Reform and Oversight Efforts: Los Angeles County Sheriff's Department

June 2018

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INTRODUCTION

The Office of Inspector General (OIG) is entering its fourth year in existence. What started with just two employees, the Inspector General and his Special Assistant, has now grown into a twenty- plus person office. The office is divided into three sections: 1) Monitoring and Community Outreach, 2) Audits and Investigation, and 3) Review and Analysis. Each of the three sections is supervised by its corresponding Assistant Inspector General. In turn, all three Assistant Inspector Generals report to the Chief Deputy, and ultimately the Inspector General. The three sections job duties and responsibilities are based on the primary functions delineated in the ordinance that created the OIG.[1]

On September 27, 2016, the Board of Supervisors (Board) approved the ordinance creating the Civilian Oversight Commission (COC),[2] which oversees the Los Angeles County Sheriff's Department (LASD or Department). With the creation of the COC, the Board amended and expanded the OIG's original ordinance to include the relationship between the OIG and the COC.

Now the four primary functions of the OIG are as follows:

- Monitoring the Department's operations and conditions in the jail facilities, including the Department's response to prisoner and public complaints.

- Periodically reviewing data on the Department's use of force, the Department's investigations of force incidents and allegations of misconduct and the Department's disciplinary decisions.

- Conducting periodic audits and inspections of Department operations and reviewing the quality of the Department's audits and inspections.

- Regularly communicating with the public, the Board, the COC and the Sheriff's Department regarding the Department's operations.

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[1] *See Los Angeles County Municipal Code section 6.44.190.*
[2] *See Los Angeles County Municipal Code section 3.79 et. seq.*

The amended ordinance also tasks the Inspector General to serve as an agent not only of the Board of Supervisors, but also as an agent to the COC, and to make regular reports to the COC and the Board of Supervisors on the Sheriff's Department's operations. This Quarterly Report, and others published before, along with other periodically published reports, attempt to keep the public, the COC, and the Board of Supervisors apprised of the Department operations.

The OIG Quarterly Report (Report) has functioned as a way for the OIG to provide the Board, the COC and the public greater information and insight into the Department. As the Office embarks into its fourth year of existence, an attempt will be made to expand the amount of information provided in the Report. In the past, the Report has focused on updates to the Citizens' Commission on Jail Violence's (CCJV) recommendations and custody related incidents. In the future, the Report will provide more robust data on disciplinary issues and use of force data. This Report encompasses data gathered from April 1, 2018, until June 30, 2018, unless otherwise specified in the Report.

ACCESS

The Department has continued to provide the Office of Inspector General access in compliance with the December 2015 Memorandum of Agreement to Share and Protect Confidential LASD Information.

MONITORING

Department Use of Unmanned Aircraft Systems

The Department's Unmanned Aircraft System was not deployed this quarter.

Deputy Involved Shootings

Shootings: April 1 through June 30, 2018

The OIG categorizes a Deputy Involved Shooting as any shooting in which: 1) a person was intentionally shot at by a Department member, whether a person was injured by the gunfire or not; 2) another person was injured, including fatally, by the Department member's gunfire, whether intentionally or not; or 3) the Department member shot at a vehicle occupied by a

person, unless it is clear from the circumstances that the purpose of the use of the firearm was to disable the vehicle (i.e. shoot tires).

The Department's definitions of shootings can be found in the Manual of Policies and Procedures, 3-10/300.00. The Department categorizes accidental shootings of persons by the tactical nature of the shooting itself. The Department has added to its data sharing web site a "Persons Accidentally Struck by Gunfire" table to identify those shootings in which a person was accidentally struck by a Department member's gunfire in tactical situations or in situations in which the gun was discharged unintentionally.

The Department's Homicide Bureau investigates all Deputy Involved Shootings in which a person is injured, regardless of the shooting's category.[3]

From April 1, 2018, to June 30, 2018, the OIG responded to four investigations of Deputy Involved Shootings. Three people were injured, none of them fatally. These shootings are described below. The OIG recommends that similar narrative descriptions be provided on the Department's website for all Deputy Involved Shootings. These descriptions are offered to provide an understanding of situations that commonly lead to Deputy Involved Shootings.

Los Angeles The Department reported on April 4, 2018, at about 7:23 p.m., a deputy contacted a male who had been identified as waving a knife and possibly under the influence of a controlled substance. The deputy gave the male commands to drop the knife as the deputy began to retreat away from the advancing male. The male ignored the deputy's command and continued to walk towards the deputy with the knife in his hand. The deputy shot and hit the male's torso. The knife was recovered.

The male was transported to the hospital and survived his wound.

Agoura Hills The Department reported that on May 4, 2018, at about 2:22 p.m., deputies responded to a call of a female threatening suicide with a gun. One deputy contacted the female via cell phone and was able to talk her into getting out of her car and into leaving her gun behind in the car. A

[3] *See Los Angeles County Sheriff's Department Manual of Policies and Procedures 3-10/440.00.*

deputy attempted to physically restrain her to prevent her from gaining access to the gun in the front passenger seat. The female resisted and was able to grab the gun. The deputy fired one shot into the floor board as a warning shot. The shot caused the female to stop resisting and allowed the deputy to take custody of the female.

No one was injured by the gun fire and because it was meant as a warning, the Department does not categorized this incident as a deputy involved shooting.

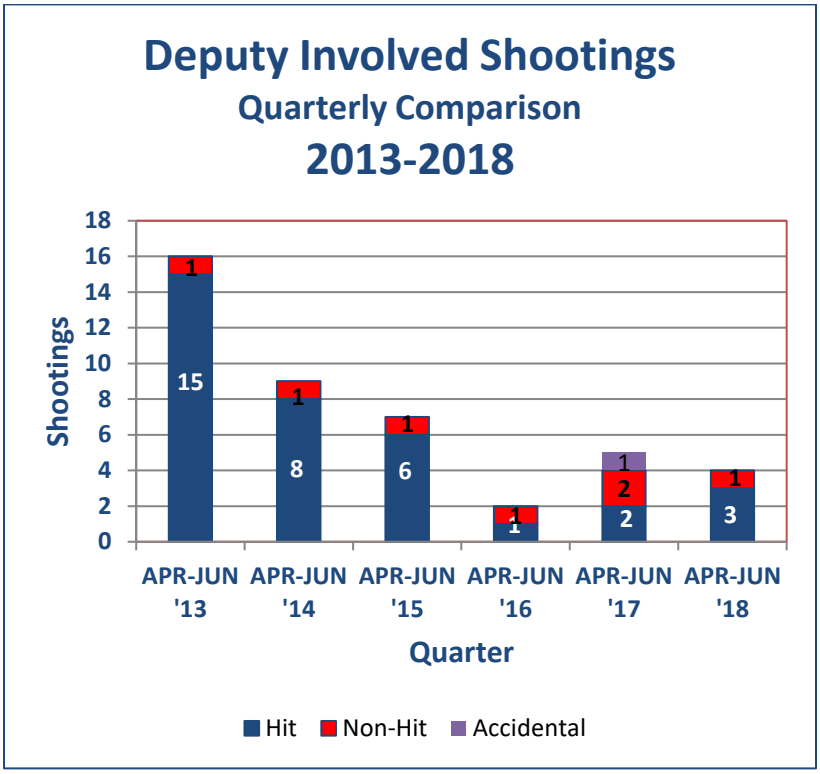
El Monte The Department reported that on May 8, 2018, at about 11:30 p.m., deputies attempted to contact a man who was acting suspiciously. One of the deputies called out to the male pedestrian. The male took several steps away from the deputy before turning and facing the deputy. The male used his left hand to pull up his shirt, and drew a handgun with his right hand. The deputy shot and hit the male in his upper torso.

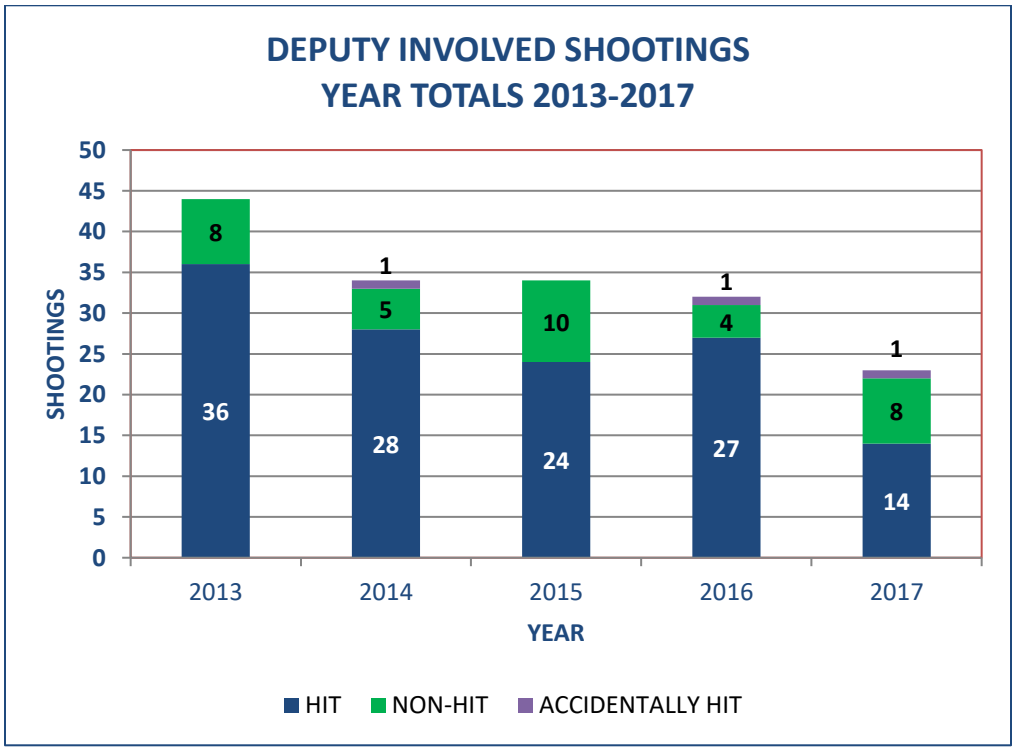
The male was transported to the hospital and survived his wound.

South El Monte The Department reported that on June 28, 2018, deputies responded to reports of a male with a knife trying to gain entry into cars as they passed by him on the street. Deputies arrived and ordered the male to drop this knife. Instead he advanced quickly toward the deputies holding the knife over his head. One deputy fired one shot, striking the man in the chest.

The man was transported to the hospital and survived his wound.

Comparison to prior years





District Attorney Review of Deputy Involved Shootings

The Sheriff's Department Homicide Bureau submits the investigation of each Deputy Involved Shooting which occurred in the County of Los Angeles and in which a person has been injured for review and possible filing of criminal charges by the District Attorney's Office.

Between April 1, 2018, and June 30, 2018, the Los Angeles District Attorney issued findings in eight Deputy Involved Shooting cases.

- In the February 14, 2016 fatal shooting of Eduardo Rodriguez, the District Attorney opined in a memorandum dated June 11, 2016, that two deputies acted lawfully in self-defense and the defense of others and that here was insufficient evidence to prove beyond a reasonable doubt that a third deputy's subsequent volley of shots was unreasonable.
- In the March 16, 2016 fatal shooting of Christian Medina, the District Attorney opined in a memorandum dated April 10, 2018, that the deputies acted in lawful self-defense and in defense of others when they used deadly force.
- In the August 7, 2016 non-fatal shooting of Robert Corral, the District Attorney opined in a memorandum dated June 28, 2018, that there was insufficient evidence to prove beyond a reasonable doubt that the shooting was unlawful.
- In the September 1, 2016 fatal shooting of Joshua Quintero, the District Attorney opined in a memorandum dated June 28, 2018, that the deputy acted lawfully in self-defense.
- In the October 5, 2016 non-fatal shooting of Trenton Lovell, the District Attorney opined in a memorandum dated April 2, 2018, that the deputy acted in lawful self-defense and used lawful force in attempting to arrest Mr. Lovell.
- In the October 31, 2016 fatal shooting of Jose Cueva, the District Attorney opined in a memorandum dated June 29, 2018, that the Department employees acted lawfully in self-defense and the defense of others.
- In the December 15, 2016 fatal shooting of Robert Hess, the District Attorney opined in a memorandum dated June 29, 2018, that the deputies acted lawfully in self-defense and the defense of others.
- In the May 24, 2017 fatal shooting of Luis Garcia, the District Attorney opined in a memorandum dated June 1, 2018, that the deputies acted lawfully in self-defense and the defense of others.

The District Attorney's findings may be found at the District Attorney's web site, http://da.lacounty.gov/reports/ois.

Homicide Bureau's Investigations of Deputy Involved Shootings

Homicide Bureau is responsible for conducting the investigation into shootings in which persons are injured by a Department employee's discharge of a firearm. Regardless of whether the deputy shot intentionally to hit the person injured or it was a result of an accidental discharge, if a person is hit, the Homicide Bureau is responsible for conducting that investigation. After completing its investigation, the Homicide Bureau submits its investigation to the Los Angeles County District Attorney's Office for consideration of filing of criminal charges. If the District Attorney's Office declines to file the case, the Department's Internal Affairs Bureau will then begin its investigation into whether the involved personnel violated any departmental policies when using force.

Going forward, the OIG will report quarterly on the number of deputy involved shooting cases Homicide Bureau is investigating, how old the oldest case is that is still being investigated, and how many are still awaiting filing decisions by prosecutors. For this Report, the data encompasses information gathered from January 1, 2018, until June 30, 2018. As of June 30, 2018, the Homicide Bureau reports having eight open shooting cases involving shootings in Los Angeles County by Department employees that it is still investigating. The Department reports that two completed investigations were pending delivery to the District Attorney and that nineteen cases are at the District Attorney's Office awaiting a filing determination.

The oldest case at the District Attorney's Office awaiting a filing determination is the September 10, 2015 fatal shooting in Downey of Eddie Tapia. The Department reports that this case has been at the District Attorney's Office since July of 2017. The oldest case that the Homicide Bureau is still investigating is from the August 16, 2017 fatal shooting of Kenneth Luis, Jr.

Internal Criminal Investigations Bureau

Internal Criminal Investigations Bureau (ICIB) reports to the Sheriff and Undersheriff. The Bureau is responsible for investigating allegations of criminal misconduct by members of the Department.

Going forward the OIG will report quarterly on the number of cases that ICIB is investigating, how old they are and where they are in the process of being filed with prosecutors. For this Report, the data reported encompasses information gathered from January 1, 2018, through June 15, 2018. The Department reports that ICIB has 63 pending cases. Out of those 63 cases, 18 have been sent to the Los Angeles County District Attorney's Office for consideration of filing of criminal charges. The District Attorney has filed two ICIB cases since January 2018. The District Attorney has rejected four cases since January 2018. There are four pending ICIB criminal cases that have been filed. The District Attorney's Office filed those cases on April 16, 2014, September 14, 2015, January 13, 2017 and February 21, 2018. The oldest open case that ICIB has on its books is from 2012 (the District attorney filed charges in that case on April 16, 2014) and it is pending trial.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) is responsible for conducting administrative investigations of policy violations and/or policy of equality violations by Department members, and responding to and conducting force review investigations of Deputy involved shootings and significant uses of force.

Going forward the OIG will report quarterly on the number of cases that IAB has opened in a quarter, closed in a quarter, how many are still pending and how many employees were terminated in a quarter based on policy related violations. In this Report the data reflects information gathered from January 1, 2018, through June 15, 2018. During that time period, the Department reports that IAB opened 268 new cases. In the same period, the IAB closed 256 cases. There are 347 pending cases on IAB's caseload.

Executive Force Review Committee

The Department outlines in its Manual of Policies and Procedures, 3-10/140.00 the tasks and duties of Executive Force Review Committee

(EFRC). The Committee evaluates every shooting and force incident to which the IAB Force/Shooting Response Team is required to respond. The IAB Force/Shooting Response Team responds to all shootings (that occur both on and off-duty) that involve any Department member. In addition to shootings, IAB responds to significant force incidents such as those in which a civilian requires hospitalization, suffered a skeletal fracture or was hit on the head with an "impact weapon"[4] during a use of force by a Department members.

IAB is required to prepare an administrative review of each incident. The completed investigation is submitted to EFRC so the Panel can determine whether the use of force and the tactics used by Department employees were in conformance with Department policy.

EFRC meets regularly to review and evaluate all of the types of cases listed above. The committee is chaired by a panel comprised of three area commanders, one of whom is designated as the chairperson. In addition, the employee who used force, his/her unit commander, the IAB (and Homicide Bureau, where applicable) investigators on the case, representatives from the Training Bureau, Advocacy Unit, OIG representatives and Risk Management Bureau staff attend these meetings.

The panel is provided copies of the IAB investigation prior to the meeting. Based on these reports, the members of the panel evaluate each incident and determine if the conduct of employees was within established policies and/or consistent with established procedures and tactics. The EFRC panel will then make a finding to determine the level of discipline to impose if the panel determines that the investigation revealed that the employee violated Department policy. In addition, the panel can also recommend that the involved personnel receive additional training.

Per Department policies, the EFRC chairperson will report, in a memorandum to an employee's unit commander, the findings of the panel. If the employee needs further training or needs to be disciplined for violating policies, the chairperson will cite his/her bases for that decision and the corresponding

[4] Per the Department, there is no set definition as to what constitutes as an impact weapon. Anything other than a personal weapon (hands, knee, head butt, etc.) that is used to strike someone can be considered an impact weapon (baton, flashlight, radio, shield, etc.).

Department policy code sections violated. Conversely, if the employee performed exemplarily in the situation, the chairperson will identify that as well in the memorandum.

Going forward the OIG will report quarterly on the number of EFRC cases heard each quarter, including details as to how many related to hit shootings, how many related to non-hit shootings and how many related to other uses of force by Department members. Break downs will be provided as to how many uses of force were found in or out of policy, how many were found to be within Department training and tactical guidelines, how many were found to be in in violation of the tactics promulgated by the Department, and lastly how many of these cases resulted in discipline.

From January 1, 2018, through June 30, 2018, the Department held 11 EFRC meetings. In those meetings they heard 29 cases involving force. The Department heard 8 hit shooting cases, 3 non-hit shooting cases and 18 other use of force cases. The cases stemmed from incidents that occurred as far back as 2013 to as recently as 2017. Out of those 29 cases heard, the Department found that the force was out of policy in one case. It found that tactics were out of policy in two cases. The Department meted out discipline to four employees based on decisions made at EFRC. In all of the other cases the panel found that the employees' uses of force were within policy and that the tactics used were in policy.

Civil Service Commission Dispositions

Going forward the OIG will report quarterly on the number of LASD cases in which the Commission issued a final decision and whether the Commission's decision resulted in discipline other than that imposed by the Department.

For this Report, the data encompasses all final decisions rendered by the Commission between January 1, 2018, and June 30, 2018. During that time period, the Commission issued a final decision in 19 cases. Of these 19 cases, the Commission sustained the Department's discipline in 15 cases; reduced the Department's number of days an employee was suspended by the Department in 2 cases and completely overturned the Department's discipline of termination in 2 cases, resulting in the employee's reinstatement.

Service Comment Reports

Per Department policies, LASD accepts and reviews any and all comments from members of the public that are germane to the Department's service or individual performance.[5] The Department categorizes these comments into three categories:

- "External Commendation: an external communication of appreciation for and/or approval of service provided by Department members;
- Service Complaint: an external communication of dissatisfaction with Department service, procedure or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Department policy, against any member of the Department."

Going forward the OIG will report quarterly on the number of External Commendation reports, Service Complaint reports and Personnel Complaint reports that the Department received in a particular quarter. The chart below lists the number and types of complaints received by each station and/or unit from January 1, 2018, through June 15, 2018.

This data is preliminary and is subject to change as the service comments are reviewed and investigated. The information is provided in an attempt to provide as much transparency as possible regarding Department operations in a timely manner.

Station/Bureau[6]	Commendation	Personal[7] Complaint	Service Complaint
Administration and Training Headquarters	0	1	0
Custody Services Administrative Headquarters	0	1	0

[5] See Manual of Policies and Procedure section 3-04/10.00 "Department Service Reviews."
[6] If a Station or Bureau does not appear on this chart, the Station or Bureau did not receive any reports from January 1, 2018 until June 15, 2018.
[7] It is possible for the same employee to get a Service Complaint Report and Personal Complaint Report based on the same incident in question.

Station/Bureau[6]	Commendation	Personal[7] Complaint	Service Complaint
Countywide Services Administrative Headquarters	2	0	0
Detective Division Headquarters	1	0	0
Central Patrol Division Headquarters	3	0	0
Technology and Support Administrative Headquarters	0	1	0
Aero Bureau	5	0	0
Altadena Station	12	11	1
AS2 Office of Assistant Sheriff	0	1	1
Avalon Station	7	1	0
Communications and Fleet Management Bureau	1	0	0
Community College Bureau	10	0	0
Custody Compliance and Sustainability Bureau	1	0	0
Century Station	24	19	2
Cerritos	15	9	0
Civil Management Bureau	26	12	4
Court Services Central	3	6	4
Compton	8	21	6
Community Partnership Bureau	12	6	2
Century Regional Detention Facility	9	0	0
Crescenta Valley Station	17	8	3
County Services Bureau	7	5	1
Carson	14	14	3
Court Services Transportation	1	2	0
East Los Angeles Station	27	22	4
Emergency Operations Bureau	6	0	0
Court Services East	2	5	3
Fraud and Cyber Crimes Bureau	8	0	0

Station/Bureau[6]	Commendation	Personal[7] Complaint	Service Complaint
Facilities Services Bureau	0	1	0
Homicide	7	3	1
Human Trafficking Bureau	5	2	0
Internal Affairs Bureau	5	2	1
Internal Criminal Investigations Bureau	1	0	0
Industry	15	21	7
Inmate Reception Center	1	2	2
Inmate Services Bureau	0	1	0
Lancaster	38	34	3
Lakewood	17	17	5
Lomita	21	8	0
Marina Del Rey	8	7	2
Major Crimes Bureau	1	0	0
Men's Central Jail	2	0	0
Malibu/Lost Hills Station	16	8	5
Narcotics	1	1	3
North County Correctional Facility	2	1	0
Pitchess North	1	1	0
Norwalk	25	25	6
Operation Safe Streets	5	3	0
Personnel Administration	2	4	0
Parks Bureau	2	2	0
Palmdale	53	34	4
Population Management Bureau	1	0	0
Pico Rivera Station	24	2	0
Records and Identification	1	3	0
Risk Management Bureau	1	0	0
Training Bureau	3	0	0
Santa Clarita Valley Station	47	25	4
San Dimas	27	11	5
Special Enforcement Bureau	2	1	0
Sheriff Information Bureau	2	0	0
South Los Angeles Station	18	20	4

Station/Bureau[6]	Commendation	Personal[7] Complaint	Service Complaint
Scientific Services Bureau	4	1	0
Special Victims Bureau	1	0	0
Training Bureau	4	1	0
Temple City Station	26	11	5
TRAP	3	0	0
Transit Services Bureau	7	0	1
Twin Towers Correctional Facility	1	4	1
Office of Undersheriff	0	0	1
Walnut	17	13	3
West Hollywood Station	30	24	3
Court Services West	11	7	0

In Custody Deaths

Between April 1 and June 30, 2018, eight individuals died while incarcerated by the Los Angeles County Sheriff's Department. The Office of Inspector General responded to the scene of the deaths that occurred in the jails. In addition, there was a stillbirth at Los Angeles County/USC Medical Center (LCMC).

On April 1, 2018, a patient died at LCMC. The individual was reportedly discovered by Sheriff's deputies in a cell at Men's Central Jail during what was described as a suicide attempt. The deputies administered CPR until paramedics arrived, and the patient was transported to LCMC where the patient died four hours later.

On April 11, 2018, an individual died at Men's Central Jail. The individual was discovered unresponsive in a cell during a Title-15 safety check. Emergency aid was rendered, paramedics were called, and they pronounced the individual dead at the scene.

On April 11, 2018, a patient died at the Henry Mayo Newhall Hospital. The patient was evaluated in the clinic at Pitchess Detention Center – South Facility and was transported to the hospital by paramedics, where the patient died six hours later.

On April 23, 2018, a patient died at the Palmdale Regional Medical Center. The individual was reportedly found unconscious in a cell at the Palmdale Patrol Station and taken to the hospital by paramedics, where the patient died a day later.

On May 9, 2018, an individual died at Twin Towers Correctional Facility. The individual was reportedly found unresponsive in a cell. Sheriff's deputies and medical personnel rendered emergency aid until paramedics arrived and pronounced the individual dead at the scene.

On June 2, 2018, an individual suffered a stillbirth at LCMC. A thorough Critical Incident Review was conducted by Correctional Health Services and Custody Services Division, where a complete chronology of the patient's incarceration at Century Regional Detention Facility was reviewed.

On June 6, 2018, an individual died at Twin Towers Correctional Facility. The individual was reportedly found unresponsive in a cell. Sheriff's deputies and medical personnel rendered emergency aid, paramedics were called, and they pronounced the individual dead at the scene.

On June 6, 2018, a second individual died at Twin Towers Correctional Facility. The individual was reportedly found unresponsive in a cell. Sheriff's deputies and medical personnel rendered emergency aid, paramedics were called, and they pronounced the individual dead at the scene. The cause of death was reportedly not immediately apparent and it does not appear that the two deaths at Twin Towers Correctional Facility on June 6, 2018 were related.

On June 7, 2018, an individual died at the Inmate Reception Center. The individual was reportedly found unresponsive in a cell. Sheriff's deputies and medical personnel rendered emergency aid, paramedics were called, and they pronounced the individual dead at the scene.

The Office of Inspector General attended the Custody Services Division administrative death reviews for each of the eight individuals. The OIG remains concerned about the quality of medical and mental health care provided, the sufficiency of the safety checks and the timeliness and quality

of life saving efforts. In the above in custody deaths where the cause of death was reportedly not immediately apparent, there was no evidence of a use of force preceding the death which might have contributed. The Office of Inspector General continues to monitor the quality and thoroughness of the administrative death reviews as well as ongoing efforts of the Department and Correctional Health Services to improve prisoner/patient care.

CUSTODY OPERATIONS

Office of Inspector General Site Assessments

Office of Inspector General personnel regularly conduct site visits and inspections to identify matters requiring attention. All site visits result in extensive follow up. OIG personnel completed 65 site assessments and logged 110 monitoring hours inside the seven LASD jail and lockup facilities in the second quarter of 2018. Typically during these visits, OIG staff meet with Department personnel at all ranks, from security and custody assistants to facility captains and commanders, and with civilian staff, clergy, and volunteers. As part of the OIG's jail monitoring, OIG personnel attended 111 Custody Services Division executive and administrative meetings and met with division executives for 147 monitoring hours.

Office of Inspector General personnel also continued to meet with individuals in the general population, administrative segregation units, and disciplinary, medical and mental health housing. Monitors met with and received input from individuals at cell front, during recreation and treatment group time, and in private interview rooms when necessary to ensure confidentiality. The following chart represents facilities visited from April 1, 2018, through June 30, 2018.

Facility	Site Visits
Century Regional Detention Facility (CRDF)	7
Inmate Reception Center (IRC)	10
Men's Central Jail (MCJ)	21
North County Correctional Facility (NCCF)	3
Pitchess Detention Center North (PDC North)	1
Pitchess Detention Center South (PDC South)	1
Twin Towers Correctional Facility (TTCF)	22
Total	**65**

Use of Force Incidents in Custody Division

The OIG monitors the Department's Custody Services Division data on use-of-force incidents, prisoner-on-prisoner violence and assaults on Department personnel.

On May 31, 2018, the Department reported that in 2017 there were 1,928 use of force incidents by custodial staff against prisoners. In the same year it reported that there were 643 assaults on custodial staff by prisoners. Lastly, there were 3,266 prisoner-on-prisoner assaults in the jail facility.

Citizen's Commission on Jail Violence Updates

CCJV Recommendation 3.12: The Department should purchase additional body scanners.

The Department continues to operate body scanners at the Inmate Reception Center, Century Regional Detention Facility, Pitchess Detention Center – South and Pitchess Detention Center – North. Each of these facilities reports that they are tracking the number of refusals, the race of the individuals refusing, and the reasons for refusals when given. Office of Inspector General personnel observed the use of the various tracking mechanisms by each facility. The Department reports that because prisoners are not forced to go through the scanner, strip searches are still utilized. According to Pitchess Detention Center – South personnel, body scanner refusals are rare; this can be attributed to the vast number of prisoner workers and program participants that will lose privileges if they refuse. This incentive based cooperation does not occur at Pitchess Detention Center – North where according to Department records, refusals average 30 percent.

As previously reported, the Department has installed three body scanner machines in the Inmate Processing Area (IPA) and one scanner near the vocational shops at North County Correctional Facility. These machines have been installed but the Department reports one of the four machines requires a change in location. Personnel discovered that the current position of the scanner near the vocational shops needs to be changed and a new staff station needs to be built. The initial placement of the body scanner staff station was not consistent with existing deputy safety protocols; therefore, the Department requested that the equipment be moved to maximize operator safety. The Department previously reported a new anticipated

completion date of May 2018; however, there is currently no timetable for the issues to be resolved and personnel must still be trained on scanner operation.

CCJV Recommendation 7.14: The grievance process should be improved to include added checks and oversight

The Department is still in the process of implementing iPads in all LASD facilities to capture information related to prisoner requests, and eventually grievances. The Department reports that it has completed the installation of 119 iPads across all facilities; 62 at CRDF, 45 at MCJ and 12 at TTCF. At MCJ, 13 iPads have been removed due to Wi-Fi connectivity issues. The Department reports that it will have Wi-Fi upgrades in September and October 2018 across all facilities. Between March 20 and June 28, 2018, the Department reports the iPads have automatically responded to 1,061,959 requests for information, averaging between 10,000 and 13,000 requests per day.

As previously reported, the Department has expanded the types of information that can be accessed from the iPads. The types of accessible information include: scheduled visits, credit calculation information, voting information, special diet information, commissary information, Education Based Incarceration (EBI) class information (specific to each facility's EBI programs), Proposition 47 information, Title 15 information, Assembly Bill 109 information, prisoner rules and regulations, state prison status, "A Guide Through Custody," Fire Camp information, mail rules and immigration information. The iPads also have government agency contact information (addresses and telephone numbers) accessible for multiple counties in the State of California, in addition to Clark County Nevada.

As reported in the Office of Inspector General's *Reform and Oversight Efforts* January 2018, the Department initiated a "Duplicate or Excessive Filings of Grievances and Appeals and Restriction of Filing Privileges Policy." The Department reports that between April 1, 2018, and June 30, 2018, 14 individuals were restricted from filing 57 grievances according to this policy. The Office of Inspector General will continue to monitor the restrictions on access to the grievance system.

CCJV Recommendation 7.15: The use of lapel cameras as an investigative tool should be broadened

As previously reported, the Department opted for an alternative implementation of this recommendation and embarked on a five-year program to install fixed cameras in the jail facilities. The Department continues to implement Closed Circuit Television (CCTV) cameras at the Pitchess Detention Center. At Pitchess Detention Center – South, the Department installed 190 total cameras, 176 of which are high definition units throughout the compound and all cameras are fully operational. There are still some areas of Pitchess Detention Center – South, including the classrooms, vocational shops, and the laundry areas that do not have cameras fully installed. The Department is working hard to have the cameras installed and fully operational by December 2018.

At Pitchess Detention Center - North, the Department has installed 190 cameras that are fully operational. The Department reports that all staff stations are now equipped with display screens that show multiple camera angles inside the dorm and the outdoor recreation areas.

Men's Central Jail – Alternative to Discipline Housing (ADH) Program

The Department has implemented its ADH program, an excellent incentive and mentor-based program for young individuals ages 18-24 with disciplinary issues in custody at Men's Central Jail. The program is designed to give participants opportunities to serve their discipline time in a dorm setting with "Merit Masters."[8] Each participant is assigned a Merit Master "mentor" and life skills course work to complete. If the individual wants to join the program, the Captain of the facility attempts to contact a family member or the participants' outside support system to assist in encouraging them to be successful in the program. Currently, four individuals have finished the three month program. All four transitioned into Education Based Incarceration and have not received any additional discipline (one of these individuals is no longer in Los Angeles County custody). There have been a total of eight participants in the program. Four transitioned into EBI as noted above, one participant dropped out, and three are currently enrolled. The

[8] Merit Masters are students who have completed all of the Education Based Incarceration coursework available to them in custody and now assist others in doing the same. Merit Masters follow strict program guidelines in their housing units and are generally considered among the most accomplished and receptive to rehabilitation.

ADH 18-24 program currently has a maximum occupancy of four students. The Department should be commended for its efforts to identify and implement effective alternatives to isolation and discipline and the OIG recommends expanding the program wherever possible.

Mental Health Patient Population Projection

In June 2018, as part of the Office of Inspector General's ongoing monitoring efforts of the mental health population in the Los Angeles County jails, Office of Inspector General personnel met with Department personnel to discuss the growing mental health patient population.

The Los Angeles County jail houses the largest population of incarcerated patients with mental health conditions in the nation. As of May 2018, there were a total of 991 male High Observation Housing (HOH) patients and 282 female HOH patients in custody. In February 2018, the Department completed an analysis and population projection based on past growth rates only. Based on this analysis, the Department projects a potential 10% increase in the total mental health population each year from 2018 to 2025. As of May 2018, there were a total of 4,112 male and 934 female[9] mental health patients in custody who are classified as either HOH, Medium Observation Housing (MOH), or are housed with the general population but are taking psychotropic medication (GP M). The patients with acute mental health conditions are classified as HOH and that subpopulation has a potential growth rate of 13% for male patients and a potential growth rate of 18% for female patients.

The Department recognizes that an accurate population projection requires a complex multi-factor analysis. The Department will ultimately need to conduct a more precise analysis but reports that this analysis reflects its efforts to proactively identify mental health population needs. Even if true values reflect the lowest totals, assuming the largest margin of error, projected growth rates are significant and concerning.

The Board of Supervisors has approved plans for two new county jails, including a 3,885 bed Consolidated Correctional Treatment Facility, to

[9] The OIG makes efforts to use terminology that does not presuppose a gender binary. The terms, "male" and "female," are utilized solely in reference to the LASD population projections and distinctions between facilities.

replace Men's Central Jail, and a 1,604 bed facility for the county's prisoners currently housed at CRDF. Anticipated completion for both projects is 2028. In the meantime, the Department is making an effort to create additional housing for the growing population by utilizing a patient matching program (iMatch) to house compatible HOH patients together in one cell. As of March 7, 2018, only 33% of male HOH patients and as of April 13, 2018, 18% of the female HOH patients were eligible and assigned a cellmate. The Department projects that by mid-2019, Tower I at Twin Towers Correctional Facility (TTCF) will reach capacity. Currently, Tower I houses HOH patients and Tower II houses MOH patients. According to the Department's projections, both Towers I and II will reach capacity in early 2024. The Department anticipates reaching capacity at CRDF, which houses the female population, by mid to late 2018.

The Forensic In-Patient Unit (FIP) is a 32-bed state licensed facility located within TTCF, which houses the Department's most acute mental health patients. Beds at the FIP are in high demand. On June 18, 2018, there were 79 patients on the FIP waitlist, but insufficient space prevented their admission. All pre-admission FIP patients, including the 79 waitlisted patients above, are housed in HOH. HOH, while generally considered safe, is clinically inappropriate and grossly insufficient for the housing of these severely ill and vulnerable patients. Patients requiring FIP level of care may display symptoms such as smearing or throwing feces, banging one's head against the cell door, not eating or drinking, severe self-mutilation, and suicidal and/or homicidal behaviors. These patients are often medication non-compliant and, despite best efforts, may decompensate even further in HOH.

Because the demand for FIP beds is so high and space is so limited, Correctional Health and Custody Services Division face daily decisions about which, if any, FIP patients have stabilized just enough to discharge in order to admit another, even more acute and endangered patient. Once the new patient admit stabilizes, the patient is released back to HOH and another is admitted to the FIP. This cycle is continuous and poses serious ethical challenges for the mental health staff charged with choosing between hundreds of equally sick patients.

In addition to patient risk, personnel who work on the HOH housing units face constant and serious safety risks. Deputies and Correctional Health Services personnel in the HOH modules are frequently assaulted with feces, urine, and other bodily fluids of highly symptomatic HOH patients. When medical and mental health personnel are unsuccessful in coaxing patients out of their cells, deputies must use force to extract them, which results in injury to staff and patients, and induces trauma for involved parties. Though the Department has hand-selected its most skilled and compassionate deputies to work with this population, they cannot reasonably be expected to manage a jail full of patients whose acuity level would warrant multi-point restraints and involuntary medication in a licensed care setting.

Within Los Angeles County, there are relatively few alternatives to incarceration for all prisoners, and particularly for the mentally ill. In September 2015 the county created the Office of Diversion and Reentry (ODR) to identify and create more alternatives to incarceration for persons with mental health and/or substance abuse disorders. The office is staffed with 27 personnel with expertise in forensic psychiatry, public policy, public health, nursing, and law. The Department reports that in May 2018, there were a total of 5,046 incarcerated patients who suffer from mental health conditions. The Director of ODR reports that his office is unable to determine how many of the 5,046 incarcerated individuals are eligible for diversion due to the ODR's staff constraints and without input from their justice partners, including the Probation and Sheriff's departments, Correctional Health Services, the District Attorney, Public Defender, Alternate Public Defender, and the LA County Superior Court. The Director reports that continued collaboration with ODR's county partners is essential to its success. ODR personnel report that primary barriers to success include the shortage of necessary community placement, resources and insufficient ODR personnel.

Since the office's inception in September 2015, the ODR reports having successfully diverted 1,972 individuals. These diversion efforts have not reduced the jail population for reasons that cannot be explained by the ODR or the Department.

The Sheriff's Department has demonstrated a commitment to collaborate with community partners in diverting individuals with mental health conditions to community based treatment programs. The OIG recommends

that the Department, with other county departments and stakeholders, continue to identify the sources of the population pressures and explore all options to increase diversion opportunities.

COMMUNITY COMMENTS REGARDING DEPARTMENT OPERATIONS

The OIG received eighty three new complaints in the second quarter of 2018 from members of the public, prisoners, prisoners' family members and friends, community organizations and County agencies.[10] Each complaint was reviewed by OIG staff. Seventy six of these complaints were related to conditions of confinement within the Department's custody facilities, as shown below:

Complaint/ Incident Classification	Totals
Personnel Issue	
Use of Force	7
Rude/Abusive Behavior	4
Failed to Take Action	1
Discrimination	3
Medical/Dental Issue	10
Mental Health Services	3
Housing	2
Dietary	4
Other Service Issue	40
No Discernable Issue	2
Total	76

Twenty seven complaints were related to civilian contacts with Department personnel by persons who were not in custody.

Complaint/ Incident Classification	Totals
Personnel Issue	
Use of Force	3
Rude/Abusive Behavior	6
Unlawful Conduct	6
Failed to Take Action	1
Off Duty Conduct	1
No Discernable Subject	1
Other Service Issue	9
Total	27

[10] When a complaint raises multiple issues, the OIG tracks and monitors the Department's response to each issue. As such, a single complaint may receive more than one classification as reflected in the referenced tables.

Four complaints were not about the Department or Department personnel and were referred to the appropriate agency or the complainant was directed to seek legal advice.