

**OIR Evaluation and Recommendations Concerning Sheriff's
Department Investigations of Five Custody Homicides Occurring
Between Oct. 21, 2003 and April 20, 2004**

EXECUTIVE SUMMARY

On April 20, 2004, inmate Raul Tinajero was killed in his cell in Men's Central Jail by another inmate. The Tinajero killing attracted notoriety for two reasons: (1) it was the bold, elaborately premeditated killing of a witness by the murderer he had just testified against; and (2) it was the fifth inmate-on-inmate homicide in the downtown jail complex within a six month period.

With the killing of Tinajero, the five murders attracted a significant amount of public attention and concern, and rightfully so. While the killings had few shared characteristics other than their custody setting, they presented to OIR a challenge to ensure accountability should the facts uncover violations of policy and an opportunity to examine LASD systems to learn whether they made the killings more facile.

Shortly after Tinajero was killed, Sheriff Baca held a news conference to report not only about the inmate murder of Tinajero, but to provide preliminary facts regarding four additional inmate homicides that had occurred in Los Angeles County jails since October 2003. In addition, Sheriff Baca opened his jails to the media so that it could view first-hand the current jail environment. During that conference and in subsequent confidential reports to the Board of Supervisors, OIR has been impressed with the candor of LASD. Moreover, the Sheriff was personally engaged in steering the investigations of these murders to ensure accountability of his employees. After chairing a several hour debriefing of the incidents, the Sheriff ordered a full investigation into each of the murders with very short completion dates. By his order, the Sheriff made clear to LASD members the priority of these investigations.

Within that milieu, OIR performed its oversight functions. From the very beginning of each of the five investigations, an OIR attorney sat down with the IAB investigators to help map out the investigative plan. During the course of the fast moving investigations, OIR received regular debriefings on their progress and continued to provide input. As the investigations neared completion, OIR requested additional areas of inquiry to be pursued. Once the investigations were completed, OIR met with the Custody Chiefs and offered recommendations regarding the identification of subject employees, the disposition of each allegation, and when founded, the level of discipline to be imposed.

OIR's review of the LASD investigations found each of them to be thorough and timely. Each investigative team met its initial deadline and did, and continues to do, supplementary investigative work requested by OIR¹. The supplementary investigation requested by OIR resulted in additional important fact finding and identified additional

¹ While most of the investigations are completed, there remains some investigative work to be done in the Tinajero murder.

systemic issues in each of the five cases. As an example of the depth and thoroughness of the investigations, the Tinajero investigation comprised three volumes and over 65 witnesses were interviewed.

With regard to accountability, the discipline handed down in the jail murders has been unprecedented in its breadth, size, and scope. Over 25 LASD employees have been disciplined as a result of actions or failures to fulfill their work responsibilities. They include deputies, sergeants, lieutenants, and custody assistants.

While the LASD investigations revealed significant lapses and failures to follow policy by personnel, the investigations revealed no evidence whatsoever of malicious intent or collusion by LASD employees in the homicides. It should also be noted that the investigations identified several LASD personnel who deserve commendation: the deputy who attempted unsuccessfully to strip inmate worker status from one of the alleged killers of Hong; the employee in West Hollywood Station who discovered Pineda after he escaped from Central Jail; and the nurse who tried unsuccessfully to refer Prendergast to a mental evaluation.

In addition to the focus on discipline and accountability, OIR soon learned that LASD needed to devise corrective actions to address deficiencies in training, policies, practices, and systems. In short, an entire reevaluation of the way the jails have been managed was called for.

OIR is heartened to report that LASD has not waited until the issuance of this, or any other report to begin that evaluation. Some facility-related corrections that were obvious, concrete, and inexpensive were immediately undertaken, such as the attachment of safety latches to the module gate control panel doors, which had been circumvented by inmates to facilitate the Hong killing. Some more costly measures have not yet been implemented, such as the installation of a wire mesh protective screen between the upper and lower tiers of Module 2900, the scene of the Faye killing.

In addition, as a result of additional monies being provided to LASD by the Board of Supervisors, a Title 15 Compliance Officer Program has been initiated. This program ensures that deputies are specially dedicated to conducting safety checks in the housing areas, a shortcoming repeatedly demonstrated in the inmate murder investigations. The deployment of personnel to this effort has already borne fruit -- several assaults and attempted inmate suicides have been discovered by this coterie of deputies.²

Other reforms have been developed by LASD in response to the inmate murders. The use of the day rooms for housing has been abolished, but there remains the need to ensure that this remain a permanent condition. A matrix has been devised so that each cell is regularly searched but controls need to be in place to ensure compliance with the matrix.

² OIR has recommended and LASD has agreed to compile and report events that have been discovered as a result of the deployment of these Title 15 Compliance Officers.

Changes in policies, practices, or procedures that do not present as easy a “fix” were assigned to a task force headed by a Commander of the Correctional Services Division. The task force, known as IMPACT, has focused on improving the tracking, classification, and identification of inmates. As a result of the initial work of the task force, the use of inmate wristband hand scanners has been greatly expanded in Central Jail, an increase from one station to eight stations. The color-coding system for inmate uniforms is being simplified and made consistent among the jails. Jail authorities are working on the development of an identification badge to supplement the wristbands and make inmate identification and tracking more facile.

OIR is a regular participant in the IMPACT meetings. As a result of OIR input, the task force has begun to devise meaningful criteria for the selection of all inmate workers. Upon the completion of this report, OIR intends to meet with LASD jail executives and present each of the recommendations that have not been implemented or considered. OIR will continue to follow and report on the degree to which OIR’s recommendations have been accepted.

It is without question that a contributing factor in these inmate homicides is the fact that the typical inmate currently housed in Central Jail has a different resume than those housed when the jail was first designed. However, while this fact is a partial explanation for the murders, it does not present a complete justification. Because the inmates currently housed in the jails are more violent, there are more severe consequences to fellow inmates and staff when those inmates are not appropriately monitored. Because the inmate population has changed in background and type, the ways in which inmates are moved both within and outside the jails must be adapted in recognition of these changes. The investigations have revealed that appropriate modifications in practices have not kept pace with the increasing challenges in maintaining the safety of persons working or housed in the county jails.

Decreased staffing has also likely played a role in the increase of violence in the jails. But again, while supplying a partial explanation, it is incumbent upon LASD to search for sufficient resources to respond to the greater needs placed upon its responsibilities. By making its plight public, LASD is making a significant step toward doing its utmost to secure the resources necessary to perform its mission. However, even with the current resource staffing, the investigations have revealed that LASD personnel could have performed better, both at the individual level and at the systems level.

Ultimately, the homicides of each of the five inmates in these cases were at the hands of other inmates. Nonetheless, LASD has the responsibility to do its utmost to keep inmates safe while in its custody. The need to recognize this responsibility has been aided by the media and the Board of Supervisors bringing attention to these cases, and has been evinced by the Sheriff’s outward and progressive response to the media reports. OIR believes that there is an inherent benefit to the mere fact that the spotlight has been aimed at the jails as a result of these tragic episodes. Perhaps that dynamic alone and the resulting increased diligence by jail personnel may partially account for the fact that since April, there has not been a homicide in the jails.

In its oversight role, OIR hopes to ensure continued transparency as LASD proceeds to move forward to address these issues. It is only by doing so that the people

of this County can be informed whether LASD continues to respond appropriately to these issues.

October 2003

The Hong Murder – Ki Hong killed by 3 inmates who entered the dayroom where Hong was housed.

- I. Inmate Lee Was Not Eligible to be an Inmate Worker and Should Have Been Removed From That Status When Incriminating Information About Him Was Discovered.**

Accountability: One Custody Assistant has been disciplined for failing to take steps to remove inmate Lee from inmate worker status after receiving information that he was a suspected drug dealer.

One Deputy has been disciplined for failing to take steps to remove inmate Lee from inmate worker status after receiving information that he was a suspected drug dealer.

One Deputy has been commended for his noble albeit unsuccessful efforts to have inmate Lee removed from inmate worker status.

Two Sergeants have been disciplined for failing to take steps to remove inmate Lee from inmate worker status after receiving information that he was a suspected drug dealer.

Systemic Recommendations: LASD should provide feasible, objective criteria for the selection of inmate workers in the modules.

LASD should require supervisory approval of module inmate worker selection.

LASD should require documentation of module inmate worker selection and disqualification.

II. Inmate Workers Lee, Chung and Cho Were Not Supervised or Accounted for Following Their Early Morning Work Shift.

Accountability: One Custody Assistant has been disciplined for leaving inmate workers unsupervised following the end of a shift.

Three Deputies have been disciplined for failing to supervise inmate workers on their shift or to place them in their cell rows.

Systemic Recommendations: LASD should require documentation of module inmate worker supervision.

III. The Control Panel Providing Access to the Dayroom Was Not Properly Secured.

Accountability: In the Hong murder, it is not known whether the door covering the control panel was left open or closed. Even if closed, the panel is vulnerable to a persistent inmate. Had module officers attempted to secure the panel, they would have been hampered by the disrepair of the equipment. Responsibility for correcting this security problem rests on almost all supervisory personnel at MCJ for the last several years. Therefore specific discipline is not feasible.

Systemic Recommendations: LASD has already provided a simple latch for all MCJ control panel doors as a quick fix. This latch is cumbersome. LASD should consider installing a better-adapted mechanism and reinforcing the steel mesh around the booths.

IV. Adequate Safety Checks Were Not Made of the Inmates Housed in the Dayroom.

Accountability: One Custody Assistant has been disciplined for performing inadequate safety checks of the day room.

Two Deputies have been disciplined for performing inadequate safety checks of the day room.

Three Sergeants have been disciplined for failing to ensure that personnel under their command conducted proper safety checks.

Systemic Recommendations: LASD's current decision not to use dayrooms for housing should be permanent.

V. An Inadequate Evening Inmate Wristband Count Was Performed.

Accountability: One Deputy has been disciplined for failing to enter or search the dayroom during the evening wristband count.

December 2003

The Prendergast Murder – Killed by two of his cellmates drunk on “pruno”.

I. The Evening Wristband Count Was Not Properly Conducted.

Accountability: One Deputy has been disciplined for failing to perform a thorough evening wristband count and for failing to remove an inmate with a missing wristband from his cell and replace the wristband.

The same Deputy has been disciplined for failing to meet performance standards by failing to observe, during the wristband count, that two inmates inside the victim's cell had been drinking jail-made alcohol and that another inmate in the cell had sustained injuries.

II. Custody Personnel Did Not Search the Cell Row Frequently Enough.

Accountability: No personnel were disciplined because the relevant policy was ambiguous.

Systemic Recommendations: LASD should continue to ensure compliance with the search matrix it has recently developed by placing responsibility for compliance on the supervisors.

III. When inmate Prendergast requested to be seen by a mental health professional, the Department of Mental Health should have provided such an evaluation.

Accountability: No LASD personnel were disciplined because the relevant personnel are Department of Mental Health employees.

One LASD nurse is due to be commended for her referral of Prendergast for evaluation.

Systemic Recommendations: LASD should forward its investigative findings to the Department of Mental Health (DMH) for appropriate action. LASD and DMH should establish a protocol whereby any inmate who expresses a request or behavior that would otherwise trigger a referral to mental health should be reevaluated regardless of when they were last evaluated.

IV. The Crime Scene Should Have Been Preserved After Homicide Bureau Was Called In.

Accountability: No LASD personnel were disciplined because the responsible employee could not be identified.

Systemic Recommendations: LASD should ensure that custody personnel receive adequate training in crime scene preservation within the jails.

LASD should refine its policies to require supervisors to ensure preservation of crime scenes in custodial settings.

V. Suspect Inmate Newell Should Not Have Been Released From Jail Without Notice to Homicide Bureau.

Accountability: Because no effective notification protocols existed regarding release of inmates under investigation for other crimes, no LASD personnel received discipline.

Systemic Recommendations: LASD should develop an effective notification procedure regarding release of inmates under investigation for other crimes.

December 2003

The Alvarado Murder – Killed by inmates in a courtline holding cell.

I. Hourly Safety Checks Were Not Performed or Documented at IRC

Accountability: The view by IRC supervisors that the safety check policy was not applicable to IRC, although mistaken, was reasonable, considering past

confusion about the applicability of Title 15 to IRC.

Systemic Recommendations: IRC should make permanent and readily accessible the current Captain's recent order that LASD's hourly safety check policy shall now be followed at IRC. To do this, IRC should make this standing order into a formal unit division or departmental directive.

II. Due to Failures to Accurately Account for Inmate Alvarado's Movement from MCJ to the Custody Line IRC Holding Cell Where Alvarado's Assault Occurred, Alvarado's Body Was Not Found Until Seven Hours After He Was Assaulted.

Accountability: One deputy will be disciplined for inaccurately reporting that she checked behind the wall of the cell where Alvarado's body was hidden, but did not see Alvarado's body, when in fact, his body probably was there.

Systemic Recommendations: MCJ/IRC deputies should account for whether inmates who are sent from MCJ to IRC actually arrive at IRC custody line. IRC custody line deputies should account for which cells inmates are placed into when they arrive From MCJ. IRC deputies should also account for the movement of all other inmates who are placed in holding cells in other areas.

TSB deputies should check every part of the holding cells at IRC court line when they enter the cells to remove inmates for transport. If necessary to maintain deputy safety, IRC deputies should back-up TSB deputies while they enter the cells.

TSB deputies should also account for the reason why inmates are "scratched," that is, inmates who are not taken on the bus, and provide this information to IRC deputies, who should then keep track of which cell these scratched inmates are held.

III. Placing High Numbers of Inmates Inside the Custody Line IRC Holding Cell Where Alvarado Was Assaulted May Have Blocked the Deputies' View of the Assault

Accountability: No deputies could have been disciplined as a result of overcrowding the holding cells, because there were no policies in place prohibiting it, and unfortunately it had been standard operating procedure for years.

Systemic Recommendations: The IRC Captain's recent order limiting the number of inmates in the holding cells should be made into a unit directive which complies with the rated capacities of the cells.

January 2004

The Faye Murder – Killed after jumping onto the tier of his module, touching off Racial disturbance.

- I. Allowing all cell gates in the module to remain open increased the danger of violence and was in violation of LASD policy.**

Accountability: One Deputy was disciplined for failing to keep cell gates closed per policy.

Systemic Recommendations: LASD should execute long-considered plans to install a wire mesh screen between the two tiers of this module.

- II. The Use of O.C. Spray to Quell the Disturbance Was a Use of Force That Required Reporting.**

Accountability: A Lieutenant was disciplined for failing to ensure that a use of force was reported and documented.

- III. Inmates of High and Low Security Designations Were Improperly Mixed in the Module.**

Accountability: No personnel were disciplined because the responsibility for maintaining security level separation is currently diffused among many employees.

Systemic Recommendations: LASD should rewrite policy so that module officers are aware that they will be held accountable for violations of the security level mixing rules.

LASD should require formal documentation procedures when FAS issues instructions to rectify improper security level mixing.

April 2004

The Tinajero Murder – Killed in his cell after testifying against another inmate.

I. Pineda Was Inaccurately Re-Classified When He Escaped From Central Jail on December 19, 2003.

Accountability: One Deputy was disciplined for his failure to request reclassification of Pineda as a “Red E”.

One Sergeant was disciplined for his failure to identify the mistake in Pineda’s reclassification.

One Training Sergeant will be counseled in writing regarding his failure to possess a working knowledge of LASD’s inmate classification system.

One Deputy was disciplined for his failure to ensure appropriate reclassification of Pineda even after obtaining a felony escape filing from the District Attorney.

One Deputy and One Custody Assistant were commended for their decision to return Pineda to IRC after questions were raised about his true identity.

Systemic Recommendations: LASD should revise its systems to ensure that only supervisors with an expertise in the Inmate Classification System review requests for reclassification.

LASD should work with the District Attorney to achieve more timely filings of criminal charges against inmates.

II. Due to Monitoring Failures, Pineda Was Able to Improperly Leave His Cell Without Being Detected.

Accountability: One Deputy was disciplined for his failure to discover that Pineda improperly inserted himself into the Court Line.

Systemic Recommendations: LASD should revise its policies so that inmates who improperly insert themselves into the Court Line are subject to greater scrutiny and

discipline, are escorted back to Central Jail, and documentation is appropriately made.

LASD should improve its wristband system to ensure that the ability to make replacement inmate wristbands are limited to certain personnel, that the creating of replacement wristbands are documented, and that inmates who tamper with or discard their wristbands are appropriately sanctioned.

III. Due to Monitoring Failures and Inadequate Procedures With Regard to the Escorting of Inmates, Pineda Was Able to Enter Tinajero's Cell Unchallenged.

Accountability: One Custody Assistant manning the floor control booth was disciplined for failure to challenge Pineda's unauthorized presence on the second floor.

Systemic Recommendations: LASD should tighten its practices and policies regarding monitoring of inmates when they are returning to their cells.

IV. There Was Insufficient Monitoring of Tinajero's Cell During the Five Hours that Pineda Was in the Cell.

Accountability: One Custody Assistant and two deputies have been disciplined for failure to properly conduct safety checks.

One Deputy has been disciplined for failure to conduct safety checks and for making false entries in the safety check log.

One Sergeant has been disciplined for failure to ensure that safety checks were properly conducted.

One Deputy has been disciplined for failure to make critical observations during a clothing exchange.

Systemic Recommendations: LASD should continue to deploy adequate personnel to ensure compliance with the spirit and letter of the state law regarding safety checks.

V. There Was Inadequate Follow Up When Pineda Was Found In a Restricted Area, In Particular the Failure to Write a Disciplinary

Report Against Pineda and On Two Prior Occasions, Allegations of Inmate Misconduct Against Pineda Were Inadequately Addressed.

Accountability: One Deputy was disciplined for failure to: investigate Pineda's story; prepare a disciplinary report; and escort Pineda to his cell.

Systemic Recommendations: LASD should re-evaluate and ramp up its efforts in responding to inmates who are caught roaming, particularly in expressly restricted areas.

LASD should examine the failures to proceed against Pineda with regard to the prior allegations of misconduct to learn how to best address apparent systemic flaws in the inmate disciplinary system.

VI. The Training Sergeant at Central Jail Was Unfamiliar with the Most Basic of LASD Policies.

Accountability: The Training Sergeant will be counseled in writing with regard to his unfamiliarity of LASD policies.

Systemic Recommendations: LASD should ensure that Training Sergeants are knowledgeable regarding current policies and practices.

VII. The Classification of Tinajero and Pineda at Long Beach Court Indicate That Existing LASD Protocols Should Be Reexamined and that Better Knowledge And Coordination of the Inmate Classification system Should be Promulgated Throughout the Criminal Justice System.

Systemic Recommendations: LASD should consider revising its classification system to distinguish between "keepaways" who are alleged crime partners and "keepaways" who are witnesses testifying against defendants.

Information about LASD's jail classification system should be readily provided to judges, prosecutors, defense attorneys and other participants in the criminal justice system.

VIII. The Existence of a Publicly Available Database that Provides Cell Housing of Inmates May Have Allowed Pineda to Learn of Tinajero's Housing Location.

- IX. The Investigation Revealed That On At Least Two Occasions, Pineda Was Designated As an Inmate Worker.**

Systemic Recommendations: As indicated above, LASD must devise workable and enforceable criteria for the selection of module inmate workers.

- X. The Investigation Revealed That Pineda Made Numerous Court Appearances and Was Housed in at Least Ten Different Modules in Three Different County Jails Which Allowed Him to Familiarize Himself with the Jail System.**

- XI. The Investigation Revealed that Proceedings Relating to Pineda and Tinajero Occurred During the Pendancy of the Long Beach Proceedings With No Knowledge or Coordination with the Long Beach Criminal Justice Participants.**

- XII. Jail Records Indicate that When Tinajero Was Booked Into County Jail, He Spent Five Days at the Inmate Reception Center Before He Was Housed in a Cell.**

Systemic Recommendations: LASD must locate resources so that inmates seeking medical attention and housing in the jail do not languish on the floors of IRC.

- XIII. The Investigation Revealed Insufficient Attention to the Subsequent Housing of Inmates Involved in these Proceedings.**

Systemic Recommendations: LASD should examine the housing of inmates involved as witnesses and defendants in the five inmate homicides to ensure that the inmate housing system can timely react to new information about the inmates in its care.

**OIR Evaluation and Recommendations Concerning Sheriff's
Department Investigations of Five Custody Homicides Occurring
Between Oct. 21, 2003 and April 20, 2004:**

The Hong Murder

Inmate Ki Hong was stabbed, beaten and strangled to death on October 21, 2003, approximately 1 1/2 hours after he arrived at his housing in Men's Central Jail. Inmates Lee and Cho allegedly killed him while inmate Chung acted as lookout and while the other 57 inmates housed in the dayroom undoubtedly looked on. This was the first of five inmate-on-inmate killings that occurred in the jail system over a six month period. Four of the killings occurred in the Men's Central Jail, and one in the Inmate Reception Center next door.

The initial homicide investigation of the incident showed that inmate Hong's killers had entered the locked dayroom by activating the electric lock on the door. At the custody death review, an IAB investigation into this matter was ordered. Later, at OIR's urging, the investigation was expanded into a broad based examination of many areas of possible policy violations related to the killing.

IAB completed a thorough investigation involving interviews of 48 witnesses. OIR conferred closely with IAB during the investigation and requested significant supplemental interviews and research, especially regarding the status of the three suspects as inmate workers and the history of using the dayroom where inmate Hong was killed as a permanent housing facility. Based on the investigative report, a total of twelve LASD personnel, including four sergeants, were found to have violated LASD policies and disciplined.

The findings of the IAB investigation follow below. The investigation also revealed systemic issues regarding the practices and policies at Central Jail and OIR has already begun to make recommendations with respect to these issues. These recommendations as well as some corrective actions already in progress are detailed below.

I. Inmate Lee Was Not Eligible to be an Inmate Worker and Should Have Been Removed From That Status When Incriminating Information About Him Was Discovered.

Inmates Lee, Chung and Cho, the murder suspects, were all inmate workers at the time that inmate Hong was placed in the dayroom. They were not official inmate workers chosen by a central office after a classification and evaluation process and housed separately from the general population. Rather, they were module workers, chosen informally by individual module deputies to help with the upkeep of the cell rows comprising the module. In recent years, a shortage of inmates who were eligible to serve as official inmate workers required the module deputies to select their workers from a pool of the ineligible inmates. A unit order from 1997 had articulated separate criteria for module inmate workers but had never been enforced, because its criteria was too stringent and thus, enforcement of the order was not feasible. Lee, Chung and Cho were, in fact, ineligible under the unit order policy because they had pending murder charges. This criminal history should also have made them questionable choices for inmate worker status regardless of the unit order criteria.

One month before the murder, a deputy concluded that Lee was dealing drugs in jail. He conveyed this information and his concerns about Lee being an inmate worker to deputies on other shifts and to two sergeants. One sergeant looked further into the matter, but failed to follow up when Lee volunteered to cease acting as a hall inmate worker (with slightly more freedom of movement than a module inmate worker). Lee remained a module inmate worker for the early morning shift, despite the deputy's warning.

Accountability: **One Custody Assistant has been disciplined for failing to take steps to remove inmate Lee from inmate worker status after receiving information that he was a suspected drug dealer.**

One Deputy has been disciplined for failing to take steps to remove inmate Lee from inmate worker status after receiving information that he was a suspected drug dealer.

One Deputy has been commended for his noble albeit unsuccessful efforts to have inmate Lee removed from inmate worker status.

Two Sergeants have been disciplined for failing to take steps to remove inmate Lee from inmate worker status after receiving information that he was a suspected drug dealer.

Systemic Recommendations: **LASD should provide feasible, objective criteria for the selection of module inmate workers in the modules.**

LASD should require supervisory approval of module inmate worker selection.

LASD should require documentation of module inmate worker selection and disqualification.

II. Inmate Workers Lee, Chung and Cho Were Not Supervised or Accounted for Following Their Early Morning Work Shift.

Lee, Chung and Cho were module inmate workers for the early morning shift – 10:00 p.m. to 6:00 a.m. They had been originally hired by predecessor deputies, but were retained and supervised by the Custody Assistant on the early morning shift. As inmate workers, they were allowed out of their cell row and given access to other cell rows and to the module common areas during their work shift. At the end of the shift on the morning of October 21, the Custody Assistant did not lock the inmate workers back in their cells, but allowed them to remain in the module common area to take showers. The Custody Assistant then went off shift. The deputies on the incoming day shift professed not to be aware of the inmate workers or to recognize them. A 1997 unit order requires module officers to count their inmate workers and to actively supervise them. The three early morning shift inmate workers remained outside their cells unsupervised for at least 2 1/2 hours into the Day shift before they entered Hong's housing area.

Accountability: One Custody Assistant has been disciplined for leaving inmate workers unsupervised following the end of a shift.

Three Deputies have been disciplined for failing to supervise inmate workers on their shift or to place them in their cell rows.

Systemic Recommendations: LASD should require documentation of module inmate worker supervision.

III. The Control Panel Providing Access to the Dayroom Was Not Properly Secured.

The dayroom where inmate Hong was placed had one entryway, a steel door with a small window in it. This door gives onto the module common areas outside the gates to the cell rows. The dayroom door can be activated by a pushbutton on a control panel mounted within the nearby control booth. The control booth, a simple enclosure made of bars and steel mesh, is one of four similar booths in the module. They are not all manned at all times because only two or three module officers are assigned to each shift and they must attend to duties outside the booth, such as safety checks on the rows, feeding and showering, and assisting court line movement.

At about 8:30 a.m., the three inmate workers discovered that Hong, a rival gang member, had arrived at the module and was housed in the dayroom. Approximately an hour after that, they gained access to the dayroom by somehow activating a button on a control panel. The investigation revealed that the inmates used a broomstick provided them as inmate workers to activate the control panel button. The control panel was

equipped with a steel door that protected the push buttons. However, the locking mechanism on this door and many others like it elsewhere in Central Jail had broken years earlier. Efforts to repair them had been by and large unsuccessful. The failed locking mechanism and the vulnerability of the pushbuttons to being accessed by broomsticks was well known to some LASD employees and to many inmates. In fact, a year 2000 memo to all MCJ personnel warned of the deficiencies in the control panel.

Accountability: **In the Hong murder, it is not known whether the door covering the control panel was left open or closed. Even if closed, the panel is vulnerable to a persistent inmate. Had module officers attempted to secure the panel, they would have been hampered by the disrepair of the equipment. Responsibility for correcting this security problem rests on almost all supervisory personnel at MCJ for the last several years. Therefore specific discipline is not feasible.**

Systemic Recommendations: **LASD has already provided a simple latch for all MCJ control panel doors as a quick fix. This latch is cumbersome. LASD should consider installing a better-adapted mechanism and reinforcing the steel mesh around the booths.**

IV. Adequate Safety Checks Were Not Made of the Inmates Housed in the Dayroom.

There were 58 inmates housed in inmate Hong's dayroom. Over the previous two years this dayroom had served as a makeshift dormitory housing between 25 and 72 inmates on any given day. Hong's dorm mates slept in rows of double-decked bunks that filled most of the room. The single door and window of the dayroom were next to each other in one corner. State regulations and LASD policy requires custody staff to make a close visual check on the welfare of each inmate in any kind of housing unit. With regard to this dayroom, the officers on all shifts assigned to make the hourly inmate welfare checks confined their observations to what they could see from the corner window. They did not enter the day room and did not ensure that they could see each of the inmates. LASD personnel indicated a concern for personal safety as their reason for not adequately performing the safety checks. The floor supervisors were aware that the module officers used this inadequate welfare check procedure for the dayrooms and failed to rectify the situation.

After killing Hong, the three inmate workers bundled his body in linens and dragged it out of the dayroom into a large waste bin that was taken to the loading dock by unknown persons. The three suspects then ordered other inmates to clean up blood from the attack.

While safety checks that conformed to policy may not have prevented the attack upon inmate Hong, they might well have led to earlier detection of the event, preservation of physical evidence and more facile identification of witnesses.

Accountability: **One Custody Assistant has been disciplined for performing inadequate safety checks of the day room.**

Two Deputies have been disciplined for performing inadequate safety checks of the day room.

Three Sergeants have been disciplined for failing to ensure that personnel under their command conducted proper safety checks.

Systemic Recommendations: **LASD's current decision not to use dayrooms for housing should be permanent.**

V. An Inadequate Evening Inmate Wristband Count Was Performed.

LASD policy requires an inmate count on every shift. However, by longstanding custom, only the PM shift count, referred to as the evening wristband count, is a full facility body count. During that count, inmate movement is brought to a halt and module officers must look at each inmate wristband and check it against a module list to determine if inmates are actually missing or unaccounted for or if the problem is due to inaccurate paperwork.

The module deputies first noticed that Hong was missing during the evening wristband count at about 8:00 p.m. The deputy conducting the wristband count did not enter the dayroom to do so. Jail employees took steps to look for Hong but still did not enter or search the dayroom. Hong's body was not discovered until 11:37 p.m. during a routine check for linens in waste bins. The evening wristband count occurred long after inmate Hong was killed and removed from the dayroom, but a proper count and search may have led to earlier identification of witnesses and discovery of Hong's body.

Accountability: **One Deputy has been disciplined for failing to enter or search the dayroom during the evening wristband count.**

The Prendergast Murder

Inmate Prendergast was beaten periodically over several hours from about 6:00 p.m. December 6, 2003, to early next morning by inmates Newell and Ferman, two of his three cellmates. Newell and Ferman had been drinking pruno before they attacked and had shown irritation when Prendergast exhibited strange behavior and talked to himself. When Prendergast cried out, other inmates on the row would start yelling to cover the sound.

Prendergast was discovered by a day shift Deputy at 7:50 a.m. and taken to the hospital where he died the following day of his injuries.

I. The Evening Wristband Count Was Not Properly Conducted.

A PM shift deputy had performed the daily wristband inspection at about 8:00 p.m., after the pruno drinking and the intermittent attack on Prendergast had commenced. Evidence indicates that Prendergast's wristband was missing at that time, and that the deputy noticed this, but did not replace it. Wristband count procedure requires that: the deputy log the wristband problem; an inmate with a missing wristband be removed from his cell and taken to have his identity confirmed; and a new wristband be created. Had this been done with inmate Prendergast, it would have likely given the deputy a chance to observe Prendergast more closely and to talk to him away from his cellmates.

OIR requested further IAB investigation of the wristband issue. This was promptly done and yielded corroborating evidence that Prendergast did not have a wristband on at the time that the wristband check would have taken place.

The deputy performing the wristband count – a procedure which requires each inmate to bring his wristband close enough to the deputy to read – also failed to notice that there was pruno in the cell, two of the inmates were getting drunk on it, and a third inmate had injuries from an ongoing beating.

Accountability: **One Deputy has been disciplined for failing to perform a thorough evening wristband count and for failing to remove an inmate with a missing wristband from his cell and replace the wristband.**

The same Deputy has been disciplined for failing to meet performance standards by failing to observe, during the wristband count, that two inmates inside the victim's cell had been drinking jail-made alcohol and that another inmate in the cell had sustained injuries.

II. Custody Personnel Did Not Search the Cell Row Frequently Enough.

Records show that the cell row containing the cell where Prendergast was killed had not been searched for five months prior to the homicide. The policy in place at the time required that each shift conduct searches but did not specify that a particular housing unit be searched with any given frequency. Men's Central Jail has since established a "search matrix" to make sure that housing areas do not go without a search for long periods.

Accountability: **No personnel were disciplined because the relevant policy was ambiguous.**

Systemic Recommendations: **LASD should continue to ensure compliance with the search matrix it has recently developed by placing responsibility for compliance on the supervisors.**

III. When inmate Prendergast requested to be seen by a mental health professional, the Department of Mental Health should have provided such an evaluation.

Inmate Prendergast had a history of mental illness. He had been arrested for arson, found criminally insane and kept at Patton State Hospital for seven months, then held at the Twin Towers mental observation ward for another eight months. He was declassified by a Department of Mental Health doctor and psychiatrically cleared for general population on September 25, 2003 because he refused to take his medications. Twelve days later, at MCJ, he asked for psychiatric medications and was sent by an LASD nurse to Mental Health for evaluation. A Mental Health Department nurse sent him back to MCJ without evaluation or medication because of what the nurse asserted was an informal Mental Health policy that inmates will not be re-evaluated if they have been recently declassified -- within the last 30 days or so.

Accountability: No LASD personnel were disciplined because the relevant personnel are Department of Mental Health employees.

One LASD nurse is due to be commended for her referral of Prendergast for evaluation.

Systemic Recommendations: LASD should forward its investigative findings to the Department of Mental Health (DMH) for appropriate action. LASD and DMH should establish a protocol whereby any inmate who expresses a request or behavior that would otherwise trigger a referral to mental health should be reevaluated regardless of when they were last evaluated.

IV. The Crime Scene Should Have Been Preserved After Homicide Bureau Was Called In.

Approximately one day after inmate Prendergast was discovered injured in his cell and taken to the hospital, Homicide Bureau was notified by Men's Central that he was "death imminent." Homicide detectives arrived at the jail and began their investigation, but when they first inspected the scene, approximately six hours after jail personnel had first called them, they found that two new inmates had been moved into the cell to replace Newell and Ferman. They had the cell cleared, but the possibility remains that evidence related to the homicide may have been contaminated or destroyed.

OIR urged the Custody Division to include the scene preservation issue with the investigation of all potential policy violations relating to the Prendergast killing and requested supplemental investigation from Internal Affairs on this issue. Internal Affairs Bureau did extensive supplemental interviews and researched the records relating to the comings and goings in the cell on December 8, 2003, but the evidence did not show conclusively who had placed new inmates in the cell.

Accountability: No LASD personnel were disciplined because the responsible employee could not be identified.

Systemic Recommendations: LASD should ensure that custody personnel receive adequate training in crime scene preservation within the jails.

LASD should refine its policies to require supervisors to ensure preservation of crime scenes in custodial settings.

V. Suspect Inmate Newell Should Not Have Been Released From Jail Without Notice to Homicide Bureau.

Suspect Newell was released from jail eight days after the killing, soon after appearing in court where his underlying case, a probation violation, was resolved. Homicide detectives had not yet filed the murder case and were not informed of Newell's release. Fortunately, he was located and re-arrested the next day.

OIR urged the Custody Division to include the unanticipated release issue with the investigation of all potential policy violations relating to the Prendergast killing and requested supplemental investigation from Internal Affairs on this issue. Internal Affairs Bureau did extensive supplemental interviews and researched the records relating to the release of Newell. The evidence showed that Homicide detectives had not anticipated the release of Newell, based on the posture of his underlying case, but did take the precaution of requesting that the Inmate Reception Center place a notation on his release documents that Homicide should be notified before any release. No effective notification of the detectives was ever made, although IRC personnel asserted that they had tried to contact the Homicide Bureau main desk.

Accountability: Because no effective notification protocol existed regarding release of inmates under investigation for other crimes, no LASD personnel received discipline.

Systemic Recommendations: LASD should develop an effective notification procedure regarding release of inmates under investigation for other crimes.

The Alvarado Murder

On December 9, 2003, inmate Mario Alvarado, aka Victor Cortez, was murdered in a holding cell at Custody Line Inmate Reception Center ("IRC"). He had previously been housed at the Men's Central Jail ("MCJ") and was awaiting transfer to the Pitchess Detention Center ("PDC"). A short time after he arrived at the IRC Custody Line holding cell, which contained about 40 inmates, he was attacked by one or more other

inmates, who punched and kicked him until he lost consciousness and continued to beat him afterward. Within about an hour of the assault, inmates noticed he appeared to stop breathing. Some time after he stopped breathing, two deputies assigned to the Transportation Services Bureau (“TSB”) entered the cell to remove the inmates whose names were written on a list and were destined to be transported to the PDC. Those two TSB deputies failed to see Alvarado’s dead body because it was partially concealed under clothes and trash behind a three-foot privacy wall in a toilet area. Apparently, they called out his name from the list, but when Alvarado did not respond, they assumed he had never been placed in the cell. Approximately seven hours after his assault, a worker inmate cleaning the cell discovered his body and notified IRC deputies.

OIR recommended that an Internal Affairs investigation be launched and LASD executives agreed. The Internal Affairs investigation focused on whether LASD performed and documented required hourly safety checks and why Alvarado’s body was not discovered until approximately seven hours after his fatal assault. The Internal Affairs file comprises a thorough two-volume report, including transcripts or summaries of 26 witness interviews and over one hundred pages of documents and reports. As with the other jail homicides, early on OIR made recommendations regarding the course and scope of the investigation and at the investigation’s end met with LASD executives to discuss its disposition.

I. Hourly Safety Checks Were Not Performed or Documented at IRC

LASD Policy Manual Section 4-11/030.00 (Inmate Safety Checks) requires that “all inmates in [LASD’s] custody shall be visually checked at least once each hour to ensure their safety and welfare.” The policy cites the specific provision in California law, California Code of Regulations, Title 15, section 1027, which requires hourly safety checks of inmates. The policy mandates that hourly safety checks shall be documented in a log called the Uniform Daily Activity Log book. The log contains the name and employee number of the employee conducting the check, the location of the check, the time the check was made and a comment section regarding what the inmates were doing when the check was conducted. Under the policy and Title 15, an acceptable hourly check consists of a deputy peering into the cell from the outside, visually inspecting each inmate to “look for obvious signs of life, i.e. breathing, talking, movement, etc.” See Title 15, California Code of Regulations, section 1027 (hourly checks consist of “direct physical observation of all inmates...”). The policy provides that “should there be any doubt regarding an inmate’s condition, staff shall attempt to illicit a response from the inmate.” If there is no response, “a supervisor and medical staff shall be requested.” Though the policy requires adequate checks and documentation of the checks, the investigation revealed that LASD executives believed the policy did not apply to IRC.

During their interviews, LASD executives, uniformly, stated that they believed that the inmate safety check policy did not apply to IRC. Each claimed it was their understanding that the policy applied only to facilities where inmates are housed, such as MCJ or PDC. They believed the policy did not apply to temporary holding facilities, such as IRC, where inmates are only temporarily held, usually for less than 24 hours.¹

¹ While seeking a permanent housing assignment or initial medical care, currently due to perhaps staffing curtailment, some inmates spend much longer than 24 hours at IRC. For example, jail records show that Tinajero, the murdered inmate in another jail

Their belief was based in part on the fact that the California State Board of Corrections, which inspects each LASD custody facility bi-annually, including IRC, had never found that IRC was not in compliance with Title 15 safety checks. Despite the fact that the Board of Corrections had suggested in its most recent 2002-2004 bi-annual report that safety check procedures at MCJ were somewhat defective, the Board of Corrections did not find that IRC safety checks were not in compliance with Title 15. In addition, LASD policy itself seemed to suggest that it may have been intended to apply solely to housing facilities. For instance, the policy makes reference to “custody housing,” “housing locations,” and “housing areas.” As a result of the potential vagueness of the policy as written, and the Board of Corrections tacit approval of the IRC safety check procedure, LASD executives’ mistaken belief that their safety check procedures did not violate Title 15, or LASD policy, was regrettable, but understandable.

During their interviews, LASD supervisors readily admitted that safety checks were not documented. These honest admissions are admirable, and tempered by the misunderstandings noted above. These witnesses claimed however, that even though they believed the safety check policy did not apply at IRC, casual safety checks nonetheless were conducted. They based this claim on the assertion that because many personnel passed down the hallway where Alvarado’s cell was located, an estimated 10-12 per hour, and supposedly looked into each cell as they walked by, each of these casual walk-by observations constituted 10-12 safety checks per hour, above and beyond the one per hour required by the policy. This claim is belied however, by the fact the policy requires more than mere casual walk-bys. As noted above, the policy requires a visual inspection of each and every inmate in the cell to observe obvious signs of life, breathing, talking or movement. This kind of careful individual visual inspection can only be accomplished by stopping in front of each cell and taking the time necessary to visually examine each inmate in the cell, not by merely passing by and off-handedly glancing into a cell without taking the time to observe each inmate’s safety. None of the executive witnesses alleged that IRC personnel stopped in front of each cell and conducted this type of careful visual inspection of each inmate. As such, the executives’ claim that personnel at IRC performed 10-12 safety checks per hour is, at best, based on a loose definition of what constitutes an adequate safety check, which is precisely the reason why the Title 15 policy should apply to IRC – to regulate the manner in which checks are conducted.

The misunderstanding as to whether the policy applies to IRC has now been rectified. The IRC captain and chief of Correctional Services Division each acknowledge that in order to more thoroughly safeguard IRC inmates, the policy should apply to IRC. The IRC captain has issued a memo ordering all IRC supervisors that LASD’s safety-check policy shall be enforced at IRC. This is laudable, however this order may carry more weight, and have more permanence, as a unit directive or an entry in either the custody division manual or the LASD manual on policies and procedures. Accordingly, OIR recommends that a more permanent order to this same effect be instituted. LASD has agreed in principle to this recommendation.²

homicide discussed in this report, spent five days at IRC before he was housed at Central Jail. While IRC was not designed for multi-day housing, its de facto use as such is another reason that the Title 15 Safety Check requirement must apply.

²OIR would like to correct another misunderstanding. Several former IRC captains were under the misapprehension that Title 15 did not apply to temporary holding facilities, like IRC. Title 15 specifically states that temporary holding facilities “shall

Accountability: The view by IRC supervisors that the safety check policy was not applicable to IRC, although mistaken, was reasonable, considering past confusion about the applicability of Title 15 to IRC.

Systemic Recommendations: IRC should make permanent and readily accessible the current Captain's recent order that LASD's hourly safety check policy shall now be followed at IRC. To do this, IRC should make this standing order into a formal unit division or departmental directive.

II. Due to Failures to Accurately Account for Inmate Alvarado's Movement from MCJ to the Custody Line IRC Holding Cell Where Alvarado's Assault Occurred, Alvarado's Body Was Not Found Until Seven Hours After He Was Assaulted.

On the day of his murder, inmate Alvarado was sent from his cell at MCJ, to a holding cell at Custody Line IRC, where he awaited transport to the PDC, his intended housing facility. Alvarado's name was contained on a list of 60 inmates who also were supposed to have been sent from MCJ to Custody Line IRC because they too were headed to PDC. Most but not all of the inmates on the list actually made it from MCJ to Custody Line IRC, but IRC personnel did not keep track of which inmates actually arrived and which ones did not. To further add to potential confusion, when the TSB deputies arrived to bus 49 inmates to PDC, (the buses seat a maximum of 49), they did not account for those remaining 11 or so inmates who did not make it on their bus. Apparently, all they did was call out the names of the inmates on the list, and once they had 49 inmates who answered to their names, they did not check the whereabouts of the remaining 11 inmates on the list, but merely placed a notation near their names indicating they were "scratched," that is, did not make it on the bus. In this case, Alvarado was inside the Custody Line IRC cell where he was supposed to be, except that he was likely dead and his body behind a three foot privacy wall. Had IRC and TSB deputies had a better system of accounting for exactly which inmates made it from MCJ to IRC, in which Custody Line cell those inmates were placed, and why it was those who did not answer their names when called, Alvarado's body would have been found much sooner than seven hours after his assault.

This is not to say that had IRC and TSB deputies accounted for each of these 11 inmates, Alvarado would not have died. In fact, there does not appear to be any causal

comply" with section 1027 of Title 15 (the inmate hourly safety check provision). Title 15, California Code of Regulations, section 1010(c)(3). This misunderstanding appears to have been repeated so often that it became accepted as gospel, which explains the need to actually read regulations rather than accepting institutional lore about what they might say. To permanently lay this inaccurate lore to rest, LASD should state in the policy manual that the Title 15 hourly safety check requirement does apply to all LASD temporary holding facilities.

connection between this systems laxity in accounting for the inmates' whereabouts and Alvarado's death. As noted above, most likely Alvarado was already dead by the time TSB deputies opened the cell to transport 49 inmates to PDC.

The TSB bus driver who was one of two TSB deputies who entered Alvarado's cell, claimed that she indeed checked behind the privacy wall in the cell. She claimed she saw nothing behind it, no body, and no pile of trash or clothing. Had she seen such a pile, she claimed that she would have checked underneath to see if anything was hidden. When asked whether she was absolutely certain that she checked behind the wall, she insisted she was. She postulated that the murder must have occurred after she left the cell. Nonetheless, this is strongly contradicted by the chronology of events developed by IA investigators from jail records, LASD witness interviews and by several inmates, who state that Alvarado's body was behind the 3-foot wall at the time the TSB deputies entered the cell. The physical layout of the cell also contradicts her assertion. It appears that if the deputy had walked just a few feet into the cell, she should have been in a position to see behind the short wall. Had this deputy entered the cell a few feet, looked behind the short wall and looked underneath the clothes and trash covering his body, she would have found Alvarado's body more than three hours before the worker inmate did.

Accountability: **One deputy will be disciplined for inaccurately reporting that she checked behind the wall of the cell where Alvarado's body was hidden, but did not see Alvarado's body, when in fact, his body probably was there.**

Systemic Recommendations: **MCJ/IRC deputies should account for whether inmates who are sent from MCJ to IRC actually arrive at IRC custody line. IRC custody line deputies should account for which cells inmates are placed into when they arrive From MCJ. IRC deputies should also account for the movement of all other inmates who are placed in holding cells in other areas.**

TSB deputies should check every part of the holding cells at IRC court line when they enter the cells to remove inmates for transport. If necessary to maintain deputy safety, IRC deputies should back-up TSB deputies while they enter the cells.

TSB deputies should also account for the reason why inmates are "scratched," that is, inmates who are not taken on the bus, and provide this information to IRC deputies, who should then keep track of which cell these scratched inmates are held.

III. Placing High Numbers of Inmates Inside the Custody Line IRC Holding Cell Where Alvarado Was Assaulted May Have Blocked the Deputies' View of the Assault

According to the California Board of Corrections, the Custody Line IRC holding cell where Alvarado was murdered had a rated capacity of 14 inmates, yet deputies placed approximately 40 inmates inside the cell.³ According to the Board of Corrections, the cell is approximately 182 square feet, has one toilet, one wash basin, one water fountain, benches mounted on the walls, and one emergency intercom. The emergency intercom could have been used to alert personnel, and was functioning at the time, but apparently none of the inmates used it during or after the assault. The cell did not have bars, but four solid walls and large transparent plexiglass windows on one side, making it somewhat difficult for anyone outside the cell to hear what was going on inside. Given the large number of inmates inside the relatively small cell, it may have been difficult for deputies to see toward the rear of the cell. As a result of the cell's relative soundproofing, the inmates not using the emergency intercom, and the inmates possibly blocking the view of the rear of the cell, deputies were unaware of the assault.

OIR stresses that there is absolutely no evidence that deputies deliberately ignored Alvarado's plight. To the contrary, OIR believes that had deputies been aware of the assault, they would have done everything in their power to protect Alvarado. This does not ameliorate, however, the practice of placing more than twice the rated capacity of inmates inside a relatively small, sound-resistant cell, with transparent windows on only one side. While OIR is cognizant of the space constraints in LASD custody facilities, this practice does not appear to have solely been the result of space constraints. Rather, it appears that IRC Custody Line deputies had a practice of crowding many inmates in these holding cells at least partially out of convenience's sake. Tragically, this motivation may have unintentionally played a role in Alvarado's death. Had there been fewer inmates inside the cell, deputies may have been able to observe the assault and possibly save Alvarado before the fatal blows were struck.⁴

As a remedial measure, the present IRC Captain recently issued an email order to personnel stating that no more than 20 inmates may be placed in these Custody Line holding cells. His order further states that if any deputy believes it is necessary to place more than 20 inmates in a cell, he must first get a sergeant's approval, and the approval must be noted in a Title 15 log. OIR notes that even 20 inmates is more than the rated

³Rated capacity means "the number of inmate occupants for which a facility's...cells...were planned and designed in conformity and to the standards and requirements" of Title 15. Title 15, California Code of Regulations, 470A.1 (Definitions).

⁴With regard to the holding tank in which Alvarado was killed, subsequent to his murder, jail authorities have installed a mirror-like surface at the top of the cell that allows LASD personnel to more easily observe the privacy area where Alvarado's body ended up.

capacity of the largest of the Custody Line cells, which, according to the Board of Corrections has a rated capacity of only 16. In any event, OIR recommends, as with the Captain's order regarding hourly safety checks, this order also be made into a more permanent directive. To the extent practicable, OIR also recommends that this unit directive comply with the Title 15 rated capacities of each holding cell.

Accountability: **No deputies could have been disciplined as a result of overcrowding the holding cells because there were no policies in place prohibiting it, and unfortunately it had been standard operating procedure for years.**

Systemic Recommendations: **The IRC Captain's recent order limiting the number of inmates in the holding cells should be made into a unit directive which complies with the rated capacities of the cells.**

The Faye Murder

On January 12, 2004, inmate Kristopher Faye was stabbed to death by several inmates with jail-made knives on the lower tier of his module after he lowered himself down from the upper tier balcony and attempted to use the phone. Faye was black; the alleged attackers were Hispanic. Fighting ensued between the two racial groups involving about 30 inmates on the two tiers immediately following the killing. The lower row had "freeway sleepers",⁵ in bunks at the time. The upper row did not. At the time of the incident, all cell doors on both rows were open and inmates were allowed to roam freely on the freeway of their row. The module deputy did not see Faye lower himself down from the upper row. This module is unique in central jail in that it has no metal mesh barrier above the upper row balcony to prevent inmates from jumping off the balcony. The lack of a metal mesh barrier in this module stems from its past use as a low security module. Since the module is no longer housing only low security inmates, the structural barrier should be installed.

I. Allowing all cell gates in the module to remain open increased the danger of violence and was in violation of LASD policy.

Allowing all cell gates on both tiers to remain open simultaneously was dangerous and unnecessary despite the presence of freeway sleepers. This violation of jail policy also allowed many inmates to involve themselves in the ensuing disturbance and prevented some inmates from seeking refuge in their cells.

Accountability: **One Deputy was disciplined for failing to keep cell gates closed per policy.**

⁵ Freeway sleepers are inmates who actually sleep outside the cells. Jail authorities assert that the existence of freeway sleepers is sometimes a necessary evil in light of budgeting issues.

Systemic Recommendations: **LASD should execute long-considered plans to install a wire mesh screen between the two tiers of this module.**

II. The Use of O.C. Spray to Quell the Disturbance Was a Use of Force That Required Reporting.

Deputies quickly regained control of the module using O.C. spray. The response to the disturbance was directed by a Sergeant who asked a supervisor whether the use of O.C. required a force report. The supervisor decided no use of force report was necessary for the O.C. use because the supervisor believed erroneously that it had not been directed at individuals. LASD policy requires that the use of O.C. spray against inmates be reported as a use of force.

Accountability: **A Lieutenant was disciplined for failing to ensure that a use of force was reported and documented.**

II. Inmates of High and Low Security Designations Were Improperly Mixed in the Module.

The custody classification process assigns each inmate one of nine security levels based on the inmate's record and behavior in jail. Levels 1 through 4 are low security, levels 5 through 7 are medium security, and 8 and 9 are high security. LASD policy forbids mixing of high and low security inmates in the same housing unit. Inmate Faye's module was designated for low and medium security inmates only.

Inmate Faye was classified as a level 4. When IAB discovered that one of the suspects in the attack on Faye had a security level of 8, OIR requested significant additional investigation to determine all the high security classification inmates living on the module at the time as well as their housing history and what employees were involved with their transfers or failure to remove them. This supplemental investigation determined that there were in fact a total of six "8s" living on the module at the time of the killing. The only reason cited for placing them there or allowing them to stay was overcrowding, due in part to the recent partial removal of inmates from dayrooms.

This is a significant deviation from explicit policy without clear justification. The policy is directly related to safety. All module employees on all shifts had the opportunity to note that there were frequent classification conflicts around the time of the killing. However, responsibility for rectifying housing/classification problems may be taken up by either the module deputies or the Facility Accountability Service ("FAS") staff but does not fall squarely on either. Additionally, a complete lack of explicit procedures and documentation makes it impossible to fairly hold individual employees accountable.

Accountability: **No personnel were disciplined because the responsibility for maintaining security level separation is currently diffused among many employees.**

Systemic Recommendations: **LASD should rewrite policy so that module officers are aware that they will be held accountable for violations of the security level mixing rules.**

LASD should require formal documentation procedures when FAS issues instructions to rectify improper security level mixing.

The Tinajero Murder

On April 20, 2004, inmate Raul Tinajero was killed in his cell, allegedly by inmate Santiago Pineda. Eventually, an Internal Affairs investigation was commenced into the circumstances surrounding Tinajero's murder, to learn how Pineda was able to enter Tinajero's cell. The focus of that investigation was not to duplicate the already ongoing Homicide investigation but to learn whether LASD personnel violated policies intended to maintain security and provide safety to inmates in the jail. An exhaustive three volume investigative report was produced that contained the interview summaries of over sixty five witnesses and collection and examination of hundreds of pages of documents. Based on the investigative report, fourteen LASD employees were found to have violated various LASD policies and were disciplined. From even before the initiation of the LASD investigation, OIR was involved in pushing for a timely IA investigation and helped shaped the investigative effort. Numerous discussions were held between OIR and the IA investigators as the investigation moved forward. At the end of the investigation, OIR met with LASD executives from the jail and offered recommendations regarding the disposition of the investigation, the LASD personnel subject to discipline, and the levels of discipline. With regard to systemic issues, the investigation also revealed significant flaws in current LASD practices and policies and OIR has already begun to make recommendations with regard to these issues.

I. Pineda Was Inaccurately Re-Classified When He Escaped From Central Jail on December 19, 2003.

On December 19, 2003, Pineda was housed in Central Jail and awaiting trial for the murder of Juan Armenta. The day before, Pineda had learned from a cellmate of his that the cell mate had been designated as an inmate worker for the West Hollywood Station. Pineda then demanded the designated wristband of his cellmate. When the cellmate refused, Pineda threatened that he would have fellow inmates harm the cellmate. At that point, the cellmate surrendered his wristband.

On December 19, Pineda used the appropriated wristband to get through the Inmate Reception Center ("IRC") and onto a bus to West Hollywood Station. Upon arriving at the Station, a Transportation Bureau deputy and Custody Assistant at West Hollywood examined the photograph they had been supplied of the inmate who was designated to work that day and decided that there were discrepancies between Pineda and the identifying information. Accordingly, they decided to send Pineda back to IRC.

When Pineda was returned to IRC, LASD personnel soon learned how he had strong-armed the wristband from his cellmate and effectuated his escape from the jail. A

report was prepared documenting the circumstances. At that point, Pineda should have been re-classified as a “Red-E” which is the classification for inmates who have attempted escape from Central Jail. Instead, Pineda was re-classified at a lower security classification. This incorrect classification was also approved by a Sergeant at IRC.

The incorrect reclassification had significant ramifications regarding Pineda’s subsequent cell assignment and freedom of movement at the jail. If he had been properly classified, he would have been assigned to a one-person cell. More importantly, such a classification would have required an escort whenever Pineda was moving about the facility.

While the current LASD classification policy is clear that inmates who attempt escape from Central Jail are to be re-classified as a “Red E”, the knowledge of the existence of this policy by LASD personnel is suspect. For example, both the deputy and Sergeant who incorrectly classified Pineda in this case claimed to have no knowledge of this policy until it was showed to them during the course of the investigation.

Of more fundamental concern is the apparent lack of knowledge about LASD’s classification system by training personnel. During the investigation, the training sergeant assigned to IRC was interviewed and possessed an incorrect understanding of the “Red E” classification. The fact that the training sergeant did not have a working knowledge of the inmate classification system demonstrates a need for remediation as to that particular sergeant and points to the need for improved training on this issue for all staff responsible for reclassifying inmates, particularly those personnel assigned to IRC.

In addition to the apparent lack of knowledge about this aspect of LASD’s classification system were the failures identified in this case as a result of the systems in place. With regard to Pineda, the LASD personnel who had the best working knowledge of the inmate classification system did not ever become aware of the escape. This is because re-classification requests are handled via a special handling card. The card has a space in which a Sergeant is to approve the request. The ideal person to approve the request is a “classification Sergeant”. In this case, because another Sergeant less familiar with the classification system approved the request filled out by a deputy equally unfamiliar with the classification system, the jail classification experts never reviewed the request. In addition, because the request was already signed and approved by a sergeant, LASD staff that input the information into the system never sought approval from the classification supervisors.

The follow-up investigation of Pineda’s escape was transferred to an investigator at Central Jail. That investigator presented an investigative report to the District Attorney’s Office and escape charges were filed against Pineda on February 23, 2004, over two months after the escape attempt. Of even greater concern, even after preparing the investigative reports against Pineda and obtaining a felony filing from the District Attorney, the investigator took no action to ensure that Pineda was reclassified as a “Red E”.⁶ As a result, Pineda continued to enjoy a freedom of movement in the jail to which

⁶ Jail Records also show that after the escape charges were filed against Pineda, his classification level was modified from a 6 (Medium) to a 7 (High Medium). However, this modification of Pineda’s classification level did not change his housing or remove him from the general population. OIR is also concerned that it was only when the actual charges were filed that Pineda was actually reclassified.

he should not have been afforded. That freedom of movement led to Pineda's ability to move unescorted within the jail on April 20, the day in which he allegedly murdered Tinajero.

Accountability:

One Deputy was disciplined for his failure to request reclassification of Pineda as a "Red E".

One Sergeant was disciplined for his failure to identify the mistake in Pineda's reclassification.

One Training Sergeant will be counseled in writing regarding for his failure to possess a working knowledge of LASD's inmate classification system.

One Deputy was disciplined for his failure to ensure appropriate reclassification of Pineda even after obtaining a felony escape filing from the District Attorney.

One Deputy and One Custody Assistant were commended for their decision to return Pineda to IRC after questions were raised about his true identity.

Systemic Recommendations:

LASD should revise its systems to ensure that only supervisors with an expertise in the Inmate Classification System review requests for reclassification.

LASD should work with the District Attorney to achieve more timely filings of criminal charges against inmates.

II. Due to Monitoring Failures, Pineda Was Able to Improperly Leave His Cell Without Being Detected.

On the date of the murder, Pineda was able to leave his module without being detected. Module deputies are to ensure that only those inmates who have passes for court are put on the court line. This is done by checking the wristbands of the inmates who possess court passes. However, in the early morning hours of April 20, Pineda made his way into the court line and was able to leave the module despite not having a pass for court.⁷ Scanning records showed that at 5:02 a.m., Pineda was scanned into

⁷OIR has previously encountered the deputy who failed to properly check Pineda's wristband and has written about him in previous public reports. On page 59 of our Second Annual Report, we discuss a patrol deputy who falsified information on a police report and pleaded no contest to criminal charges against him. Originally, LASD concurred with OIR's recommendations that the deputy should be discharged. However, during the grievance process and without consulting OIR, LASD agreed to a settlement.

IRC, where it was discovered that he did not have a court appearance. When it was discovered that Pineda did not have court, he was kept in a holding cell until 8:31 a.m. and then told to return to his cell. Pineda was not escorted back to Central Jail.

LASD does not have a policy requiring the escorting of inmates who are returned to Central Jail from IRC. One reason put forward for the non-existence of such a policy are the low staffing levels and the high number of inmates who are “scratch outs”, i.e., inmates who are originally scheduled for court but whose dates are cancelled before they are put on the bus or inmates who are due to be somewhere but are simply in the wrong line. However, in this case, Pineda was not a “scratch out”, but an inmate who never was on the court line or due to be out of his cell for any reason that morning. Moreover, at the time of the homicide, Pineda had been designated as a “keepaway” meaning that he had been expressly forbidden to enter one whole floor at Central Jail. For inmates in Pineda’s situation, LASD policy should have demanded more inquiry about why he had put himself in a court line when he did not have court or any other reason for leaving his cell. Also, for inmates in his situation, LASD should consider developing a policy requiring an escort back to his cell. In this case, Pineda was not a “scratch out” or an inmate who has “lost his way” but a “roamer” and a “keep away” and inmates caught under similar circumstances in the future should be subject to greater scrutiny, inmate discipline, and provided an escort to Central Jail. Moreover, these improved policies should assign responsibility to IRC supervisors to handle such inmates and require documentation of these follow-up inquiries. In the Tinajero case, because of the lack of documentation it proved impossible to learn who had told him to return to his cell.

It was further discovered during this aspect of the investigation that there are insufficient controls placed on the creation, discarding, and destruction of inmate wristbands. Under the current monitoring system, the inmate wristband is critical to ensuring the proper movement and housing of the inmates. Current policy requires that if an inmate is found without a wristband, he is to be sent to IRC and his identity carefully researched. However, in practice, deputies are free to make substitute wristbands for inmates without following that policy. No documentation is made regarding the creation of replacement wristbands by the module deputies and there is no careful check of the inmate’s identity. Inmates who are found not wearing wristbands are rarely “written up” for that infraction but are usually simply reissued new wristbands.

During the Tinajero Internal Affairs investigation, three discarded wristbands were found by Internal Affairs investigators at the facility in the Officer’s Security area. When the Internal Affairs team was interviewing an inmate witness, it was observed that

The settlement brought the deputy back to work in exchange for a 25 day suspension. In exchange, the deputy agreed to be taken out of patrol and reassigned to the jail. In the past, LASD has considered a custody assignment a relatively “safe” position where an employee saddled with an integrity issue could work. However, this case is an illustration of how a transfer to a custody assignment does not insulate LASD from such issues. This case demonstrates only one instance where the credibility of the deputy will be at the center of an issue – other examples include the prosecution of inmate offenses or evaluating allegations of excessive force in the jail setting.

he was not wearing a wristband. It is apparent that current LASD policy and actual practice regarding inmate wristbands are not in synch. LASD should tighten and enforce its policy and restrict the authorization to make replacement wristbands to certain personnel. The making of replacement wristbands must be documented. Finally, the destruction or discarding of wristbands by inmates should have serious ramifications for those inmates.⁸

Accountability: **One Deputy was disciplined for his failure to detect that Pineda improperly inserted himself into the Court Line.**

Systemic Recommendations: **LASD should revise its policies so that inmates who improperly insert themselves into the Court Line are subject to greater scrutiny and discipline, are escorted back to Central Jail, and documentation is appropriately made.**

LASD should improve its wristband system to ensure that the ability to make replacement inmate wristbands are limited to certain personnel, that the creating of replacement wristbands are documented, and that inmates who tamper with or discard their wristbands are appropriately sanctioned.

III. Due to Monitoring Failures and Inadequate Procedures With Regard to the Escorting of Inmates, Pineda Was Able to Enter Tinajero's Cell Unchallenged.

After Pineda was allowed to make his way back to Central Jail unescorted, he walked back through the hallway and up the stairs to the Second Floor. At the time, Pineda had been designated as a "keep away", meaning that he had been specifically restricted from the Second Floor. Pineda's wristband was marked to show that keep away designation. In order to enter the Second Floor, he would have needed to go by the Floor Control Booth. LASD policy requires personnel monitoring the Floor Control Booth to "challenge all inmates entering and exiting the floor to ascertain the validity of their business". It is apparent that despite his wristband markings designating him as an express keep away from the Second Floor, Pineda was not challenged by the Control Booth Officer. As a result, the Control Booth Officer has been disciplined for the failure to follow this policy.

After walking by the Control Booth, Pineda then walked into Module 22/2400 and waited in the laundry room with other inmates. Between 10:00 and 11:00 am, Pineda

⁸ OIR is personally aware that since the inmate murders, LASD is working towards improving the inmate tracking system such as the development of an identification card to supplement the wrist-band system. LASD also intends to fine inmates who tamper with their wristbands or identification cards. OIR will continue to monitor, provide its input, and report on those reforms.

was allowed to walk with other inmates to their cells unescorted and walked into Tinajero's cell. Pineda then allegedly murdered Tinajero. The fact that Pineda is able to walk unescorted to Tinajero's cell suggests that greater controls and monitoring should be considered by LASD with regard to the return of inmates to the modules. While the culture of Central Jail recognizes the need for vigilance in monitoring the departure of inmates from their cells, that same level of vigilance has not been recognized in ensuring that the inmates return to their proper housing module. This case demonstrates the need for increasing such vigilance regarding such inmate movement as well.

Accountability: **One Custody Assistant manning the floor control booth was disciplined for failure to challenge Pineda's unauthorized presence on the second floor.**

Systemic Recommendations: **LASD should tighten its practices and policies regarding monitoring of inmates when they are returning to their cells.**

IV. There Was Insufficient Monitoring of Tinajero's Cell During the Five Hours that Pineda Was in the Cell.

Pineda remained in the cell with Tinajero and other inmates for over five hours. Tinajero's body was eventually found on a mattress pushed underneath one of the bunks. Tinajero was covered with a blanket except for the top portion of his head. The investigation revealed several failures in the module with regard to monitoring of the inmates:

The day shift and "PM" module officers indicated that they had done four and three safety checks respectively of the inmates during the time that Pineda would have been in Tinajero's cell. During each of the checks, neither module officer detected the unauthorized inmate in the cell and both failed to notice Tinajero's body on the floor. LASD policy requires that safety checks are to detect obvious signs of life, such as breathing. LASD policy also requires that safety checks be documented in "real time". Because both module officers failed to properly conduct the safety checks and document the safety checks in real time, they received discipline for these policy violations.

The investigation further revealed that a deputy assigned to one of the second floor modules did not conduct hourly safety checks at all in violation of policy. Moreover, the investigation revealed that this module officer falsified entries in the Title 15 Log Book, indicating that he had conducted safety checks when in fact he had not done so. The Title 15 Log Book is maintained to document compliance with the state mandated safety checks. This module officer will receive discipline as a result of his failure to conduct the safety checks and placing false information into the logbooks.

During the time that Pineda was in Tinajero's cell, there was a "third man" officer assigned to the module. That officer is responsible for conducting safety checks and ensuring that the safety checks done by the module officers were conducted and documented properly. The "third man" officer received discipline for failing to live up to these responsibilities.

The investigation revealed that the Sergeant assigned to the Floor at the time of the incident failed to ensure that the safety checks were being properly conducted. Accordingly, the Sergeant was disciplined for his supervisory failure.⁹

During the time that Pineda was in Tinajero's cell, there was a clothing exchange conducted by a deputy. The deputy failed to detect any irregularities in Tinajero's cell during the exchange even though an unauthorized inmate and dead inmate were in Tinajero's cell. The deputy has been disciplined for his failure to make any observations during the clothing exchange.

The failure to perform adequate safety checks is a common theme running through several of the jail inmate homicides. The homicides themselves and the failure to detect the murder for hours in some cases demonstrate a need that such checks be conducted appropriately. Since this murder, as a result of receiving additional funding from the Board of Supervisors, LASD has specially designated personnel as Title 15 officers, whose primary responsibility is to conduct safety checks. Since implementation of this program, OIR is aware of several inmate assaults and inmate attempted suicides that were discovered by Title 15 deputies in the jails. OIR is hopeful that this increased dedication of personnel to this matter will improve the frequency and vigilance by which safety checks are conducted in Central Jail.

Accountability:

One Custody Assistant and two deputies have been disciplined for failure to properly conduct safety checks.

One Deputy has been disciplined for failure to conduct safety checks and for making false entries in the safety check log.

One Sergeant has been disciplined for failure to ensure that safety checks were properly conducted.

One Deputy has been disciplined for failure to make critical observations during a clothing exchange.

Systemic Recommendations:

LASD should continue to deploy adequate personnel to ensure compliance with the spirit and letter of the state law regarding safety checks.

- V. There Was Inadequate Follow Up When Pineda Was Found In a Restricted Area, In Particular the Failure to Write a Disciplinary Report Against Pineda and On Two Prior Occasions, Allegations of Inmate Misconduct Against Pineda Were Inadequately Addressed.**

⁹This same Sergeant was disciplined in the Hong case for his similar failure to ensure the proper conduct of safety checks.

Pineda remained in Tinajero's cell until sometime between 2:30 and 3:00 p.m., when inmates were being released to go to a transfer line. At that time, Pineda was detected trying to sneak past the deputy monitoring the line. Pineda was then directed to a day room and interviewed by LASD personnel; Pineda told the deputy that he was merely visiting his "cousin". Because Pineda was polite, the story about visiting his cousin was not further investigated nor was a disciplinary report prepared against Pineda for "roaming". Rather, the deputy simply walked Pineda back to the Third Floor and allowed him to walk to his module unescorted.

The deputy who did not follow up on Pineda's story, failed to write a disciplinary report, and did not escort Pineda back to his cell has been disciplined for those failures. These failures were particularly troubling in this case, where a "keep away" inmate has been discovered on a floor from which he has been expressly restricted. With regard to more systemic issues, OIR believes that LASD should ramp up its efforts with regard to inmates caught roaming. In the twelve-month period previous to this murder, only 408 roaming charges had been written by LASD Central Jail personnel. OIR has received anecdotal information that the roaming inmates who receive discipline for doing so are those who display an "attitude" when caught. With the admittedly changed and more violent inmate population in the County jails, inmates who break the rules and "roam" should be written up and dealt with seriously. This is particularly so, when, as in this case, the roaming inmate is found in an area of the jail from which he has been previously restricted. To not do so will increase the likelihood of repercussions such as the murders that are the subject of this report.

The disciplinary records of Pineda indicated that on June 30, 2002, he had allegedly been involved in a violent racial disturbance. The paperwork indicated that Pineda was observed to have redness to his left and right knuckles as evidence of his involvement in the fight. The records further indicate that on March 13, 2003, Pineda was found with a shank in his cell. While both of these alleged infractions were documented, the records indicated that both cases were dismissed for failure to timely prosecute the allegations. The fact that LASD did not timely proceed on these serious infractions suggests problems with the inmate disciplinary system. OIR intends to work with LASD to further examine this issue to learn whether there exist systemic flaws with regard to the handling of inmate discipline.

Accountability:

One Deputy was disciplined for failure to: investigate Pineda's story; prepare a disciplinary report; and escort Pineda to his cell.

Systemic Recommendations:

LASD should re-evaluate and ramp up its efforts in responding to inmates who are caught roaming, particularly in expressly restricted areas.

LASD should examine the failures to proceed against Pineda with regard to the prior allegations of misconduct to learn how to best address apparent systemic flaws in the inmate disciplinary system.

VI. The Training Sergeant at Central Jail Was Unfamiliar with the Most Basic of LASD Policies.

The investigation revealed a lack of familiarity of jail policies by the training sergeant. For example, the training sergeant indicated his belief that the Control Booth Officer was not required to check wristbands, even though policy dictates such a requirement. In addition, the Training Sergeant opined that it was discretionary whether to write up an inmate caught roaming, even if he was a “keepaway” and found on the floor from which he was restricted. LASD must ensure that its training sergeants have a functional knowledge of LASD policies.

Accountability: **The Training Sergeant will be counseled in writing with regard to his unfamiliarity of LASD policies**

Systemic Recommendations: **LASD should ensure that Training Sergeants are knowledgeable regarding current policies and practices.**

VII. The Classification of Tinajero and Pineda at Long Beach Court Indicate That Existing LASD Protocols Should Be Re-examined and that Better Knowledge And Coordination of the Inmate Classification system Should be Promulgated Throughout the Criminal Justice System.

The apparent motive for the killing of Tinajero is because he had testified against Pineda in Long Beach Court, implicating Pineda in the murder of Juan Carlos Armenta. Prior to Tinajero’s testimony at Pineda’s trial, discussions were held in court between the judge, the prosecutor, the Alternate Public Defender appointed to represent Tinajero, and Pineda’s attorney. As a result of those discussions, Tinajero and Pineda were both designated as keep aways. In LASD jargon, a “keep away” means that jail authorities were to house Tinajero and Pineda on separate floors of the jail. Keep away status does not mean that either Tinajero or Pineda were to be kept in one person cells, segregated away from the general inmate population, or required escorts when being moved.

It is unclear from the investigation whether the participants in the court proceedings were of the same mind requiring what level of jail housing was desirable for Tinajero and Pineda during the pendency of those proceedings. What is clear is that the participants had different levels of understanding with regard to LASD nomenclature which instructs jail authorities as to how county inmates are housed, classified, and handled. In other words, the designation of “keep away” meant different things to different participants in the proceedings.

In any event, with regard to the Long Beach proceedings, while the acts of LASD personnel in the designations of Tinajero and Pineda did not violate current policy, the investigation did reveal that judges, prosecutors, and defense attorneys should receive accurate information about the jail classification system so that the requests of those parties with regard to inmate housing and classification can be better informed.

In addition, an examination of the inmate classification system revealed that most inmates who are designated as “keep aways” are so designated because they are alleged to be confederates in criminal proceedings and are kept away from each other to avoid collusion. Only a small percentage of “keep aways” involve witnesses testifying against defendants, such as occurred in this case. OIR recommends that the current LASD singular classification for two very different situations deserves reexamination. The consequences of “keep aways” who are alleged crime partners being able to violate that restriction are entirely different than “keep aways” who are pitted against each other in a criminal proceeding. To lump both types of scenarios in one classification scheme is ill-advised.¹⁰

Systemic Recommendations:

LASD should consider revising its classification system to distinguish between “keepaways” whom are alleged crime partners and “keepaways” who are witnesses testifying against defendants.

Information about LASD’s jail classification system should be readily provided to judges, prosecutors, defense attorneys and other participants in the criminal justice system.

VIII. The Existence of a Publicly Available Database that Provides Cell Housing of Inmates May Have Allowed Pineda to Learn of Tinajero’s Housing Location.

Information from the investigation indicated that Pineda may have been able to ascertain Tinajero’s housing location via the Internet. Since this discovery, an inmate’s specific housing location is no longer available on the Internet site.

IX. The Investigation Revealed That On At Least Two Occasions, Pineda Was Designated As an Inmate Worker.

The investigation revealed that while awaiting trial for murder and escape, Pineda had been designated as an inmate worker. The fact that someone with Pineda’s level of violence and security risk would be able to achieve such an assignment is problematic. In particular, to permit such an assignment after Pineda had strong-armed another designated inmate worker and escaped the institution suggests weaknesses in the

¹⁰ In addition, it is unclear under LASD policy whether Tinajero should have been considered a “material witness”. If he had been in custody solely because of his witness status, LASD policy clearly states that he would need to be segregated from the remainder of the jail population. While his witness status was not the sole reason Tinajero was in custody, it was the sole reason that he was being housed in Central Jail. Accordingly, it may be prudent for LASD to house witnesses who are in its jails solely because of their witness status differently than those who are present for other reasons.

inmate worker selection system. As discussed above, this issue presented itself in the Hong murder as well.¹¹

Systemic Recommendations: As indicated above, LASD must devise workable and enforceable criteria for the selection of module inmate workers.

X. The Investigation Revealed That Pineda Made Numerous Court Appearances and Was Housed in at Least Ten Different Modules in Three Different County Jails That Allowed Him to Familiarize Himself with the Jail System.

Prior to the aborted Long Beach murder trial, jail records show that Pineda had made at least 21 court appearances in Long Beach and four court appearances relating to his escape charge. That meant that Pineda was moved through IRC to court at least twenty-five times. Every time that Pineda was moved he could have gained knowledge about the jail system and identified weak points in that system. The records show that the virtually all of the appearances in Long Beach court were merely continuances of the trial date.

Jail records also show that while awaiting trial, Pineda was housed in at least ten different modules in three different county jails. This assignment of Pineda to different housing in the jails also increased his familiarity with the system.

While OIR does not intend to make specific recommendations with regard to these facts at this time, it feels that these circumstances may have contributed to Pineda's ability to effectuate entry into Tinajero's cell on April 20. If procedures could be adopted to limit the travel of defendants to essential criminal proceedings without derogation of the Constitutional rights of defendants to attend necessary proceedings, it would assist an already overburdened jail system which is required to move hundreds of inmates every day and prevent savvy inmates from gaining familiarity with the jail system.

XI. The Investigation Revealed that Proceedings Relating to Pineda and Tinajero Occurred During the Pendency of the Long Beach Proceedings With No Knowledge or Coordination with the Long Beach Criminal Justice Participants.

This investigation revealed that certain events occurred in the criminal justice system unbeknownst to the participants in the criminal proceedings in Long Beach. For example, at the time of Pineda's murder trial, the prosecutor was unaware that Pineda had been charged with escape and was actively involved in defending those proceedings. In addition, while Pineda was awaiting murder charges, Tinajero was arrested on an unrelated charge, pleaded guilty to that charge, spent time in Central Jail, and was eventually sent to state prison. All of these proceedings occurred without knowledge of the Long Beach prosecutor or the Long Beach detective handling the homicide case. As a result, Tinajero was housed in Central Jail at the same time as Pineda and during that time, was not even designated as a "keep away". The fact that participants in the criminal

¹¹ As noted in the Hong discussion, efforts are underway by LASD to develop workable criteria for the selection of module inmate workers.

justice system were not aware of proceedings that directly impinged on witnesses and defendants in their cases is problematic and deserving of additional reflection by those participants in order to find better ways to ensure knowledge of those events.¹²

XII. Jail Records Indicate that When Tinajero Was Booked Into County Jail, He Spent Five Days at the Inmate Reception Center Before He Was Housed in a Cell.

Tinajero was transported from Kern State Prison to Long Beach Court by Long Beach authorities on April 1, 2004. The next day Tinajero was ordered by the Long Beach Court into the Sheriff's custody. Jail records show that from April 2 to April 7, 2004, Tinajero slept at IRC before he was assigned a cell at Central Jail.

The five-day delay in assigning Tinajero to a cell with a bunk is unfortunately, not an unusual circumstance. Inmates often spend days waiting in lines to receive medical attention or jail housing assignments. Clearly, LASD must find resources and ways to speed up the process of housing inmates as they enter IRC.

Systemic Recommendations: LASD must locate resources so that inmates seeking medical attention and housing in the jail do not languish on the floors of IRC.

XIII. The Investigation Revealed Insufficient Attention to the Subsequent Housing of Inmates Involved in these Proceedings.

During the investigation, IA interviewed Jonathon Newell, an inmate who had been charged with the killing of inmate Prendergast as a potential witness in the Tinajero killing. At the time of the Tinajero killing as well as the subsequent IA interview, Newell was housed in general population with at least one cell mate and housed on the same module as Tinajero. A review of Newell's subsequent housing showed that for eleven days subsequent to his alleged murder of Prendergast, he had been placed in medium/low security housing. When OIR discovered this fact, we questioned the advisability of housing an inmate in general population who had been charged with killing a fellow inmate. As a result of a direct inquiry from OIR, Newell was removed from general population and placed in segregation.

OIR also examined the post murder housing records of the witness inmates to Tinajero's murder and discovered that with regard to two of those inmates, they were placed in general population for over three weeks before being placed in segregation. Clearly, the Newell situation and the delay in segregating the witnesses to the Tinajero murder suggests that practices regarding inmate housing assignments require reexamination. OIR will work with LASD to find ways to improve this aspect of the jail classification process.

¹² The lack of knowledge of the Long Beach detective and prosecutorial authorities regarding the escape charge stands in sharp contrast to the information gained by the Alternate Public Defender. Court records establish that the Alternate Public Defender's Office refused to represent Pineda in his escape case after the Office learned that they had represented Tinajero in the pending murder trial.

Systemic Recommendations: **LASD should examine the housing of inmates involved as witnesses and defendants in the five inmate homicides to ensure that the inmate housing system can timely react to new information about the inmates in its care.**

CONCLUSION

The size and scope of reform suggested by this report may seem daunting at first blush, but the vigor with which LASD has already begun to respond provides a hopeful sign. Some issues will require much more creativity and resolve to address. While additional resources are always a welcome part of the solution, jail authorities must rethink the ways things have been done knowing that they will never have all of the resources they would want. By this continual reexamination of their operational systems, solutions will emerge that will make inmates and staff safer. OIR believes that its novel and outside perspective will aid LASD as it continues this critical review.