations advance the goals that OIR has pursued since 2001.

Many of these sessions have been continuations of commitments that OIR has discussed in previous reports. For example, OIR periodically presents an hour-long course to supervisors, investigators, and Department executives regarding the rights and obligations of deputies facing allegations of misconduct. (See OIR's Second Annual Report, at pp. 39-40).

The class discusses the current state of the law, the overlap of criminal and administrative proceedings, and the special issues that can arise when peace officers are accused of wrongdoing. While rigor in addressing misconduct must remain a Depart- mental priority, respect for the deputies' rights as citizens, peace officers, and county employees must also guide the Department's actions. Finding this balance can be especially difficult for supervisors at the individual patrol stations and jail facilities. They often lack extensive training as investigators or experience in dealing with controversial events, but are nonetheless expected to "get it right" as the Department's first responders to unfolding incidents or public complaints. OIR's overview and discussion of scenarios seeks to provide a framework for carrying out this important responsibility.

Additionally, thanks to the ongoing consideration and support of the LASD Custody Training Division, OIR appears regularly at the Custody Incident Command Schools. These schools offer a week of intensive training to newly-promoted supervisors in the jails. OIR's curriculum revolves around the importance of effective and unbiased investigations into inmate complaints of deputy misconduct. As described in the Third Annual Report, it includes a bulletin of practical suggestions and reminders about the process of evidence-gathering and report compilation. The point is to recognize some of the impediments to objectivity that exist when inmates make complaints, and to help Department personnel overcome those in order to make the inquiries sound and results appropriate.

OIR has received other invitations to discuss it own mission and perspectives with different groups within the Department. In June, for example, the new Captain of Safe Streets Bureau (which specializes in gang-related crime) asked OIR to speak at the training day that brought all the Safe Streets deputies and supervisors together. Having encountered OIR at the scene of a few recent deputy-involved shootings that involved his officers, the Captain wanted OIR to provide his personnel with some general insights into the various types of scrutiny that a shooting receives, and to discuss its own functions in particular. Ideally, this provided the deputies with new and useful information as to how and why shootings are reviewed. It also gave OIR a welcome opportunity to meet a large group of deputies and better understand their issues and concerns about the investigative process.

OIR has also discussed its oversight model and its relationship with the Department in outside contexts. This included a panel discussion at the annual convention of NACOLE –the National Association of Civilian Oversight of Law

Enforcement, held in Chicago in late October of 2004. There, OIR attorneys and Department representatives discussed the role and potential benefits of civilian oversight in the risk management arena for law enforcement. The following month, OIR had the chance to explain its approach at the annual International Association of Chiefs of Police gathering, held in Los Angeles. In a presentation entitled "Everybody Wins," OIR talked about the ways in which meaningful outside oversight can benefit the agency, both internally and as a means of defusing public tension and distrust when controversial incidents arise. OIR has also participated in a discussion of topical oversight issues at a conference in Portland, Oregon and a discussion of disciplinary matrices in Oakland, California.

OIR continues to see training and outreach as a significant part of its responsibilities in working with LASD. The Department's receptivity and willingness to involve OIR in this capacity has worked to the advantage of both entities.

OIR Comment on LASD Training Videos

Because OIR attorneys have access to LASD internal emails and bulletins, whenever Training Bureau posts a new video and announces it to the Department, OIR also receives the announcement. During the past year, OIR viewed one of these new training videos and had questions about it. An OIR attorney met with the video unit to discuss the content of the video. As a result of that conversation, the video unit offered to provide OIR with drafts of the scripts for videos and of videos awaiting approval so that OIR could review them and provide any comments it might have. OIR accepted this offer and has been receiving scripts and videos for comment.

This practice provides a unique opportunity for OIR to help the Department ensure that it has a consistent message from policy to training to enforcement of that policy at Executive Force Review and elsewhere. In addition, as outsiders and attorneys trained to view things critically, OIR will sometimes spot potential ambiguities or mixed messages that individuals more immersed in the subject might overlook. OIR raises these with the video unit so that they can determine whether they merit a change in the video.

This procedure worked very well for the video created to help train the Department on the new Assaults by Moving Vehicles – Firearm Policy. Because OIR participated in discussions with the Sheriff and the Executives about the policy, OIR was very familiar with the intent of the policy. At both the script stage and the raw footage stage, OIR provided a number of suggestions to make the video consistent with the policy. In addition, OIR raised questions about certain scenes where OIR was not certain what message the scene would deliver to a deputy viewing the video. Many of OIR's suggestions were accepted. Ultimately the Video Unit deserves praise for putting out a good product in a very short period of time.

OIR continues to receive scripts and videos awaiting approval to provide feedback where appropriate. Many of them do not result in any OIR comments. But, for those where there are questions, this is a meaningful opportunity to advance OIR's mission and assist the Department as it improves its training.

OIR Recommendation Leads to Professional Staff Training

A disciplinary investigation of non-sworn professional staff resulted in a finding that one of the staff members had behaved in an unprofessional manner toward a deputy district attorney during discussions in preparation for court testimony. OIR agreed with this finding and suggested that some focused training on the needs and constraints of the criminal court system might improve staff performance and avoid a recurrence of the misconduct. The unit in question agreed to implement an even more thorough training than originally discussed, putting its professional staff through a two day instruction and mock trial program conducted by litigators and a superior court judge.

OIR Involvement as Monitor for LASD Settlements of Litigation

On two occasions now LASD has settled litigation and OIR has been asked jointly by both parties to the litigation to assist with the implementation of the settlement. As reported in the Second Annual Report, at pp. 39-40, OIR was approached regarding a lawsuit brought by two deputies and their union against LASD alleging that LASD investigators violated the deputies' rights while investigating allegations of misconduct. As part of the settlement LASD agreed to provide training to supervisors regarding conducting investigations without impinging on the rights of employees. To assist with the settlement, at the request of both parties, OIR agreed that it would conduct that training. (See above at p. 85)

This past year, OIR was again approached regarding a settlement of litigation. In this case, the Western Law Center for Disability Rights had sued regarding LASD's provision of interpreters for deaf individuals who come in contact with LASD, either in public or through the jails. The proposed settlement required

LASD to undertake certain changes and perform certain tasks. OIR was asked to monitor LASD's compliance with the agreement and performance of those tasks. OIR has agreed to do so, and LASD and the plaintiffs are currently working on the final language for their settlement and the framework for OIR's role.

OIR's structure allows it to play this unique role to assist both parties with settlements. Because OIR is independent of LASD, it can provide an independent perspective on LASD's performance. But, because OIR has unfettered access to LASD, it can gather the information necessary to monitor LASD's performance under the settlement. Because of OIR's familiarity with LASD, it can do this much more easily than plaintiffs could, and with less disruption to LASD.

It is not OIR's primary function to monitor LASD performance under settlements or to provide training required by settlements. In these two examples, however, the substance of the settlements related to core areas of OIR's concern – respect of employee rights during investigations, and LASD's provision of services to a portion of the community. Therefore, assisting with these settlements advances OIR's mission and OIR readily will provide any constructive assistance that both parties request.

PART SEVEN Issues of Deputy Misconduct

Off-Duty Conduct

As OIR has described in previous reports, the Department holds deputies to a high standard for their off-duty conduct, and deputies are subject to discipline or even discharge based on incidents that arise away from the job. OIR monitors these incidents as part of its regular protocols. OIR supports the Department's view that the authority and prominence of peace officers makes their personal conduct relevant for discipline and for the assessment of their suitability as officers. Additionally, as with some of the categories of misconduct discussed below, problematic relationships or behaviors in a deputy's personal life can very easily compromise on-the-job integrity and effectiveness.

Since the publication of the last OIR Annual Report, several cases have involved particularly serious offenses and have been followed with special care by this office.

Burglary

Soon after a deputy's relationship with a woman came to an end against his wishes, the woman returned from a weekend trip to find that her home had been vandalized, and that a number of her personal items were missing. The alleged damage included a television ruined with bleach and furniture that the intruder had urinated on. She immediately suspected her former boyfriend, who had continued his efforts to contact her and who knew she was leaving town. In light of the things that were taken, and things that were left behind, and the nature of the damage (including, for example, numerous holes in the fabric of a couch that she had repeatedly urged the deputy to treat carefully when they were dating), the act did not seem consistent with a straight property crime.

The Department initiated a criminal investigation and focused its attention on the deputy as the primary suspect. Early in the investigation, an attorney representing the deputy informed the Department that she had a number of the victim's possessions, and she arranged for their return without accounting for how the attorney had acquired them. This began a series of informal communications that ultimately resulted in the recovery of much of the victim's property, as well as a subsequent financial settlement between the deputy and the victim.

Meanwhile, the investigation revealed other issues. Along with a stalking allegation that lacked significant evidentiary support, the victim claimed that the deputy/suspect had improperly "fixed" a ticket on behalf of a friend of hers and had inappropriately accessed law enforcement databases in order to obtain personal information about her and her new boyfriend. These latter claims were substantiated by the Department's criminal investigators. However, the District Attorney's Office declined to prosecute.

The ensuing administrative investigation was extremely straightforward: the deputy admitted his culpability in a brief interview with Internal Affairs. This left the Department with a decision about how to respond. The charges certainly warranted termination, but this was counterbalanced by a lengthy and well-regarded on-duty career and the Department's belief that this "crime of passion" was an extreme and aberrational episode from a personal life that had re-stabilized. One obvious concern was whether he was continuing to bother the victim in this case, but she confirmed that all contact with him had ceased.

Though the decision was a difficult one, OIR eventually came to believe that discharge was warranted. This was due not only to the severity of the main offense, but also to the abuses of authority that were involved in the ticket-fixing episode and the inappropriate use of confidential law enforcement databases. The Department agreed and decided to fire the deputy.

Another case involving burglary allegations that ended in March of this year resulted in a 10-day suspension for the deputy subject, who had allegedly broken into his ex-wife's home (where he had once lived also) and stolen property belonging to her. He allegedly took wedding photos, china, and a bracelet, and claimed later that he took the latter item as collateral for money owed to him. Again, the conduct at issue was potentially criminal, but ambiguities in the evidence and the ultimate return of the property led to a declination by the District Attorney. The Department then moved forward with the administrative case, and the suspension ensued when the investigation was complete.

DUI Update

In our 2004 annual report, we highlighted a disturbing increase in arrests of off-duty LASD employees for driving under the influence. Unfortunately, this trend has continued. This year's statistics show that the number of off-duty LASD employees arrested for driving under the influence remains high. Through the middle of September 2005, 18 off-duty LASD employees had been arrested for driving under the influence, and this figure does not include two LASD employees who were arrested for public drunkenness or disorderly conduct because of intoxication. Ten of the 18 arrested off-duty LASD employees were sworn personnel, including two sergeants.

In comparison to last year, there were several interesting contrasts in terms of which LASD personnel were involved in driving under the influence incidents. Most strikingly, there was a significant reduction in the number of driving under the influence incidents involving custody personnel. In 2005, only five of the 18 arrested LASD employees were assigned to custody facilities, and four of those employees were civilian custody assistants. This represents a significant reduction from last year's proportions. This reduction in the number of custody personnel arrested for intoxication offenses may be a result of the focused training provided by the Department to custody personnel in the past year and described in our Third Annual Report (pp. 20-21).

In 2005, LASD disciplined several of its employees for driving under the influence of alcohol. In addition to creating a public safety hazard by driving, several of the involved personnel further discredited the Department through additional misconduct that complicated their arrests. Three cases in particular are worthy of further discussion.

CASE

In 2003, an outside police department arrested an LASD deputy for driving under the influence. Although the deputy was off-duty when arrested, he was in a county car. The deputy had passed out at the wheel of the county car. To compound this situation, the deputy became belligerent when police officers tried to effectuate their arrest and refused to perform field sobriety tests or chemical blood tests as required by law. The local district attorney filed criminal charges against the deputy, and the deputy pled nolo contendere to driving under the influence of alcohol. In 2005, after completing its internal administrative investigation, LASD found that the deputy had violated Department policies and imposed a 30-day suspension.

C A S E

In 2004, an out of state law enforcement agency received complaints from several witnesses that a watercraft was traveling at excessive speeds and in a reckless manner in a "no wake" zone. An officer responded to the scene, observed an off-duty LASD deputy operating the identified watercraft and spoke with the deputy. The deputy admitted that he had operated his water craft in the no wake zone at excessive speeds and that he had nearly run the watercraft aground. At a distance of four to five feet, the officer could clearly observe that the deputy had been drinking. The deputy admitted to having approximately eight beers within the past two hours, and he failed a number of field sobriety tests.

However, when responding officers attempted to arrest and handcuff him, the deputy refused to cooperate. With closed fists, he began walking away from the officers. The officers repeatedly requested that the deputy stop and put his hands behind his back, and the deputy refused to comply with each request. As the officers tried to grab the deputy's arms, they were nearly struck by the deputy's elbows and fists as the deputy violently broke out of officers' holds. The conflict continued until one of the officers sprayed the deputy with OC spray. As the deputy began to bend over, the officers grabbed him, forced him to the ground and handcuffed him.

At the law enforcement agency's station, the deputy's non-compliance continued. The deputy refused to submit to breath testing, and, after an examination by medical staff, to have his blood drawn. The local county attorney filed criminal charges against the deputy. Those charges related to operating a watercraft while intoxicated and resisting arrest. Subsequently, the deputy pled guilty to one misdemeanor count of operating a watercraft while intoxicated.

In 2005, after conducting its internal administrative investigation, LASD found that the deputy had violated its policy and procedures and recommended a 15-day suspension. OIR concurred with the findings and the recommended range of discipline.

C A S E

In 2004, after celebrating with other LASD personnel at a bar and consuming alcoholic beverages, Deputy A drove a private car with Deputy B as her passenger. After driving a distance, Deputy A side swiped one parked car, rear-ended a second parked car and drove that second car into a third parked car. The impact of the crash caused Deputy B's to strike the windshield and dashboard and resulted in injury to Deputy B's nose. While Deputy B remained in the car, Deputy A exited the car, called a friend and walked away from the accident. Via a cellular telephone, Deputy B called a fellow deputy, Deputy C, and advised Deputy C about the collision.

Meanwhile, an eyewitness to the car accident called 911 and reported the traffic collision with injuries. Several minutes later, Deputy A returned to the accident scene, and Deputies A and B gathered their personal belongings from the car and departed. They walked several blocks away and met with Deputy A's friend, who had driven to the area in response to Deputy A's call. Deputy A and the friend then returned to the crash site. After examining the damage, the friend got into the car on the driver's side, while Deputy A entered the passenger side.

At this point, fire department personnel and paramedics arrived at the accident site; however, they left because they were unable to locate a person with a bloody nose. When responding police personnel arrived to investigate the car accident and asked for the driver, Deputy A's friend gave his driver's license and Deputy A's auto insurance card to the officers and told the officers that no one was injured and that while changing the radio channels, he crashed Deputy A's car. Deputy A's friend also informed the officers that Deputy A was an off-duty deputy. During this time, Deputy A was off to the side of the crash site, talking on a cellular telephone and ignoring the officers' presence. Neither Deputy A nor the friend informed the officers of Deputy B's injuries or involvement in the car accident.

When the handling officers inspected Deputy A's car, they found fresh blood on the passenger door handles and small cracks on the passenger side of the windshield. This led to further inquiry, and further misinformation from Deputy A and her friend. Eventually, though, eyewitnesses correctly informed the officers that Deputy A had been the driver.

An investigating police sergeant arrived on the scene and spoke privately with Deputy A. Only after being confronted with the witness statements did Deputy A finally acknowledge her role as driver, with Deputy B as the injured passenger. At this time, Deputy C arrived on the accident scene and inserted himself into the investigation. In a conversation with the investigating officer, Deputy C tried to persuade the officer to not take any criminal action against Deputy A and to handle the car accident as a disturbance call. Police personnel at the accident scene concluded that Deputy C was himself under the influence of alcoholic beverages. The officers arrested Deputy A for driving under the influence, and Deputy A registered a 0.126% on the Intoximeter.

While investigating personnel were booking Deputy A at a local jail, Deputies B and C arrived at the station. They compounded the earlier problems by asking to speak with the handling officers and continuing to mislead and obfuscate. Finally, in a written statement to the handling agency, Deputy B admitted the truth.

In 2004, the district attorney filed two felony counts against Deputy A. Count one charged Deputy A with, while under the influence of an alcoholic beverage or drugs, illegally driving a vehicle which caused bodily injury to another person. Count two charged Deputy A with driving with a .08% blood alcohol and causing injury to another person. Subsequently, Deputy A pled nolo contendere to a misdemeanor charge of driving under the influence.

In 2005, after an internal administrative investigation, LASD found that Deputies A, B and C violated Department policies and recommended discipline for the involved personnel ranged from a 10-day suspension to discharge. OIR concurred with these findings and the recommended range of discipline. Pursuant to its model of oversight, OIR will continue to monitor this case through any grievance process.

The above examples demonstrate the need for LASD vigilance in addressing off duty conduct involving abuse of alcohol. First, for peace officers to violate any law which they are empowered to enforce when they are in uniform sends the wrong message to the community the peace officers serve. More importantly, as these case studies indicate, the influence of alcohol often results in boorish behavior by LASD deputies that causes embarrassment and disgrace to the organization in the eyes of fellow law enforcement agencies. In addition, the clouding of judgment caused by alcohol may tempt a deputy to try to use his law enforcement position to seek special treatment as a result of his position. Finally, alcohol influence may cause peace officers to mislead responding officers about the incident and thereby result in not only embarrassment, but also the undermining of reputation for all deputies who wear the LASD badge.

For these reasons, in addition to addressing these incidents sternly, LASD must continue to educate its deputies about the threat that alcohol abuse may have on a deputy's career. As noted above, the Custody Training Division's efforts may have gained dividends as evidenced by the downward trend of incidents among custody personnel. Similar training and instruction must be exported to all units of LASD and OIR has seen some promising signs of such outreach. Recently, a video entitled "Red Wristband" documented a first-hand account of a former LASD deputy who spent years in prison as a result of his involvement in an alcohol-related traffic collision that resulted in a death. OIR understands there is a similar video under production featuring one of the deputies whose behavior was described elsewhere in this Report, and who agreed to discuss the negative impact on his career that abuse of alcohol has had. OIR will continue to encourage LASD to address this important issue in the months to come.

Sexual Misconduct On and Off Duty

As mentioned in OIR's Third Annual Report, at p. 17, OIR continues to monitor allegations of sexual misconduct by LASD employees. As we reported last year, two deputies were indicted for using their position to force women to engage in sexual conduct. One case was recently tried and the deputy found guilty. In August 2005, a Los Angeles Superior Court jury convicted the deputy of two counts of misdemeanor sexual battery, and one felony count of filing a false police report. The jury was deadlocked and could not render a verdict on a separate felony count of sexual penetration by foreign object.

During the trial, one woman and an underage girl testified that, on separate occasions, the deputy stopped them, asked them a sexually suggestive question and either had them sit in the back seat of this patrol car or stand nearby, where he inserted his finger into their vaginas. A third woman testified that she was an unauthorized ride-along with the deputy, when he asked her a similar question, and then arrested a driver of a vehicle for a crime he may not have witnessed. In September of 2005, the court sentenced the deputy to thirty months in prison. Additionally, as a result of the convictions, he will have to register as a sex offender. The deputy recently resigned from the Department.

The second case, filed in federal court, is currently pending and the trial is scheduled to begin in early 2006. This deputy stands charged with deprivation of civil rights under color of law, in that he allegedly forced two women to engage in vaginal intercourse, engaged in an inappropriate sexual contact with a third woman, and forced a fourth woman to perform oral sex. The deputy is currently relieved of duty without pay. OIR will monitor this case as it proceeds to verdict.

Sexual misconduct, especially where a victim is coerced due to a threat or fear, obviously discredits law enforcement to the point where mere suspension or demotion is inadequate.[1] LASD should, and for the most part does, take these and related allegations seriously, and OIR monitors these cases from the perspective that proven allegations – even in the absence of criminal conviction, should usually end in discharge.

The cases summarized below are further examples of troubling behavior that LASD has addressed within the past year. At the time of publication of this Report, the cases are at various phases of the administrative discipline/grievance/appeal process.

[1] *Fout v. State Personnel Board*, 136 Cal.App. 3d 817, 819-22 (2d Dist. 1982); "The Harm to the Public Service Standard in Police Misconduct Cases," Ray Jurado, Los Angeles Lawyer Magazine, July-August 2005, at 26.

CASE

An on-duty deputy is alleged to have inappropriately touched or digitally penetrated women that he had stopped as they were driving or walking down the street. The misconduct occurred in three separate incidents over a nine-month period. A fourth incident did not involve sexual misconduct, but may corroborate a modus operandi.

In the first alleged incident, the deputy stopped two women in a car. He threatened to arrest the driver if she did not show him her undergarments. He made the same demand of the passenger, illuminated her pelvic area with his flashlight, and commented on the color of her underwear. He then placed his fingers between the passenger's dress and body, pulling the garment away, and looking down her dress.

In the second alleged incident, the deputy stopped a female pedestrian on her way to work. The deputy made a pretext of searching the back of her pants pockets, touching her buttocks. He then had her turn around, and pulled the front of her pants away from her body exposing her skin and underwear. The deputy threatened to deport her and made sexually suggestive comments.

In the third alleged incident, the deputy stopped another female pedestrian. The deputy ran her name and address in his patrol car computer, found she had a record, and threatened to violate her parole unless she cooperated with him. He then told her to pull her pants down and show her underwear. The deputy touched her buttock. He had her get into his patrol car and pull her pants down. He then inserted his finger into her vagina, and suggested she orally copulate him. After releasing her, he later drove to her house, and stated he would return when his shift was over.

In a fourth alleged incident, the deputy contacted a woman driving her car alone late at night. He pulled alongside her at a stoplight, and asked her where she was coming from. She responded she was coming from a party, and drove home. A short time later, the woman saw the deputy's patrol car with its lights out drive up as she was about to get out of her car in front of her house. The deputy then asked her personal questions, and for her phone number. She asked what he was doing at that location, and he claimed he had a call in the area, but she lived in a city that was not patrolled by LASD, and he was outside the area he was assigned to patrol.

Based on investigation into these incidents, LASD fired him for violating policy, including general behavior (discrediting himself and the department), conduct toward others, performance of duty, immoral conduct, obedience to regulations (failing to log public contacts), and false statements. His appeal of his discharge is currently being heard before a Los Angeles County Civil Service hearing officer.

CASE

In this case a deputy, who worked with a youth athletic league, is alleged to have established a personal relationship with a seventeen-year-old girl, whom he met while on-duty. The deputy on many occasions while on-duty and in uniform and using a department vehicle visited the girl's home, where she lived with her parents, and visited her at work. He is also alleged to have attended her graduation while on-duty, and drove her in his Department vehicle on this and numerous other occasions. Soon after the girl turned eighteen-years old, he is alleged to have had sexual intercourse with her in his office. After the deputy was told he was being investigated, he was ordered by his captain not to have contact with the girl or her family. He disobeyed the order, contacted them while on-duty, and falsified his daily logs to indicate that he was at another location. LASD fired him for violating policy, including performance of duty, performance to standards, general behavior (discrediting himself and the department), obedience to orders, and false information in records. His appeal of his discharge is currently pending before a Los Angeles County Civil Service hearing officer.

CASE

A deputy in a custody facility is alleged to have masturbated while on-duty. The incident was witnessed by a female colleague. DNA forensic testing established that the seminal fluid recovered at the scene matched DNA obtained from the deputy. LASD fired him for violating policy, including sexual harassment, inappropriate conduct toward others, general behavior, and performance of duty. His appeal of his discharge is currently pending before a Los Angeles County Civil Service hearing officer.

CASE

In this case, an off-duty custody assistant is alleged to have engaged in inappropriate sexual contact with a minor female. The custody assistant is alleged on several occasions to have fondled the minor's breasts, inserted his finger into her vagina, and placed her hand on his penis. He is also alleged to have poured hot wax on his body in her presence and engaged her in inappropriate horseplay. Initially, the case was investigated criminally, and he was charged with continuous sexual abuse, and tried twice. The first jury hung, and the second acquitted him.

Following the criminal case, the incidents were investigated administratively, and the Department fired him for violating policy, including immoral conduct, general behavior, and conduct toward others. The custody assistant appealed. Currently, the case is pending before the Los Angeles County Civil Service Commission.

Fraternization and Prohibited Associations

Along with the cases that revolve around sexual misconduct, OIR has also reviewed a number of equally disturbing allegations of deputies and other LASD custodial personnel having inappropriate relationships with inmates or known criminals. These cases have not risen to the level of criminal misconduct. But, when a deputy is seen associating with a criminal, the breach of the public trust is no less significant.

LASD policy, MPP 3-01/050.90, prohibits deputies from:

> maintain[ing] a personal association with persons... who have an open and notorious reputation in the community for criminal activity, where such association would be detrimental to the image of the Department, unless express written permission is received from the member's unit commander.

Permission can be granted only after the employee articulates the necessity of the relationship and why it should be allowed to commence or continue.

This policy is an important means for protecting the reputation of LASD and individual deputies. When law enforcement officers are associated with notorious individuals with reputations for criminal activity, the public invariably begins to question the integrity of those officers. The public rightfully wonders how someone who has taken an oath to uphold the law, associates with someone known to break the law. And if an officer has a duty to apprehend criminals, it appears to be preferential treatment to associate with, but not arrest, a person known to engage in criminal activity. The public may get the impression that the notorious individual is untouchable by law enforcement because of his or her friends in law enforcement. Alternatively, when a deputy develops a relationship with someone as a result of his assignment as an officer and the other individual's role as an inmate or arrestee, there is the potential for corruption of the criminal justice system.

The policy does, however, recognize that not everyone's life can be so easily segregated. There may be extenuating circumstances that necessitate an otherwise prohibited association. For instance, a deputy may have a relative who is a known drug addict. Therefore the policy does have an escape clause for obtaining permission for the association.

In addition, LASD prohibits fraternization between its employees and anyone in custody or whom the member knows to have been released from custody in the preceding 30 days. Not only are those in custody either accused or convicted of criminal activity, but the fact of their incarceration, or even recent release, creates a huge imbalance of power between them and an LASD employee, or as illustrated below, creates a scenario that jeopardizes the objectivity necessary for a principled system of justice.

C A S E

A deputy, while off-duty, was observed by officers of another police department in the company of a known prostitute and drug user. The officers detained the deputy and the known prostitute for a criminal investigation. Several weeks later, the deputy was again contacted by officers from the other police agency. This time he was driving in his car with the prostitute. The deputy admitted to knowing that his female friend was a known prostitute. By the time of the conclusion of the investigation, the deputy and the prostitute had begun to live together and he called her his "significant other." The deputy never, however, sought an exception authorizing this otherwise prohibited association. After an investigation the deputy was found to have participated in a prohibited association, and to have made false statements during the internal investigation of the association. LASD discharged the deputy.

C A S E

A senior cook was witnessed by a deputy and a custody assistant holding hands with an inmate while laughing and having a conversation. The deputy and custody assistant reported the behavior to their supervisor. After an investigation, LASD concluded that this was improper fraternization and discharged the cook. The cook appealed to the Civil Service Commission. Despite denials by the cook, the Commission concluded that the conduct had occurred, that it was a prohibited fraternization, and that discharge was the appropriate remedy for improper fraternization.

C A S E

A deputy arrested a female driver for DUI after responding to a call of a motorist running into parked cars. Within several hours of releasing her from custody, the deputy began calling her from his cell phone. Over the next four and a half months, the deputy made more than one hundred and twenty calls to the woman. LASD became aware of this after the motorist taped some of the conversations and provided the tape to the prosecuting Deputy District Attorney. In a taped conversation, the deputy discussed how he had written his arrest report with intentional ambiguities and suggested how the woman could use those problems with the report for her defense. In other taped conversations, the deputy repeatedly asked the woman to go out for coffee, dinner, or otherwise meet. As a result of the taped conversations, the DDA dismissed the charges against the woman and LASD began a criminal investigation into whether the deputy had committed perjury. In the meantime, the woman and the deputy appeared for her DMV license suspension hearing. The deputy had indicated on the night of the arrest that the woman had refused to provide a chemical test and therefore should forfeit her license. At the *hearing, it was shown that when she was asked on videotape by the deputy whether she would agree to a test, she agreed to it. The deputy asserted that prior to that time she had repeatedly refused and by the time of the videotape it was too late to accurately test her intoxication level. The DMV dismissed the administrative action against her. When interviewed as part of LASD's investigation, the deputy initially claimed he had made only a handful of telephone calls to the woman. He also initially denied ever meeting with her in person after her arrest. His telephone records, however, revealed the much larger number of calls, that continued up until the day of the DMV hearing. In addition, the deputy ultimately admitted at least one face to face contact with the woman. No personal relationship ever developed, but the deputy admitted that that was what he was seeking. The District Attorney concluded there was no criminal conduct. However, after its administrative investigation, LASD concluded that the deputy had violated the prohibition on fraternization. The deputy was discharged.*

CASE

On several occasions a deputy approached a female inmate in custody and engaged her in conversations of a personal nature. The deputy also physically touched the inmate, including hugging her, kissing her forehead, and touching her buttocks. As the inmate's release date approached, the deputy offered to drive the inmate home upon her release from custody and asked whether they could date each other. After the inmate's release, the deputy called her.

When LASD became aware of this, it initiated a criminal investigation. During that investigation, the Department's Internal Criminal Investigation Bureau ("ICIB") connected a recording device to the inmate's home telephone. During one of the deputy's telephone conversations with the inmate, he admitted to touching her inappropriately while she was in LASD custody. A day after the deputy's admission, the inmate told the deputy about the criminal investigation and that his admission had been recorded. The deputy went to the inmate's house, seized the audiotape recording of his admission, and took the inmate with him to a local store to purchase a new audiotape. The deputy then replaced the original recorded conversation with the new audiotape containing a new staged recording of a conversation between the inmate and himself. Through exemplary investigative work, ICIB learned of the deputy's efforts to cover up his fraternization with the inmate. ICIB investigators recovered videotape recordings of the deputy purchasing the replacement audiotape at the store. ICIB's thorough investigation led to the deputy's conviction by a jury of a misdemeanor criminal charge for destroying or concealing documentary evidence.

After the criminal conviction, LASD commenced its internal administrative investigation of the deputy's fraternization with the inmate. LASD found that the deputy had violated its policies by fraternizing with the inmate and by obstructing ICIB's investigation through the intentional seizure of the recorded audiotape, and replacement of it with the fabricated conversation. Based on its findings, LASD discharged the deputy from the Department. The deputy appealed to the Civil Service Commission. This past year the Civil Service Commission sustained LASD's decision to discharge the deputy.

Because fraternization or prohibited associations are serious issues, LASD Guidelines for Discipline recommend discharge as the sole appropriate discipline. It is a "zero tolerance" policy. The propriety of zero tolerance for such violations has been recognized by the Civil Service Commission. In upholding the discharge of the cook in the case above, the Civil Service Commission Hearing Officer found that:

> The policy makes it clear that fraternization is one of those violations for which no other disciplinary action but termination will suffice. The Department's heightened concern for public safety in upholding this particular work rule is well founded. One can easily see how once the line of fraternization is crossed, the probability of contraband entering the prison or assisting escapees is increased. Such conduct can only serve to be disruptive and place both the other employees and the general public at risk.

OIR similarly agrees that a fraternization or prohibited association is such a serious breach of the public trust that discharge is the only appropriate discipline. OIR and LASD executives have discussed this issue on a number of occasions. OIR is not aware of any instance where LASD has not discharged an individual found to have improperly fraternized or had a prohibited association. OIR will continue to monitor this.

Other On-Duty Misconduct Issues

Misappropriation of Property from Members of the Public

The Department has disciplined deputies who misappropriate property from members of the public for personal use. LASD must remain particularly vigilant in addressing these misappropriation cases. When LASD personnel take advantage of their police powers and law enforcement positions to improperly gain financially, it presents the precise type of corruption of the criminal justice system that is of significant consequence and concern. Fortunately, the number of these cases within the Department has remained few. In the case below, the deputies were on-duty and abused their positions of trust. LASD held the deputies accountable for abusing their positions and the misappropriation.

CASE

In December 2003, a citizen brought two assault weapons, including a banned assault weapon, into an LASD station to arrange for their destruction. Working the station's front desk, Deputy A offered the citizen a small sum of money and a handwritten receipt for the weapons. The citizen refused the money, stated that he did not intend to sell the weapons but wanted them destroyed, and left the station. Deputy A took the weapons into his possession and later transferred the banned assault weapon to Deputy B, who kept the banned weapon in his personal locker at the station. In 2005, after the completion of an internal administrative investigation, LASD found that Deputies A and B violated Department policy and recommended that Deputy A receive a 30-day suspension and Deputy B receive a 10-day suspension.

False Reports

In the summer of 2004, LASD learned that one of its deputies, in the course of applying for lateral transfers to other agencies, had responded to integrity questions in the screening process by admitting a number of improprieties. Specifically, he told interviewers from two separate departments that he had written a number of false police reports in support of arrests, and that he had testified falsely in court to corroborate those reports. After eliminating him from hiring consideration, one of the agencies contacted LASD to express its concerns, and the Department quickly relieved the deputy of duty and began a criminal investigation.

Though the deputy declined to cooperate with the investigation, the Department did have material to work with, including an actual transcript of his remarks to one of the interviewers. It reviewed arrest records and spoke with the deputy's colleagues and former training officer, whom he had claimed taught him to write his reports in a streamlined, simplified, and less contestable fashion – even if it came at the expense of accuracy. (The training officer denied any such involvement.) Nonetheless, at the conclusion of the criminal investigation, the District Attorney declined to prosecute.

When the criminal case closed, the administrative investigation into the allegations began, and centered on a compelled interview with the deputy himself. He expressed extreme remorse and took responsibility for his actions – up to a point.

As he explained it, he never manufactured evidence against a suspect or falsely accused someone of a crime. Instead, he would alter the sequence of an encounter with a suspect in order to present a "cleaner" version that he could write quickly and that would be less likely to run into problems down the line. For example, he might encounter someone on the street who looked "under the influence" of drugs and alcohol or who had committed a minor infraction such as jaywalking. He would then legitimately search the person in the context of that initial detention, find illegal drugs or perhaps a weapon, and then initiate a lawful arrest of that person.

The irregularity, according to his account, was that he would then run the individual's information in his radio car's computer system, and perhaps learn that there was already a warrant for that person's arrest. At that point, he would re-arrange the sequence in his report and claim — in the interest of a "cleaner," tighter presentation, that he had contacted the person, *then* run him on the computer, *then* conducted a search incident to the warrant arrest that yielded the contraband. If necessary, he would then testify to this false sequence in court as the case moved along through the system.

On a scale of moral blameworthiness, such a practice was obviously less disturbing than planting drugs or lying about the justification for excessive force against a suspect. It was however, significantly problematic nonetheless. The deputy's admitted modus operandi denied the suspects the ability to challenge the actual arrest circumstances in court, and perhaps benefit from a judge's skepticism about the "consensual" nature of an encounter or of the adequacy of the officer's probable cause. As importantly, the deputy's "practice" showed a cavalier attitude toward the facts that reinforces some of the public's worst conceptions about officer integrity and trustworthiness.

The deputy's revelations had the potential to create an extremely problematic situation for the Department, particularly given his claims during the job interviews that the practice was widespread and had, in fact, been one that he was informally instructed to do. However, the deputy, while blaming himself unequivocally, recanted on some of his earlier remarks and therefore limited their implications. He said he had mis-spoken when claiming that his training officer — or anyone else — had "taught" him to falsify reports, and denied being aware of other officers who followed this practice. He also claimed that—while still admitting the actions in a generalized sense — he could not recollect a single specific arrest where he had lied in his report or in a court proceeding. (This was in spite of several actual reports of the deputy's past narcotics arrests that the investigator had produced for him to review.) The significance of this "failure to recall" was, of course, that there was no basis to re-visit existing arrests or convictions, even though significant doubts about the deputy's work product obviously continued to exist.

OIR initially recommended that the deputy be discharged. The actions themselves were highly problematic, and his apparent pulling of punches during his administrative interview undermined some of the mitigation to which he might be entitled. However, an interesting problem of proof existed in the eyes of Department executives: without a specific case to cite, what concrete indication of misconduct could LASD use to support its allegations? It effectively had nothing but the deputy's own story with which to proceed, and might therefore face problems during the subsequent hearing process.[1]

That made it an unusual challenge, but not necessarily an insurmountable one. However, because of this significant hurdle, OIR reluctantly concurred with a proposed course of action in which the deputy would accept a lengthy suspension, a founded charge for "false reporting," and a transfer out of a patrol assignment. In exchange, he would be allowed to keep his job.

Unfortunately, even this seemingly lenient approach became further weakened when executives from the deputy's chain of command met with him and his counsel to discuss a proposed settlement. For reasons still not entirely clear to OIR, and without OIR's input or knowledge, LASD made an agreement in which the suspension was a mere 15 days, the "false reporting" charge was dropped, and the removal from patrol was limited to a three-year duration.

OIR is hopeful that this deputy has "learned his lesson," was sincere about understanding and acknowledging his mistake, and will not be a future integrity problem for the Department. However, his case raises issues that transcend his individual circumstances. For one thing, the disappointing reduction from discharge to something significantly less severe was only one instance of a handful in which the executives' willingness to contact and consult OIR fizzled at a climactic moment.

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[1] An additional potential lead that did not surface during the investigation was the existence of citizen complaints regarding false or inaccurate report writing. If there had been any, LASD could have followed up those allegations and wedded them to the deputy's general admissions.

The fact that no civilian had ever lodged a complaint about the deputy's admitted practice of "fudging" leads to one of two conclusions. Either the deputy's statements were an ill-considered exaggeration, embellishment, or fabrication of his actual practices, or the complaint system has yet to gain the confidence of those who may need it most.

These lapses in the Department's protocol with OIR occur less frequently than they used to, but it remains frustrating and perplexing that they occur at all.

More importantly, the deputy's oddly candid (and self-defeating) interviews with other agencies offered a troubling window into potential abuses of the report-writing process. Deputies who make frequent arrests, are swamped with calls for service, and have seen dangerous suspects go free on "technicalities" undoubtedly experience the temptation to smooth the rough edges of their reports in the interest of "efficiency." For a host of reasons, the Department can not tolerate this type of thinking. The power of the police in our society has trust as its necessary foundation.[2]

This case illustrates a breach of that trust, regardless of the deputy's initial belief that his lies were harmless and that the actual wrongdoing of the suspect was the only justification required for sloppy work. OIR has spoken with the Department about taking the lessons of this completed case and finding a way to re-emphasize its views on the importance of accuracy and integrity in all areas of police work.

Mishandled Calls For Service

When a member of the public calls the Sheriff's Department in an emergency, the station desk personnel are often that person's first and most important source of assistance. Desk personnel must quickly determine the nature of the call, obtain information from sometimes frantic people, decide what type of assistance to send, and if appropriate, maintain contact with the caller, the responding units and other agencies simultaneously. Desk personnel are trained to be efficient even under great stress. Discourtesy and mistakes can destroy that efficiency and have a corrosive effect on the LASD's relationship with a neighborhood or a community. OIR has found that the Department recognizes that the administrative disciplinary system has a role in maintaining the quality of this vital function. If the mistakes and discourtesy are serious and persistent enough, it can ultimately cost an employee his or her career. Here is one striking example.

[2] Other commentators have noted the existence of a problematic viewpoint among some peace officers: while they would never lie about matters directly related to the guilt or innocence of a person they arrest, they believe that shading the truth in order to insulate the arrest from legalistic attacks (on issues such as probable cause to effectuate the arrest) is a justified and harmless means of insuring that the "bad guys" do not escape punishment on the basis of a technicality.

On a Friday night a woman called a station desk and pleaded for protection from her estranged boyfriend, who had come to her house and threatened and choked her. She said that she had fled the house with her children and was out front and feared that he would come after them. She was emotional but coherent and able to give details to the desk deputy. The desk deputy inadvertently hung up on the caller. The caller called right back and pleaded for a patrol car. The desk deputy still failed to transfer the call immediately to the appropriate station that could dispatch patrol deputies. The deputy also failed to contact the Fire Department. Meanwhile the woman's young son came on the line and said his mother was being stabbed. The deputy failed to recognize that the caller was no longer the original woman and continued to delay dispatch action. The final result was a short but unnecessary delay in the response of patrol deputies and emergency medical personnel. The woman later died from her stab wounds.

Later that evening, the desk deputy was talking to another employee on the telephone about the recent call from the stabbing victim when the deputy received a "burglary now" call. The deputy placed the burglary call on hold for over two minutes and resumed the conversation with the fellow employee, commenting before going back to the burglary call, "People breaking into an empty house, like I care." Also that evening, when the deputy failed to successfully transfer another 9-1-1 call to another station, the caller called back. The deputy gave the caller the telephone number of the other station and ended the call with obscenities.

Two months later, late on a Saturday night the same desk deputy received a 9-1-1 call from a distraught female caller. The woman stated that two men were approaching her home and she believed that they were the same men that deputies had been seeking in connection with a murder earlier that evening. Despite the caller's urgent concern, the desk deputy became confrontational with her, insisted on obtaining standard background information that could be obtained at a later time and ultimately placed the caller on hold and failed to return her call. The deputy then typed up the request for service and sent it to dispatch but failed to point out that it might relate to the active murder investigation in the neighborhood a few hours earlier.

A few months previous to these two incidents, this same deputy had been warned twice about poor performance handling calls for service.

The above incidents were separately investigated, found to be true, and evaluated for appropriate discipline. The penalty of discharge was imposed for the most serious violation—an appropriate recognition of the scope and consequences of the deputy's lapses in handling critical calls. The deputy then asked to resign and was allowed to do so.

Medical Issues: Lapses in Providing Care to Inmates

The provision of appropriate medical attention to inmate patients is a significant LASD responsibility. As the inmate population in Los Angeles County jails continues to grow, there is a greater demand for medical services, which are provided by LASD through its Medical Services Bureau. Not including the approximately 200,000 annual new bookings of inmates at the Inmate Reception Center ("IRC") at the Twin Towers Correctional Facility ("TTCF"), where each new inmate is medically and psychologically evaluated, the Medical Services Bureau personnel respond to more than 7,000 daily inmate patient sick calls and provide daily medical treatment to approximately 900 inmate patients on the medical line and distribute daily prescribed medication (multiple doses in most cases) to more than 6,000 inmates. Moreover, while the average county jail inmate is 33 years of age, the inmate is typically much sicker than an average patient because of lifestyle choices.

In the vast majority of medical encounters with inmate patients, Medical Services Bureau provides quality medical treatment. An indicator of the overall quality of medical treatment provided by Medical Services Bureau personnel to inmate patients is the receipt of a provisional licensure from the California State Department of Health Services. In October 2004, after several years of determined and focused effort, Medical Services Bureau received the provisional licensure for LASD's 196 bed in-patient Correctional Treatment Center ("CTC") within TTCF. More than just another milestone, LASD became the first and only county sheriff's department within California to achieve such licensure. As LASD maintains the largest CTC in the California, it is worth noting that LASD joins only a limited number of California correctional facilities who have also been licensed. Earlier this year, Medical Services Bureau received an extension of the provisional licensure. In September 2005, state inspectors recently completed another facility survey, and will decide whether LASD will receive a permanent licensure.

Where the evidence has demonstrated a failure or lapse in the provision of appropriate medical treatment to an inmate patient, or another violation of Department policy and procedures, LASD has demonstrate a commitment to hold those involved employees accountable. Though the issues in these cases obviously vary greatly from the substance of deputy-involved investigations, the Department's need to investigate, hold its employees accountable, and initiate reform is just as applicable. Accordingly, OIR monitors these cases in keeping with its usual protocols.

While there have been failures and lapses in performance by a small percentage of medical personnel assigned to the Medical Services Bureau, LASD has employed its own quality assurance program. In those rare instances, LASD has investigated the failure or lapse and, where appropriate, held those involved employees accountable. OIR's review of LASD's investigations found no systemic negligent or intentional acts by medical personnel that directly led to an inmate's death. Much of the identified employee misconduct occurred because of performance failures, which – in the context of the volume of daily medical responses and magnitude of Medical Services Bureau's work – may be attributable in part to a significant shortage of medical personnel. The following four cases provide a representative sampling of the types of misconduct that Medical Services Bureau has confronted in the past year, and are not evidence of any systemic breakdown.

CASE

In 2003, LASD received into its custody a 62 year-old man. Subject Nurse A, the initial intake nurse, failed to identify the inmate as a person older than 55 years of age and to initiate the Departmental protocol for such an inmate: additional testing, extensive medical screening and a mandatory examination by a physician before transfer to inmate's housing assignment. While Subject Nurse B changed the Department database to reflect that the inmate was older than 55 years old, Subject Nurse B did not initiate the applicable protocols for inmates older than 55 years of age and failed to ensure that the inmate received the mandatory examination by a physician. Subject Nurse C did not adequately review the inmate's medical records, failed to initiate the applicable protocols for inmates older than 55 years of age, and authorized the inmate's transfer to a housing unit without his receipt of the mandatory examination by a physician. Approximately three weeks later, the inmate went into cardiac arrest and died at the County of Los Angeles Medical Center. In 2005, LASD found that the three nurses had violated Department policy designed to ensure enhanced medical screening of inmates older than 55 years of age and recommended that each nurse receive a written reprimand for violating the policy.

CASE

In 2003, LASD received an inmate patient at its Inmate Reception Center ("IRC") at the Twin Towers Correctional Facility. Before his arrival at IRC, the inmate patient had received medical care at a hospital for injuries, including fractures to his right orbit and nose, that he had sustained in car accident. Twelve days after his arrival at IRC, the *inmate patient died from an infection of the right orbit, nose and other areas of his face that contaminated his bloodstream.*

During his ten-day detention at County jail, several LASD medical personnel were involved in the provision of medical care to the inmate. During the first-day screening of the inmate patient, a physician ordered an eye appointment for the inmate patient within a week with the Department ophthalmologist. However, because the Department ophthalmologist was away for two weeks, a week passed without the inmate receiving the appointment, and Physician A neglected to make other arrangements for the exam. On his eighth day at the jail, the inmate patient complained for the first time of a headache and received medication. The next day, the inmate patient again complained of a headache, and, as required by Department policy, a staff nurse reported this complaint to Senior Nurse B. However, Senior Nurse B did not examine the inmate patient, call the on-duty physician, or document the complaint on the inmate patient's medical chart.

On his tenth day in custody, the inmate patient experienced difficulty breathing and a significant drop in his oxygen saturation level. A staff nurse gave the inmate oxygen and restored his oxygen level and then notified Physician B. By telephone, Physician B ordered a course of medical treatment for the inmate patient; however, Physician B did not respond personally to examine the inmate patient. Later on the tenth day, Physician A examined the inmate patient and arranged for the inmate patient's transportation to the Los Angeles County Medical Center ("LCMC") for further examination. At LCMC, doctors learned that the inmate patient was a diabetic with a severe sinus infection and recommended radical surgery; however, the inmate patient's family declined to authorize the surgery.

In 2005, LASD found that the failure to re-schedule an inmate patient for an eye examination appoinment and/or to conduct an in-person examination of the inmate patient by Physician A, Senior Nurse B and Physician B violated Department performance standards and recommended discipline in the range of a four-to seven-day suspension.

CASE

In 2005, LASD found that a Medical Services Bureau physician, who delayed calling paramedics, violated Department policy and recommended a seven-day suspension for failing to provide timely access to medical treatment to an inmate patient. This case involved an inmate patient who died from a heart attack in 2004. Approximately 40 minutes before the inmate died, the physician received an update on the inmate patient's condition that indicated possible respiratory problems, chest pains and a clot in one of the inmate patient's arteries. Despite a nurse's suggestions to the physician to call para-

medics, the physician declined to call paramedics for several minutes as the physician and medical personnel made efforts to stabilize the inmate patient's condition. When the paramedics arrived and commenced CPR, the inmate patient was in respiratory distress. Approximately 27 minutes later, after being transported to LCMC, the inmate patient died from a heart attack.

After conducting an administrative investigation into the physician's treatment of the inmate patient, LASD found that by delaying the call to paramedics, the physician failed to provide timely access to medical treatment to the inmate patient and that this failure fell below the level of performance expected by LASD. OIR concurred with LASD's finding of policy violations and its recommended discipline.

CASE

In 2004, a nurse improperly discarded pre-packaged prescription medication. As part of his responsibilities, the nurse distributed prescription and non-prescription medication to inmates at a county jail facility. During a particular "pill call," a process where inmates are called to the front of a cell to receive their medication, the nurse placed prescribed medication into one of his pockets. At the end of his shift, the nurse discovered the medication in his pocket, and rather than follow Department procedures regarding the disposal of prescription medication, he threw the medication into a trash bin. This trash bin was accessible to inmates as well as LASD employees. Another LASD employee discovered the prescription medication in the trash bin. If consumed by someone not suffering from the relevant condition, the medication could have resulted in death or significant injury.

After the medication was initially discovered, and later during the administrative investigation, the nurse repeatedly and falsely denied disposing of the medication in the trash bin. In 2005, LASD found that the nurse violated Department policy and procedures and recommended discharge. This decision was based, in part, on the nurse's integrity lapses as well as the underlying misconduct.

OIR is certainly not the first to report regarding the tremendous responsibilities faced by LASD medical staff and the resource constraints that impact on their abilities to fulfill those responsibilities professionally. However, regardless of the challenges faced by personnel on a daily basis, LASD must continue to hold those personnel accountable when performance failures are discovered. To LASD's credit, the review mechanisms in existence to examine the circumstances of an inmate's death are largely responsible for the detection of the performance lapses detailed above.

Severe treatment must be reserved for those personnel who compound their mistakes by intentionally heightening the danger to custody staff and inmates alike and who continue to lie about their misdeeds as detailed in the final case discussed above. Medical staff who unintentionally err can be held accountable

APPENDIX A

LASD/OIR

Working to Achieve Systemic Change – Year Four

OIR Identification of Systemic Problem	OIR Recommendation	LASD Response	Implementation of OIR Recommendation
Shooting at cars	Improve the policy to provide better guidance to deputies	Agreed to work with OIR to improve policy	Implemented, see pages 7-10.
Contagious fire	Improve policy to inform deputies to recognize and avoid contagious fire	Agreed to work with OIR to develop policy	Implemented, see page 8.
Insufficient guidance regarding treatment of suspect at end of pursuit	Treat non-compliant suspect at end of pursuit as barricaded suspect	Agreed to work with OIR to develop policy	Implemented, see page 8.
Training needed re: new shooting at cars policy	Develop training video regarding the new shooting at cars policy	Agreed to produce video	Produced, see pages 9, 87.
Revised disciplinary guidelines stalled	Move to implement long-stalled disciplinary guidelines revisions	Agreed to implement	Implemented, see pages 17-18.
Settlement agreements non-uniform and difficult to ensure compliance	Develop standard settlement agreements in which compliance can be detected	Agreed to work with OIR to develop standard agreements	Implemented, see pages 22-23.

OIR Identification of Systemic Problem	OIR Recommendation	LASD Response	Implementation of OIR Recommendation
Standard discipline did not directly address violation of policy	Incorporate apology or correction as part of the discipline	Agreed to impose such conditions in appropriate cases	Implemented, see pages 23-25.
No objective criteria for module inmate work selection	Provide feasible objective criteria for the selection of inmate workers in the modules	Agreed to establish criteria	Implemented, see pages 44-45.
Module inmate worker selection did not require supervisory approval	Require supervisory approval of module inmate worker selection	Agreed to require such approval	Implemented, see pages 44-45.
No formal documentation of module inmate worker selection and disqualification	Require documentation of module inmate worker selection and disqualification	Agreed to establish documentation requirement	Implemented, see pages 44-45.
Day rooms used inappropriately for housing	Make permanent the practice of using day rooms for housing	Agreed to stop using day rooms for housing, with limited expectations.	Implemented, see pages 44-46.
No protocol with Department of Mental Health where there is no minimum time between when an inmate may be re-evaluated	Develop such a protocol that allows an inmate to be re-evaluated at any time	Agreed with the principle	Not yet implemented, see page 46.
No training of custody personnel in crime scene preservation	Establish custody training module for preservation of evidence	Agreed to develop training	Training developed, see page 47.
No policy requiring transportation deputies to carefully check holding cells when removing inmates for transport	Adopt such a policy	LASD agreed this should be a required practice	No formal policy yet

OIR Identification of Systemic Problem	OIR Recommendation	LASD Response	Implementation of OIR Recommendation
No written directive limiting the number of inmates in the IRC holding cells	Adopt such a written directive	LASD issued a Captain's order limiting the inmate population	Implemented, see page ________.
No physical barrier between two tiers of jail module where homicide occurred	Construct a physical barrier	LASD agreed to install a wire mesh	Barrier installed, see page page 48.
No documentation procedures when housing assignment office issues orders to address improper security mixing	Develop documentation procedures	Informal documentation procedures adopted	No formal documaentation procedures yet adopted, see pages 49-50.
Slow movement of inmates at IRC seeking housing and medical attention at IRC	Find systems improvements to speed up processing of such inmates	LASD opened up floor at Twin Towers for use as an IRC clinic	Bottleneck alleviated. See page 51.
Wristband identification system susceptible to tampering	Develop additional inmate identification system to reduce tampering and help with identification	Inmate identification cards developed to augment wristband system	Phasing in of identification cards initiated, see page 51-52.
Insufficient information about LASD's jail classification system to provide to other components of the criminal justice system	Devise a way to better inform judges, prosecutors, and defense attorneys regarding the classification system	Custody authorities completing glossary,	Not yet completed, see page 52.
The inmate classification system reacts too slowly to changes that should affect an inmate's security level or housing	Improve the inmate classification system so that it can more timely react to changed conditions of inmate	LASD agrees that inmate classification system is in need of improvement	LASD still in process of redesign, see pages 52-53
Outstanding complaint forms not completed in a timely fashion	Ensure that complaint forms processed and timely entered into tracking system	LASD agreed to complete complaint investigations and process them in a timely manner	Remedial plan agreed upon, see pages 53-54

OIR Identification of Systemic Problem	OIR Recommendation	LASD Response	Implementation of OIR Recommendation
Telephone cords at lockup facilities used by inmates to attempt suicide	Redesign telephone cords so that they could not be used to facilitate attempted suicides	LASD agreed to redesign cords	Cards redesigned, see page 56.
No comprehensive TASER policy	Implement TASER policy that had been stalled	LASD agreed to implement TASER policy	Policy implemented, see page 56-58.
Inaccurate record keeping regarding TASER deployment	Develop system to accurately develop TASER deployment records	LASD agreed to develop accurate and timely TASER deployment system	Implementation in process, see pages 56-58.
Supervisors involved in tactical command also serving as videographers	Devise protocols to educate supervisors to delegate videographing functions in tactical situations	LASD has revised policy to educate supervisors to delegate such tasks	Revised Policy Implemented, see pages 58-59, 61.
VIDA Program had ambiguous use of force policies	Establish clear use of force policies	LASD has revised its manual to establish clear use of force and reporting policies	Revised Policy Implemented, see page 82.
VIDA Program did not clearly address how to deal with student walkaways	Establish protocols for dealing with walkaways	LASD has revised its manual to establish clear protocols for student walkaways	Revised Policy Implemented, see page 82.
VIDA Program Did Not prohibit handcuffing as punishment	Establish protocols prohibiting using handcuffing as punishment	LASD has revised its manual to prohibit handcuffing as punishment of students	Revised Policy Implemented, see page 82-83.
Explorer Program did not contain notification of off-site activity to supervisors	Establish protocols requiring notification to supervisors of offsite activity	LASD has revised its manual to require notification of off-site activity to supervisors	Revised Policy Implemented, see page 84.

OIR Identification of Systemic Problem	OIR Recommendation	LASD Response	Implementation of OIR Recommendation
Explorer Program did not require preparation of after action report	Establish after action report requirement	LASD has revised its manual to require preparation of after action report	Revised Policy Implemented, see page 84.
Explorer Program had no limitation on number of ride alongs per deputy	Limit number of ride alongs per deputy	LASD has revised its manual to limit ride alongs per deputy to two per month	Revised Policy Implemented, see page 84
Explorer Program has no explicit prohibition on inappropriate relationships between deputies and explorers	Devise clear policy prohibiting inappropriate relationships	LASD has revised its manual to expressly prohibit inappropriate relationships	Revised Policy Implemented, see pages 84-85.

APPENDIX B

Core Values for Overseers?

An Initiating Discussion

by Michael J. Gennaco
Chief Attorney, OIR

In our oversight role with the Los Angeles Sheriff's Department, we are often asked: who is it that oversees us and ensures that our recommendations are fair and principled? The short answer is that while we do not have a group examining us in a formal way, our work is continuously available for review, criticism, and comment by a number of entities: the Board of Supervisors; the Sheriff, his command staff, and all members of LASD; advocacy groups and community-based organizations; and the public at-large. This question, however, suggests a broader inquiry, namely, what basic principles guide the OIR group as you go about your business as overseers? When we took a cursory look at outside literature on this topic, we discovered very little discussion of this issue among oversight groups. Perhaps that is because the oversight of law enforcement by civilians is still a relatively new concept. Likely the challenges of defining and performing this new function have left little additional time for introspection and self-assessment. In the hopes of initiating such a discussion, however, we offer the following views.

Any oversight group must first develop expertise in the subject matter it intends to oversee. The group must learn about the agency itself and the makeup of its members. This doesn't mean merely going on an occasional "ride along" with hand-picked personnel, though such experiences certainly have their place. Rather, it requires the oversight group members to immerse themselves into the department's organization, culture, values, personalities, and operations. Policies, procedures, and practices written and unwritten must be examined. If at all possible, any startup oversight group must be provided lead time to "listen and learn" before being required to offer recommendations and conclusions.

The ability to be afforded "run up time" to learn about the way the agency goes about its work will help provide credibility to the oversight group from the department itself. In essence, there will be recognition that the group has done its homework. Oversight agencies who begin to opine based on preconceived notions of what they think about policing before learning how the department they oversee does policing will have difficulty gaining credibility with the department members they are entrusted to oversee.

Once the oversight group becomes operational, it is imperative that any recommendations it makes are grounded in facts. Nothing can undermine an oversight group faster than "findings" that can be proven to be based on faulty facts. It is essential from the very beginning that the oversight group "get it right" with regard to the factual underpinnings that form the basis for its conclusions.

Any oversight group should not shy away from consultation with members of the law enforcement agency with which it is working. While any overseer needs to remain both objectively and subjectively distinct from the department it is assessing, the answers to a better way of doing things will usually lie among the members of the law enforcement agency itself. The overseers should build bridges to these experts within the department, be they executives, lower level supervisors, or the rank and file and consult regularly with them as they formulate their recommendations. Ultimately, the recommendations and conclusions must emanate from the oversight group – but those conclusions will be better formed after discussion with voices from both within and outside the law enforcement organization.

An oversight group should be candid and forthright with the members of the department when it forms its recommendations. Rather than running off to the media with its "findings" and playing a game of "gotcha", the oversight group will be better served by sharing its conclusions with the police agency first. That dialogue may result in the oversight group learning about facts and circumstances that warrant reexamination of its own conclusions. Alternatively, that dialogue may well lead to recognition by the department that the issue identified is in need of remediation and agree to do so in conjunction with the oversight group. Rather than simply hunkering down and defending the status quo, as it might in the face of a more public or adversarial critique, the department can focus its energies on problem-solving and constructive reform.

Even if the oversight group concludes that the department's reaction is less than ideal in terms of either acceptance or correction of an identified issue, the group still benefits from a collaborative approach. It can always bring the issue to the public's attention later as opposed to sooner, and has lost little in that regard. Meanwhile, the oversight group has reinforced to the department its desire to act in good-faith rather than intent on simply scoring cheap points and grabbing headlines.

Finally, perhaps as important as the findings and recommendations reached by any oversight group is the way in which such conclusions are disseminated. The findings — both positive and negative — of the oversight group should not be communicated with hyperbole. The assessment need not "blame" the agency for the problematic state of affairs in order to identify issues and make recommendations for change. When discussing its findings, the overseer should never gloat or indulge in rancor. The oversight group will not gain credibility with the department's members — or advance the cause of fair and effective law enforcement — should animus of the department, its members, or policing in general be evidenced in its reporting. The overseer's findings should not be geared toward inflaming emotions. The report should not seek to embarrass or belittle. Rather than reflecting outrage or moral indignation, the overseer's findings should be communicated dispassionately and objectively. The role of the overseer is to gather facts, assess, conclude, and report. While it is non inconsistent with the role of the overseer to give credit to departmental actions when credit is due and express disappointment when lapses in judgment are evidenced; the facts and objective observations that form the bases for those conclusions are fundamentally more important for an oversight group to convey to the public.

All oversight groups should recognize that they have been provided a window to organizations that have long been shuttered from public view. The transparency that they will be able to provide will be more effective in the long run if the information is conveyed factually and without the filter of bias or emotion.

* * *

The above essay was written before the release of OIR's most recent annual report. The press coverage of that release reminded me that while an oversight group can steadfastly adhere to the principles described above, the media's role in reporting any findings will certainly shape the way in which the information is conveyed to the general public. While most of the media coverage of OIR's latest report provided a balanced and accurate portrayal of the report's findings, one media headline, in OIR's view, was not supported by either our Report or the ensuing article itself. In short, the headline did not fairly characterize our observations of LASD actions of the past year. While media sources and the public at large certainly are encouraged to react to the information in our Report, we're grateful for the opportunity to respond and to present our perspective. Perhaps one response to that headline is simply to quote from the closing remarks of the Foreword of our Third Annual Report:

"Before I close, however, I must remind the public that there are thousands of competent, hard-working, dedicated deputies and professional staff at LASD whose files never cross our desk because they are ably carrying out their duties to the public. Moreover, under our model, it is LASD itself that retains the ultimate responsibility to hold its employees accountable. By doing so, it is actually reaffirming the reputations of the vast majority of deputies and professional staff who are serving the public honorably, and instilling confidence in the public regarding the men and women of LASD. It is for that reason that we see our roles as an outside check and reporting mechanism for that process as meaningful and self-rewarding."

APPENDIX C

The Myth of the Ruthless Investigator

Clarifying the Discipline Process

by Stephen Connolly

For those of us who work closely with the law enforcement disciplinary process, a recurring source of frustration is the "molehills into mountains" phenomenon. This happens when officers turn a low-level incident of misconduct into a protracted, contentious, and potentially career-damaging battle through a lack of candor and forthrightness during the investigation.

Many of the possible explanations for this trace back to the simple fact that deputies are people, and that people in general are not famous for their eagerness to admit mistakes, accept blame, and embrace the consequences of their transgressions. In the law enforcement arena, another potential factor might be that deputies lack the necessary trust that their Department will hold up its end of the bargain and apply proportionate, mitigated discipline when the officers acknowledge mistakes promptly and fully.

As complex and insurmountable as these issues may be, they are at least understandable. More frustrating are instances when false assumptions or misconceptions about the process contribute to the reluctance to cooperate.

An example of this phenomenon can be found among officers who harbor and promote a distrust of their own department's internal affairs bureau. In this biased and seemingly pervasive view of the world, internal affairs investigators are a ruthless collection of Monday morning quarterbacks who live to "get" deputies regardless of the facts. What results, unfortunately, is a determination among some officers never to give an inch when they are subjects (or even witnesses) in a misconduct investigation. No one is well-served by such an approach, especially when it comes at the expense of candor and clarity.

* * *

The internal affairs group of any law enforcement agency is unlikely to win any popularity contests: the public is unaware of what they do, for the most part, and the agencies that these investigators serve are rarely enthusiastic fans. There are obvious reasons for this. The dentist's patient would always prefer not to have the problem in the first place, and therefore rarely celebrates when skilled examination uncovers a troublesome cavity or two. Moreover, an investigation is certainly never good news for the subjects themselves. It is stressful under the best of circumstances, and "winning" in the form of exoneration does little more than restore the deputy to even ground.

This reality, however, does not account for all of the hostility and resentment often directed at internal investigators by other officers within a department. Instead, much of the animosity is driven by rumor, misunderstanding, and obsolete mythology about their role. The implications are significant, and often work to the detriment of all parties in the process. Clearly, then, a heightened understanding of internal affairs would be an easy and influential step toward improvement of the discipline system.

* * *

OIR's greatest familiarity is with the LA County Sheriff's Department, of course, but the simple truths about that agency's Internal Affairs Bureau are undoubtedly applicable to other law enforcement groups. Those interested in understanding IAB might start by recognizing the variety of personalities and backgrounds that its members possess. The investigators, supervisors, and command staff that comprise the IAB come from all different branches of the Department. Their career paths, priorities, and individual strengths and weaknesses are wide-ranging. Like the officers who serve at any other unit, they can not be fairly or accurately understood in terms of stereotypes and sweeping generalizations.

There are systemic realities that also merit consideration by those who insist that IA has an agenda. For example, even if the existence of the occasional hostile or unfair investigator were conceded for the sake of argument, that person would still have no control over whom he investigates, and for what reasons. Instead, the requests for investigation usually come from the Chief's office or another division, and the individual case assignments come to the investigators from their own supervisors. Nor do the internal investigators in the Sheriff's Department offer recommendations or make decisions about what the outcomes of the cases should be.

It is also important to note that the investigators are not rewarded for "getting" deputies, or penalized for investigations that end up supporting the officers' actions. Their performance is assessed by the extent to which they establish the knowable facts in any case. Moreover, contrary to another common lament, internal investigators are not "out of touch" with the stresses and dangers faced by the patrol deputy on the street or in the jails. Their understanding of law enforcement is based on years of personal experience in the very situations they are now assigned to investigate, including shootings and uses of significant force. They continue to have friends, former partners, and even family members in various jobs throughout the Department, and virtually all will go on to other assignments when their tour as investigators is over. They are not the enemy.

* * *

By and large, an internal investigator is paid to have a thick skin. Even so, there are times when good investigators feel frustrated by the adverse effects of distrust on their investigations and on the disciplinary process as a whole. They shake their heads when a minor incident becomes a potential discharge because false statements in an investigation have compounded an offense. They regret the suspicions and fears that complicate and protract even simple cases for months. And, as anyone would, they bristle when their character and integrity is derogated or distorted in contexts that leave them with no meaningful opportunity to respond.

In our role as monitors of the Sheriff's Department discipline process since 2001, OIR deals with internal investigators on a daily basis. While not every investigation has been flawless, the work has been largely effective and often impressive. Importantly, we have also found the fundamental good faith of the investigators to be consistent and deserving of recognition. OIR does know of isolated instances in the Department's recent history where investigators have pushed the envelope too far in their efforts to pursue allegations, but those episodes of questionable tactics have been addressed and are not part of a larger pattern or problematic philosophy.

Instead, the rights of officers under investigation are emphasized and given appropriate deference by LASD's internal investigations units. Those who devote time and attention to asserting otherwise are ignoring the key issue: the responsibility of all involved parties to ensure that the discipline process for law enforcement agencies is constructive, effective, and fair. More importantly, such critics are contributing to an atmosphere in which molehills too often turn into mountains, to the detriment of all involved.