Eighth
Office of Independent Review **Annual Report**

Michael J. Gennaco
Chief Attorney

Robert S. Miller
Benjamin Jones, Jr.
Deputy Chief Attorneys

Julie Ruhlin
Erica Broido
Cynthia L. Hernandez
Angelica Arias
Attorneys

Angie Calderon
Sylvia Newkirk-Ma
Maria Avery
Professional Staff

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

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Contents

Foreword

Another year monitoring the Sheriff's Department has sped by and even though we have been at this oversight for eight years now, old thorny challenges and new ones continue to keep us occupied. This year, the spike in both deputy-involved shootings and suicides and homicides in the jails have caused us concern; ameliorated somewhat by the rigorous and exacting review the Department routinely applies to each case.

As reported here, there were eight suicides in 2009, a significant increase from two the previous year. Each suicide raises the specter of possible performance lapses, violations of policy, equipment failures, lapsed supervision, and training issues. Over the years, we have heard some supervisors view the suicides fatalistically, suggesting that a determined inmate will find a way to end his life. Fortunately, the dominant view for jail supervisors is to use each suicide as a teaching tool to better ready the Department so that the next time an inmate has such ideation, he will not be able to successfully carry out his intent of self-inflicted death.

We also report on the Department's continued struggle with alcohol-related incidents. As the Department continues to identify more and varied ways to address this problem, the number and type of "aggravated" cases presented this past year are particularly disturbing. In these cases, deputies are belligerent with arresting authorities, a firearm is involved, there is a refusal to cooperate with the breath or blood test, or the deputies are arrested on child endangerment charges because a child is in the car. While the Department has yet to crack the code that might significantly diminish the numbers, we can attest to the fact that it is not for lack of trying. We will continue to closely follow these incidents and the Department's clear resolve to address them.

By far the most promising new program that was launched this year was Education Based Discipline, an alternative universe to the traditional discipline system that is designed through classes, briefing, and public displays of acceptance of responsibility to remediate problem behavior and prevent employees from feeling the alienation and disgruntlement that was often the fallout of the traditional and clumsy discipline system. OIR was proud to have played a role in helping to design the EBD system and early returns suggest a win-win for both management and its employees. We will continue to monitor the impact this program has for the Department. OIR also played a critical role in the Department's significant policy reform regarding fraternization and prohibited association. The new policy now provides more guidance to Departmental personnel, ensuring that clearer lines are drawn between Department personnel and the criminal element.

The Sheriff's Department has not been immune from resource constraints as a result of recent economic woes. Fortunately, we have not seen any significant retreat in providing training to its people, but the slowdown in hiring and movement within the organization and shrinking of the budgetary belt can no doubt have consequences in the long run. While the Department cannot ignore the budgetary realities, it has also recognized the need to remain on point with a continued commitment of staff, and as well as a robust review program for critical incidents and allegations of misconduct.

We appreciate your interest in the internal workings of the Sheriff's Department and our work that is designed to ensure accountability and reform. Of course, a good part of that work goes for naught unless we have the ability to report out the Department's challenges and its response as we do here. We appreciate the ability each year to provide that transparency through this annual report.

As the entity responsible for effective investigations, robust accountability, and systems reform, we appreciate any feedback from you regarding the matters discussed here.

PART ONE

Custody Incidents and Concerns

The Sheriff's Department is responsible for managing the largest local jail system in the United States. Housing approximately 19,000 inmates daily requires a significant dedication of the Department's resources and personnel. The sheer volume of inmates, large number of inmates suffering from mental illness and physical combativeness make custodial facilities a potential tinderbox twenty-four hours a day, seven days a week. Force incidents between custody personnel and inmates, the potential for suicides, inmate-on-inmate violence, including inmate homicides, are a constant source of concern. As discussed below, OIR continues to closely monitor these critical incidents occurring in LASD jails and provide the Department with workable solutions aimed at improving safety for both its personnel and inmates alike.

Jail Suicides: 2009 Update

In OIR's Seventh Annual Report, we noted a two-year decline in suicides in the County jails, from eight in 2006 to three in 2007 and only two in 2008. We congratulated the Department on its ongoing efforts to prevent inmate suicides while noting that the data points are too small for any meaningful analysis. Unfortunately, the number of completed suicides rose in 2009, with seven occurring in the County jails and one in a patrol station lockup. Again, with a daily inmate

population around 19,000, this increase may not be statistically significant. Nonetheless, jail managers are appropriately troubled by the upswing and continue their efforts to address issues raised by each incident. OIR continues to monitor these efforts. We report below on each of the suicides from 2009.

Case

In this suicide, an issue was raised regarding the physical structure of the cells in which the inmate was housed. In this case, the inmate hanged himself by using a shower curtain rod at Men's Central Jail. This housing area is unique in that the inmates have showers in their cells. The inquiry into this inmate's medical history revealed no identifiable mental health issues or suicidal ideation or tendencies and thus it was not inappropriate to house the inmate alone in this housing area.[1] The Department determined that there were no violations of policy and no training issues related to this death.

Case

In this suicide, concerns were raised regarding the completion of safety checks. The resulting Internal Affairs investigation has revealed that the requisite safety checks had not been completed for upwards of three hours and records of some checks may have been falsified. In addition, the investigation is reviewing whether deputies manning the housing area were allowed to leave the inmates unmonitored to go to the gym and go off-premises on a "chow run." The Internal Affairs investigation remains pending and OIR is monitoring those cases.

Case

This suicide occurred in a patrol station lock-up rather than in one of the custodial facilities. In this case, the post death inquiry pointed to the desirability of improved electronic record-keeping to allow a greater degree of information sharing between the County's Department of Mental Health ("DMH") and LASD officials. The arrestee/inmate in this case had been a DMH patient with a history of suicide attempts during a prior incarceration. If the inmate had been booked at IRC, this information would have been available to the intake personnel, but could not be accessed by the deputies doing the medical and mental health screening at the station jail. Because the inmate did not disclose upon booking any mental health issues, and showed no obvious indications of

1 This was in the jail's MRSA module, where inmates either have or are particularly susceptible to Methicillin-resistant Staphylococcus aureus (aka "staph" infection), a bacterial infection that can spread rapidly in inmate populations and has been a concern in the jail for a number of years.

a need for mental health care, the inmate was not identified as someone who presented a heightened risk of suicide. The Department has made efforts to close this communication gap, but has been unable to reach a resolution with DMH.

Case

In this suicide, issues were also raised regarding the completion of safety checks. The resultinginvestigation determined, however, that the time gaps between required checks were minimal and resulted in no more than a several minute delay in responding to the inmate's cell, where he was still alive at the time deputies arrived.

Here, the inmate tore the cover from his mattress to fashion a noose. This was particularly disturbing because the inmate was housed in a mental health observation area, where inmates are given special blankets and mattresses that are designed and marketed as "suicide prevention" items. A very timely inquiry by Custody Support Services ("CSS") staff revealed that the Department has recently switched to a different manufacturer, who sold these items at a substantially lower price than the previous provider. In addition, CSS in its regular review of all attempted suicides, had noticed that a handful of other inmates had torn their so-called "suicide prevention" blankets or mattresses in efforts to take their own lives. In these cases, deputies or other staff had intervened and prevented the suicides. CSS staff immediately notified its chain of command of the problem and researched various brands of prevention items. CSS staff discovered that many of the products marketed as "safety" or "suicide prevention" items were, in fact, relatively easy for a motivated inmate to tear apart. This factor, coupled with the large number of blankets and mattresses that needed to be replaced and the unfortunate but usual bureaucratic delays, prevented immediate corrective action. The Department does appear committed to making this important change once a suitable supplier is identified. We are hopeful that the bureaucracy and institutional delays do not defeat the good will of those leading this initiative.

Case

This suicide presented an issue regarding the Jail Mental Health Evaluation Teams ("JMET") and the way in which Custody interfaces with DMH, which provides mental health services in the jail. The inmate in this case told custody staff he was thinking of killing himself. The conscientious deputy immediately sent the inmate to IRC to talk to a mental health clinician. A nurse interviewed him and determined he was not suicidal and should be returned to general population housing, but also requested a follow-up by JMET. There was a regrettable delay in communicating that request, and JMET never met with the inmate, who

hanged himself three days later. We understand that the DMH mechanism for treating inmates easily could be overwhelmed by the number of inmates who claim to be suicidal in an attempt to manipulate their housing assignments. Thus, DMH must carefully screen inmates before admitting them to the high observation portion of the jail. Nonetheless, the breakdown in communication systems in this case is symptomatic of the ongoing need for the LASD and DMH to find creative ways to improve and streamline their working relationship.

Case

In this suicide, the inmate also hanged himself by using a shower curtain rod at Men's Central jail. This suicide occurred in the same housing area as in the case referenced above, where the inmates have showers in their cells. The after death inquiry revealed no identifiable mental health issues or suicidal ideation or tendencies with regard to this inmate and thus there were no issues regarding his housing assignment. The Department determined that there were no violations of policy and no training issues related to this death.

However, and unfortunately, in the seven months between this suicide and the other one involving a shower curtain rod, no corrective action had been implemented to address the ease with which inmates can use the shower rods to hang themselves. In an effort to address the instrumentality used in both suicides, the Department committed to examining what types of shower stalls and rods other county jails and state prisons are using. The Department continues to research alternatives to the existing shower rods, though it is proving difficult to find a product that is suitably durable for the correctional setting while at the same time being incapable of supporting a person's weight or being used as some type of weapon.

Fortunately, the Department is not dominated by the fatalistic belief that since a determined inmate will find some way to kill himself while in custody, it is fruitless to work too hard to eliminate potential instrumentalities. While it is true that inmates continue to be very creative in finding ways to end their lives, it is the responsibility of the Department to react to and learn from each suicide and continue to find ways to reduce the likelihood of a successful subsequent suicide. We are hopeful that the Department will continue to press this matter and are confident it can devise a solution. It is important however, that the persons tasked with finding solutions are supported by the Division, so that the fix is in place before another inmate takes advantage of the shower rods in this housing area to attempt to end his life.

Case

In this suicide, the inmate used long tube socks purchased through inmate services to make a noose and successfully hanged himself. Unfortunately, this problem was not unpredictable. We reported last year:

> *Custody Support Services recently began reviewing all attempted suicides in an effort to spot trends and patterns in connection with these incidents. An attempt suicide can reveal the same issues in inmate care, screening, and security measures as a completed one, and warrants the same type of scrutiny. By looking beyond completed suicides to all attempts, the Department broadens its view and can more quickly identify what may become more serious problems in the future. For example, CSS recently noticed that some inmates were using tube socks to fashion nooses and has initiated a move to replace them with shorter socks that cannot be used as readily for this purpose. No inmate, to our knowledge, has used tube socks in a completed suicide, so the issue would not have been raised absent this proactive approach to reviewing attempted suicides.*

The effort to replace inmates' socks that we reported on last year stalled, at least in part because of concerns that different socks would complicate laundry operations. Unfortunately, we can no longer report that socks have never been used in a completed suicide.

The socks the inmate used here used were not the Department-issued socks, but a pair the inmate purchased through an approved vendor. The Department no longer allows its outside vendor to sell long (knee-high) tube socks to inmates, however it continues to issue mid/lower calf tube socks as part of the inmate uniform. With the exception of inmate workers, who regularly wear high boots while performing various cleaning and maintenance tasks, we have not been persuaded why inmates need these mid-length socks and continue to encourage the Department to move to shorter, ankle-length socks.[2]

This suicide also revealed weaknesses in the processing and follow-up mental health care of inmates once classified as suicidal. Here, the inmate had attempted suicide approximately five months before his eventual completed suicide and had spent some time in custody under the supervision of Department of Mental Health personnel. However, the inmate was declassified shortly after his attempted suicide and remained in custody without any further outward indication that he was suffering from mental health problems. Nonetheless, there was no evidence of any ongoing evaluation conducted by mental health staff members.

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2 It has been suggested that the longer socks provide greater warmth to inmates when the cell temperature drops. Without more evidence of this being an issue, we continue to advocate switching to shorter socks.

This is not unusual, or, as far as we know, contrary to DMH policy. We understand that the sheer number of inmates moving in and out of mental health housing at the jail makes meaningful follow-up care difficult, if not impossible, for the finite DMH staff working at the jails. That being said, we have in the past recommended that the Department work with DMH to find some way to address the treatment and care of inmates declassified from mental health housing and will continue to press this issue.

Case

In this suicide, the inmate hanged himself from a bunk that had been temporarily placed in a cell to create additional housing. The bunk provided a more convenient anchor to tie a noose than a regular fixed bunk. As a result of gaining knowledge from this suicide, the Department removed these moveable bunks.

Reviewing Inmate Deaths

Custody continues to convene very prompt inmate Death Reviews, which continue to make for more substantive, meaningful reviews. Indeed, two of the 2009 suicides occurred on one day, and within three days of an inmate homicide (discussed later in this Section), and Custody held its Death Review just four days after the suicides in an effort to quickly address the issues presented. In addition, we also remain impressed with the increased vigor with which Custody Support Services identifies issues in preparation for the death review and the more candid discussions that emanate from the death reviews themselves. Unfortunately, while the Department is quick to identify and discuss needed reforms, as noted here, actual change often comes more slowly, if at all. The issue with the tube socks discussed above is an excellent example of this dynamic.

In the past year, OIR worked with Custody to plug this significant hole in an otherwise robust system for reviewing inmate deaths by developing a mechanism for following up on issues identified during the pre-death review inquiry and the death review itself. Custody Support Services has long had a system for documenting and following through on tasks that are its responsibility to complete—typically those dealing with policy, documentation, facilities or equipment, and training issues. OIR has asked for years to be included on the distribution list for these memos, and has at various times received assurances that we would be, yet we have never consistently been provided these follow-up memos. We will continue to press for inclusion as a means of ensuring that we can more regularly monitor the Department's progress on these issues.

For issues identified at the death review that are not within the CSS job description, however—orders to open administrative investigations, instructions to a captain or commander to take some action, or requests for information or reform made to Medical Services Bureau personnel—there has been no guaranteed follow-up. One purpose of inmate death reviews is to present to Custody and Correctional Services Division executives the facts surrounding each in-custody death so that issues of individual accountability as well as shortcomings in procedures can be identified, discussed, and handled in a systematic way. In the past, unfortunately, the review process lacked an orderly way in which executives could follow up on all of those issues. Death review participants often talked about issues of importance, e.g., mental health treatment, classification issues, bail issues, conditions of confinement, security checks. A Chief would often recognize the need for a particular unit to do some research or take some action to address a systemic issue, but there was no apparent structure to ensure that the issue was reviewed, and more importantly, no protocols to ensure a report back to the interested Chief. Moreover, there generally were no time expectations provided at the death review for reporting back on these assignments. As a result, OIR often left death review with assurances that the Department would be "looking into" a particular policy or practice, but the lack of an effective feedback loop caused us to lose confidence that there would be a timely fix to the problem.

Recently, at OIR's urging, Custody has taken positive steps to close the gap between identifying issues and implementing solutions.

Recently, at OIR's urging, Custody has taken positive steps to close the gap between identifying issues and implementing solutions. In a post-death review meeting with the Chiefs, Custody Support Services outlines all of the action items identified, including those administrative issues that had not previously been documented by CSS, and identifies the persons or units responsible. CSS is to record these assignments, track their progress, and report back at the following death review. With this assignment of responsibility and development of a structured follow up report, we hope that many of the issues identified during the death review process will lead to faster and more robust systemic reform. We look forward to an ongoing positive relationship with CSS as we continue to monitor this reform with interest.

Inmate Murders Cellmate

In August 2009, a fifty-five year old inmate was murdered by his twenty-one year old cellmate. Under the Department's classification system, both inmates had been

evaluated and designated the same security level.[3] The assault took place shortly after both inmates were placed together in the acute mental housing floor of one of the Department's custody facilities. The victim was found lying in a pool of blood in his cell by a mental health staff doctor who was making his regular rounds. The incident highlighted the vulnerabilities in the Department's classification system and potential safety risks when inmates are not suited to be cellmates. In the aftermath of the incident, OIR examined whether there were ways the Department could implement safeguards to "catch" the potential mismatching of inmates. Subsequent revelations in this case, for instance, suggested that factors such as age, in-custody disciplinary history and mental stability may have indicated that the pairing would have been unsuitable.

In the aftermath of the incident, OIR examined whether there were ways the Department could implement safeguards to "catch" the potential mismatching of inmates.

As mentioned above, the victim was thirty-four years older than the suspect.[4] Although the disparity in age alone may have not necessitated separate housing, these factors coupled with their respective in-custody disciplinary history may have warranted a more careful assessment of the match. For instance, while in the Department's custody, the victim had no in-custody disciplinary record. The suspect, on the other hand, was involved in three separate fights—two with inmates and one with a custody assistant who was taken to the hospital and was treated for his injuries. The suspect's discipline offenses also included challenging staff to fight, being disrespectful to staff and refusing to follow orders. Despite these documented incidents, there was no change in the suspect's classification. In addition, it appears that the suspect's disciplinary history was not considered when he was paired with the victim.

Consideration of the inmates' mental stability may have also been an indicator of a mismatch. Typically, mental health personnel determine whether an inmate is stable

3 During the initial custodial intake process, inmates are classified into security levels so that housing and handling designations can be made. Security levels range from 1 (low security concern) to 10 (high security concern). Classifications are primarily based on the inmate's current arrest charges and past criminal history. Here, the suspect was in custody for battery on a custodial officer and had a prior conviction for discharging a firearm in public. The victim was booked for felony vandalism and had a prior robbery and prior burglary conviction. The victim's robbery conviction, however, had occurred over thirty years earlier and the burglary conviction was over fifteen years old. Also, approximately one month before the homicide, the victim made an appearance in court to answer to his pending criminal charges and bail was set for one million dollars. It appears that the unusually high bail amount may have been a response from the presiding judge who was upset that the inmate failed to state his proper name for the record.

4 There was also a significant difference in height. The victim was eight inches shorter than the 6'2" suspect.

enough to have cellmates. If stable, then LASD personnel do the actual placement of inmates based on the classification system. Here, the victim was stabilized and recommended for double-man housing. The suspect, however, had not been med-compliant and remained in single-man housing for several weeks leading up to the day of the incident. It is unclear whether the suspect's mental stability and readiness to be paired had been effectively communicated from mental health professionals to Department personnel.

After OIR raised theses issues, immediately following the incident, the Department acknowledged that it needed to take steps to increase inmate safety, particularly in the acute mental housing floor where behavior can be erratic. Department personnel assigned to that floor have now been instructed to reassess the suitability of cellmates and consider factors such as age and disciplinary history before pairing inmates. OIR continues to work with the Department to formalize this change in practice.

Jackhammer Incident Causes Inmate Death

At a custody facility in the county, the Sheriff's Department was in the process of constructing a new security fence. Construction supervisors from the Department's internal Maintenance and Construction unit headed up the project and utilized some jail deputies, custody assistants and volunteer inmate trustees to assist with the job.

During an initial stage of the project, the inmate crew and custody personnel were excavating four-foot-deep holes for the fence posts using a tractor-mounted drill when they ran into solid material a few feet down in one of the holes. An inmate with experience and skill using a jack hammer was instructed to jump in the hole to break up the obstacles. The jail personnel had used the jackhammer technique before and knew that there was a lot of rubble and broken asphalt in this underground area. They had also been told that there could be underground hazards encased in red concrete, but it was difficult to see anything but dirt at the bottom of the holes. Shortly after the inmate began jack hammering, there was a small explosion. Fire and smoke shot out of the hole and the inmate was electrocuted.
He had hit a high-voltage electric power line.

OIR urged Department executives to hold the construction supervisors accountable within the framework of the administrative discipline system. The Department ultimately declined to do this, maintaining that historic practices and guidelines failed to point out safer procedures to the construction project managers. While the administrative discipline system has proved inadequate to the task of holding individuals accountable, the administrative investigation was extensive and revealed some significant lapses in the way such work was carried out.

First, in drawing up the plan to position the fence posts, no diagram or map of underground hazards had been consulted. Specifically, no effort had been made to locate any underground power lines or other hazards before excavation through probes or remote sensing or diagnostic trenches. Also, no trained construction supervisor had been on-site during the excavations.

Notwithstanding our failure to reach an agreement on the issue of discipline, Department executives have agreed to work with OIR to develop a plan of remediation for construction practices within the Department. We expect this plan to enhance the Department's compliance with construction safety standards and to place paramount importance on the safety of employees and inmates. We will monitor the Department's commitment closely in the months to come.

Commendable Response to a Major Disturbance

Last year, there was a major disturbance involving hundreds of detainees at one of LASD facilities. The disturbance was met with a swift response from the facility's Emergency Response Team ("ERT"). An immediate lockdown was called, which effectively contained the disturbance. With assistance of personnel from two nearby LASD stations, the on-site ERT strategically positioned themselves and deployed stinger rounds, pepper spray, and tear gas. The fighting was quelled within minutes. Approximately twenty-seven detainees were injured. No department personnel were injured during the disturbance.

Initially, it was alleged by a detainee that the incident was facilitated by a custody assistant who opened a gate that allowed detainees access into the barracks that housed their rivals. Based on these allegations, the region commander ordered an immediate internal investigation to determine what role, if any, the custody assistant had in the disturbance and whether any policy violations occurred. OIR monitored the progress of that investigation and weighed in on the final disposition.

Tension Between Rival Groups

The investigation revealed that the disturbance was primarily a conflict between two Hispanic groups: the Southsiders and the Paisas.[5] Tensions were particularly

5 Southsiders are a jail gang comprised of members of Southern California Hispanic street gangs. Paisas are not affiliated with street gangs but are Hispanic and are typically migrant farm workers from Central America.

high between the groups due to an altercation earlier that day that resulted in the involved Southsiders being sent to disciplinary housing.

Before the disturbance erupted, as regularly scheduled, a group of Southsiders were in the central recreation area for yard time. It was not uncommon for Southsider detainees to migrate across the park area towards the barracks that were comprised of primarily Paisa detainees to talk to them.[6] However, on this day, a deputy who was aware of the earlier altercation positioned himself between the rows of barracks to ensure that the Southsiders did not cross the park area. While monitoring the movement of the detainees, he noticed that some Southsiders started "staring down" the detainees housed inside the "Paisa" barracks. He also noticed that there was an unusually large number of Paisa detainees outside their barracks (but still confined inside the security fence). He then heard an announcement over the PA system that classes were open and detainees were being released from their barracks. At this point, a custody assistant—who allegedly had a role in the disturbance—walked over to Paisa barracks and opened the security gate so that they could attend classes which were held in a different part of the facility.

...LASD personnel responded quickly to the melee, immediately took their positions and, with less lethal weapons, gained control of the situation.

Sensing that something sinister was brewing, the deputy immediately requested, via radio, that all compound officers have the detainees go back inside their barracks. He then requested that Main Control make a PA announcement directing all detainees to return to their barracks. He also advised compound deputies and custody assistants that the front of the barracks was not safe and instructed them to exit through the rear gates.

As the announcements were being made, the Southsiders, seeing an opportunity to gain access to their rivals, rushed the custody assistant as she stood by the open gate and made their way into the Paisa barracks. The custody assistant was pulled away from the melee by a deputy and the gate was closed to contain the disturbance. Southsiders breached security gates and entered adjoining compounds to engage in the fight. During the disturbance, detainees broke wooden benches, rain gutter down pipes and other objects and used them as weapons. As mentioned earlier, LASD personnel responded quickly to the melee, immediately took their positions and, with less lethal weapons, gained control of the situation.

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6 The facility has a large central recreation area which is adjacent to two rows of barracks. The barrack compounds are self-contained and are separated from each other by chain link fences. The two rows of barracks are physically divided by an area called "the park"—a lengthy grassy lawn punctuated by trees, park benches and one "guard shack."

The Aftermath

In the end, the evidence did not support the claim that the disturbance was preplanned or that the custody assistant was attempting to aid the Southsiders. Several witnesses saw the custody assistant being rushed and grabbed as the incident began and saw her upset. The detainees who claimed that the custody assistant purposefully opened the gate were unable to give any specific facts to support their allegations. OIR concurred that the evidence did not substantiate the allegation of misconduct committed by the custody assistant.

In analyzing the incident, the Department and OIR agreed that the facility's effective orchestrated response was a testament to the leadership of the command staff and the structured training that the facility personnel participate in regularly. There were lessons, however, to be learned from the incident. Although approximately forty-five detainees involved in the disturbance were identified as gang members and were transported immediately to other federal facilities, the Department recognized that the tension between the rival groups—for those that remained—may never fully dissipate. In light of that acknowledgment, the Department took additional steps to prevent similar events from occurring in the future. For instance, the facility eliminated Southsiders' access to common areas when other detainees are present. Also, Southsider detainees are now segregated from all other detainees (i.e. placed in separate barracks) and are escorted to and from all activities, including meal time and yard time. The facility also enhanced the security of its interior pedestrian and vehicle gates. OIR continues to monitor the implementation of these safeguards.

New Guidelines for Handling Recalcitrant Inmates

In 2009, the Department implemented a new policy establishing guidelines on how personnel should handle recalcitrant inmates. The purpose of the recalcitrant inmate policy is to ensure that deputies overcome their instinctive reaction to take immediate action when an inmate is behaving defiantly or aggressively. Experience has shown that outcomes are better and force is less likely when supervisors are called and additional resources are marshaled to address the situation. Moreover, from an officer safety perspective, the likelihood of injury to the deputy is reduced when a plan for dealing with the recalcitrant inmate can be formulated and tactical equipment options available. Finally, when time is on the Department's side, as in situations in which the inmate is confined in a cell, the frustration understandably felt by the deputy when an inmate challenges his or her authority can be dissipated by that time and the assistance of supervisors and other resources on scene. Most LASD custodial facilities already had a unit order addressing the issue but the new policy makes the protocol uniform Department-wide.

The new policy identifies a recalcitrant inmate as one who is:

- Continually verbally defiant
- Uncooperative to any verbal commands given by personnel
- Displays aggressive, assaultive, hostile, or violent behavior toward personnel or other inmates
- Passively resists the efforts of personnel by ignoring commands or not acknowledging their presence

Absent an immediate threat of physical injury, if an inmate is recalcitrant then personnel must request back-up and a supervising line deputy prior to contacting the inmate. A plan must be established and personnel must equip themselves with tactical equipment in the event the inmate is resistive. The new policy does not replace the Department's use of force protocols. Rather, it is to be used in conjunction with it.

OIR commends the Department for standardizing its protocols. Uniform expectations and enforcement of the policy will result in consistent outcomes when assessing the conduct of the involved personnel.

5-05/090.05 HANDLING INSUBORDINATE, RECALCITRANT, HOSTILE, OR AGGRESSIVE INMATES

The following policy is to be used in conjunction with all current use of force policies as well as all other applicable policies, procedures, and guidelines. When confronted with an immediate threat by an inmate to their safety or the safety of others, personnel shall take necessary and reasonable actions to defend themselves and control the inmate.

An insubordinate or recalcitrant inmate shall be defined as any inmate who displays any of the following characteristics:

- Is continually verbally defiant
- Uncooperative to any verbal commands given by personnel
- Displays aggressive, assaultive, hostile, or violent behavior toward personnel or other inmates
- Passively resists the efforts of personnel by ignoring commands or not acknowledging their presence

Personnel encountering such inmates shall be guided by the following:

- Withstanding the imminent threat of physical injury or the need for immediate intervention, personnel shall request the presence of appropriate back-up and a sergeant or supervising line deputy, prior to handling any recalcitrant inmate.

- Personnel should not make an attempt to enter a cell, dayroom, holding area or confined space to contact or remove an uncooperative, aggressive, hostile or armed inmate unless an immediate threat is present. A sergeant shall develop a planned tactical approach to the situation that will reduce the possibility of physical confrontation or injuries. Tactical equipment, such as OC spray, may be utilized if an inmate displays resistive behavior.

- In the instance of an immediate threat of physical harm or the need for immediate intervention, custody personnel shall not be restricted from taking appropriate action, including the use of force. Should the need arise to use force, all personnel shall immediately contact a sergeant at the conclusion of the incident.

- When the inmate is, or appears to be mentally ill, personnel shall request a sergeant and a mental health professional to respond.

- Should the need arise to confront and/or handcuff a recalcitrant, hostile or aggressive inmate, they shall be searched and kept in normal traffic areas and not be taken to secluded areas such as recreation yards, dayrooms, or laundry rooms, without the direction of a supervisor.

- Inmates who are uncooperative and combative, or have a history of making false allegations, shall be escorted by two deputy or custody assistants, and one sergeant. The movement should be videotaped in order to safeguard personnel against potential future litigation.

- Personnel involved in an altercation with an insubordinate inmate shall not be part of the escorting team.

PART TWO

The Investigative Process

Lapses and Lessons Learned

One of OIR's missions is to ensure that all critical incidents, such as significant force cases and officer-involved shootings, are investigated thoroughly and that all appropriate evidence is collected and included in the investigative file. A complete and thorough investigative file includes a collection of all available physical and forensic evidence which may help determine the sequence of events and corroborate witness accounts. It also contains documented follow-up to leads of all known and possible witnesses of the reported force. Because OIR conducts "real time" monitoring of cases, we have the unique opportunity of identifying whether relevant information is missing in a file before a case has been completed. Discussed below, are summaries of cases where OIR intervened during the investigative process to ensure that the Department had all the information necessary to assess the incident. Also, presented here are examples of cases in which OIR identified collateral issues and missteps committed by LASD investigators, followed by a discussion of how the Department addressed those lapses in investigative protocols.

Unexplained Bullet Hole

During the past year, OIR reviewed an officer-involved shooting during which a sergeant shot a number of rounds at a driver inside a vehicle. While one of the

rounds which had struck the vehicle's windshield was photographed, there was no documented description of the round in the accompanying lab report. Again, while each of the other rounds was mapped and the trajectory of the rounds was assessed, there was no such mapping and assessment for the round into the windshield.

This unmapped round proved important with respect to the positioning of the sergeant during the shooting episode. At OIR's recommendation, the panel requested that the investigator discuss the unmapped round with the crime lab. It was soon learned that the failure of the forensic investigators to assess the windshield round was simple oversight. As a result, the laboratory provided supplemental information about the probable trajectory of the round. This information helped the Department and OIR better determine the movement and positioning of the involved sergeant during the shooting incident. As this example demonstrates, OIR plays an important "quality control" role in the review process by ensuring that decision-makers have the most thorough forensic evidence before they assess a critical incident.

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Failure to Gather Station Evidence

During this past year, OIR reviewed a significant force case in which the Internal Affairs Bureau investigation referenced a private cell phone that might contain photographs of the incident. The phone was obtained at the scene by station personnel but there was no follow up documented in the IAB file. OIR made contact with station personnel and learned that a review of the cell phone's camera memory revealed that photographs had, in fact, been taken of the incident. The photographs depicted the placement of the suspect and the involved deputy, which were consistent with the deputy's version of events.

The inclusion of the cell phone photographs was important corroborative evidence that had not been gathered by the IAB investigator. This fact was shared with IAB supervisory personnel who agreed to brief IAB investigators about the need to check with the local units to learn whether additional evidence pertinent to a critical incident analysis had been retrieved.

Inaccuracy in Homicide Summary

Once the Homicide Bureau completes an investigation surrounding a deputy-involved shooting, information is packaged and presented to the District Attorney's office. That file includes a summary of witness statements, forensic evidence and other supporting materials (i.e. diagrams, photographs, etc.) The District Attorney then analyzes the information to determine whether the use of deadly force was legally justified. As one can imagine, it is critical that the information is accurate so that a proper final disposition can be made. That information also becomes part of the record of any subsequent administrative review. In one shooting case—involving an off-duty deputy— OIR discovered that Homicide's investigative summary contained a statement that was inconsistent with the supporting documents.

Specifically, the summary stated that after a shooting had been reported a responding deputy observed an individual holding an injured suspect "at gunpoint" and that she then initiated a foot pursuit of a second suspect who was fleeing the scene. In anticipation of the administrative review, OIR initially questioned why the responding deputy decided to follow the fleeing suspect when it appeared there was an armed person in plain clothes hunched over an injured individual. Review of the deputy's written report and recorded interview, however, revealed that the deputy had not seen a weapon. Instead, she observed what she believed were two injured individuals that may have been shot by the fleeing suspect.

OIR raised the inaccuracy with the Homicide Bureau, and the investigator readily admitted that he misread his own handwritten notes of the interview which were then transferred into the summary. Although the inaccuracy was not a material fact that went to the heart of whether the use of deadly force was justified, they were facts that, if went undetected, may have caused confusion and had consequences during the administrative phase of the process in which the deputy's tactics and decision-making would be assessed. The Homicide Bureau recognized the potential impact of the error and conducted a briefing which stressed the importance of accurately reflecting witness statements in summaries.

The "Meatheads" Comment

At times, information collateral to the investigation can be used for counseling and training purposes. In 2009, OIR reviewed a use of force case which the Department found to be within policy. Although OIR concurred with the Department's finding, OIR's shared its concern that during a deputy's interview, he referred to the arrestee as a "meathead". OIR raised this issue with the captain of the unit who agreed that such a reference detracted from the professionalism of the deputy. The captain

returned to the station and raised this issue with the deputy and counseled him. While not central to the issue of whether the force and tactics were within policy, using the investigative results holistically and as learning tools to improve personnel conduct is consistent with progressive policing. It is OIR's intention to have the Department take advantage of such learning moments whenever they present themselves.

The Manhattan Beach Murder Investigation

In April 2005, the charred remains of a woman were found in an apartment in Manhattan Beach, California. The woman had been bound, gagged, raped, stabbed and her body set on fire. LASD Homicide Bureau detectives were responsible for investigating the murder. During their investigation, they learned that surveillance video captured a person walking away from the apartment building carrying a laptop bag—which was the only item reported missing from the crime scene. That person was eventually identified and interviewed. After the interview, that person was charged with the murder of the woman. He pled not guilty and the case proceeded to trial. If convicted, he could have faced the death penalty.

During the pre-trial phase, the defense filed a Motion to Suppress Evidence to exclude incriminating statements made by the defendant during the Homicide interview. The defendant argued that he was not properly read his Miranda rights, had not waived those rights and had been tricked into making incriminating statements—which he later recanted—in exchange for an offer of leniency. Citing concerns about the interrogation and possible constitutional violations, the presiding judge ultimately ruled that the incriminating statements were inadmissible and could not be used against the defendant at trial. In light of the ruling, the District Attorney dropped the charges against the defendant.

The Basis for the Judge's Ruling

Unrecorded Portion of the In-Custody Interrogation

The LASD Homicide detectives conducted a lengthy interrogation of the accused. One of the detectives, however, acknowledged that it was approximately thirty minutes before she started recording the interview. The detective also conceded that she showed the defendant the video surveillance during the "off-tape" portion of the interview. Additionally, she admitted that during the unrecorded conversation, the defendant made statements about who might have committed the crime.

In explaining her actions, the detective stated that it was not customary to record

a "pre-Miranda" conversation which only elicited background information (i.e. names, addresses and phone numbers of interviewees). The detective added that once the accused starting talking about the incident, the tape recorder was turned on and Miranda was administered. The judge, however, was not convinced that the unrecorded portions of the thirty minute interview only elicited background information. Instead, the judge believed that the accused likely provided great detail about the events surrounding the murder and that he was shown the videotape with the specific intent to "get him to start incriminating himself."

Miranda Rights

The judge found equally troubling that when Miranda warnings were administered on tape, the recording did not capture any verbal response or waiver from the defendant. The Homicide detective stated that the accused gave a verbal and non-verbal (affirmative head nod) waiver but a review of the transcription noted 'no audible response'. The judge found that the failure to capture a recorded verbal waiver from the defendant called into question whether the entire interview was voluntary.

False Promise

Finally, the judge found that the detective made a false offer to the defendant that he would not be charged with murder if he admitted to being at the crime scene. In the following audio tape excerpt of the interview, the detective stated:

> You don't have anything to do with her death … Just talk to us about how you came into possession of the laptop, and don't worry about going down for murder, because you're not.

In reliance on that promise, the defendant made incriminating statements. Based on those admissions, the District Attorney filed murder charges. Not only did it appear that the detective made a promise she had no intention of keeping but it was a promise which she had no authority to make. The decision to prosecute a suspect for murder or offer leniency rests solely with the District Attorney. The court found that the promise improperly induced the suspect to make incriminating statements, which violated his constitutional rights. The judge found that the remedy for the improper investigative tactic was to suppress the statements.

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Review Prompts Additional Training and Policy Reform

After the charges were dismissed, the Department reviewed its investigative practices and considered a recommendation from an expert panel that all investigative interviews should be tape recorded. In addition to logistics concerns, there was a common belief that requiring investigators to immediately place a tape recorder in front of a suspect or witness could chill any attempt to develop a rapport between questioner and the person being questioned. Ideally, investigative units would have interview rooms at their disposal where interviews could be taped without needing to bring an intrusive tape recorder into every interview scenario. However, currently the Sheriff's Department does not have such capabilities in most of their station facilities.

Meanwhile, after the case was dismissed against him, the defendant filed a lawsuit against the Department, alleging false arrest. Because of the issues identified by the judge in the criminal trial, the Department agreed to settle the case for a significant amount of money. Eventually, another person was convicted for the murder in Manhattan Beach.

In response to the lawsuit, OIR did work with the Department to devise a more tailored corrective action plan. The entire Homicide Bureau received training on "best practice" investigative techniques. Among the topics discussed included laws and constitutional rights of suspects and proper interrogation techniques. Also, although there is no law requiring electronic recordings of in-custody interrogations, detectives were instructed that if they elect to use tape recorders during an interrogation they must begin recording as soon as the conversation begins. Detectives were also instructed to capture a clear and audible waiver on tape. Finally, detectives were reminded that they should not make promises to suspects that they did not have the authority to make. The Department's willingness to work with OIR to better its investigative techniques and improve the fair administration of justice of these issues is critical to all stakeholders.

Investigative Missteps Hamper a Criminal Investigation of a Deputy Sheriff

Sheriff's investigators received information from an informant that a deputy was dealing in or receiving stolen property. The Internal Criminal Investigations Bureau ("ICIB")—the special unit exclusively devoted to investigating illegal criminal conduct by deputies—began an investigation into these allegations. ICIB assigned a relatively new investigator to the case who was acquainted with the subject deputy because they previously had worked in the same unit.

It was a complex investigation that quickly started to unravel. ICIB did not make effective use of the informant, inadvertently tipped off the subject deputy before service of the search warrant, and allowed the subject deputy–an experienced investigator himself–to insert himself improperly in an interview of a key witness. The missteps resulted in a weak investigation, and the District Attorney declined to file charges against the deputy. Following some additional work by administrative investigators in Internal Affairs, the subject deputy was initially discharged. Because of weaknesses in the criminal investigation, however, the Department later settled the case, allowing the deputy to return to work in a different assignment.

In this case, investigative deficiencies hampered a potential criminal prosecution and forced the Department to continue to employ a deputy it believed had committed serious crimes. While the flaws in this case were fact specific, the case was symptomatic of a broader problem any law enforcement agency has when it investigates one of its own for criminal misconduct namely, being able to strike a balance between the need to treat employees with dignity and respect while still conducting effective investigative operations. The Department did not strike that balance properly here. Tactics designed to protect the subject deputy's family from embarrassment had the effect of notifying the deputy his conduct was being investigated. Also, for obvious reasons, investigative practices do not advise allowing a suspect to participate in a witness interview.

That review persuaded OIR that the missteps originated from poor investigative work and "short-cutting" as opposed to a more sinister motivation.

The Department held several executive level meetings following this case in an attempt to dissect these flaws and take necessary corrective action. This review was critical to discern whether the missteps were devised intentionally to allow a fellow deputy to avoid criminal culpability. That review persuaded OIR that the missteps originated from poor investigative work and "short-cutting" as opposed to a more sinister motivation. While we are hopeful that these problems do not repeat themselves, OIR will continue to monitor the Department's ongoing efforts to vigorously investigate allegations of criminal misconduct by its employees.

Failure to Pursue Child Abuse Investigations

This past year, the Department imposed discipline on a deputy for failing to adequately investigate two suspected child abuse cases. In each case, the deputy

aborted his investigation prematurely and failed to follow Department procedures instituted to ensure that a suspected child abuse report ("SCAR") is properly pursued and investigated.

Pursuant to the Department's SCAR procedures, if the initial investigating deputy is unable to make contact with the parties named in a SCAR during his or her shift, the deputy is required to inform the station watch commander. The watch commander then is responsible for re-assigning the case to another deputy.

In the first case, the SCAR alleged that a teenage victim's parent was physically and emotionally abusive. When the initial deputy received the SCAR, he went to the location of the alleged abuse and attempted to make contact with the residents. However, no one answered the door. The deputy returned to the station and failed to notify the watch commander of the results. To make matters worse, in his report he wrote that he "responded" to the location of the alleged abuse and concluded—based solely on the preliminary information contained in the SCAR—that no crime had occurred. He intentionally failed to mention that he had no contact with any of the known parties.

To their credit, Department supervisors inquired further and ultimately rejected the deputy's report. The case was reassigned to another deputy who then conducted a thorough investigation.

In the second case, the same deputy was assigned to follow-up on a suspected emotional abuse case. Once again, he went to the location of the alleged abuse and knocked on the door. When he received no answer, the deputy returned to the station and failed to conduct any further investigation of the allegations noted in the SCAR. The deputy wrote in his report that because the victims may have only suffered emotional trauma, no crime had occurred. His interpretation of the relevant state law, however, was incorrect. Moreover, as noted above, the deputy's failure to follow up on the allegations is contrary to Department policy. Again, Department supervisors rejected the deputy's report and the case was reassigned to another deputy for a full investigation.

After completing two administrative investigations, the Department determined that the deputy's conduct fell below the Department's expectations and imposed a significant suspension. OIR concurred with the Department's findings, sustaining the administrative charges, and continues to monitor the deputy's progress. The "corner-cutting" displayed here is indicative of a deputy who may have work ethic issues. Should there be additional incidents of deputies failing to follow the SCAR process OIR will work with the Department to ensure compliance with theses critical protocols.

A Review of an In-Custody Death Lawsuit

In 2009, the Department settled a civil lawsuit filed by the family of an individual who died after deputies applied the Total Appendage Restraint Procedure ("TARP")—a device used to restrain and immobilize combative individuals by securing all of a person's limbs (arms and legs)[7]. The person remains restrained until it appears the person's behavior no longer poses a serious or significant threat to their own safety or the safety of others.

In this case, two deputies had engaged in an intense, physical struggle with the individual, who they believed was a burglary suspect. As both deputies were nearing the point of exhaustion, responding deputies arrived and were able to handcuff the man. However, the man—who had a history of fighting with law enforcement—remained combative. Deputies then restrained the man's feet using the TARP procedure but he continued to buck his body and began scraping his face on the asphalt. The paramedics were summoned to the scene and shortly after they arrived, the man stopped breathing. He later died at a local hospital. The suspect's next of kin filed a lawsuit, alleging wrongful death.

For a lawsuit, the Department is required to complete a Corrective Action Report ("CAR") which is forwarded to the Los Angeles County Board of Supervisors for case-evaluation purposes. The CAR is a brief memorandum that includes a summary of facts and the Department's internal evaluation of the use of force. OIR received a copy of the CAR which stated that the Department's Executive Force Review Committee ("EFRC")[8] had reviewed the matter and concluded there were no policy violations or training issues. However, OIR knew that it had not yet been reviewed by EFRC and notified the Department which, in turn, made that notification to the Board of Supervisors. The case was subsequently reviewed by EFRC and it was ultimately determined that the use of force was within policy. OIR concurred.

In reviewing the case, OIR learned that the autopsy report listed multiple causes of death, one of which was "restraint maneuvers." The Coroner's Office indicated that it could not determine the exact cause of death because it lacked details of the incident, the blood cocaine levels were unavailable and there were "other unknown factors during the arrest and altercation." This was unusual, since the autopsy

7 The individual's arms are immobilized with handcuffs (behind the back) and their feet are secured together with a rope-like instrument called a Rip Hobble device. Then, the end of the hobble restraint is connected to the chain on the handcuffs.

8 The EFRC is responsible for reviewing in-custody deaths and determining whether there are violations of policy.

typically occurs while a Homicide detective is present and therefore, is available to answer any questions the Coroner may have. In this case, however, as a result of a communication breakdown, a Homicide detective was not present and, in a markedly rare move, the involved deputies initially declined to be interviewed by Homicide. Later, however, the involved deputies voluntarily gave a statement to Homicide but that information was unfortunately not shared with the Coroner's Office.

In identifying some of the issues in the case, OIR recommended that Homicide Bureau conduct a final review of the Coroner's Report before concluding its investigation. Even if the Report has been drafted and submitted, if new information is deemed relevant, the Coroner may consider amending the report.
In this case, the information that the Department had that was not presented to the Coroner could well have made a difference in the cause of death determination.
In addition, the Department has upgraded its protocols with the Coroner to ensure that further communication issues will not cause them to miss attending an autopsy.

PART THREE

Deputy-Involved Shootings
Case Summaries and Outcomes

The Department's use of firearms policy specifically states that a member who discharges his or her weapon must establish independent reasoning for using the deadly force. When a deputy can articulate a reasonable belief of a threat, and that belief is congruent with the facts of the case, the use of the deadly force will be found legally justified and within Department policy. However, that finding does not end the Department's review of the incident. Though a shooting may be within policy, the facts may reveal that the tactics and decisions made prior to, during or immediately after the use of deadly force do not meet Department standards and must be addressed through remedial measures (i.e. training). If performance by Department personnel falls below standards, the Department may determine that the deputy violated policy and decide to discipline the deputy. Through recent changes in the Department's discipline approach, the discipline may be converted by the deputy to a training regiment, maintaining individual accountability but resulting in a more tailored remedial measure.

Although the incidents discussed below differ widely in context, circumstance and outcome each has added to the necessary augmentation and reemphasis of aspects of training so that individual accountability and discipline is afforded in the appropriate cases and/or targeted training is ordered so that tactical deficiencies are not repeated and officer safety is not compromised in future similar incidents.

Use of the Spike Strip

During a vehicle pursuit, responding deputies decided to lay down a "spike strip" in the hope of ending the pursuit. A spike strip is a device that is placed in the path of a vehicle. If successful, the spike strip will puncture the tires of the vehicle and prevent the driver from continuing. While efficacious in theory, in practice there have been problems successfully deploying the spike strip. In this case, the deputy laying down the spike strip had not finished the deployment when the vehicle came upon him. Fearing that the vehicle would strike the deputy, another responding deputy felt constrained to use deadly force, resulting in the death of the driver. While not a violation of policy, the investigation revealed that the vehicle was too close to the deputy and driving at too high a rate of speed for the spike strip to have been deployed successfully.

At the executive review of this case, it was determined to provide additional training to the involved deputies. The Department also tasked its training unit to enhance its training—Department-wide—with regard to the use of spike strips.

Single-Man Foot Pursuit

Deputies responded to a hotel and encountered a narcotics suspect. During a struggle with the suspect, the deputies learned that he was armed. When the suspect broke away one deputy went in foot pursuit of the suspect. At one point, the suspect turned and pointed his weapon at the deputy, requiring the deputy to use deadly force. The three rounds fired at the suspect did not strike him. The suspect was eventually apprehended without further incident.

While the review of this case did not result in a finding that the deputy violated policy, he was ordered to undergo targeted training that will address the officer safety issues presented by engaging in a single man foot pursuit of an armed suspect.

Failure to Broadcast a Vehicle Pursuit

A deputy conducted a traffic stop of a suspect and detected alcohol on the suspect's breath. When the deputy asked the suspect for his driver's license, the suspect sped away and the deputy initiated a vehicle pursuit. Eventually, the suspect's vehicle came to a stop. As the deputy exited his vehicle, he saw the suspect point a handgun and fire at him. The deputy returned fire, fatally striking the suspect.

Upon review of the shooting, OIR concurred with the Department's determination that the shooting was within policy. However, the investigation revealed that

contrary to LASD policy, the deputy never broadcast that he was in pursuit of the suspect vehicle. This failure to broadcast the pursuit could have had serious consequences to the deputy had the suspect's initial rounds struck the deputy, leaving the deputy alone and location unknown to support units.

As a result of this violation of policy, the deputy received a suspension. However, in lieu of serving the suspension, the deputy agreed to use his experience to brief his peers on the need to broadcast pursuits and the potential consequences when there was a failure to do so. This remedial action is a testament to the fact that the deputy had learned from his mistake and the briefing allowed his knowledge to be exported to his peers in an instructive and helpful way.

Weapon Qualification

An off-duty deputy and his wife were taking a walk around their neighborhood one evening. A vehicle approached them slowly and the deputy heard "popping" sounds coming from the vehicle. He also saw a male leaning out of the vehicle holding onto to what appeared to be a rifle. Both he and his wife were struck. Believing that he and his wife had been shot, the deputy drew his off-duty weapon and fired two rounds at the moving vehicle. The suspect fled the scene and was never apprehended. It was learned later that the deputy and his wife had been struck by paint ball pellets.

Although it was determined that the deputy did not violate the Department's shooting at vehicles policy, it was discovered that the deputy had failed to satisfy the Department's firearms proficiency requirements to use his off-duty weapon. He received discipline for failing to qualify and train on his off-duty weapon and was ordered to fulfill the qualification requirements for that weapon.

Partner-Splitting

Two deputies were on patrol at night in a residential area. They observed a lone male who appeared to see their marked car and who quickly started running down the block. As he reached the corner, the suspect grabbed the top of a low fence and vaulted over it into the yard of a house. As he put his hands on the top of the fence, the deputies believed they saw a gun in his hand. The yard was surrounded by tall bushes and the deputies soon lost sight of the suspect. One of the deputies positioned himself at the corner of the yard to anchor a containment of the suspect. The other deputy drove to the far end of the yard, got out and posted himself in a location where he could still look back and see his partner. The deputy then heard some rustling and began to run up a heavily shaded driveway causing him to lose

sight of his partner. Suddenly, the suspect jumped down from a fence, appeared to thrust his hand near his waistband then turned toward the deputy. Perceiving a deadly threat, the deputy fired his weapon. The suspect collapsed and died soon thereafter. An extensive search of the surrounding area yielded no gun.

At the review of this case, it was determined that the deputy who shot the suspect had failed to maintain visual contact with his partner, failed to communicate with his partner and did not broadcast his foot pursuit. These actions failed to meet Department performance expectations and subjected the deputy and his partner to unnecessary danger. As a result of the violation of policy, the deputy received a suspension. The deputy agreed to an extensive course of training in tactics and decision-making as a condition of his discipline.

Inadequate Operation Plan

Deputies planned to execute a search warrant by apprehending a suspect as he left his apartment. The operation went awry, however, mainly due to poor communication and insufficient advance planning for contingencies. The suspect got to his car before deputies reached him and refused to exit the car. He then started the engine and accelerated backwards, striking the vehicle of a sergeant who had arrived to assist. The suspect then accelerated forward, straight toward the deputies, each of whom fired two rounds at the suspect, striking him four times. The suspect survived his injuries and was taken into custody. One deputy sustained a minor leg injury as a result of being struck by the suspect's vehicle.

The shooting was found to be within policy, but significant deficiencies in the planning, organization, and execution of the operation were identified.

The shooting was found to be within policy, but significant deficiencies in the planning, organization, and execution of the operation were identified. It was learned that the team had conducted a briefing and initiated the plan before all personnel had arrived at the targeted location. Specifically, one deputy participated in the briefing telephonically as he was en route to the scene and did not arrive at his assigned position until after the shooting. Because they had performed this type of operation numerous times, personnel involved seemed to have a too-relaxed attitude about the dangers of this type of operation. The supervising sergeant received a performance log entry as a result of his failure to ensure a thorough briefing.[9]

9 A performance log entry, while not formal discipline, is recorded and can be used by supervisors in the annual evaluation of a deputy.

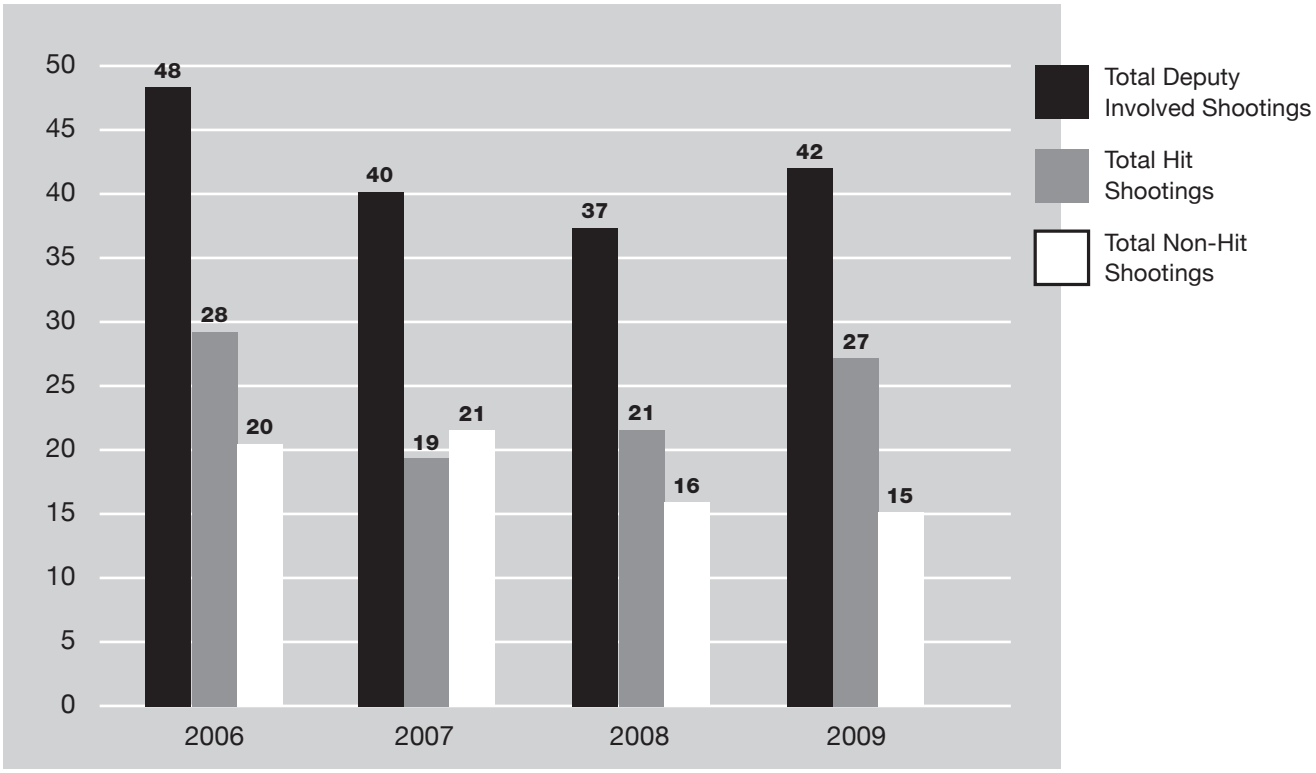
This incident serves as a caution about the dangers of inadequate planning and preparation, uninvolved supervisors, and reliance on past experience as a sufficient guide to present and future operations. Even before a formal review of the incident had taken place, the captain of the unit recognized the problems with this operation and had used it as a vehicle for training his entire unit.

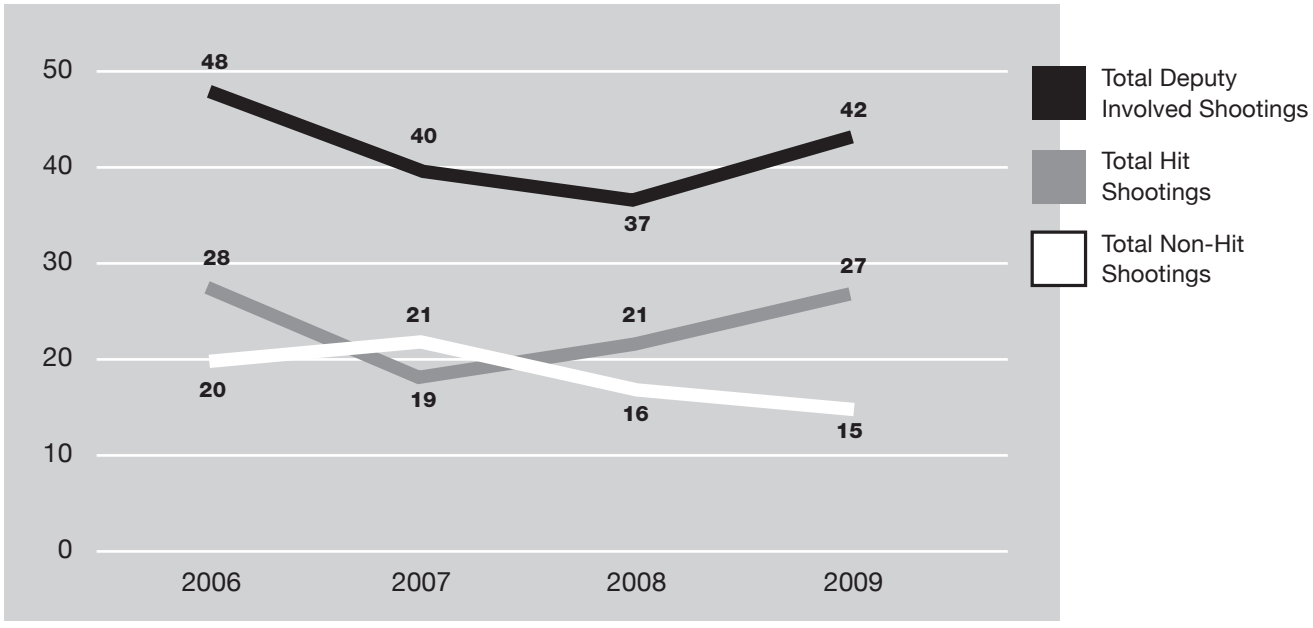
Lack of Communication

Two deputies on a saturation patrol spotted a vehicle that aroused their suspicions because it lacked a rear license plate. The deputies followed the vehicle and saw the driver and passenger both bolt from the vehicle and run in opposite directions. One deputy followed the driver down a driveway. The other deputy pursued the passenger but then turned and followed his partner after that suspect jumped a fence and ran out of sight. The driver fled through a backyard crowded with furniture and debris. As the suspect leaped over a fence, he paused atop a table and turned toward the deputy, brandishing a handgun. The first deputy fired several shots, all of which missed the fleeing suspect. Deputies established a containment and, with the assistance of an SEB canine unit, eventually apprehended both suspects.

Although the shooting was found to be within policy, there were some tactical issues that were subsequently addressed through training. The deputies had not immediately broadcasted their brief pursuit of the suspect and had not communicated with each other effectively. The unit commander briefed both deputies regarding their tactical performance and the shooter deputy prepared a briefing for the station on the tactical concerns presented in this case.

Total Number of Deputy-Involved Shootings from 2006 – 2009





PART FOUR

Policy Updates And Innovations

Departmental policies are never static. Just as police work is a dynamic process so too must be the policies that regulate it. At times, policy reform is prompted by external forces. For instance, this year the Department made a change in its retention and hiring standards as a direct result of a United States Supreme Court decision regarding the possession of firearms. Other times, new policies are driven by a set of specific circumstances. In this section, for example, we describe the proactive approach taken by two deputies who identified a need to use and establish protocol for crime scene barriers. Most often, however, policy revisions emanate from actual cases where it becomes clear that Department personnel could benefit from additional guidance. Accordingly, when OIR reviews each case it does so with an eye toward refinement and improvement of existing policies. Once the need for policy reform is evidenced, OIR actively participates in the development, crafting and uniform enforcement of the new policies.

The Supreme Court, Domestic Violence and Guns

In February 2009, the United States Supreme Court issued an opinion in *U.S. v. Hayes* that had unique significance for law enforcement officers. At issue in *Hayes* was

whether a 1996 Amendment passed by Congress—which prohibited the possession of a firearm by a person convicted of a "misdemeanor crime of domestic violence"—also applied to persons convicted of a general violent misdemeanor (i.e. battery) as long as the victim had a domestic relationship with the perpetrator.[10]

In *Hayes*, police officers responded to a domestic violence call at Mr. Hayes' home. During a consensual search of the home, officers discovered a rifle. Officers also discovered that, ten years earlier, Hayes had pled guilty to a misdemeanor "battery" against his wife. Hayes was arrested and indicted for violating the 1996 Amendment to the federal Gun Control Act of 1968. Hayes argued that the charges should be dismissed on the grounds that his prior conviction was not a misdemeanor crime of "domestic violence." Reversing a lower court's decision, the Supreme Court ultimately held that the plain language, legislative history and intent of the Amendment extended a gun ban to any person convicted of a generic violent misdemeanor crime if the battered victim is in fact a spouse, former spouse or family relative (i.e. parent, etc.) of the offender.

This seemingly minor clarification in criminal law meant that anyone who had once been convicted of an assault or battery type misdemeanor could no longer possess a gun if the victim was a domestic partner, even if the specified crime was not explicitly labeled a domestic violence crime. Under state law, one of the indispensable qualities of a peace officer is that he or she must be able to possess and use a firearm competently. Any deputy who is prohibited from possessing a gun can no longer perform the duties of a peace officer and cannot remain a sworn member of the Sheriff's Department.

The nature of this case law meant that it had immediate retroactive effect. Recognizing this, the Department conducted a search of its personnel files to determine whether any sworn members of the Department had previously been convicted of misdemeanors that would prohibit them from possessing a firearm under the *Hayes* rule. The Department's search revealed three deputies who were in jeopardy. Each had been previously convicted at some time in the past of a misdemeanor offense that fell within the *Hayes* rule. It was now unequivocally clear that these three deputies could no longer remain sworn members of the LASD. All three deputies were permitted to take a non-sworn position or to retire or resign from the Department. One accepted a position as a custody assistant (a non-sworn

10 By way of background, the federal Gun Control Act of 1968 prohibited convicted felons from possessing firearms. However, because many domestic violent crimes were prosecuted as a misdemeanor, abusers continued to lawfully purchase and maintain possession of their firearms even after being convicted of "domestic violence." To address the issue, Congress, in 1996, amended the Act and extended the gun ban to persons convicted of a "misdemeanor crime of domestic violence".

position); one retired and one insisted on being discharged in order to preserve his appeal rights. OIR conferred with Department executives during this period and agreed that the Department took the only legally appropriate course available to it.

Retention is not the only impact the *Hayes* ruling had on LASD. Looking forward, the Department also had to consider the way in which it conducted background investigations that involved LASD applicants. As part of the hiring process, if an applicant has been convicted of a generic violent misdemeanor, the Department investigator must now determine if the victim had a domestic relationship with the applicant. If the victim was a family member, then the applicant would be prohibited from possessing a firearm and would therefore, not be eligible for an offer as a sworn peace officer. OIR continues to monitor the application review and hiring process of LASD candidates to ensure that the Department complies with current law.

An Update on the Alcohol and Firearms Policy

In our Seventh Annual Report we described an incident that had caused the Sheriff to call for a new Department policy banning deputies from carrying their firearms when drinking alcohol off-duty. A deputy had been drinking heavily at a New Year's Eve party with relatives. While handling his loaded weapon, he accidentally shot his cousin. It was a serious but non-fatal wound. The facts of the investigation made it clear that the event would likely not have happened if either the deputy had not been intoxicated or he had not had his firearm on him.

After the incident, a special task force—in which OIR participated—drafted a policy that provided specific guidance to deputies who intend to carry their firearms off-duty and indulge in alcohol. The policy was further refined after constructive input from the employee unions, but as time passed, the Department and the unions reached an impasse on the precise elements of the policy.

In our last annual report, we expressed optimism that the policy would be shortly implemented. However, the policy remains in limbo. As a result of the deputies' union remaining in steadfast opposition to the policy, they filed an action before the County's Employee Relations Commission. OIR's concern about the slowness of those proceedings was brought directly to the Sheriff's attention recently, and the Department has renewed its efforts to achieve closure in this matter. We are hopeful that when we write our next annual report, that we will be able to report that this policy has finally been implemented.

Meanwhile, the incident that inspired this policy resulted in disciplinary findings against the deputy. He was initially discharged, but pursuant to the internal appeal process, he was allowed to return to the Department in a non-sworn position. OIR opposed this compromise. However, when the Department persisted with the settlement, OIR persuaded the Department to insert language into the agreement that permanently prevented the former deputy from reapplying for a sworn position.

The Anti-Huddling Policy is Tested

In earlier annual reports, OIR has noted the progress of the Department's implementation of an anti-huddling policy following deputy-involved shootings. As explained in those reports, in the past, the Department had tolerated a practice where deputies involved in shootings would convene as a group to discuss the incident before being interviewed by Homicide investigators. As we further noted, this ability to "huddle" raised the appearance if not the reality of collusion and impacted on the integrity of the Department's investigation. At OIR's urging, the Department eventually developed an anti-huddling policy which prevented involved deputies from meeting as a group with their attorneys to discuss the incident prior to being interviewed by investigators. This policy was unsuccessfully challenged by union attorneys in court and the policy has since been in place in full force.

Fortunately, the station supervisors were well informed about the anti-huddling policy and quickly and steadfastly aborted the attorney's attempt to circumvent the policy.

This year, OIR became aware of a situation following a deputy-involved shooting in which a union attorney responded to the station. Upon her arrival, the attorney insisted on meeting with the two involved deputies together before they had been interviewed by LASD Homicide. Eventually, a station supervisor agreed to allow the attorney to meet with the deputies with the understanding that the discussion would be limited to the investigative process and that a Department monitor would be present. However, once the door was closed, the attorney asked the monitor to leave the meeting and tried to talk with the two involved deputies as a group. When the "monitor" reported this to LASD supervisory personnel, the group meeting between the union attorney and the two involved personnel was immediately terminated.

It would have been an unfortunate circumstance for the union attorneys' actions to have caused the deputies to violate Department policy. Moreover, the attorneys' actions could have potentially impinged on the integrity of the investigation

which, in turn, could have resulted in negative consequences on the criminal, administrative, and civil liability of the involved deputies.

Fortunately, the station supervisors were well informed about the anti-huddling policy and quickly and steadfastly aborted the attorney's attempt to circumvent the policy. OIR will continue to monitor this issue since compliance with existing Department policy is important to all stakeholders.

Crime Scene Barriers: A Clever Approach to an Ongoing Issue

When deputies respond to a homicide call, one of the first things they must do on scene is contain and secure the crime scene area. A perimeter is usually secured with yellow tape preventing any unauthorized individuals from entering the crime scene and potentially contaminating any physical evidence, including the body of the deceased person or persons. The body remains undisturbed until investigators have had the opportunity to examine the position and condition of the body or bodies. As a result, a body can remain at the crime scene for an extended period of time before the Coroner's office is able to remove it. Until a body is removed, it is not uncommon for a crowd to gather outside the perimeter of the secured crime scene area. Often, the incident can evoke strong emotions from a crowd and viewing the body lying on a street or sidewalk for a lengthy period of time can be very upsetting to the community and certainly to the decedent's family and friends.

Two field deputies who had been at numerous homicide scenes where bodies were lying out for extended periods of time began discussing ways of shielding the body from public viewing. They understood that placing a blanket over the body was not a viable solution because it had the potential to destroy or contaminate evidence. After some thought, they decided that constructing a physical barrier would be the most practical solution to the dilemma.

The two deputies brainstormed and drafted a blueprint of a prototype barrier. With material donated from a metal shop, they asked a local towing company to weld posts for the barrier. They then enlisted the assistance of the jail sewing shop which used uniform material to make panels to be hung between the posts. After the initial prototype was constructed, the deputies decided that plastic banners between the posts would be more practical and more weather-tolerant. In an effort to solicit potential witnesses of the incident, the deputies printed the telephone numbers for LASD's Homicide Bureau and the anonymous tip line on the plastic banners.

Los Angeles County Sheriff's Department

FIELD OPERATIONS DIRECTIVE

Field Operations Support Services, (323) 526-5760

FIELD OPERATIONS DIRECTIVE: 09-03 DATE: July 9, 2009

ISSUED FOR: OFFICE OF HOMELAND SECURITY
FIELD OPERATIONS REGIONS
DETECTIVE DIVISION

USE OF CRIME SCENE BARRIERS

Purpose

This directive establishes procedures for the use of crime scene barriers.

Background

Homicide scenes are often contained for extended periods of time as homicide investigators gather the necessary information for the preparation of their case. Often the victim and/or victims have been left at the scene of the crime pending the completion of the investigation and the recovery of the body by the Coroner's Office. In these cases the victim(s) may be in an area that is visible to the general public for an extended period of time. In order to preserve the dignity of the victim(s), crime scene barriers should be considered in order to help eliminate the view of the victim(s) from the general public.

Policy and Procedures

At the scene of a dead body or homicide, the responsibility for preliminary investigation lies with the initial responding deputy sheriff. Once emergency services have responded and concluded that the victim is deceased and will be left at the crime scene for further investigation by Homicide Bureau detectives and the ultimate recovery of the body by the Coroner's Office, the following procedures should be followed.

The initial responding deputy shall be responsible for establishing, protecting, and preserving the crime scene until relieved by Homicide Bureau detectives. The crime scene shall be secured, contained, and sectored (separate areas for homicide investigators, command staff, media, and general public). A Major Incident Log (SH-CR-620) shall be maintained by the handling deputy until all Department personnel have left the scene and the containment is discontinued.

In cases wherein the victim(s) is viewable to the general public and/or the media, and the scene cannot be sufficiently contained using conventional methods, (complete closure of the area, crime scene tape, or the use of radio cars) crime scene barriers should be considered in order to preserve the dignity of the victim(s).

Crime scene barriers shall be maintained at each station/unit within Field Operations Regions and all stations/units shall have the ability to deploy them at anytime. Once it has been determined by the handling deputy that a crime scene barrier is necessary, the handling unit of assignment (handling deputy, field supervisor, or watch commander) shall contact the Homicide Bureau lieutenant prior to deploying the crime scene barrier. The contact person should get an ETA for Homicide Bureau's response to the crime scene. Should Homicide Bureau have an extended ETA, the contact person should request deployment of the crime scene barrier. Only after concurrence of the Homicide Bureau lieutenant should the crime scene barrier be erected.

The unit should request deployment of the barrier via desk personnel (preferably via the MDT system). Desk personnel will assign an uninvolved unit to respond to the station, or barrier storage location, to pick-up the crime scene barrier for deployment.

Placement of the barrier shall be done so as not to interfere with any potential evidence (i.e., placing the support post over the flow of bodily fluid). All efforts shall be made to ensure that the crime scene is maintained intact pending the arrival of Homicide Bureau detectives.

The crime scene barrier shall remain in place, unless otherwise directed by Homicide Bureau detectives to have it removed. Upon conclusion of the investigation and recovery of the body by the Coroner's Office, the crime scene barrier shall be returned to the original storage location. In the event the crime scene barrier becomes contaminated while at a crime scene, it shall be cleaned prior to storage.

Cleaning of the crime scene barrier shall be done as follows: If the barrier comes into contact with any biological evidence at the scene, they shall be cleaned with a 20% bleach solution (household chlorine bleach will suffice). There are also cleaners available from forensic supply companies that can be purchased for use.

Logging the use of the barriers shall be done as follows: There will be a log sheet kept with each barrier. Each time the barrier is used, it will be documented on the sheet. Also, each time the barrier is cleaned, it will be documented with the date, time and person's name who cleaned it.

Cites/References

MPP 5-09/47.00	Major Incident Scene Containment
FOD 93-7	Handling of a Crime Scene Involving a Person Dead and an Unruly or Hostile Crowd
Newsletter #80	Homicide Scene Preservation
Newsletter #94	Crime Scene Secondary Perimeter Containment

WJM:NBT:CWR:TPA:WJM:RRD:JLS:MNP:mp

Originally Issued: 07-09-09
Revised:
Latest Revision:

With the support of executives, these deputies were able to make a prototype quickly and, within about three months, each station in their division received two barriers. These barriers continue to be constructed internally with little cost to the Department. Other policing agencies have expressed interest in using these barriers.

Soon after the prototype was constructed, the Department promulgated a Field Operations Directive mandating the use of these crime scene barriers in delineated situations and set forth procedures for their deployment, maintenance and logging of their use. The deputies' proactive approach to addressing the issue is commendable.

Fraternization and Prohibited Association

In 2009, OIR monitored a number of cases in which the Department found that a member had violated its Fraternization and/or Prohibited Association policies. These policies are intended to define strict boundaries between Department personnel and criminals in order to deter inappropriate associations that could foster corruption and divided loyalties. Because maintenance of these boundaries is so crucial to ensuring integrity among Department members, violations of the policies are automatic terminable offenses. Although most personnel had a passing familiarity with the Fraternization policy, many claimed to not understand or know about the Prohibited Association policy. This confusion led to a lack of uniformity in enforcing the rules. At the urging of OIR, the Department agreed to modify its guidelines.

The Department's former Fraternization policy provided that a member shall not:

> fraternize with, engage the services of, accept services from, or do favors for any person in the custody of the Department or who is known by the member to have been released from the custody of the Department within a period of 30 days.

It is universally understood by Department members that befriending an inmate while he or she is in jail or for thirty days after their release is impermissible. Members, however, were less clear about what was required of them if the inmate was a family member. The policy mandates that if a member has contact with an inmate (or one who has been released from custody within thirty days) the member must report such contact to their unit commander. A Department member is permitted to have the proscribed contact if they have been given written authorization from their unit commander. While a number of unit commanders have granted permission to have contact with relatives, others mistakenly believed that they either could not grant permission or that if the inmate was a family member, permission was not required under the policy. OIR worked with the Department to clarify the procedures for requesting exemptions. We also recommended that the

new policy provide a presumption that, absent extenuating circumstances, requests by members to associate with immediate family members be granted.

The Prohibited Association policy does not provide a wait period before a Department member can associate with "questionable" individuals. It flatly forbids a member from maintaining a "personal association" with persons who have an "open and notorious reputation" for criminal activity and/or persons under criminal investigation or indictment. It also proscribes knowingly socializing with the spouse, immediate family member or romantic companion of any person in the Department's custody. Similar to the Fraternization policy, all of these prohibitions can be overridden by written permission granted to the member by their unit commander.

In many prohibited association cases, subjects claimed they did not know the Department maintained such a policy. Members are, however, made aware of these and other Department policies in the academy or during new employee orientation, and revisit the policies briefly during custody training. That being said, there appeared to be confusion among Department members regarding the dictates of the fraternization and prohibited association policies:

> *A deputy met an inmate while he was in the Department's custody and she intentionally waited thirty days after he was transferred to state prison before beginning a relationship with him. By doing this, the deputy believed she had not violated the Fraternization policy. However, she did violate the Prohibited Association policy by maintaining a relationship with the inmate, exchanging over one hundred personal letters with him and visiting him in state prison. Moreover, an investigation revealed that she had not, in fact, waited the required thirty days before beginning a relationship with the inmate.*
>
> *A deputy violated policy when she became engaged to gang member inmate just months after he completed a 3 ½ year prison sentence.*
>
> *Another member began a relationship with an inmate's fiancé.*
>
> *A Department member repeatedly visited felons in prison and had romantic associations with some of them. On appeal of her discharge, her attorney unsuccessfully argued that the policy did not apply because some of the individuals she visited were juveniles.*
>
> *In these cases, the subjects claimed to not know of the Department's Prohibited Association policy. All four subjects were discharged.*

As discussed above, violations of these policies can have career-ending consequences. For that reason, OIR recommended to the Department that it clarify the policies,

combine them and provide additional training so that members are put on better notice of the Department's expectations in these areas. OIR's worked on a redraft of the policies and the recommended changes were presented to top Department executives who agreed that a modification was called for. The revised policy was finalized this year.

3-01/050.85 FRATERNIZATION AND PROHIBITED ASSOCIATIONS

Members shall not knowingly fraternize with, engage the services of, accept services from, do favors for, or maintain a business or personal relationship or association with persons who are in the custody of any federal, state, or county law enforcement agency or who have been released from the custody of any law enforcement agency within the preceding 30 days. Additionally, members shall not knowingly fraternize with, engage the services of, accept services from, do favors for, or maintain a business or personal relationship or association with the spouse, immediate family member, or romantic companion of any person in the custody of any law enforcement agency.

Any member contacted by, or on behalf of, a former inmate who has been released from the custody of any law enforcement agency within the preceding 30 days shall immediately report such contact in a memorandum to the member's Unit Commander.

Members shall not knowingly maintain a business or personal relationship or association with persons who have an open and notorious reputation for criminal activity, or where the association would otherwise be detrimental to the image of the Department. Examples include, but are not limited to, persons members know or reasonably should know are:

- under criminal investigation or indictment;
- on parole;
- gang members; and/or,
- adjudged guilty of a felony crime.

Exceptions to this policy require the express written authorization of the member's Unit Commander. Absent extraordinary circumstances, there is a presumption that requests to associate with immediate family members will be granted; however, express written authorization shall still be sought and received. The member's request, accompanied by the Unit Commander's response, shall be placed in the member's unit personnel file and become a permanent part of the member's personnel file.

A subsequent request shall be submitted any time the circumstances upon which the original authorization was based change. Subsequent authorization(s) will be considered on a case by case basis.

Revised 05/01/10
04/01/96 MPP

Reform to the Citizen Complaint Process

In 2009, OIR assisted the Department in the revision of its Service Comment Review ("SCR") process and creation of an SCR handbook. The SCR process provides the public a way to formally comment about their concerns regarding their contacts with Department personnel. The Department conducts an inquiry into the concerns raised in an SCR complaint and, when appropriate, a complaint may result in a formal investigation. Over a several-month period, OIR, external stakeholders and Department personnel met frequently to discuss ways to improve and standardize the process, promote timeliness of dispositions and create alternatives to resolving disputes.

Under the revised SCR process, supervisors have discretion to employ existing technology to streamline the process. With the proper consent, Department personnel are encouraged to record non-Department witness interviews using video and audio recording equipment. Such recordings reduce the amount of time it takes to produce written documentation of statements and provide a way to record information accurately. The saved time and resources can then be devoted to completing more thorough inquiries and investigations. Whether tape-recorded or not, supervisors must review the contents of the interviews with the reporting party and witness to confirm that their statements were correctly received. The recordings are also intended to enable supervisors to draft more concise service review memorandums.

Under the revised SCR process, supervisors have discretion to employ existing technology to streamline the process.

Further, Department supervisors are now instructed to take "ownership" of the complaints, be responsive and resolve them in a timely fashion. The Watch Commander of the Unit, specifically, has been given the responsibility to immediately interview any member of the public who, whether in person or by telephone offers a "comment." The Watch Commander must field the call on a taped line and provide the person with the SCR number on the form and ensure that the acknowledgment letter is sent to the reporting party. Assigning these responsibilities to one Department employee helps avoid lapses in the process and increases accountability.

The revised SCR process is also intended to promote increased use of conflict resolution and mediation sessions. Where appropriate, these sessions afford the affected member of the public and involved personnel the opportunity to meet and discuss their respective points of view and work towards a workable resolution. This purpose of providing this alternative is to promote constructive communication and

mutual understanding. LASD personnel who agree to participate in the process will receive a positive performance log entry in their record. In an effort to expedite the process, the conflict resolution meetings must be held within thirty days of the contact that generated the complaint.

The new SCR Handbook covers virtually every aspect of the revised process including: (1) the intake and classification of service comments; (2) the procedures for conducting a service comment review; (3) the adjudication of service comments; (4) the rights of Department personnel after the adjudication of service comments; and (5) the constitutional rights of the involved parties.

OIR continues to monitor the Department's review of service comments and its implementation of the revised SCR process.

PART FIVE

Misconduct Cases

Whether on-duty or off-duty, officer misconduct is an unfortunate but persistent fact in the Department. Peace officers, non-sworn personnel, probationary employees, veterans and members holding high ranking supervisory positions have all committed offenses that have disappointed or brought discredit upon the Department. The misconduct discussed in this section ranges in seriousness from minor to criminal.

OIR continues to closely monitor misconduct cases, probes thoroughly into the allegations and actively participates in the Department's disciplinary process. Although officer misconduct will never be totally eradicated, OIR remains steadfast in its role to oversee the Department to ensure fair and thorough investigations and individual accountability when warranted by the facts.

On-Duty Misconduct

Embezzlement of Towing Fees

LASD's Internal Criminal Investigations Bureau ("ICIB") initiated an investigation after it received information that a traffic sergeant may have embezzled nearly half a million dollars in towing fees over a period of three or more years. This was not

the first time a Department member had been investigated for allegedly embezzling towing fees. As OIR reported in its 1st Quarter Report of 2008, a deputy was disciplined for similar conduct albeit in that case the amount of missing fees was a fraction of what was allegedly stolen in this case.[11] The facts in this case further exposed the systemic vulnerabilities in the way fees were collected and, ultimately, caused the Department to implement safeguards (as discussed in detail below) to prevent these situations from happening in the future.

Background

In this case, the traffic sergeant's duties included handling and recording towing fee transactions for a city that was within the station's jurisdiction. The city, in turn, contracted with a local towing company for tow services. When a vehicle was towed/impounded/seized, the vehicle's owner would go to the station and pay an administrative towing fee—in cash. In return for paying the fee, Department personnel (i.e. desk sergeant) would provide the owner a receipt and a vehicle release form. The owner would then go to the tow yard and provide a copy of the release form and pay a separate storage fee directly to the towing company.

On the Department's end, the cash, a copy of the receipt and the release form would be given to the traffic sergeant who maintained a log of all the transactions. The traffic sergeant would then periodically deliver the collected cash and copies of the receipts to the city. However, there was no other station personnel who monitored or verified that the traffic sergeant actually logged all the transactions or delivered all the fees to the city. Also, it appears that the receipts issued to citizens were not sequentially numbered which clearly contributed to the ease in which the sergeant was able to embezzle the money.

How the Problem was Discovered

A city official had prepared the upcoming year's budget and projected (based on records it maintained) that a certain amount of revenue would be raised from towing fees After reviewing the projection, city officials believed that the projected revenue appeared low and recommended that they entertain bids. The contracted towing company learned of the recommendation and was surprised. Based on the towing company's records of stored and released vehicles, the amount of administrative fees the city should have received in the past fiscal year was much higher than what was

11 In that case, the District Attorney declined to file criminal charges due to insufficient evidence. Administratively, the deputy received significant discipline for failing to follow established protocols relating to the accepting and recording of towing fees.

reported. The towing company's records were then compared to the city's records and significant discrepancies were discovered. It was then suspected that the traffic sergeant was not providing the city with all the money or all of the receipts. The city had never previously audited its towing records.

Alarmed at the discovery, the information was forwarded to the Sheriff's Department. The traffic sergeant was relieved of duty pending the criminal investigation. Within days of a search conducted at the sergeant's home, he retired from the Department. The criminal investigation, however, continued and, in 2009, the retired sergeant was indicted by a Grand Jury for one count of embezzlement, one count of embezzlement by a public officer and five counts for filing false tax returns.

Station Unit Order

When the discrepancies were discovered, the station immediately reassigned the responsibility of receiving and transporting the towing fees to another sergeant. It also issued a station order that provided better accountability and oversight of the fees collected. For instance, the new procedures required that the Watch Deputy reconcile all collected fees at the beginning and end of each shift and document the results. The incoming Watch Deputy must verify the log and immediately report any discrepancies to the shift Watch Commander. Also, all the collected fees are to remain in a locked container at the Watch Deputy's desk and only the Watch Deputy will maintain control of the key at all times. Since the implementation of this order, there have been no reported discrepancies of towing fees at this particular station.

The Department-Wide "Audit"

As the criminal investigation of the traffic sergeant was pending, the Department conducted an internal audit of how its stations collected administrative fees for contract cities. The purpose of the audit was to identify vulnerabilities in the process and remedy them. The audit revealed that there was no uniform Department-wide procedure for collecting these fees. In fact, there was no Department policy regarding the collection of towing fees. Each station had developed its own procedures based on the needs and requests of the concerned contract city. The one common thread throughout all the stations, however, was that cash and checks were the only acceptable forms of payment. Also, it appeared that there was no standard as to when the station should deliver the fees and related documentation to the contract city. In light of the audit revelations, the

The audit revealed that there was no uniform Department-wide procedure for collecting these fees.

Department issued a Field Operations Directive, which established Department-wide expectations:

- Receipts shall be sequentially numbered
- Fees and receipts must be stored into a lock box; the on-duty Watch Deputy shall maintain control of the key at all times
- Fees may be paid in the form of cash, personal check, cashier's check, or money order, as specified by the concerned contract city
- The payee shall receive a receipt showing the amount paid, the manner of payment and the person accepting payment
- The vehicle release form issued to the payee shall have the corresponding receipt number written on it
- Only one receipt book shall be maintained at the desk
- At least twice per week when fees are being held, or whenever cash and checks total $500 or more, the fees shall be delivered/transferred to the city

More Missing Towing Fees

Before the Field Operations Directive went into effect in January 2009, ICIB opened another criminal investigation regarding an allegation that $1,100 in towing fees was stolen from a locked box located at the front desk of a different station. During the investigation, it was discovered that the lock on the cashbox malfunctioned occasionally causing the key to lodge rendering the safe unlockable. Also, there were two keys for the safe. One was kept with the Watch deputy; the other was maintained in a drawer of the Watch deputy's desk. It was unknown who knew about the location of the second key. Eighteen employees who had direct access to the locked box were interviewed. There were many other station personnel who potentially had the opportunity to access the money. The person or persons responsible for the theft could not be identified and therefore the case was closed and forwarded to the unit for disposition.

Based on impound vehicle logs, the unit was able to determine that the theft could have occurred over a span of six shifts. Personnel working these shifts were counseled by the station captain for failing to follow a unit order that the captain had issued a year prior to the incident. Had the towing fees been reconciled at the start and end of each shift, pursuant to the unit order, the discrepancies would have been detected immediately. Also, a second key to the safe should not have been placed where others had potential access to it. Immediately after the discrepancy was discovered the station purchased a new functioning lock box. The station also distributed the new Department Directive and conducted a briefing of its contents.

Although there was immediate corrective action taken at the unit level to prevent this occurrence from happening in the future, the main issue is that where there is cash there may always be the potential and opportunity for people to take the money—no matter how many functioning lock boxes are purchased or how many unit orders and Field Directives the Department issues. In fact, soon after the Field Directive was issued, yet another station discovered that, over a period of about a year, one of its volunteers had stolen approximately $2,000 from its towing fees cashbox. That case is now being pursued criminally.

Other Alternatives

Even after the Department issued the Field Directive, it continued to consider other options, including eliminating itself entirely from the process. One option would be for citizens to pay their fees directly to the contract city. The problem with this alternative is that the city is not likely to provide 24 hour service that enables a citizen to retrieve his/her vehicle. If a citizen, for instance, has his/her vehicle impounded on a Friday evening he/she would likely have to wait until Monday morning to retrieve the vehicle—a scenario that would be frustrating to the citizen and unpleasant to the city employee who has to deal with an angry citizen.

Another option is for the Department to only accept debit or credit cards. The problem here is that there are potential issues with fraud and identity theft, which could create a host of new liability issues for the Department.

Ultimately, the goal for the Department is to eliminate the responsibility and inherent risk it assumes when it handles, collects and transfer cash to the cities. OIR will work closely with the Department as it weighs its options. Although there is a tendency to put thorny issues on the back burner, we are hopeful that the matter will be resolved before another theft occurs.

The following is a copy of the Department's Field Operations Directive which established uniform procedures on how patrol stations should collect administrative fees on behalf of contract cities. It became effective on January 1, 2009.

Los Angeles County Sheriff's Department

FIELD OPERATIONS DIRECTIVE

Field Operations Support Services, (323) 526-5760

FIELD OPERATIONS DIRECTIVE: 08-03 ISSUE DATE: 11/24/2008
EFFECTIVE DATE: 01/01/2009

ISSUED FOR: FIELD OPERATIONS REGION I
FIELD OPERATIONS REGION II
FIELD OPERATIONS REGION III

COLLECTION OF CONTRACT CITY ADMINISTRATIVE FEES

Purpose

The purpose of this directive is to establish uniform procedures for patrol stations that collect administrative fees on behalf of contract cities.

Policy and Procedures

Collection of Fees and Documentation

When a person requests to pay for contract city fees at a station, station desk personnel shall:

- Accept the contract city fees
- Issue a sequentially numbered receipt to the payee
- Place the fees and receipt into a lock box designated for each city
- Enter the amount of the fees and the receipt information into the contract city fee ledger
- Secure the lock box, receipt book/pad, and ledger with the watch deputy

The fees may be paid in the form of cash, personal check, cashiers check, or money order, as specified by the concerned contract city. Persons wishing to pay by check shall present valid identification. The identification number shall be noted on the face of the check next to the account holder's name. All checks shall be immediately restrictively endorsed in the following manner, "For Deposit Only To The City of _____."

The payee shall receive a receipt showing the amount paid, the manner of payment, the person accepting payment, and the applicable URN number. The vehicle release form issued to the payee shall have the corresponding receipt number written on it.

COLLECTION OF CONTRACT CITY ADMINISTRATIVE TOW FEES

Receipts for the collection of fees on behalf of a contract city shall be in triplicate (3 copies), be numbered sequentially and issued sequentially, preprinted with the name of the city, and shall be bound in booklets or pads.

If city fees are waived, the payee shall receive a receipt with the words, "Fees Waived," written in the amount paid area. The name of the city employee or watch commander authorizing the waived fee shall be written on the receipt.

Distribution of the receipts shall be as follows: original to payee, one copy kept intact in the receipt book for the contract city, and one copy for station files.

Voided receipts shall have "Void" written across the face. The original and one copy shall remain in the receipt book, and one copy shall be filed at the station.

Only one receipt book shall be maintained at the desk. Additional receipt books shall be issued as needed by the watch commander or a supervisor who has been designated by the unit commander. Before issuing a new receipt book, the watch commander or the designated supervisor and the watch deputy shall ensure that all receipts in the used receipt book have been accounted for and issued in sequence. Depleted receipt books with intact copies of receipts shall be returned to the city.

All fees and corresponding receipts (including "Fees Waived" and voided receipts) shall be listed in a city fee ledger that will contain the following information, as appropriate, for each transaction:

- Receipt number
- Date/ Time
- Name of payee
- Truncated URN
- Amount paid
- Balance
- Name and employee number of employee accepting fees

Existing Department policy requires that stations maintain a Station Daily Log of Stolen, Stored, Repossessed, and Impounded Vehicles (MPP 5-01/020.00). This log provides an effective tool for cross-referencing vehicles for which administrative fees would be due upon release. On the Station Daily Log, the amount of County or city fees paid, or the word "waived," shall be indicated for each released vehicle. The Station Daily Log shall be audited by the unit commander at least quarterly to ensure that administrative fees have been properly collected or waived for all vehicles that have been released.

COLLECTION OF CONTRACT CITY ADMINISTRATIVE TOW FEES

City Fee Cash Box

A key-locked cash box for each contract city's fees shall be kept at the front desk area. The on-duty watch deputy shall maintain control of the key. The watch deputy is also responsible for the security of the cash box during their shift and ensuring the accuracy of the ledger, receipts and collected fees. The cash box, city receipts, and fee ledger shall be kept locked at the watch deputy's desk unless they are being used.

At the beginning of their shift, the oncoming watch deputy shall reconcile the money in the cash box to the ledger to ensure that all monies are accounted for. This accounting shall be noted in the ledger with the following information:

- Date/Shift
- Balance
- Watch Deputy's name and employee number

Any discrepancy between the running total and the amount of fees on hand shall be immediately reported to the watch commander and handled as a cash shortage or overage (see MPP Sections 3-05/080.00 through 3-05/080.15).

Transferring/Depositing City Fees

Transferring to a City Official:

At least twice per week when fees are being held, or whenever cash and checks total $500 or more, the unit commander's designee shall be responsible for having the city fees and applicable ledger page(s) transferred to a designated city official or having them deposited into a city bank account.

If fees being held exceed $500 and a transfer or deposit cannot be made for any reason, the following procedures shall apply: The early morning watch deputy shall collect all funds and receipts being held, reconcile them against the ledger, make an entry showing a transfer to the watch commander's safe, and show a "0" balance in the ledger. The watch commander shall count the fees, reconcile them against the receipts and ledger, and place them into the safe with a corresponding entry in the safe ledger.

If transferred to a city official, the unit commander's designee will request the city official to count and verify the amount of cash and checks and reconcile them against the ledger to confirm that the balances are accurate and that all receipt numbers have been accounted for.

The ledger page(s) shall reflect the fees transferred to the city with the following information:

- Amount of transfer
- Transporting employee name and number
- Printed name of city official accepting fees
- Signature of city official accepting fees

The transporting employee shall make a copy of the signed ledger page(s) for the city's files and return the signed original to the station operations office. The operations sergeant or lieutenant shall review the ledger for accuracy and see that it is kept on file along with corresponding copies of receipts for five years.

Depositing into a City Bank Account:

If the collected fees are deposited into a city bank account, the deposit shall be prepared in the same manner as those for the Miscellaneous Fees Account (see MPP 3-05/060.15). Once the deposit has been made, the certified copies of the bank deposit slip shall be distributed as follows:

- One shall be attached to a copy of the signed city fee ledger and given to a city official
- One shall be attached to the original signed city fee ledger and returned to the Station Operations office as described above

Optional Additional Security Measures

Nothing in this directive shall preclude any station from taking additional security measures.

Affected Directives/Publications

Manual of Policy and Procedures §3-05/060.05 (Acceptance of Checks and Handling of Non-Sufficient Fund Checks) - Additional policy guidance is provided.
Field Operations Directive 04-01 (Cash Register Operations) - Additional policy guidance is provided.

Cites/References

Manual of Policy and Procedures §3-05/060.05 (Acceptance of Checks and Handling of Non-Sufficient Fund Checks)
Manual of Policy and Procedures §3-05/080.05 (Shortage-Under $20)
Manual of Policy and Procedures §3-05/080.10 (Shortage-Other)
Manual of Policy and Procedures §3-05/080.15 (Overage)
Manual of Policy and Procedures §5-01/080.00 (Notification and Hearing Procedure for Stored Vehicles)
Manual of Policy and Procedures §5-01/020.00 (Station Daily Log)
Manual of Policy and Procedures §5-01/090.00 (Release of Stored and Impounded Vehicles)
Manual of Policy and Procedures §5-03/090.45 (Bail Shortages/Overages)
Field Operations Directive 96-06 (Vehicle Release Administration Fee)
Field Operations Directive 04-01 (Cash Register Operations)

WJM:NBT:CWR:TPA:RRD:JLS:EPF:epf

Sex-Related Misconduct Cases

In the past year, OIR monitored several sex-related misconduct cases involving higher level, supervisory Department personnel. OIR remains committed to ensuring that all Department members, regardless of rank, receive fair and thorough investigations and that outcomes are appropriate and consistent with the Department's historic response to these types of offenses.

Case

While on-duty, utilizing a County vehicle and wearing a variation of the Department uniform—that still identified him as a law enforcement officer—a lieutenant was seen in a church parking lot engaging in consensual sexual activity with a woman.

A church custodian first observed the pair standing in the parking lot hugging, kissing, and fodling each other. They were standing next to the lieutenant's unmarked County vehicle, which the custodian recognized as a police vehicle due to its California exempt license plate and the lights in the back window. The custodian was embarrassed by this public display at his place of worship, but initially did not report it.

Several weeks after the first incident, the custodian saw the same County vehicle parked in the church parking lot. The lieutenant, who was wearing his badge, was inside his vehicle receiving oral sex from the same woman. The distressed janitor wrote down the vehicle's license plate number and reported the incidents to his local police department. After running the plates, the local agency determined that the vehicle belonged to the Sheriff's Department.

When questioned, the lieutenant admitted to having engaged in sexual activity on-duty with the same woman on at least eleven occasions, including a number of rendezvous in the church parking lot and a meeting at a neighborhood hotel. The lieutenant expressed deep remorse for his actions.

In light of the lieutenant's acceptance of responsibility for his conduct, prior good record, length of Department service (over twenty years), as well as the absence of any coercion of the woman, the Department concluded, and OIR agreed, that demotion and reassignment was the appropriate discipline. The employee—now a sergeant—is in a non-field assignment.

Case

Based on an anonymous tip, a local law enforcement agency sent its Vice Team to an apartment complex alleged to be the location of an illegal massage parlor and prostitution ring. While conducting surveillance, the undercover officers saw a man knock on the apartment door and enter the residence. Unbeknownst to the Team, the man was a prominent high level professional Department employee.

When the Team entered the apartment, they found two women dressed in provocative lingerie. The employee was found in a bedroom with one of the women and he was partially undressed—he had removed his shoes and outer shirt, but was still wearing pants, a t-shirt and socks. The employee was immediately ordered to raise his hands, was patted down then handcuffed and moved to another room while a search of the apartment was conducted.

In the course of the search, the officers found several thousand dollars in cash inside the apartment and a large stash of condoms. The officers interviewed the women and both admitted to exchanging sexual acts for money.

The employee told the Vice Team that he had been referred to the location by "a friend" from the Department and was only there to receive a massage. During the LASD internal investigation, the employee claimed to not remember which friend had told him of the "massage parlor." Although he disavowed any knowledge of the illegal prostitution business, he admitted that he may have learned of the apartment address from a website—which was sexually provocative. Because the employee was not observed violating any law, the Vice Team ultimately released him. The local agency then immediately reported the incident to LASD.

Department policy requires that when an employee is "detained as a potential suspect in a criminal matter" he/she must immediately notify the on-duty Watch Commander at his/her unit of assignment. The employee failed to report the incident to anyone until he was questioned directly about the incident the next day. The employee argued that because he was ultimately released as a witness, he was not "detained as a potential suspect" and, therefore, was not bound by the policy's reporting requirements. OIR pointed out to the Department that when the employee was patted-down, handcuffed, detained and questioned by the Vice Team, he was detained as a potential suspect pending further investigation. Although the evidence did not support a finding the employee knew of the illegal enterprise, the employee should have immediately left the apartment once scantily-clad women opened the door. The employee received significant suspension days for bringing discredit upon himself and the Department and for failing to make the required notification.

Case

The Sheriff's Department is responsible for security at a number of large public facilities. A sergeant worked at one location, supervising a small group of deputies as well as non-sworn security officers. The sergeant had struck up a friendship with a security officer and while on-duty the two arranged times and places to be alone. At one point, the security officer was offended by some of the sergeant's overtures, among these, exposing his erect penis to her in the office of the facility. When the security officer complained, the Department initiated a criminal investigation because the complainant alleged that some of the physical acts were not entirely consensual. The security officer cooperated with the initial investigation but later declined to be interviewed by the District Attorney investigator. The DA ultimately declined to file a criminal case. The Department then initiated an administrative investigation of possible violations of the sexual harassment policy as well as policies on relationships with subordinates, general behavior and performance of duty. The Department's Equity Oversight Panel determined that sexual harassment had occurred and that the violation warranted discharge, citing the disparity in rank between the sergeant and the security officer as a major aggravator. Additionally, Department executives determined that the sergeant had also neglected his duties and failed to uphold the department guidelines for relationships with subordinates and approved the discharge. During the appeal process the Department agreed to allow the sergeant to remain in the Department but only if demoted to the position of deputy. OIR did not object to the agreement because of the thin evidence supporting the sexual harassment charge and because demotion was a fitting remedy for the employee's failure to live up to supervisory responsibilities.

While all sexual misconduct is problematic, when the acts involve law enforcement officers on duty, it is an egregious misuse of the awesome power and authority given to them. Further, it potentially stigmatizes all the other officers who zealously and honorably do their job...

Case

This past year, a sergeant was relieved of duty surrounding a criminal indictment arising out of on duty sexual misconduct allegations. There are three female victims listed in the criminal case. The victims allege that during a traffic stop the sergeant requested they expose themselves, held them against their will and/or threatened them with a citation if they refused to do as the sergeant requested. One woman also alleges that the sergeant followed her to another location and digitally penetrated her against her will.

This same sergeant, while a deputy, had three administrative cases involving allegations of sexual misconduct. Two of the three cases involved allegations that the deputy was seen "flashing" a woman and young girl and then masturbated while he was home in his garage. The incidents occurred months apart from each other and it does not appear the woman and young girl knew each other.

In the case involving the young girl, her parents, once learning that the man was a deputy, did not wish to seek criminal action. The Department did, however, conduct an internal investigation but concluded the case was a "he-said-she-said" and thus, closed the case as "unresolved." The woman's case was pursued criminally but no charges were filed. Again, the Department investigated the matter internally, including undercover surveillance of the deputy, but after unsuccessful attempts to gather new information, the case was inactivated.

The third administrative case occurred approximately ten years ago but strikes an eerie resemblance to the allegations asserted in the pending criminal case. In that case, the deputy and his partner initiated a traffic stop of two women in a car and separated them to question them about possible narcotics possession. The victim alleged that the deputy requested she show him her breasts and vagina to assure him she was not concealing any drugs. She complied. She also alleged he placed his fingers inside of her vagina and rubbed her chest. The women were then released with no citation. After the women complained to the station a criminal investigation was initiated. However, because DNA test results came back "weak positive" for DNA found on the woman's chest and under the deputy's fingernails, the District Attorney declined to file criminal charges. The Department's administrative investigation initially concluded that the charges were "unresolved" but later changed the final disposition to "unfounded." OIR was not in existence at the time of the decision, and therefore, cannot provide any details for the change in determination.

OIR is closely monitoring the progress of the current criminal case. While all sexual misconduct is problematic, when the acts involve law enforcement officers on duty, it is an egregious misuse of the awesome power and authority given to them. Further, it potentially stigmatizes all the other officers who zealously and honorably do their job for the Department. The harm is even greater when it is perpetrated by supervising personnel. OIR continues in its mission to assist the Department in maintaining transparency and ensuring consistency and appropriate accountability in the handling of these types of cases.

Failure to Report Force

A group of deputies and a field sergeant responded to a disturbance call at a department store parking lot. They contacted the disheveled and possibly intoxicated suspect who had been released from prison that day. He was belligerent and asserted that he would not leave the area peaceably and that the deputies would have to shoot him. Because of his aggressive behavior, the field sergeant ordered one of the deputies to take out his TASER. Shortly thereafter, the suspect became increasingly aggressive prompting the deputy to fire the TASER. The TASER, however, had no apparent effect on the suspect, who reached up and pulled one of the darts out of his chest. The suspect continued to challenge the deputies, saying they would need to use more force to take him into custody.

Taking a different approach, the sergeant proposed to the suspect that if he gathered his belongings and left the area, he would not be arrested. The man agreed and was allowed to walk away. When the deputies asked the sergeant how they should document the encounter, he told them he would "take care of it." The sergeant also instructed one deputy to "clear" the call on his patrol car computer and indicate that the suspect was cooperative and left the area. None of the other deputies reported the use of force. Pursuant to Department policy, the deputies expected the sergeant to report the use of the TASER which requires immediate reporting.

The investigation revealed that the sergeant had gathered up the expended TASER cartridge, threw it in a trash can and did not report the use of force.

Later that day, the suspect met with a municipal official and mentioned being shot with a TASER earlier. The official reported this to the Department. Finding no appropriate reporting of the incident, the sergeant's station requested an Internal Affairs investigation. The investigation revealed that the sergeant had gathered up the expended TASER cartridge, threw it in a trash can and did not report the use of force to the watch commander until three days after the incident (and after it had been independently reported to the Department).

As a result of the investigation, the sergeant was demoted and two of the deputies present received short suspensions.

OIR conferred extensively with Department executives on the disposition of this case. In determining an appropriate outcome, the sergeant's years of service, level of responsibility, past performance, opportunity to cure the misconduct and responsibility to the suspect, were considered. OIR recommended that a demotion would be reasonable because of three factors: (1) the sergeant had previously been

disciplined for another controversial and notorious incident where he exercised poor supervision (2) the sergeant's actions contributed to the deputies' failure to report force and (3) a recent revision of the TASER policy published Department-wide reminded all supervisors of their responsibilities to preserve and retain evidence.

The sergeant appealed his demotion. Although finding that the Department proved "most of the allegations" against the sergeant (i.e. that he failed to exercise proper supervision, gave deputies the impression that he would report the force, failed to report the force as required and failed to preserve the TASER evidence), the hearing officer also found that the Department had not proven that the sergeant specifically directed a deputy to make a false report entry and recommended that the demotion be reduced to a thirty day suspension. While this fact may be true, it does not follow that the other supervisory failures established by the evidence were not sufficient to support the Department's demotion decision. For the hearing officer to substitute his judgment and return the employee to supervisory rank, in our view, gives insufficient deference to the Department's determination. Unfortunately, in a split vote, the Commission affirmed the hearing officer's findings and the employee was returned to work as a supervisor.

Practical Jokes Gone Too Far

Not unlike non-law enforcement employees, deputies sometimes play practical jokes on their co-workers. Unlike most people, though, deputies have access to specialized equipment and sensitive information, and may rightfully be held to a higher standard than the general public because of their duties as law-enforcement officers. In the past, we have heard of deputies spraying each other with Oleoresin Capsicum (pepper) spray for laughs and putting inmates in harm's way while playing games. The Department does not condone pranks at work, and the Department recently disciplined several members for such behavior.

Case

Three Custody deputies dressed in the Department's yellow "turn-out" gear[12] and armed themselves with old fashioned fire extinguishers (water inside a bucket-like device). The deputies began a game of hide-and-seek, spraying each other with water as they ran about a discipline row.[13] At one point, a deputy got sprayed with water and an inmate on-looker made a wisecrack. The deputy responded by spraying the inmate with

12 "Turn-out" gear is fire retardant safety clothing.

13 A discipline row is a special part of the jail that houses inmates who have violated jail rules.

water. There was no evidence the deputy acted maliciously. Nonetheless, the inmate and his cell both got wet. The inmate, however, was not issued a change of clothing and bed sheets until the next shift of deputies arrived.

The facility had partial video tape of the incident. The deputies all admitted to their participation in the prank and received discipline for their actions.

In addition to concerns about the conduct of the deputies and its effect on inmates, OIR was concerned about the apparent lack of supervision. It appeared the supervisor responsible for the three deputies did not know about the prank until well after it had occurred, despite the fact the three deputies had to leave their posts, get the "turn-out" gear from storage, and fill the extinguishers with water in order to play their game of water wars. While the facility is very large and one supervisor is often responsible for numerous deputies and several housing areas, it is troubling that deputies believe they can engage in such behavior without detection.

Case

In 2008, a group of custody assistants became subjects of an internal investigation after a fellow custody assistant almost died from eating a "prank" sandwich they had prepared for him. Three custody assistants filled the sandwich with an assortment of food items such as peanut butter, chicken, mayonnaise, chili peppers, Tabasco sauce, Worcestershire sauce, sugar and lemon juice. One custody assistant was responsible for delivering the sandwich.

The group was unaware that the subject of their prank ("complainant") was deathly allergic to peanut butter. After eating several bites of the sandwich, the complainant asked the custody assistant who delivered the sandwich whether it contained peanut butter, explaining that he was allergic. The custody assistant immediately revealed that the sandwich did, in fact, contain peanut butter. By this point, however, the complainant had ingested enough peanut butter to cause an immediate allergic reaction. He began to vomit and had difficulty breathing. He collapsed in a parking lot on his way to the nearby infirmary.

The custody assistant who delivered the sandwich was worried about the complainant so he called him on the radio to find out where he was. Although short of breath, the complainant was able to communicate his location and the custody assistant immediately summoned for help. A fellow employee found the complainant and escorted him to the infirmary. The complainant was hospitalized and, although his condition was severe, he made a complete recovery.

14 The training video remains in the development stage.

After a thorough investigation, there was no evidence that any of the custody assistants knew of the complainant's allergy or that they intended to harm him. Despite the absence of malice, the consequences of the prank were extremely serious. The attending physician reported that the complainant could have died if prompt medical assistance had not been available.

All involved custody assistants received significant suspensions for their participation in the prank. However, in lieu of serving the unpaid suspension days, the subjects agreed to a plan which included their required participation in the writing and production of a training video about the potential harmful consequences of pranks.[14]

Case

A drill instructor working at the Academy was agitated at a recruit who was fidgeting while he was supposed to be standing at attention in formation. The instructor ordered him to the front of the class, then directed him to take several steps to the side so that he was standing in a puddle of water. The instructor then ordered him to sit down and perform a stretching exercise, resulting in the recruit's sweatpants, shorts, and underwear getting wet. The recruit was ordered to stand up just a few seconds later and then ordered to change into dry clothes.

The Training Bureau command staff initially was concerned this incident may have been racially motivated. The Internal Affairs investigation quickly and easily dispelled that notion. Nonetheless, this incident represented the kind of humiliation and mistreatment of recruits that the Training Bureau has sought to eliminate in furtherance of the philosophy that everything a drill instructor does or requires a recruit to do must serve a legitimate training purpose. Placing a recruit in a puddle to make it appear as though he had wet his pants serves no such purpose. Following a thorough and complete investigation, the drill instructor received discipline and was transferred to a different assignment where he no longer trains recruits.

Sleeping On-Duty

Like most employers, the Sheriff's Department expects its employees to work—not sleep—while on-duty. As with any 24-hour a day operation where round-the-clock supervision is problematic, deputies and professional employees occasionally nod off when they should be working. It is a sufficiently significant problem that the LASD has a specific policy explicitly prohibiting it. For first time offenders, the discipline typically is minor, ranging from a written reprimand to a one- or two-day suspension. For repeat offenders, however, discipline is more severe.

Case

On three different occasions involving three different custody deputies last year, a non-Department member photographed a deputy sleeping on duty and forwarded the photo to the Department. In each case, the deputy was away from his assigned custody facility, responsible for supervising an inmate taken from the jail to the hospital.

The deputies all admitted their violations and were remorseful for their actions. One deputy was on an overtime shift and another deputy admitted not getting enough sleep the night before. In all three cases, the deputies stated it was not their intention to fall asleep, but they were sitting outside the hospital room and "dozed off." OIR was consulted on all three cases and concurred with the Department's decisions to impose short suspensions.The unit commander of these three deputies recognized that being "caught" sleeping on duty by members of the public brings more discredit to the Department than when it is detected by a supervisor. To address the issue more globally, the unit commander ordered that a briefing be conducted reminding deputies of the importance of staying alert when guarding a prisoner.

Case

A sergeant found two non-sworn employees sitting in a trailer in a remote location. When the sergeant inquired why the employees were not at their assigned posts, the subject employee failed to respond and the sergeant realized the employee was asleep. The other employee kicked the chair in which the subject employee sat, awakening him. Neither employee could, at the time, provide the sergeant a good reason why they were in the trailer.

During the administrative interview, the subject employee stated that his allergies had become aggravated and he had taken some medication that made him drowsy. The subject employee stated that he entered the trailer and quickly fell asleep. He acknowledged that he and his fellow employee should have consulted a supervisor before taking their break.

Because it appeared that the subject employee had purposefully gone to the remote area with the intention to sleep, the Department issued a more significant suspension. OIR monitored this administrative investigation and concurred with the disciplinary decision.

Los Angeles County Sheriff's Department
North County Correctional Facility

Watch Briefing

Date: 04/22/2010 Briefing Number: 2010 - 04

From: GREGORY H. JOHNSON, CAPTAIN

By: Sergeant Randy Lawrence

To: ALL CONCERNED PERSONNEL

Subject: HOSPITAL SECURITY

Recently, the Office of Independent Review returned their findings regarding recent incidents of deputy personnel falling asleep while providing security at local hospitals. In these incidents, photographs were taken of the deputies. Obviously, this is embarrassing, not only to the personnel involved, but to the Department as a whole. Fortunately for us, none of the pictures have shown up on Facebook, Youtube or any of the myriad other websites available. We have also been fortunate that nobody has been harmed or taken advantage of while our personnel were dozing.

I am aware that working hospital security is not the most exciting assignment and that it is easy to fall asleep; therefore, get plenty of sleep before you come to work as it is your responsibility to stay awake.

If you find yourself becoming drowsy, take the necessary measures to wake up. Try standing up and walking around in the room. Have your partner cover for you while you take a walk outside. Watch the television and make frequent channel changes to break up the monotony. These are just a few methods for remaining awake.

Whatever you do, remember to be professional and keep a close eye on the prisoner you are guarding. You never know who is watching you and waiting for an opportunity to take advantage of the situation.

Be alert, and be safe.

Brief From: 4/22/2010 To: 05/03/2010

Via E-Mail: YES Printed - Briefing Boards: YES Printed - Mail Boxes: NO

Case

In yet another sleeping on duty case last year, inmates filed an internal complaint alleging that a custody assistant was asleep during count and meal times. On one occasion, inmates had lined up to retrieve their lunches from kitchen servers who were waiting outside a security gate for the employee to let them in. After waiting for some time, several inmates went back into the housing area and found the custody assistant asleep in a chair in the staff station.

During the initial inquiry, the unit learned that the custody assistant's Title 15 log, for the time period in question, was missing the required security check entries. Soon thereafter, the unit informed the custody assistant that it was about to initiate an administrative investigation to address the allegations. Before the investigation concluded, however, the custody assistant was again caught sleeping on duty. This time, a supervisor discovered him sleeping when the supervisor went to the housing area after the custody assistant failed to respond to a radio call. Again, the unit reviewed his Title 15 log for that time period and discovered missing security checks.

Remaining alert and conducting required security checks are basic duties of a custody assistant assigned to a housing area. By sleeping on duty, this custody assistant compromised the safety of the inmates and the security of his assigned barrack, as well as the facility as a whole, and created the potential for inmates to escape from the facility.

The custody assistant had been warned on two previous occasions of sleeping on duty and failure to conduct required security checks. He also had been disciplined in the past for failure to perform his duties. Because of this pattern of misconduct, he received a significant suspension, but agreed to take advantage of the Department's Education Based Discipline program to minimize the financial impact of the discipline. OIR concurred with this disposition. In order to help the employee change his behavior, the Department changed his shift to a time that allowed him to get the proper rest at home, which enabled him to stay alert at work.

Off Duty Misconduct

Alcohol-Related Misconduct

Last year we reported that, despite energetic efforts on the Department's part, driving under the influence arrests and other alcohol-related arrests had continued to rise alarmingly. This year, the story is different. Although the DUI arrest total

in 2009 is still significantly higher than it was every year from 2002 through 2007, it is down about 10% from the previous year. In 2008, there were thirty-eight DUI arrests. In 2009, the total was thirty-four.

In addition, other alcohol-related arrests (i.e. domestic violence, public disturbances, interfering with police officers) are down almost 40% from last year. Since this is only the second year that the Department has compiled non-DUI alcohol-related arrests with a consistent methodology, it may be too early to know whether this year's numbers reveal a mere statistical quiver or a real turning point.

We commend the Department on its combination of significant deterrence and earnest re-education and remain optimistic. OIR will continue to focus closely on this issue and continue to share any detectable trends or results with the Department. The following is a sampling of this year's off-duty alcohol-related offenses.

Case

An off-duty sergeant struck a parked car while pulling out of a parking space after leaving a restaurant/bar. The owner of the other vehicle reported that the sergeant was aggressive and uncooperative and boasted that he was a "cop" and that other cops would not do anything to him. The sergeant was similarly belligerent and uncooperative with responding deputies from a local law enforcement agency. He used profanity, lashed out with insults, and repeatedly announced that he was a sergeant with the LASD. Deputies reported that he was stumbling and had a hard time even standing up. His behavior at the station and in the jail was no better, where he belittled a female deputy, insulted supervisory staff, and continued to use profanity. He refused to perform field sobriety tests and would not consent to either a breath or blood test. He was eventually subjected to a forced blood draw and his blood alcohol content was .23 percent, almost three times the legal limit.

The subject sergeant was relieved of duty pending the outcome of his case and a very thorough investigation was completed within about a month. Department executives initially decided to discharge the sergeant but later amended the discipline to a thirty-day suspension. OIR believed that a demotion would have been a more appropriate disposition in this case.

Case

An off-duty deputy was involved in a non-injury traffic collision with another car. The deputy provided insurance information but was rude and displayed his badge in an apparent attempt to intimidate the other

motorist. The deputy then left the scene of the accident. Police from another agency responded and located the deputy at home. He was unable to perform field sobriety tests, and his blood alcohol level was measured at .25 percent. The deputy was a recent hire, still in his probationary period. Consistent with its new policy, the Department re-evaluated the deputy's background package and learned he had a history of drunk in public arrests prior to joining the Sheriff's Department. After initially being relieved of duty, the deputy returned to work, but was demoted to custody assistant. OIR believed that discharge was the more appropriate outcome, given this deputy's probationary status and pattern of alcohol abuse, but the Department hopes to make an example of this former deputy by having him speak to new deputies arriving at a Custody assignment about the perils of off-duty conduct.

Case

An off-duty deputy was at a bar with his brother and some friends when they got involved in a fight with some other bar patrons. The deputy and the others were told to leave. The deputy was cooperative and even agreed to pay to repair a door that had been broken during the fight. When they left the establishment, however, the deputy's brother and friends were detained by police officers who were responding to the bar fight. The subject deputy became agitated, used profanity, and started to challenge the responding officers. As his brother fought with officers, the deputy was perceived to be encouraging him to continue the fight rather than to comply. The deputy ultimately was arrested for being drunk in public.

This deputy was almost immediately relieved of duty. Again, Department executives made an initial decision to discharge the deputy, but then settled with the deputy for a voluntary demotion to a custody assistant position. The Department also intends to have this former deputy address his former peers using his story as a cautionary tale.

The results in these cases exemplify the increasingly stern approach Department managers have taken with alcohol related off-duty misconduct. The Undersheriff continues to send every member of the Department a weekly e-mail message reporting on alcohol-related arrests.

In late 2009, in a bulletin, the Department specifically instructed unit commanders that personnel arrested for DUI and other alcohol-related offences could be "relieved of duty" (deprived of gun and badge and told to remain at home for an extended period of time) for aggravated circumstances, such as collisions, second offences or grossly rude or abusive behavior toward the arresting agency. Unit commanders were also instructed to notify personnel that if they are arrested for an alcohol-related offense the employee will have a face-to-face meeting with the Undersheriff within days of the incident. Department Chiefs were also told that aggravated cases could even merit discharge.

SHERIFF'S BULLETIN **580** **December 21, 2009**

ALCOHOL-RELATED ARRESTS AND EMPLOYEES OF THE LOS ANGELES COUNTY SHERIFF'S DEPARTMENT

"The experience was very expensive and embarrassing!" - a Department member disciplined for an alcohol-related incident.

"I thought everything might be okay, but then the officer asked me to do FSTs and I thought, 'This isn't good.'" - a Department member arrested for driving under the influence.

"Well, I have to admit, it's been a life-changing experience for me." - a Department member arrested for driving under the influence.

As community leaders, employees of the Sheriff's Department assume a significant responsibility in protecting and serving the public. Consequently, high standards and high expectations are placed upon our conduct. As a result of our Core Values and dedication to duty, our employees enjoy a considerable level of public trust. In order to remain beneficiaries of that trust, we must balance the rights of our employees with the responsibility to maintain the highest standards of professional and personal conduct.

Over the course of the last several years, a number of Department members have brought discredit to themselves, their families, and the Department by choosing to consume alcohol to the point where their behavior required the attention of law enforcement officers. In the majority of these cases, the employees' conduct resulted in their detention or arrest for one or more alcohol-related offenses, including public intoxication, driving under the influence of alcohol, sexual misconduct, domestic violence, discharging/brandishing a weapon, and assault with a deadly weapon.

Employees who have been detained or arrested for alcohol-related offenses come in all ages, from all experience levels, and every division within the Department.

The Department has employed a number of strategies in the recent past to raise awareness and reverse this alarming and troubling trend. The Office of the Undersheriff publishes weekly informational bulletins to all employees about the circumstances that resulted in employees being arrested. Risk Management Bureau published a newsletter summarizing the significant financial toll a single drunk driving arrest can take over the course of a lifetime.

Internal Affairs Bureau has made presentations to more than 1,000 employees about the personal and professional consequences of being involved in an alcohol-related incident. The Bureau of Labor Relations and Compliance has designed and incorporated graphic images that appear during the initial login process on every Department computer. Sheriff's Headquarters Bureau has distributed relevant information via the Department-wide Digital Briefing Boards.

Importantly, we are also fortunate to have the longstanding services of a wide range of

professionals who are ready to assist Department members before there is an incident. Employee Support Services Bureau, including the Chaplain Program, Peer Support Program, and Counseling and Consulting Services, provides the foundation for early intervention. They are available away from Sheriff's Department work assignments and are free and confidential to all employees. Skilled professionals are prepared to provide referrals to other resources as needed.

In addition to these educational, informational, and counseling opportunities, the Department has significantly increased the discipline guideline range for violations of alcohol-related policies. Meanwhile, Education-Based Discipline alternatives have been offered and their availability expanded.

Despite these and other innovative approaches, arrests of employees are often compounded by a number of aggravating factors. These include traffic collisions, participation in other criminal misconduct, and even the inexplicable lack of cooperation and/or disrespectfulness directed toward the arresting officer.
Unit commanders are required to immediately notify Internal Affairs Bureau and immediately respond to the member's location if the member is arrested and taken into custody. In addition, unit commanders shall, after being notified of an employee in their command who has been arrested, detained, or named as a suspect and the incident is accompanied by any aggravating factor (especially those enumerated above), give strong consideration to relieving the employee of duty during the course of the subsequent criminal and/or administrative investigation. Founded investigations accompanied by significant aggravating factors may subject the employee to discharge.

As a result, an innovative measure has been implemented.

In addition, any off-duty employee who is arrested, detained, or named as a suspect in a criminal matter and the consumption of alcohol is confirmed, alleged, or suspected shall be required to have a personal meeting with the Undersheriff. During this meeting, topics such as training, experience, career goals, and job satisfaction will be discussed.

Employees of our great organization have an affirmative duty to avail themselves of any Department resource they believe would enhance their professional and/or personal development, as well as their ability to meet the very highest standards expected of law enforcement professionals.

If you know of a person in need, or if you are that person, show the courage and leadership it takes to do the right thing. Lead by example, don't become one.

Unsecured Weapon Used in Shooting

While a deputy was vacationing out-of-town, his off-duty firearm, Department-issued flat badge and Sheriff's Department identification was stolen from his personal vehicle, which was parked and left unlocked in the driveway of his residence. Because the deputy believed he lived in a "safe" neighborhood, he did not regularly lock his vehicle. His personal weapon was kept in the unlocked glove compartment.

After the deputy's weapon was stolen it is believed that it was used by a suspect in two shooting incidents involving officers from a local police department. At the first incident, officers responded to an indecent exposure call and encountered the suspect in a hotel parking lot. As the officers arrived, the suspect entered his vehicle and shots were fired. One officer was shot in the leg. Authorities could not determine whether or not the deputy's stolen firearm inflicted the officer's non-threatening leg injury. The suspect fled the scene.

Several hours later, officers again encountered the suspect driving on a highway and a vehicle pursuit commenced. At the end of the pursuit, the suspect crashed and disabled his vehicle. He then exited his car with a handgun and exchanged gun shots with officers. During the exchange, a female motorist was shot and wounded. The suspect was fatally wounded. The officers were not injured. The deputy's personal weapon, flat badge and identification card were recovered from inside the suspect's vehicle. The local law enforcement agency notified the Department of its discovery and an internal investigation was initiated.

The Department has a policy entitled "County Property and Equipment" that reads, in pertinent part,

> *…Reasonable and prudent precaution shall be taken to prevent the loss or theft of County property. Exceptional care shall be exercised to prevent the loss or theft of security items such as evidence, weapons, radios, vests and tasers.*
>
> *Loss or preventable theft of County Property when the circumstances indicate that a greater degree of caution should have been taken to prevent such loss or theft, willful or negligent abuse, misuse, damage or destruction, shall be grounds for disciplinary action.*
>
> *A parked vehicle left unattended on the street or in a driveway is particularly vulnerable to theft or burglary. Therefore, personnel shall assure that any County vehicle or any personally owned vehicle which contains County equipment is parked in a safe location and that any firearm, portable radio, evidence, confidential documents or high value County property are secured in the vehicle's trunk, in a rack or a locked container (when available). All weapons shall be removed from any vehicle parked overnight outside of a secure garage…*

Arguably, a strict reading of the policy would have only justified discipline for the deputy's failure to properly secure the "County" items i.e. the Department-issued flat badge and Sheriff's Department identification. OIR and the Department agreed, however, that the spirit of the policy promotes the security of all sensitive and vulnerable items whether they are County property or personally owned. As such, a more liberal and sensible reading of the policy requires Department members to exercise extra precautions when securing their weapons—including off-duty firearms—and remove them from any vehicle parked overnight outside of a secure garage. The deputy received significant discipline for violating this Department policy.

Form 700: Additional Training on Reporting Requirements

Last year, in our Seventh Annual Report, we wrote about how an investigation involving alleged acceptance of gifts and gratuities resulted in systemic reform involving compliance to the California Political Reform Act ("CPRA"). As we indicated, the CPRA requires that certain managerial Department employees report the receipt of all gifts valued at more than $50 and prohibits accepting gifts from a single source totaling more than $420. We reported favorably on the systemic efforts made by the Department to provide additional training on the CPRA requirements.

Since that time, a past incident involving alleged violations of the CPRA has been resolved. In that case, it was alleged that some years prior, a Department executive failed to report on his 700 form a gift he had received. It was further alleged that this same executive received two additional gifts that were over the single source value limit, as delineated in the CPRA. The investigation revealed that, in fact, the executive violated the CPRA with regard to these three items.

However, the investigation also discovered important mitigating factors to the transgressions. First, it was noted that while the violations were newly discovered by LASD, the violations stemmed from actions that occurred nearly a decade prior. Second, as with every designated LASD employee, the Department noted that it shared the blame for failing to train its managers regarding the parameters of the CPRA. While ignorance of the law cannot excuse policy violations, the lack of guidance provided employees is often considered in fashioning an appropriate response.

Accordingly, the Department determined that the allegations should result in a "founded" charge but in lieu of discipline, the employee agreed to share with other command staff the "lessons learned" from the investigation. The employee also

agreed to talk to newly promoted captains about the importance of complying with the reporting requirements of the statute. OIR concurred with the handling of this incident and agreed that the Department could better benefit by having the executive reflect on his transgressions and share with others the "lessons learned".

In addition to making a "teaching moment" out of this incident, the Department has made strides in providing training to those employees who fall within the reporting requirements of the CPRA. It has also developed a review and tracking system of the forms filed pursuant to the statute.

While ignorance of the law cannot excuse policy violations, the lack of guidance provided employees is often considered in fashioning an appropriate response.

Off Duty Security Work by LASD Command Staff

Generally speaking, LASD personnel may apply for permission to work outside security. LASD policy has certain restrictions on secondary employment. The decision to grant permission to work outside security rests within the discretion of the Department.

During this past year, OIR was informed that three Department executives were working outside security positions at business establishments. OIR brought this fact to the attention of the Department who determined that the secondary work was not consistent with their roles in the organization. As a result, the secondary work assignments were terminated.

While OIR agrees that the option to pursue secondary employment should remain within the purview of LASD employees, the Department- must remain vigilant to ensure that such employment is consistent and does not conflict with the primary responsibilities of its members.

Probationary Employees

Newly hired Department employees, including sworn personnel, serve an initial one year probationary period. If, during that period, an employee engages in on-duty or off-duty misconduct or performs his or her duties unsatisfactorily, the Department can release the employee from probation and terminate his or her employment. Depending on the circumstances, the Department may also demote the employee. In 2009, due to criminal conduct or administrative violations, nine deputies failed to

complete their probationary period.

Among the criminal conduct committed included public intoxication, domestic violence, vehicular hit and run, driving under the influence, disorderly conduct and theft. The administrative policy violations included excessive or unreasonable force, false statements during an investigation and general behavior and performance issues.

Of the nine probationary deputies, five were demoted to custody assistant positions and one accepted a position as a security officer. The remaining three probationary deputies were discharged. The following are summaries of the discharge cases.

Case

While on probation, a deputy entered a plea agreement and was convicted for a prior theft charge. The deputy failed to disclose during the Department's background investigative process that he had a criminal charge pending. He also failed to notify the Department of the subsequent conviction. The deputy has appealed the discharge.

Case

On several different days, a probationary deputy was absent from work without the appropriate permission. When confronted about the unauthorized absences, the deputy lied that she had received authorization from a supervisor. On another occasion, the deputy lied about remaining at home when she claimed to be ill. An investigation also revealed that the deputy altered a doctor's note to cover all the days that she was absent.

Case

A probationary deputy was terminated after an internal investigation showed he used unreasonable and excessive force against an inmate. Without any apparent threat posed by the inmate, the deputy had mounted the inmate, straddled him and delivered elbow strikes to his head. One witness stated that during the deputy's use of force, the inmate's head bounced off the floor and that he appeared unconscious. In order to stop the deputy's use of force, other department personnel had to "rip" the deputy off the inmate. The inmate suffered a number of injuries, including serious head trauma that required major surgery.

OIR will continue to monitor the probationary cases and will report on any further

developments.

Updates on Cases Involving Sworn Personnel

Theft Cases

In our last report, OIR reported that it was monitoring three theft cases involving a deputy, sergeant and lieutenant. The following is an update on the dispositions of those criminal and administrative investigations. We also discuss another theft incident that occurred in 2009 involving a sworn member of the Department.

Deputy
In 2008, a deputy stole a pair of sunglasses from an optometrist's store. Despite the fact that the crime was captured on the store's video surveillance system, the District Attorney declined to file criminal charges. The administrative investigation concluded that the deputy's conduct violated Department policy which warranted discharge. However, the deputy elected to retire before the discharge was imposed.

Sergeant
In late 2007, an off-duty sergeant attempted to steal DVDs from an electronics store. The Department conducted an administrative investigation and determined that discharge was warranted. OIR concurred with the Department. The sergeant grieved the discipline and exercised his right to appeal to the Civil Service Commission. OIR will continue to monitor this appeal.

Lieutenant
In early 2008, an off-duty lieutenant shoplifted a gardening tool. When local police arrived, the lieutenant tried to flee on foot and fought with police officers. The criminal and administrative investigations concluded. The local District Attorney filed misdemeanor criminal charges, including shoplifting, resisting arrest and fighting in public. As part of a plea bargain, the lieutenant pled no contest to resisting arrest and fighting in public. The shoplifting charge was dismissed. OIR recommended, and the Department agreed, that the lieutenant should be discharged. Before the discharge was imposed, the lieutenant resigned from the Department.

2009 Theft Incident

In early 2009, a deputy entered a non-public storage room at a golf course and took an expensive putter from a member's golf bag. The theft was captured on the club's security camera. A club manager contacted the deputy, advised him that he was

captured on videotape taking the putter, and informed him that if he did not return it law enforcement authorities would be contacted. The deputy returned the putter and told club personnel that he had lost his putter there on a prior date and thought the putter he took was his.

The local law enforcement agency presented its investigative findings to the local district attorney who declined to file charges against the deputy. OIR will continue to monitor the Department's administrative investigation of this matter.

Perjury

As reported in our Seventh Annual Report, the Department initiated two separate administrative cases on two deputies who allegedly made false statements under oath. These cases were brought to the Department's attention by the Office of the Public Defender.[15] In both cases, the Department's Internal Criminal Investigations Bureau conducted a criminal investigation of the alleged perjury charges and presented the results to the District Attorney's office.

In one case, the District Attorney has yet to make a determination about whether to file charges. The other case, however, resulted in the District Attorney filing one felony count of perjury under oath and one misdemeanor count of filing a false report. The deputy entered a plea bargain deal and pled no contest to the misdemeanor count; the felony count was dismissed. The following is a summary of the concluded criminal case.

During a routine patrol, the deputy detained three individuals at a public parking lot. Two of the three individuals were arrested—one for possession of narcotics and the other for an outstanding warrant.

According to the deputy's arrest report and court testimony, before detaining the three individuals, the deputy ran a warrants check on the car they occupied. Because the Mobil Digital Terminal ("MDT") returned numerous warrants to the registered owner's address, the deputy contacted the occupants in the car to determine whether any of them were the subjects of the warrants. The deputy reported that he conducted a pat-down search of one of the male individuals and then obtained consent to look inside the individual's wallet for proof of his identification. Inside

15 The direct referral from the Public Defender cannot be overlooked as it shows some evidence in the Department's ability to investigate itself as demonstrated by the outcome here. In our experience, it is too frequent when Public Defenders in other jurisdictions do not bother making such referrals because of an inherent distrust of the police being able to investigate their own.

the wallet the deputy found a baggie containing cocaine. The deputy further reported that the individual stated that the cocaine belonged to him.

At the subsequent court hearing, contrary to the police report and deputy's testimony, the MDT records revealed that when the deputy ran the car license plate for warrants there were "no hits" on the registered owner. The MDT also recorded that there were "no hits" when the deputy ran the driver's license of the individual who was arrested on the narcotics charge. Approximately one minute after the individual was arrested, the deputy ran the license plate a second time and again, it returned with "no hits" for the same registered owner. Finally, the deputy ran the registered owner's address for warrants and it returned with eleven outstanding warrants for multiple individuals. None of the returns, however, were for the registered owner's apartment number.

On cross examination, the deputy testified that he may have made a mistake and contacted the three individuals prior to running the registered owner's address. Finding that the MDT records were in "complete odds" and "completely irreconcilable" with the deputy's court testimony, the judge suppressed the seizure of the illegal narcotics and the case was dismissed. It was clear that the warrants on the apartment complex were discovered twenty minutes after the deputy contacted the individual who was arrested for possession of narcotics.

After the criminal case concluded, the Department commenced an administrative review of the deputy's conviction. OIR will continue to monitor the Department's review of the pending cases.

Discharge Sustained by the Civil Service Commission

In early 2007, a deputy was discharged by the Department based on the results of three separate IAB investigations. The first investigation related back to an incident that occurred in September 2005, when the off-duty deputy displayed a handgun in a threatening manner toward a taxi driver. The deputy was on his way to work in his personal vehicle when a taxi cab swerved toward the deputy's car. The deputy drove up toward the taxi cab and pointed a blue steel handgun at him. The deputy denied he pointed the gun at the taxi driver but acknowledged he owned and carried a blue steel off-duty weapon. The investigation revealed, however, that he had told a fellow deputy that he had pointed the gun at the taxi driver.

Later that same day, while on-duty, the deputy saw the taxi driver and pulled him over, called him a "f***ing Iraqi" and threatened him, shouting, "I should have shot you for this. I should have killed you for this. You tried to put me into the curb." He then told the taxi driver, "Every time I see you…I will f*** you over and I will report

you to INS." The taxi driver immediately reported the incident to the Department. The investigation revealed that the deputy had failed to note his contact with the taxi driver on his Daily Worksheet, as required by Department policy. Also, during the investigative interview about his contact with the taxi driver, the deputy made false and/or misleading statements.

The second investigation related to the deputy being absent on three shifts in April 2006. The deputy admitted that he had not obtained permission for the dates in question.

The third investigation was prompted by citizen complaints that the deputy was rude and unprofessional during calls for service. The deputy admitted that he was rude and inappropriate and hung up on each of the callers. He explained that he was stressed by a number of factors, including being investigated for the taxi driver incident.

The deputy appealed the discharge and the matter was heard by a hearing officer in early 2008. After considering all the testimony and evidence, the hearing officer sustained the discharge. The decision was based primarily on the taxi driver incident. In her own words, the hearing officer stated:

> *…[P]ointing a weapon in response at [the taxi driver] and later threatening him, as well as his denying in the IAB interview that he pointed his gun at [the taxi driver] or that he threatened him are sufficient, in and of themselves, to justify the discharge. Under the Brady standard, [the deputy's] usefulness to the Department is very seriously impaired…[The deputy] seems to have been a fine officer most of the time, but the times he wasn't are so severe that they cannot be balanced out.*

In early 2009, the Civil Service Commission upheld the hearing officer's findings of fact and sustained the discharge.

PART SIX

The Discipline Process

The Discipline process has always been an area of major concern to OIR. Fair, effective and timely discipline is vital to the maintenance of internal order and respect for Departmental policies and standards. This section revisits the innovative program of Education-Based Discipline, instituted by the Sheriff in 2008, which has received national recognition. The program is an excellent work in progress which OIR continues to monitor and advise for its improvement. This section also looks at the Pre-Disposition Settlement Agreement process in the field of discipline. OIR continues on the alert to make certain that Departmental executives do indeed consult on disciplinary decisions. That this consultation may not occur remains a foremost OIR concern.

Education-Based Discipline Update

In our Seventh Annual Report, we described a project the Sheriff launched in 2008 In our Seventh Annual Report, we described a project the Sheriff launched in 2008 to create an alternative to the traditional disciplinary system by which personnel received suspensions for misconduct. The new system—called "Education Based Discipline" or "EBD"—was implemented in May, 2009. The concept is rooted in the Sheriff's belief that the traditional relatively arbitrary "days off" discipline may unfairly burden an employee's family and does not require the Department

leaders to engage with the employee in a way that could benefit the employee and reduce the likelihood that the misconduct will reoccur. With EBD, most disciplined employees who otherwise would have received unpaid suspension days can opt for an education-based plan specifically designed to remediate past transgressions and improve future behavior.

Implementation of the EBD system has not changed the way disciplinary decisions are made, and much of the process for imposing discipline remains the same. When a captain decides to discipline an employee, he or she assigns a number of suspension days appropriate to address the misconduct at issue and notifies the subject of this decision in the usual way. At the same time, the captain presents the employee with a proposal for EBD pursuant to which an employee, instead of serving all or some of the suspension days, is tasked with taking certain classes, conducting briefings, attending counseling sessions, writing a responsibility memo or letter of apology, or doing any number of other projects a captain may find appropriate with the goal of remedying the employee's shortcomings. If the employee elects to complete the EBD plan, he or she relinquishes the right to appeal the disciplinary decision through the Civil Service process, but also does not lose any income for those days he or she otherwise would have been suspended. The employee's personnel record will show the suspension days, but also will indicate the employee chose an EBD plan.

With EBD, most disciplined employees who otherwise would have received unpaid suspension days can opt for an education-based plan specifically designed to remediate past transgressions and improve future behavior.

Based on statistics from the past two years, roughly 350 to 400 employees receive some form of discipline each year. The majority of the discipline handed out by Department leaders—between 60 and 70 percent—is relatively minor, a suspension of five days or fewer. Only around three percent of those disciplined receive 15 – 30 day suspensions, one to two percent face demotion, and five to ten percent are discharged.

Barring some exceptional circumstances and approval of the Division Chief, employees are to be given the option of EBD in lieu of the first ten days of his or her suspension. For any additional suspension days, the employee's unit commander may provide an EBD option or may choose to require the employee to serve some actual days off. Employees who face serious discipline, such as a demotion or discharge, are not provided the option of completing an EBD plan to avoid those consequences.

One requirement of all Education Based Discipline plans is attendance and participation in an eight-hour class entitled "Lieutenants' Interactive Forum for Education" or LIFE class. As the name suggests, this course is facilitated by Sheriff's Department lieutenants and is designed to be participatory, with students breaking into small groups for various discussions and exercises. The goal of the class is to distill the factors that go into effective decision making and to help students understand the influences that may cause them to make poor decisions. OIR monitored this class in its development stages and believes that the class will have a positive effect on employees whose poor judgment created the circumstances for which they received discipline. Students' evaluations seem to support this conclusion, as more than 80 percent of the 70 students who took the course in 2009 agreed they would make better decisions as a result of attending the LIFE class. The following are excerpts from evaluations written by EBD participants:

"The Education-Based program provided the opportunity to learn essential decision making tools in order to make yourself a more productive individual and employee."

"This course refocused me toward the mind set of thinking outside the box for solutions in all aspects within the department…This course is not only beneficial for those participating in Education Based Discipline, but for each and every employee of the department. This truly is cutting edge."

"Overall, the entire Education Based Discipline curriculum was an excellent opportunity to develop new ideas which not only benefit myself, but also my peers and subordinates."

"I am grateful for the opportunity to participate in this program and look forward to imparting my knowledge on others."

Beyond the LIFE class, unit commanders have wide discretion in what can be included in the EBD plan they propose to their disciplined employees. In one case, for instance, a training regiment was included in an EBD plan to specifically address a deputy's poor tactics during a shooting incident (i.e. failure to establish a safe plan before approaching a suspect, failing accurately assess or anticipate the level of threat posed by the suspect and failing to immediately communicate that threat to his partner):

- Behavior Stress Management Class
- Tactical Communications Course
- Inoculation Training
- Stress Training
- Weapons Training
- Shoot, Don't Shoot Training

The Department conducts a number of established classes that it is offering with greater frequency to meet the needs of EBD participants, including classes on anger management and effective communication, self control, critical decision making, tactical communications, force decision making, and stress management, as well as some longer, multi-day courses addressing general leadership skills. In addition, unit commanders may offer what the Department calls "Independent Study Teach to Learn" options, which include alternatives such as preparing and conducting briefings, writing responsibility memos or letters of apology, and relevant community service.

The Department's EBD program has received a great deal of attention nationwide. The unit charged with implementing EBD has received informational requests from more than 100 other law enforcement agencies and has conducted more than 20 briefings for various agencies and organizations, including the National Sheriff's Association and the International Association of Chiefs of Police. Some local agencies have even begun sending their employees to the Department's LIFE classes.

OIR has always supported creative and more tailored forms of discipline by which an employee may improve his or her own performance, have an impact on the Department through the effective dissemination of lessons learned, and/or improve relations with the public through outreach and meaningful acceptance of responsibility. We will not be able to measure the success of the EBD program for some time, though, as we look at the future careers of those who have completed EBD plans and assess how well they avoid further disciplinary actions. OIR remains optimistic about the Department's new EBD system, with a couple of cautions. First, because the Department mandates that EBD classes be completed while employees are on duty, we will be monitoring how well units balance this obligation against substantive training requirements and goals. Units should not have to sacrifice the kinds of training its non-disciplined employees require for skills maintenance and career advancement so that disciplined employees can attend EBD classes. Second, OIR is concerned that unit commanders will view the list of available EBD classes simply as a way for an employee to earn a requisite number of credits and will not employ the kind of innovation or creativity that might most effectively remediate a disciplined employee. Because OIR has an established role in the disciplinary process, we are well-positioned to monitor the Department's implementation of the new EBD program and will continue to do so.

Pre-Disposition Settlement Agreements

Not every alleged misconduct case requires a full internal investigation. Cases where the facts are not disputed, the misconduct is of low to moderate seriousness and the

proposed discipline would not exceed fifteen days suspension may be disposed of by utilizing a Pre-Disposition Settlement Agreement ("PDSA"). One of the other key components to determining whether a case is suitable for a PDSA is if the employee is prepared to take full responsibility for the misconduct. The admission can be acknowledged by the employee in a written statement or in a verbal assertion made in a taped interview. If all these components are present, a PDSA can be a convenient, time-efficient and fair alternative to resolving the matter and obviating the need for a conventional investigation. The Department has recognized the advantage of utilizing the PDSA and, in the last two years, has made steady use of them.

In keeping in line with OIR's oversight responsibilities, the Department has agreed to consult with OIR on anticipated PDSAs before committing to a disciplinary decision. Moreover, for purposes of consistency, protocols require approved by the Captain of Internal Affairs. And, while OIR agrees that the use of a PDSA can be an efficient and useful tool in the discipline process, there have been instances where reports associated with the incident revealed additional probing was necessary.

Case

In 2009, an off-duty deputy was arrested for disorderly conduct at a night club. After the District Attorney's Office declined to file charges, the unit requested that the case be resolved by utilizing a PDSA. The incident report, however, mentioned that the deputy was "belligerent." At the urging of OIR, the unit conducted further inquiry about the deputy's conduct that night which ultimately resulted in allegations that he may have started a fight, was rude and yelled profanities at both the security guards and responding law enforcement officers. These revelations compelled the unit to request a more formal internal investigation. OIR continues to monitor the case.

Case

In this case, a deputy was arrested for vandalism for slashing the tires of his soon-to-be ex-wife's car. When consulted on the proposed discipline and PDSA request, OIR noticed that the arrest report mentioned a previous domestic violence incident involving the deputy. OIR requested the unit obtain more information about the incident. The unit conducted an inquiry and learned that the deputy was the victim, not the aggressor and thus, no further action was warranted. OIR ultimately concurred with the PDSA and proposed discipline in the vandalism case.

Case

In another case, a deputy was involved in a vehicle collision on the freeway. The investigating law enforcement agency determined that the deputy

was at fault for the accident. In a request to dispose of the matter using a PDSA, it was represented that the deputy was "off-duty" at the time of the incident and that he had no prior disciplinary history. OIR requested to review the traffic collision report and learned, after some follow-up, that the deputy was "on-duty", was not wearing his seatbelt and that he did, in fact, have a prior disciplinary history. Based on these new facts, OIR recommended that the initially proposed discipline in the PDSA be increased.

Failure to Consult OIR During Appeals Process

OIR worked hard in its initial years to get Department executives to consult with OIR prior to making disciplinary decisions. While we still sometimes have to remind the Department of its agreement to do so and are occasionally left out of the decision-making loop, OIR's consultative role is firmly established. Unfortunately, staying in the loop through the entire appeals process has proven to be continually challenging, even for the Department executives who made the disciplinary decisions.

In one case, a deputy was given a one day suspension for failing to provide appropriate medical care to a juvenile in his care as part of the Department's VIDA ("Vital Intervention Directional Alternatives") program. In that same case, another deputy also received a one day suspension, and a lieutenant got three days off. Both the second deputy and the lieutenant served their suspension time without grievance. The first deputy appealed his suspension and, a year and a half later, the Department Advocate responsible for handling the case before the County's Employee Relations Commission settled the case by rescinding the one day suspension and changing the findings to "unresolved." Neither OIR nor the Chief responsible for the disciplinary decision was consulted.

OIR met with the Advocate and the Chief to discuss our concerns about this erosion of discipline. While we were satisfied with the outcome of that meeting, it remains an ongoing struggle to stay on top of cases that may be settled years after the initial discipline is imposed.

PART SEVEN

A Review of the Department's Hiring Process and Standards

In 2008, OIR began a review of the Department's background investigation process for its deputy positions. The Background Investigations Unit ("BIU") of the Department's Personnel Bureau conducts these investigations. OIR's interest in reviewing the Department's hiring process was heightened when OIR had discovered that several newly hired deputies had engaged in misconduct. In 2009, after a review of hundreds of background files (dating from 2003-2008), OIR issued its report. In the report, OIR discussed the Department's general hiring process, assessed the quality and completeness of the background investigations, identified potential vulnerabilities in its evaluation standards (including the handling of "Friends of the Sheriff" applicants) and highlighted issues related to psychological evaluation process. The report concluded with a list of recommendations designed to improve the Department's background investigative process.

The Hiring Process

During the Department's hiring process for a sworn position an applicant must pass a written and medical examination, participate in a series of interviews and be subject to a polygraph examination and psychological evaluation. Once an applicant completes the background investigation phase he or she is eligible to enter the Sheriff's Training Academy. If the deputy sheriff trainee graduates from the

academy, he or she is assigned as a deputy to a unit within the Department and is on probation for at least twelve months. During the probation period, the Department can terminate the deputy for any reason. When a deputy completes the probationary period, he or she becomes a permanent deputy sheriff with Civil Service rights and protections.

From 2005 through 2007, the Department conducted a vigorous recruitment campaign, which resulted in more than 2,500 deputies being hired during this period. Interestingly, while the push to hire deputies was occurring there was a striking decrease in the percentage of applicants disqualified during the background investigation process as compared to those disqualified in 2004. Also, while the Department technically adhered to its official internal standards, it developed a new "holistic" approach, which required hiring personnel to look at negative information as just one aspect in the entire applicant's history. This "holistic" approach resulted in the hiring of individuals who would have been automatically disqualified in years past.

From 2005 through 2007, the Department conducted a vigorous recruitment campaign, which resulted in more than 2,500 deputies being hired during this period.

Between 2003 and 2008, the Department had a substantial increase in the number of background investigations. The number of investigations initiated and deputies hired increased each year until 2008. Then, the number of investigations remained high but the number of deputies hired substantially decreased. Also, during the hiring push, the Department exceeded the minimal requirements set out by California's Commission on Peace Officer Standards and Training ("POST") for background investigations. For instance, the Department's background investigation process includes a polygraph examination but is not mandated by POST. Because the polygraph can detect deception, applicants respond candidly about questionable behavior or activity. This type of elicited information is helpful in the hiring process because it allows the Department to make additional inquiry into specific areas.

In the course of its review, OIR also examined BIU's structure and its potential impact on how background investigations were conducted. During the hiring push years, many professional staff and BIU deputies and sergeants were re-assigned to different units. According to some affected personnel, this change left BIU with a new group who lacked experience in conducting background investigations.

The BIU lieutenant supervises the Department's background investigation process and reviews certain completed background investigation files. The BIU lieutenant

supervises seven sergeants who each have a team of background investigators. The lieutenant reviews the intake page of all completed background investigation files and the entire file of all applicants who are recommended for disqualification. During the lieutenant's review of disqualified applicants, the lieutenant ensures that the background investigations are thorough, that there was no bias in the recommendation for disqualification. The lieutenant also selectively reviews background investigation files for those applicants who are recommended for hire but are noted as having a clinical interview "with concerns."

OIR believes it is critical to ensure that peace officers have the necessary talent, skill, and judgment to exercise the authority to use force and take persons into custody. Thus, the lieutenant should be using the Department resources to review all the "for hire" applications.

The Background Investigations

With significant exceptions, OIR found that the large majority of background investigations conducted by BIU were objective and thorough. That said OIR found that there were some variances in the investigators' assessment of the "warning signs" elicited through the background process. For example, in some instances, investigators failed to verify possible criminal activity with local law enforcement agencies and neglected to probe further into an applicant's questionable explanation of negative information. OIR also discovered instances in which there was a seemingly under appreciation of "warning signs" (e.g., alcohol or drug abuse, criminal activity, negative credit history, and disqualification or termination by other law enforcement agencies).

From 1999 to 2006, the Department maintained a "rigid" application standard. Under the "rigid" standard, if the applicant's background showed any questionable or prohibited activity, BIU would disqualify the applicant. Under the "holistic approach," an occurrence of questionable or prohibited activity alone does not generally disqualify an applicant.

The potential drawbacks of this more liberal approach were compounded by the Department's failure to provide written guidance regarding how to implement the new philosophy. Neither the contract psychologists (who conduct the psychological evaluations) nor the BIU background investigators received formal training and thus, they were left to make their own interpretations regarding the appropriate application of the Department's new approach. A few former BIU background investigators suggested that the increase in applicants coupled with the discretion to evaluate applicants "holistically" the Department compromised or relaxed its standards to the point where a significant number of questionable applicants

were passed on to the next phase of the process. Indeed, it is evident that the Department's approach resulted in the hiring of applicants who would not have been hired in years past.

"Friends of the Sheriff"

During its review, OIR learned of a "Friends of the Sheriff" ("FOS") list. The Sheriff himself, however, knows virtually none of the individuals on the list. The FOS list might more aptly be titled "Applicants Who Know Someone on the Sheriff's Department."

In reviewing a sampling of those applicants on the FOS list, OIR determined that there is no evidence that these applicants routinely received preferential treatment during the background investigation process. If anything, these applicants received greater scrutiny.

The Psychological Evaluation

The Department contracts with independent psychologists who conduct the psychological evaluations of deputy applicants. From 1983 to 2002, the Department contracted with only one psychologist who conducted all the evaluations. From 2002 to 2007, the Department used the three contract psychologists.

...OIR reviewed two cases that exposed the need for uniformity in how psychologists disqualify applicants.

Prior to a psychological evaluation, an applicant takes a personality test. Along with the test results, the psychologist received a packet of selected information from the applicant's personnel file which was compiled by BIU. During interviews with contract psychologists and BIU personnel, there was no persuasive argument advanced for why the psychologists should not receive the entire personnel file. After discussions with OIR, BIU began providing the contract psychologist with an applicant's entire file.

Former BIU personnel stated that after the personnel changes in 2006 communication between BIU investigators and contract psychologists about applicants was limited. Two contract psychologists opined that the decrease in information may have been attributable to the increase in the volume of applicants and the increased demand on the investigator's time.

Despite these revelations, for the most part, OIR found there were no meaningful differences in the disqualification rates of the three contract psychologists. However, as discussed below, OIR reviewed two cases that exposed the need for uniformity in how psychologists disqualify applicants.

Deviation from the Psychological Disqualification Appeals Process

In 2006, there were two disqualified applicants (disqualified by the same contract psychologist) who proceeded through the appeals process. Typically, when an applicant is disqualified, the applicant can elect to wait a year and then re-apply or file a formal appeal with the County's Department of Human Resources. If an applicant, however, has been disqualified as a result of a psychological evaluation, the applicant can request a second psychological evaluation. Under this process, the applicant usually incurs the expense for his or her own psychological evaluation, submits those independent results to the Department of Human Resources, and requests the County of Los Angeles conduct a third psychological evaluation. Under these circumstances, the county psychologist who conducts the third psychological evaluation is not one of the psychologists under contract with the Department.

In both these 2006 cases, BIU assigned the same contract psychologist to perform the initial psychological evaluations. When the contract psychologist disqualified both applicants, a former BIU lieutenant scheduled each applicant to receive a second psychological evaluation. The second evaluations were conducted by a psychologist under contract with the Department, not a county psychologist. Departing from standard practice, neither applicant was required to retain his or her independent psychologist and present those results to the Department or county. Also, neither applicant was required to file a formal appeal with the Department of Human Resources. The personnel files of the involved applicants contained no documentation noting the Department's decision to schedule each applicant a second psychological evaluation, or an explanation for the deviation from established procedure. Former and current BIU personnel stated that the deviation occurred because the Department had received numerous complaints from disqualified applicants, academy admitted applicants, and Department members regarding the initial psychologists who evaluated the two applicants.

From interviews and documents reviews, OIR found no evidence that Department members pressured BIU to deviate from the established appeals procedures in the two cases. While the two cases clearly deviated from the standard Department processes, there was no written Department or county policy that prohibited the unique appeals process. That said, the arguable special treatment afforded the two

applicants in these cases suggested the need for uniformity with regard to how all disqualified applicants (due to a psychological evaluation) appeal their cases. The Department adopted a directive to ensure such uniformity, or at least appropriate authorization and documentation for such deviation.

Recommendations

Based on its review and findings, OIR made provided the Department with recommendations, including, but not limited to:[16]

- Document the reasons for any modifications to the internal guidelines;
- Require background investigators to obtain, or document efforts to obtain documents that verify or refute an applicant's explanation of his or her criminal behavior;
- Audit background investigations to identify any trends or patterns of deficient investigations;
- Ensure appropriate communication with contract psychologists and ensure that any additional information is provided to the contract psychologists;
- Ensure that the BIU lieutenant reviews the entire personnel files of all applicants recommended for hire;
- Require the delivery of the entire completed background file to the psychologist assigned to conduct the psychological evaluation and
- Draft policy and/or procedures requiring that a request for any deviation in appeals process for a disqualified applicant must be in writing and set forth the reasons for the decision and must also be approved by the Captain of Personnel Bureau.

OIR continues to monitor the Department's progress under the implemented recommendations.

16 For the complete report and list of recommendation please visit www.laoir.com.

Summary of Systemic Changes
Year Eight

OIR Identification of Systemic Issue	OIR Recommendation	LASD Response	Implementation of Recommendation
Confusion regarding the Fraternization and Prohibited Association policies.	Revise policies.	Both polices revised.	Yes, see pages 38-40
Insufficient guidance on assessment of suitability of cellmates.	Develop more specific guidelines.	Jail personnel instructed to consider age and discipline history before pairing cellmates.	Yes, see pages 6-11
Use of knee-high socks in an inmate suicide.	Provide inmates with shorter-length socks.	LASD no longer allows vendor to sell knee-high socks to inmates.	Yes, see page 5
Investigative lapses in in-custody interrogations	Provide additional training to detectives.	LASD detectives received training on constitutional rights and “best practice” investigative techniques.	Yes, see pages 18-20
Communication breakdown between the Coroner’s Office and LASD Homicide Bureau.	Develop specific protocols	New protocols about communication with Coroner’s Office and attendance at autopsies were upgraded.	Yes, see pages 35-38
Citizen Complaint Process inefficient.	Standardize process and create alternatives to resolving disputes.	Revised and improved guidelines. Instituted conflict resolution and mediation process.	Yes, see pages 41-42
Vulnerabilities in background investigation hiring process	Create new evaluation standards.	Drafted policy improving hiring procedures.	Yes, see pages 81-86