*The Los Angeles County*

# Sheriff's Department

8th Semiannual Report by

Special Counsel Merrick J. Bobb & Staff

October 1997

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# Special Counsel and Staff

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# Introduction

This **Eighth Semiannual Report** of Special Counsel Merrick Bobb and staff, with particular assistance from Deputy Special Counsel Nicolas Miller, departs from the form of previous reports. Rather than attempting a broad survey, this report focuses in on the operations of the Los Angeles County jail system. The decision to channel our resources in a special report on the jails does not flow from any perception that the patrol side of the Sheriff's operations are undeserving of full reporting or are progressing at so promising a rate that a complete investigation is unnecessary. Indeed, we are conducting our usual investigation and audit of patrol operations and will soon issue a report thereon.

Rather, the decision to concentrate on the jails reflects our perception that over the last several years there has been a critical breakdown in the operations on the Custody side. To be sure, there are areas which have been recently stabilized. With respect to mistaken releases in general and with respect to work release in particular, prior deterioration has been halted currently as best it can, absent the automation which we have repeatedly urged the Supervisors to authorize and advocate again in Chapter Two herein. In other areas, however, including health issues and others detailed in Chapter One of this report, the Custody operations of the Sheriff's Department remain deeply troubled and must urgently be addressed.

There are also areas of genuine progress on the Custody side. Chapter Three describes a better-functioning Inmate Reception Center (IRC), a revived and successful work release program, increases in percentages of sentences served, better control of over-crowding, and better population management and classification. Chapter Four describes a promising and energetic effort to collect and analyze information about custody operations in a more rigorous way.

On the other hand, problems in the provision of mental health care have already prompted the extraordinary step of a special investigation by the United States Department of Justice as to whether the conditions in the jails violate inmates' constitutional rights. The September 5, 1997 Department of Justice report ("DOJ Study"), is a recent

examination of the provision of mental health services in the jails. Resolution of the issues raised by the DOJ Study are in the hands of County Counsel, and the County disputes some of the Study's conclusions and findings. Moreover, attorneys from County Counsel, including Fred Bennett, have worked hard to craft solutions. We cannot and do not speak in County Counsel's stead, and it must be remembered that County Counsel alone represents the County as regards DOJ. It is not within the ambit of Special Counsel either to embrace or reject the DOJ's findings or to suggest in this context how the issues raised therein should be resolved. On the other hand, it is clearly within the province of Special Counsel to discuss areas of potential liability and the organizational and managerial issues that impinge on these risks.

The current troubles in the Sheriff's Department's Custody operations are no particular surprise to us: We have tried to sound an alarm for at least the last three years with respect to the lack of resources and attention to the Custody operations — be it erroneous releases, mistaken assignment of individuals to work release, over-detention of inmates, excessive force in the jails, inmate-on-inmate violence, inmate-on-staff violence, escape attempts, crumbling and overtaxed facilities like Sybil Brand and Men's Central Jail (MCJ or CJ), the delays in the opening of Twin Towers, the breakdown of systems at IRC, the inability to track inmates, or the errors and malpractice in the delivery of medical and mental health services. Although current management in Custody is an improvement, there is still room for new brooms to sweep clean. The failures over the last several years to deal with mental health and medical issues alone raise hard questions. The Sheriff of Los Angeles County has said in unambiguous terms that he will never allow there to be an unconstitutional jail while he is in charge. Although there is no gainsaying real improvement in the last six months, Sheriff Block will need to continue working hard on Custody issues for the foreseeable future.

Our view is that the problems in mental health services are similar to the other medical problems in the jails and that solutions to one will result in solutions to the other.

Some of the solutions are greater automation, and our chapter herein on automation is an urgent plea to the Board of Supervisors to quickly approve and fund a Three Year Custody Automation Plan that Special Counsel and others have helped to devise. But not all issues can be addressed by automation. As Chapter One in this report describes, there has been a near-collapse in accountability and responsibility for mentally disturbed inmates who, after all, are among the most vulnerable and least capable of protecting themselves.

As stated earlier, in the next few months, we will issue our usual report that will cover all the areas we traditionally discuss in our semiannual reports — the Sheriff's patrol operations, force investigation and discipline, citizen complaints and their resolution, litigation and risk management, and issues related to the Department's progress in eliminating discrimination based upon race, ethnicity, sexual orientation, and gender. But for today, public attention needs to be focused on the jails, and for that reason, we offer this special report.

## *Introduction*

Over the last six months, we have conducted a special study of mental health issues, particularly suicides and suicide attempts in the Los Angeles County jails. We have done so for many different reasons. First, in response to our **Seventh Semiannual Report,** in which we first expanded upon our concerns and recommendations with respect to mental health issues and suicides, Supervisor Gloria Molina requested Special Counsel to conduct a further investigation and to specially report back on the topic. This Report is intended to respond to the Supervisor's concerns.

Second, as discussed below, our previous investigation of suicides and other mental health issues led us to conclude that the Los Angeles County Sheriff's Department, directly through its own Medical Services unit and indirectly through its engagement of the County Department of Mental Health Services (DMH), has been providing substandard mental health care in the jails. At the same time, the federal Department of Justice, through its Civil Rights enforcement powers, suspected similar problems and embarked upon a year-long inquiry of mental health care in the Los Angeles County jail system culminating in a recent study to which the County is currently responding. Our investigation led to a series of recommendations to the Sheriff's Department and to DMH, which, we found, were largely ignored. In our last report, we promised continuing investigation and follow-up on the recommendations until we were satisfied that permanent solutions had been instituted. We are still not sure they have been.

At the root of it, the problem is that there are two County Departments—the LASD and DMH—that are strapped for staff and resources to cover the profoundly serious responsibilities of each. For years, the two Departments have been at loggerheads over who will perform what services for the mentally ill. The issue is not ultimately the will to provide consistent, compassionate care — we are convinced that the leadership of each would provide it willingly if they could. The issue, rather, is that two County Departments, perhaps like two brothers both needing scarce and limited parental resources, have been

left to fend for themselves and protect their own personal interests against the other instead of getting guidance and a sense of priorities from sources that have the wider interests of each and the community in mind.

Third, the issue of mental health care in general, and suicides in particular, brings into sharp focus what we believe to be seriously misconceived allocations of responsibility between the Sheriff's Department's Custody personnel, the Department's Medical Services unit, and the DMH. The misallocation of responsibility translates directly into deaths and other serious injuries that could and should have been avoided, as well as additional liability to the taxpayers of Los Angeles County.

Fourth, and perhaps most importantly, the issue of mental health in the jails is an introduction and jumping off place for a long-overdue, wider inquiry into the deeper problem of general medical care that has its roots in the same elements that contribute to the specific mishandling of cases of mental illness. Stated plainly, the problems include chaotic record keeping; multiple and inconsistent medical charts which are frequently unavailable on short notice; lack of adequate consultation and coordination between custody workers, medical staff, and mental health staff; and the absence of reliable records tracking the location of inmates at any particular time. The competition between the equally pressing needs of medical services, mental health services, the courts, and custody services — both inside the jails and outside in the courthouses — means that any given inmate may be short-changed in the process, or made to wait for intolerable delays, or may simply not get the medical and other health- related attention that is needed.

Although complex and difficult to resolve, the issues cannot be swept under a rug or excused. Putting aside that the Los Angeles jails house large numbers of individuals who have never been convicted of any crime and that the United States Constitution, in any event, guarantees inmates protection against deliberate indifference to serious medical needs, including mental health needs, the stark truth is that quality and consistency of care in the jails is not only a problem for inmates; it is just as much a core public health problem.

If tuberculosis in the jail population is not caught and treated, there are serious implications for the spread of this highly contagious disease throughout the population, and greater dangers arise if the treatment is applied in so haphazard a manner that resistant strains are encouraged. In 1995, there were approximately 1750 annual active TB cases in the jails. In 1994, 13.43 percent of HIV tests administered in the jails turned up positive. If careful administration of protease inhibitors and other antiviral medications is not properly performed, the risk of resistant strains, which will spread to the general population, is heightened. If seriously disturbed mentally ill inmates are let out of jail in a delusional or improperly medicated state, they pose appreciable dangers to themselves and to others. The reasons why the Supervisors and the general public need to pay attention to the problems of medical and mental health treatment in the jails are not simply a matter of taxpayer dollars wasted on avoidable judgments and settlements in malpractice cases. Nor is it simply a matter of the level of care we expect to provide in the most medically advanced nation on earth. It also is a public health issue that touches all of our own lives and those of our children. With these thoughts in mind, we turn now to a detailed examination of why mental health care in the jails is substandard.

## *The Problem*

The problem, as we have said, is that neither the LASD nor DMH have the staff and resources to provide adequate coverage and care. That being so, we have nonetheless been concerned for several years by the apparent stalemate between the two Departments. Each bears responsibility for its seeming intransigence, and the County as a whole bears responsibility for not helping each to resolve it. Although there have been some very recent signs of greater flexibility, proactivity as regards female inmates, and a better understanding of issues under Richard Kushi's leadership of DMH's jail hospital mental health staff, we remain dismayed by the degree to which DMH seems historically-entrenched and stubborn. An equal problem is the apparent entrenched and stubborn

unwillingness by the Sheriff's Department's own Medical Services unit to step into the breach. And, over the years, far too much finger pointing has occurred between mental health personnel, medical staff, and Custody.

But most puzzling in the current circumstance is that the Sheriff's Department — which bears the lion's share of the liability risk, is the ultimate guarantor of a constitutional jail, directly controls Medical Services, and is in a position to demand better performance by DMH — has been cast in the position of seeming oddly frozen. The LASD appears unable or unwilling to confront DMH head on and either demand what it deems to be appropriate staffing and performance or to ask DMH to leave the jails so that the LASD can mold itself a mental health unit responsive to the needs in the jails. Similarly, the LASD seems unable or unwilling to confront its own doctors in Medical Services and demand that they at least, as an interim measure, hire psychiatrists and psychologists to screen out the mentally ill at the front end and supervise the modules at Central Jail and elsewhere where mentally disturbed inmates are housed. The problem, obviously, is that there are not enough resources for the LASD to do alone or to compensate DMH to do it. So the head butting continues.

At the Department of Justice's suggestion, the Sheriff's Department, including its Medical Services unit, and DMH conducted protracted negotiations about allocation of responsibility which resulted in a recently-drafted memorandum of understanding (MOU) between the Department, Medical Services, and DMH. Although purporting to reallocate and rationalize responsibility and accountability in the area of mental health, and although making some progress in terms of better coordination, additional staffing and additional money, it does not substantially change the basic unsatisfactory allocation of duties that has led mental health care in the jails to become a disturbing source of risk and possible malfeasance. Purported commitments are phrased in highly qualified language with too many escape hatches. It does not do the job and it is far too imprecise.

Admittedly, under the MOU, DMH's staff and monetary commitment appreciably

will be expanded, and that is at least a start. But it will not provide the LASD with the necessary 24 hour, 7 day coverage at all facilities that is necessary. To DMH's credit, it has begun to clean house and rid itself of professional staff who are not up to the challenging job of treating mental disease in the jails. Nonetheless, perhaps because resources have not been committed to back it, DMH is still not ready to assume plenary charge of all mentally ill inmates wherever located in the jail system, be it in the forensic outpatient unit, or the 4000 modules at Men's Central Jail, or Twin Towers, or in general population elsewhere.

Even though the Sheriff's Department, Medical Services, and DMH have commenced a useful dialog, the MOU is not a sufficiently complete answer to our concerns. DMH still deflects criticisms and offers little by way of new commitment to wider accountability. The Sheriff's Department's Medical Services unit does not pick up the slack. The fundamental flaw in the MOU is in its assumption that Custody or Medical Services staff should be trained to identify and deal with almost all male mentally ill inmates until DMH can see them. The second basic error in the MOU is the assumption that almost all the mentally ill except for the imminently suicidal or actively violent mentally ill inmates should be turned back to custody staff and medical services for ongoing care and medication after seeing DMH.

These fundamentally flawed assumptions and premises must be changed. The Sheriff's Department must demand that DMH provide, or must itself provide through the LASD's own Medical Services, sufficient numbers of willing mental health professionals prepared to assume plenary professional responsibility in the jails. The County must give the Sheriff's Department the resources to take on the job or give DMH the resources to do it. The MOU merely papers over this fundamental problem.

Candid discussions with an overwhelming number of knowledgeable Sheriff's Department personnel bring up long-standing dissatisfaction with the level and quality of service provided by DMH, particularly as regards male inmates. In essence, DMH takes

the position that with the possible exception of female inmates, it will not assume plenary responsibility for identifying mentally ill inmates either in the first instance, as they arrive at the Inmate Reception Center for processing, or, later on, as mental illness manifests itself within the jail population.

This inability to screen all inmates, to walk the floors, and otherwise respond in a proactive manner is unacceptable as well as highly ironic: At least 20 percent of the males and 30 percent of the females who come into the jails are already known to DMH through their own databases and records. Some already have DMH mental health workers assigned or may already been prescribed medication by DMH in outpatient clinics. But rather than step forward, take responsibility, and act, DMH seems to prefer to wait for these same mentally disturbed inmates to be identified either by custody staff or by Medical Services staff and referred to DMH, where it is then often the case that DMH takes days to get around to evaluating the inmate. To be sure, DMH is more willing than it has been in the past to share appropriate information in its databases with Medical Services, and that is a step forward. But it again is not enough. If an inmate arrives who is on psychotropic medication — even medication that in many cases was prescribed by DMH outside of custody — DMH still seems unwilling to take principal responsibility to assure continuity of medication in custody and adequate continuing mental health care by DMH mental health professionals.

Moreover, throughout the jail, the Justice Department found that medications were improperly prescribed their effects improperly monitored, and documentation on their use and effect incomplete and inaccurate.

DMH acknowledges candidly that there has historically been a problem with respect to inmates who have their prescribed medication on them at the time of arrest. Typically, the medication is separated from the inmate or discarded as contraband upon booking. Medications confiscated by arresting or investigating agencies that is not thrown away may nonetheless not be transported with the arrestee. Rather than fully using its own

databases, resources, and staff to identify inmates already in DMH treatment or on medication before coming to the jails, DMH continues at least in part to rely on a system of special handling cards filled out by custody personnel to identifying inmates previously prescribed medication.

This misallocation of responsibility onto Custody is again shortsighted in our view. If the card should be mishandled or lost, the inmates will suffer serious interruption of medication unless and until they so seriously decompensate that Custody or medical staff brings them to the attention of DMH. It would be far better if there were mental health professionals who were willing to take responsibility for identifying mentally ill inmates at the front end, whether they are already in DMH databases or not and whether already prescribed psychotropic medication by DMH or not. Mental health professionals should assume responsibility for the distribution of psychotropic medication throughout the jails, and assure that inmates are closely monitored and maintained on medication without interruption. The current division of responsibility between DMH and Medical Services, we believe, causes gaps and errors in dispensing medication to occur. We would prefer that there be a unified, single medical staff in the jails.

Perhaps fearing that it will be overwhelmed, perhaps understandably unwilling to shoulder responsibility and the attendant liability without deeper pockets to help spread the risk, DMH limits itself to referrals of inmates to those few who are deemed by Custody staff or medical staff to be possibly suicidal or else engaged in highly disruptive conduct. DMH thus limits itself to plenary responsibility for what some estimate is only about a third of the persons it should be seeing. The burden of many mentally disturbed inmates falls largely on an already over-extended Custody staff whose job in the first place should be to provide security and safe surroundings, and not to function, as they have increasingly been forced to do, as lay psychiatric nurses performing off-the-cuff diagnosis and triage.

The failure to identify and treat adequate numbers of mentally disturbed inmates has ironic and sometimes tragic consequences. Although not a practice entirely free from

controversy, inmates identified as mentally ill wear different colored clothing from other inmates. We at least tentatively conclude that concerns for staff and inmate safety outweigh fears that the different uniforms unfairly stigmatize the mentally ill. Nonetheless, the clothing allows the deputies to make a rough judgment as to who is deemed mentally ill and who is not. An inmate who is not dressed in the identifiable clothing, then, is assumed to be healthy, and thus any bizarre behavior or aggressive acting out may be misinterpreted by deputies as willful defiance of authority and not as a product of unrecognized mental illness. Hence, there may be much more force deployed in the jails than is necessary. Accordingly, limitations on the numbers of inmates seen by mental health professionals may work a grave disservice on mentally troubled inmates in general who are subject to unwarranted force and otherwise treated as recalcitrant and uncooperative when in fact their conduct may flow directly from their mental illness or from decompensation resulting from mistakes in the prescribing, distributing, and assessment of medication on inmates.

In our **Seventh Semiannual Report,** we described a suicide at Men's Central Jail in which a man who had on three occasions within a month attempted suicide by hanging himself with bed sheets was left one more time in a cell with sheets and succeeded in killing himself. The case resulted in a settlement with the decedent's family that cost the taxpayers of the County approximately $400,000. The case was a series of tragic errors as the man was shuttled between various facilities without DMH remaining in charge and responsible throughout, whether the man was located in DMH's in-patient ward at Men's Central Jail (FIP), or in the jail ward at County-USC hospital (LCMC), or on suicide watch in the 4000 or 7100 modules. We concluded that "immediate improvement must be ordered regarding the inadequate staffing and service provided the jails by the County's Department of Mental Health Services." Our analysis of problems within the jails led us to conclude that the trifurcation of responsibility for mentally ill inmates between the Custody, medical, and mental health staff allowed too great a margin for potential error.

Our view then, as it is now, is that plenary responsibility to identify and screen suicidal, potentially suicidal, and serious mentally ill inmates, as well as for delivery of mental health services within the jails, should fall to mental health professionals. Since mental health professionals are currently supplied by the DMH to the Sheriff's Department pursuant to contract, it seemed appropriate to look to DMH professionals to take responsibility if given financial resources to do it. Accordingly, we made and now reiterate specific recommendations about expansion of DMH's role. But if DMH cannot or will not so expand, then the LASD must, with appropriate additional County financial resources, immediately step into the breach by expanding Medical Services to cover mental health. **We urge that the jails be immediately provided with:**

- **sufficient qualified mental health staff to screen all incoming inmates, to prevent deterioration of newly-incarcerated mentally disturbed inmates, and to quickly identify, evaluate, and treat serious mental illness arising during detention;**
- **proper management of drug prescription, drug delivery and follow-up, particularly regarding the use of psychotropic drugs; and**
- **constant supervision by mental health professionals of inmates in any mental observation setting, including any delineated areas, safety cells, or suicide watch or disciplinary cells. Any inmate in restraints, for any reason, whether in the forensic in patient unit or elsewhere, should be under constant supervision by mental health professionals; and**
- **formal procedures and fully-elaborated protocols which set forth in exact detail how combined medical/mental health decisions are to be made with fixed timetables and rules for joint consultation and supervision where appropriate. The day when custody, medical services, and DMH all can point the finger at the other for a failure must come to an end. If a patient is seriously ill — mentally, medically, or both — the various responsibilities of the medical,**

**mental health, and custody workers must be spelled out in exacting detail so that accountability rests in one place alone and no one can blame the other for failure to respond or take responsibility.**

Although the Sheriff's Department is to be commended for the recent improved performance of its own Custody staff in providing intensified monitoring for suicidal inmates and by using new padded clothing and blankets in suicide modules that cannot be used in suicide attempts, it must be recognized that the custody staff, at the end of the day, should not be forced to diagnose or treat medical or mental disease simply because Medical Services or DMH have been unable to coordinate their activities and respond with clear lines of authority.

In our view, the Custody risk management staff within the Sheriff's Department has recently done a commendable job of auditing Custody with respect to suicide prevention practices. It has increased the staffing for monitoring of suicidal inmates, provided additional safety and security checks for suicide watch, established better procedures for communication between Medical Services, Custody, and DMH, including daily briefings and weekly meetings. All this being so, it is still a matter of deep concern that so little has been done by the medical and mental health professionals to mesh their activities and provide each other with back-up and safeguards. At base, the mental health and medical staff seem to have played — and in our view continue to play — a game of passing the hot potato of responsibility out of concern for additional staffing costs and a fear of legal liability, all at the expense of inmate welfare and the cost of lives that could have and should have been saved. Neither the LASD nor DMH should be forced by external circumstance or internal intransigence to play this game. The County as a whole needs to play a useful and supportive role, financially and otherwise, to help the two Departments out of this deadly game.

It is not Custody staff that should be stepping in to fill the breaches left by the medical and mental health staff. With all due respect for their intelligence, talent, ability,

and devotion, sworn and civilian Custody staff are not trained psychiatrists and no amount of coaching by DMH, in our view, can turn them into para-psychiatrists for DMH.

## *Finding Reliable Data*

During the last six months, our study of mental health issues began with an effort to get reliable and consistent statistics for suicides and attempted suicides over the past few years in the jails. In particular, we wanted to study Men's Central Jail, where the greatest number of suicides and attempts historically have occurred. As we have found before with respect to statistics about the jails, the numbers proved to be hard to pin down, and even the numbers for recent years cannot be viewed without caveats: For example, we asked the Department for the number of suicides for 1995, 1996, and 1997 to date. The Department provided us a table showing, among other things, 7 suicides for 1996. We independently asked for a custody data analysis unit breakdown, and it showed 9 suicides for the same year. We cannot account definitively for the disparity, but our opinion is that the table showing 7 suicides failed to include suicides at Sybil Brand Institute where female inmates are housed.

We have yet another document that states that 2 of the 6 suicides for 1996 credited to Men's Central Jail were actually suicides at Lennox and Carson stations. One document we reviewed stated that there were 15 successful suicides in 1995-97 and that they all took place in MCJ, except for one 1996 suicide at the Century Regional Detention Facility. Another document stated that there were 12 successful suicides in the same period and that they all took place in MCJ with the exception of one suicide that purportedly occurred in the jail ward at County-USC Medical Center. Given the disparities, we have less than complete confidence in the numbers provided on actual suicides.

As we have stressed in the past, the penchant of the Department at times to produce inconsistent numbers raises a concern that the Department does not care enough about what the numbers mean to compile them with the requisite care. It is true that numbers

as such do not tell the full story. Numbers need to be placed in context and it is information, rather than mere numbers, that are ultimately important. But one cannot go confidently from numbers to assess what they mean unless the numbers themselves are reliable.

The numbers are even more fluid with respect to attempted suicides. The reasons for this in part may have to do with the way numbers are gathered in the Department. Often, those who are gathering and reporting the numbers do not have any particular personal investment in the precise accuracy of the data and do not have personal responsibility for interpreting the numbers and formulating policy or action thereupon. Accordingly, statistics are occasionally reported carelessly or haphazardly. Again, we found significant variations in the numbers of attempted suicides in different reports. This is in the process of change, and the custody data analysis unit, under the supervision of Sgt. Richard Myers, is actively embarked upon a solid program to upgrade the reporting and reliability of data from the various custody units by assigning and training supervisors with personal responsibility for assuring that data are collected accurately and uniformly. We anticipate, therefore, that we will be able to report substantial progress in this area in our next report.

Another reason why it is difficult to get reliable numbers on attempted suicides is that there have not been uniform rules for defining and interpreting whether a certain set of facts constitute a suicide attempt. Some custody facilities take an expansive view and consider a verbal suicide threat accompanied by any self-inflicted injury, however slight or unlikely to result in death, as an attempted suicide. Other facilities attempt to distinguish between feigned attempts and real attempts, and judgment calls at one facility may be different from those at another facility. It has been observed, for example, that inmates at Men's Central Jail on a transfer list will feign suicide as a way to be kept at Men's Central rather than be transferred to a facility where it is more difficult to see family and other visitors. Accordingly, there may be more of a temptation to read as feigned a

purported suicide attempt at Men's Central that in another facility might be read as a serious suicide attempt. Again, the custody data analysis unit is attempting to bring greater uniformity to the reporting.

With these caveats in mind, and with the further caveat that these figures may understate suicides because of inconsistencies we discovered with respect to 1996 in particular, we set forth the following figures provided by the Department on successful suicides in recent years: 1994: 5 suicides; 1995: 6 suicides; 1996: 9 suicides; January - May 1997: 2 suicides. As noted above, the statistics with respect to attempted suicides have much wider margins of error and should be taken with a hefty handful of salt: 1994: 189 attempts; 1995: 277 attempts; 1996: 243 attempts; January - May 1997: 207 attempts.

In order to figure out more precisely where the suicides at MCJ were taking place, we tried to reconstruct module-by-module breakdowns. Again, we found the numbers impossible to reconcile. The results were quite revealing, even if the numbers themselves may be subject to a margin of error. As might be predicted, suicides and attempted suicides are heavily concentrated in the 4000 series modules at Men's Central Jail which house inmates under general mental observation and in the 7000 modules reserved for the most severely mentally disturbed. Because the 4000 mental observation modules house many more inmates than the 7100 out-patient module and the 7200 in-patient module, there are more attempted suicides in the 4000 modules. The 7100 unit currently has

1

**Men's Central Jail, Suicides in Mental Observation Modules**

| Year | 4300 | 4500 | 4600 | 4800 | 7100 | 7200 | Total |
|---|---|---|---|---|---|---|---|
| **1995** | 1 | 1 | 0 | 1 | 0 | 0 | 3 |
| **1996** | 0 | 0 | 1 | 0 | 1 | 0 | 2 |
| **1/97 to 8/97** | 1 | 1 | 0 | 0 | 0 | 0 | 2 |

**Men's Central Jail, Suicide Attempts in Mental Observation Modules**

| Year | 4300 | 4500 | 4600 | 4800 | 7100 | 7200 | Total |
|---|---|---|---|---|---|---|---|
| **1995** | 64 | 22 | 19 | 0 | 2 | 0 | 107 |
| **1996** | 22 | 6 | 8 | 5 | 3 | 3 | 47 |
| **1/97 to 8/97** | 13 | 8 | 8 | 2 | 0 | 0 | 31 |

46 beds; the 7200 unit has 35. The average daily count for the 4000 mental observation modules currently is approximately 350. All of the successful suicides in those modules were by bed sheet for the years 1995, 1996, and 1997 through mid-year. The data is set forth in Table 1.

Further study of the pattern of suicides at MCJ for the same time period reveals that more than 80 percent occurred during the early morning watch and, disturbingly, that 25 percent of the suicides occurred in special suicide watch cells. It further appears that more than half the suicides tended to take place in the first month of incarceration. No particular trends could be discerned respecting the kind of housing the inmate was in — suicides occurred in single cells as well as multi-person cells.

## *The Issues*

Inmates entering the jail system are not adequately screened for mental illness. Our objection to the screening process is three-fold: first, it relies in the first instance primarily upon self-reporting by the inmate; second, the screening of those who self-report mental problems is usually performed in the first instance by medical staff and not by mental health professionals; and third, even when referred by medical personnel, it often takes DMH days to perform an evaluation. As DOJ notes, the delay is unacceptable and dangerous. An incident recounted in the DOJ Study underscores the results of a failure to perform a timely evaluation. We have not independently investigated this same incident or other incidents we cite from the DOJ Study, and thus we want to make clear that we are assuming but have not independently verified that the DOJ versions are true:

"*An inmate was screened positive for mental illness and a mental health assessment was ordered at the that time. By the time a mental health worker was able to get to that inmate's evaluation two days later, it was too late — the inmate had killed himself earlier that day. Further, it appears that the mental health worker was not even aware that the inmate killed himself, as the notation in the inmate's chart states 'discharged.'*" DOJ study, p. 6.

As also is pointed out by the DOJ Study, if an inmate enters the jail system with properly prescribed psychotropic medications, the medications are taken away from them and they receive no medication until they are assessed by a mental health worker. Given the lengthy delays we have described, the inmate is in danger of decompensating to crisis level soon after admission to the jails. When this fact is juxtaposed with our earlier finding that suicides most often occur during the first month of incarceration, it can be inferred that the sloppiness and imprecision of the intake and evaluation procedures for mentally ill inmates, combined with the disruptions in the provision of already-prescribed medication, account for the high number of suicides early in incarceration.

Given that many inmates entering the jail system are already being treated in other contexts by DMH and are already in DMH's database and may already have been prescribed medication prior to arrest, it would seem to make sense for DMH to do the screening in the first place and assure the continuity in the provision of prescribed medication. Indeed, highly-placed sources within Men's Central Jail state that an overwhelming percentage of suicides result from errors in the prescribing, delivery, and monitoring of inmates on medication. In our view, all mentally ill patients on psychotropic medication should be under the plenary and primary care of mental health professionals who are part of a unified staff with the rest of the medical community in the jails. It should be a unified staff's responsibility to prescribe the drugs, dispense the medication, monitor the inmates and coordinate with medical and custody staff as necessary.

The bifurcation of responsibility between DMH, which currently prescribes the pills, and Medical Services, which dispenses them, makes no sense to us. If a unified staff were both prescribing and dispensing, mental health officials would have daily contact with their patients and could better monitor their status and condition. If medical questions arose with respect to combinations of medical and mental health medication, protocols could be established to require timely mutual consultation and coordination. Under current practice, DMH seems to wall itself off as much as it can from the patients they are

supposed to be treating, preferring to deal through intermediaries like custody personnel or the custody medical staff. As the Justice Department noted, MCJ visits with the DMH psychiatrist were "grossly inadequate in length and frequency." DOJ Study at 12.

These deficiencies are not ameliorated under current circumstance by subsequent purported fail safe systems that provide for referrals to DMH if the custody or medical staff run across mentally disturbed inmates who evaded the intake process and later decompensated. First, DMH sets the bar far too high: They will not even consider referrals of less than "high impact" mentally ill individuals. In other words, as stated by the DOJ, an "inmate must be actively and observably suicidal or psychotic, or in the words of one deputy 'bouncing off the walls' before he or she has a chance of being referred to mental health for treatment." DOJ Study, p.7.

The problem is further exacerbated by an apparent unwillingness by DMH to tour any or all of the jail's housing facilities with frequency to seek out individuals in need of treatment. Rather, the practice is to passively await references. And even if a mentally ill inmate surmounts the various hurdles and gets to see a psychiatrist, there is inadequate assurance that the treatment plan will be properly administered.

The DOJ Study cited an instance of a seriously mentally ill inmate who was doing well when transferred from Patton State Hospital to the Sybil Brand women's jail pending release from the jail system. After three days, the inmate decompensated at Sybil Brand and had to be transferred to the Forensic Inpatient Unit. Two days after the transfer there, she had a seizure, and a few days later died. Review of the medical charts disclosed that the inmate did not receive proper dosage of prescribed medications and that the prescription of inappropriate medication in the first place may have resulted in the inmate's dangerous decompensation upon transfer to Sybil Brand and the necessity for her to be placed in restraints. DOJ Study at p. 11.

More disturbing still is the general inadequacy of suicide prevention efforts in the jails even when suicidal-prone inmates are identified by custody staff or by Medical

Services and referred to DMH. An example cited by the Department of Justice highlights this point. An inmate awaiting transfer to a County-operated mental health facility was being held in the interim in Men's Central Jail's FIP, which is administered and managed by DMH. For reasons that are unclear, the DMH personnel released the inmate from FIP without the medication that had stabilized his severe depression while in FIP. According to the DOJ Study, despite repeated requests over a period of six days, the inmate was never given his medication. The inmate had been admitted to the County Jail with a history of suicide attempts and mental illness and had been in the FIP unit for an extended period of time.

Nonetheless, when discharged without his medication, instead of being placed in a suicide watch cell, he was put in a mental observation unit where he received minimal attention and supervision. Indeed, he did not even see a jail social worker until four days after he had been discharged from FIP, during which time he reported agitation and a desire to resume his medication. The social worker immediately placed the inmate on a list to see a DMH mental health worker.

When the social worker checked back two days later, the inmate still had not received his medication. He was agitated and apparently hallucinating about bugs crawling over his body. The social worker went to the clinic to try to see that the inmate got his medication immediately. He did not, and the inmate hanged himself that evening, apparently dying without ever having received his needed medication. DOJ Study at p. 16.

In another similar instance, an inmate who had previously attempted to kill himself was inexplicably released from suicide observation in FIP. Despite repeated statements to staff and other inmates that he would kill himself, the inmate was placed alone in a single cell and did not received his prescribed medication for the two days prior to his suicide, again according to the DOJ Study. Id.

Granted, sworn personnel in the jails may lack the medical and psychiatric expertise to second-guess certain of the medical decisions that are made. On the other hand, it is

the executives in Custody, and not the doctors, who know how to run a jail and deal with the attendant logistical difficulties. And whether or not the ultimate failures are those of the mental health and medical staff, the Sheriff's Department has the plenary responsibility under the law to run a jail that meets California Title 15 standards and United States Constitutional provisions. As such, the Sheriff's Department cannot sit back and tolerate malpractice or malfeasance on the part of medical personnel and must be as aggressive in terms of policing the doctors and nurses as it is in policing itself or jail inmates. And if inadequate resources preclude the LASD from taking this responsibility fully, then it is up to the County to see to it that resources are provided.

But that does not mean that the Sheriff's Department must necessarily pick up and do the job of doctors and nurses when the medical personnel fall down on the job. To be sure, we are in favor of extensive training of deputies who work with the mentally ill in the jails. When the Sheriff's Department was able to use the Biscailuz facility to house mentally disturbed inmates, we understand that the deputies working there received as much as 80 hours of additional training in order to deal with the mental health and security issues involved. If so, nothing less ambitious should be ordered for those deputies who work the mental observation units currently.

Certainly, all personnel working in the jails should be given adequate training to be able to detect signs of mental illness or suicidal behavior. But this is not so the deputies can do the jobs that doctors and nurses should do. Neither DMH nor Medical Services should be permitted to devolve substantial responsibility for identification and classification of the mentally ill to custody staff. Custody staff needs to know enough to be alert to a medical problem and call the proper authorities and to guarantee the safety of the inmate and the medical staff. They should not, in our view, be required to perform triage or diagnose illness; and the mere presence of a mental health worker at intake to provide some generalized supervision does not suffice in our view.

We also believe that the well being of the Custody staff must be taken into account. It is not only the mentally ill inmate who may need assistance. Just as the LASD provides critical incident debriefings and the support of psychologists when a patrol officer is involved in a shooting and has taken a life, so too should the LASD support the Custody employees who must deal with the consequences and aftermath of suicides and suicide attempts as well as what must seem at times to be incomprehensibly bizarre behavior by mentally ill inmates. As our consulting psychologist, Dr. Gross, notes, "the deputies working in Custody need somewhere to go and someone to talk to in order to try to make sense out of what doesn't make sense."

We have additional concerns about the physical surrounding in which the mentally ill are housed and where Custody staff must work. As our own repeat visits confirm, mental health housing is insufficient and is in poor repair. The absence of sufficient safety cells increases reliance on restraints. And, as noted by the DOJ, isolation cells at the Pitchess East facility, in which mentally ill inmates may be held if they act out, reduce auditory and visual stimulation to such an "extremely low level that they could severely exacerbate existing mental illness." DOJ Study at 12.

Moreover, critical decisions in a custody setting demand a coordinated response from the medical, mental health, and custody representatives. We have run across instances where individuals are released from FIP without adequate provision having been made for continuing medication or proper housing. We have seen instances where individuals are returned to custody from off-site mental hospitals and are essentially lost in the general population.

In our view, any inmate should not be released from FIP or reintroduced into the jails from a mental hospital, including LCMC, without the specific concurrence and coordination of responsible individuals from the head of Medical Services, DMH, and Custody. Better yet, we advocate a unified medical and mental health staff. A recent chilling anecdote will suffice to illustrate our point.

On or about July 14, 1997, a fight erupted between an inmate assigned to general population and deputies who were trying to remove the inmate from the cell for his own safety after he had apparently caused the toilet in his cell to backup and begin to flood the area. The inmate alleged that deputies beat him for no reason, suggesting that 50 to 60 deputies beat him for 10 to 15 minutes with flashlights. The inmate's allegations appeared substantially exaggerated, although the inmate was found to have two cuts on his face, abrasions on the shoulders and back of this right arm, a chipped upper front tooth and a small scratch on his lower back.

The inmate was a 34-year-old male who was 6 feet 3 inches tall and weighed 230 pounds. Significantly, he had been returned to the Los Angeles County Jail System from Vacaville State Prison some 6 days earlier and apparently had not received his psychiatric medication since entering the LA County jail system. He was placed in general population on his return to the LA County jails. An internal analysis of the incident was absolutely correct: The inmate should have been identified as a mental observation inmate during the initial screening that normally takes place at IRC. He should never have been approved for housing in the general population's areas. His statements that he was on psychiatric medication coupled with the fact that he was sent from Vacaville State prison should have alerted the medical/mental health personnel when he was booked at IRC. We urge consideration of this story from the perspective of the custody deputies, confronted with a 6 foot 3 inch, 230-pound man in the throes of unfathomable mental distress, undoubtedly thrashing wildly. We similarly urge consideration of this story from the perspective of the inmate, perhaps in abject terror and hallucinating from sudden with-drawal from necessary medication, being set upon by several deputies. This war between a delusional inmate and foot soldier deputies broke out because doctors and nurses were not doing their job and the LASD executives were not doing theirs. The fact that the inmate was on medication should not have escaped the doctors' and nurses' attention and it was their responsibility to see that he got it.

If there are not enough beds in other mental observation units so that the inmate can be guaranteed adequate suicide monitoring by DMH, then Custody should have a decisive voice regarding movement of the inmate. At times, this will create difficulties, especially where there are too few beds in the forensic in-patient unit. The answer may be expanded transfer of seriously ill inmates who meet legal admission standards to Metropolitan State Hospital or Patton. Complaints that such transfers are impossible because of security objections from Custody do not appear well grounded: Indeed, one senior manager in Custody said he would transport the mentally ill in his own car if necessary to provide adequate supervision by mental health professionals, especially if the alternative is dumping them on the Custody staff to monitor. Better yet, the number of beds in the 4000 and 7000 modules should be increased. But if DMH cannot feasibly house an inmate in FIP, then Custody should hold up a transfer or insist that mental health professionals, preferably from a unified medical staff, remain in control of the inmate wherever the inmate must be moved in the facility.

As noted earlier, the Sheriff's Department seems oddly frozen and unable to respond aggressively, at least with respect to those aspects of the solution that are not strictly custody-related. On the other hand, credit must be given to the executives and risk managers in custody — from Commander Carole Freeman to Captain Bill Christiansen to Lieutenant John Vander Horck to Jake Katz to Sgt. Rick Myers — all of whom have pointed out the problems and each of whom have taken steps to begin correcting those aspects of the problems that are amenable to correction by sworn and civilian custody personnel and custody assistants.

It may be time to consider radical solutions. It goes without saying that mental health professionals must be required to screen inmates at the front end, segregate those in need of treatment, and have plenary responsibility for dealing with them. Perhaps one or more facilities should be earmarked within the jail system to deal with mentally ill persons. Perhaps Sybil Brand could so be used, or perhaps Twin Towers.

Any visit to Men's Central jail convinces one beyond peradventure of a doubt that the 4000 modules should be completely remodeled or closed down as housing for the mentally ill. The stark fact is that adequate care cannot be provided there, well meaning and conscientious as are the custody assistants and deputies who work those hard assignments. And the problems are getting worse rather than better. In 1996, the average daily count of inmates in mental observation housing was approximately 350 inmates. In 1997, the 4000 mental observation modules at Men's Central jail are scheduled to accommodate more than 500 such inmates. As is also apparent, the frequency of force incidents in MCJ is clearly related to the 4000 mental observation modules, which account for nearly one-third of all the force incidents in MCJ.

In our view, the Sheriff's Department should insist that the County consider radical alternatives that would produce a unified medical and mental health staff. The responsibilities for the mentally ill could be assumed either by the Sheriff's Department Medical Services unit or privatized. Medical Services could be merged with DMH professionals and a unified staff created. Although we are somewhat skeptical, it might make sense to consider whether to turn medical and mental health care over to the County's Department of Health. Perhaps the medical and mental health functions should be privatized entirely to bring in a qualified health maintenance organization with a unified medical and mental health staff.

In the interim, we recommend that Medical Services immediately hire adequate numbers of psychiatrists and other mental health professionals to assure a basic level of screening and treatment that cannot currently be provided. We so recommend even though it will tax the LASD painfully at the moment and the County should ultimately provide the financial resources. In so recommending, we acknowledge that many problems already exist within Medical Services itself. We have reported in the past on unacceptable mistakes in medical procedure, failures to provide proper care, chaotic records, missed deliveries of medication, and other serious problems. We recognize that for Medical

Services to get its house in order is no small task, and that to ask it to pick up additional responsibilities in the mental health area runs some risk of compounding an already intolerable situation. Nonetheless, it is no answer to leave things in the status quo.

Whatever the ultimate solution, Special Counsel finds the current situation inexcusable, and the taxpayers of Los Angeles County are paying and will pay millions of unnecessary dollars for medical and psychiatric malfeasance that could and should be avoided. As noted earlier, the County may need to re-think from the beginning how best to provide medical and mental health care to inmates. We will continue to monitor this area with deep concern and great care.

# 2. Automation in Custody

For the last six years, in the **Kolts Report** and thereafter in each of the **Semiannual Reports** of Special Counsel, we have repeatedly expressed our concern about the Los Angeles County jail system's deepening data-related problems, and, with increasing urgency in our last two **Semiannual Reports,** we have urged the Board of Supervisors to authorize greater automation of data.

In the investigation leading to our **Seventh Semiannual Report,** our concerns deepened further. While acknowledging progress by the Department in drafting and implementing uniform internal reporting requirements, we frankly did not believe that the County and the LASD had a reasonable plan for upgrading the inefficient, mistake-ridden, paper-driven information systems that were leading to erroneous releases, over-detentions, haphazard and substandard delivery of medicine and mental health services, incomplete or improper classification of inmates, and chronic and unacceptable levels of clerical and medical error. The best estimates we heard was that it would take five to six years to attack some of the problems, and that did not even include automation of medical records. We said flatly that the "County cannot afford to wait five or six years" and that we could not "stress enough" how "critically deficient" were the information systems on the Custody side of the Sheriff's Department's operations.

Given the depth of our concerns, it is good to report that during the last six months, at the direction of the Board of Supervisors, the County has begun to move on those aspects of these problems that are amenable to improvement by automation. At the strong insistence of Special Counsel that only a comprehensive automation plan covering all aspects of custody operations would do the job, the Board of Supervisors formed a county-wide task force to formulate a comprehensive, countywide plan under the auspices of the County's Coordinated Law Enforcement Justice Information Systems Committee ("CLEJIS" or "Committee"). Led by the County's Chief Information Officer, Jon Fulinwider, the Sheriff's Department's Captain David Betkey, and Special Counsel, with substantial help from the Sheriff's Data Systems Bureau, the Committee has drafted a Three Year Plan for custody automation.

CLEJIS held the first meeting of the task force on June 4, 1997 to formulate an automation strategy for Custody. The Committee's first task was to negotiate more cooperative relationships between and among the Sheriff's Department, the Municipal and Superior Courts, and the District Attorney's Office to facilitate faster communication between these criminal justice agencies with respect to the charging and holding of inmates and the scheduling of court dates and release dates.

There was unanimity among the group that the existing level of automation for inmate tracking and delivery of mental health and medical services was grossly inadequate. Priority issues, all of which needed to be immediately addressed, included medical and mental health, classification, erroneous release, and over-detention.

The Committee devised the proposed Three Year Plan for custody automation over the summer months of 1997. The Board of Supervisors' deputies met with the Committee on September 3 and September 10 to review the Committee's proposed Three Year Plan for custody automation. When and if the plan is fully implemented, the County will have improved access to data necessary for managing, tracking, housing, classifying, providing medical and mental health care, and releasing inmates in a timely fashion. The plan, discussed in greater detail below, will be introduced in a phased program, and benefits should begin to accrue incrementally starting in late 1997, with the most immediate impact felt in the Sheriff's Department's systems to prevent erroneous release and over-detention of inmates. **Although we cannot say that it will address all automation needs in custody, we believe that it is an urgently needed first step and we strongly advocate that the Board of Supervisors order its speedy implementation.**

The custody automation plan proposed to the Board of Supervisors will have several distinct components and phases. We group them for discussion below by the principal needs they address: delivery of health services; automation to reduce the risk of erroneous releases and over-detentions; automation to keep track of inmates as they move back and

forth between the jail and the courts; and automation to help identify, classify, and track inmates in the different county jails.

## *The Jail Hospital Information System*

As described in Chapter One of this report, medical services to inmates are currently provided by the Sheriff's Department's own Medical Services unit while mental health services are currently provided by contract with the County's Department of Mental Health ("DMH"). The logistical problems in the jails are daunting in general, and they have become overwhelming in the context of timely and consistent provisions of health services. Putting aside the longer-staying second- and third-strikers awaiting trial, the inmate population in general turns over rapidly. There are frequent transfers of inmates between facilities, and inmates are often ferried to and from court in connection with appearances and trials. As noted below, there is currently no automated tracking system to locate given inmates or to follow them through the jail system and the courts, thereby adding to the difficulty of finding a given inmate at any moment in time and substantially impeding consistent and uninterrupted delivery of medication.

The problem is severely aggravated by a lack of centralized, automated medical records. Paper medical records are supposed to follow the inmate from facility to facility but often do not. They arrive late, may contain inconsistent and conflicting notations— if they can be deciphered at all— and thus cannot be carefully coordinated with the inmate to assure continuity of care. The flow of paper among doctors, nurses, the pharmacy, the laboratory, radiology, and custody personnel exacerbate the difficulties of there being a complete, up-to-date medical record on a given inmate.

Current practice is that separate medical records are kept at each of the Sheriff's jail facilities. Accordingly, an inmate may have a separate medical record at each facility to which he is transferred during his stay in the County jails. The practice was harshly criticized by the Justice Department in its recently-released September 5, 1997 report

on mental health in the Los Angeles County jails, ("DOJ Study"): "Maintaining several medical/mental health records for each inmate exacerbates communication problems, creates unnecessary duplication of work, and increases the likelihood that important medical information will be missed... Multiple records create delays of days or even weeks before information from an inmate's medical record at one facility can be transferred to medical staff at another. In some instances, medical information is not transferred at all." DOJ Study at 22. The reliance on inadequate paper records also means that the Sheriff's Department has difficulty seeking the reimbursement to which it is entitled for medical care delivery.

The inadequacy of medical record keeping contributed significantly to the sharp criticism by the Department of Justice of mental health services provided to inmates, and the criticisms apply with equal force to other medical needs. The Department of Justice concluded that the Los Angeles County jail's "record system, including the mental health record system, is inadequate. It significantly impedes, and sometimes makes impossible, the provision of mental health services to inmates. Jail staff reported that the County's jail and medical computer systems are wholly inadequate to track and manage the care of inmates with mental illness and medical needs." DOJ Study at 21.

In order to deal with aspects of the problem that can be eased by automation, the Committee has proposed a Jail Hospital Information System (JHIS) to the Board of Supervisors. It will be an on-line electronic medical record accessible from any Custody facility. In addition to being an integrated master patient index and medical record, the system will also support patient and resource scheduling; patient care management; and the laboratory, radiology, and the pharmacy, among other functions. The JHIS will be implemented in phases. Under current anticipated scheduling, the JHIS will not be fully implemented until the end of 1999. Although it will address many of the concerns expressed jointly by DOJ and Special Counsel, we would like to see its implementation speeded up. **It is Special Counsel's considered judgment after three years of study that the current paperwork system for medical and mental health records**

**is wholly deficient and is incapable of more than interim, band-aid like fixes. The Sheriff has said time and again that he insists on running a jail that meets all constitutional and statutory standards, and in our judgment he must have the proposed automated jail hospital system to do as he has pledged.**

Seen from a narrow perspective, the JHIS system is not cheap: it is estimated to cost in the range of $6 to $8 million as well as another $1.725 million for installation, training, and management along with estimated yearly maintenance costs of an estimated $775,000 per year. Seen from a wider perspective — which sweeps in the recurring costs of liability associated with the failures of the present paper-driven system and the sometimes tragic consequences to seriously ill persons — many of whom have not been convicted and are awaiting trial — the project will quickly pay for itself in terms of reduced current and future liability. The County cannot afford not to have it, and it will remain necessary even if, at some future date, it is determined to transfer the Sheriff's medical service responsibilities or DMH's mental health services to a private company or other external provider.

## *Systems to Address Over-Detentions and Mistaken Releases*

The second set of elements in the proposed automation plan is directed to the problem of over-detentions and erroneous releases. Current manual methods of processing court documents relating to a given inmate's status has overtaxed the staff and resources of the Inmate Reception Center, leading to instances of over-detention of inmates and erroneous releases. Interim fixes at IRC have substantially scaled back on erroneous releases by expanding the staff in the IRC's document section and by setting up additional fail-safes to prevent error. The additional personnel is a very costly way to deal with a set of problems that can be easily cured by better electronic communication between the jail and the courts.

As has been described in our previous reports and in the press, communication between the various different branches of the Superior and Municipal Courts and the

Sheriff's Department about charging, scheduling, transportation, and sentencing of inmates is done on paper. The manual, paper-driven system has been strained past the breaking point. Not only are the documents not necessarily uniform from court to court, but they are often difficult to decipher and interpret and may be superseded or counter-mandated by other documentation respecting the inmate originating from the District Attorney's office.

For example, the prosecutor may determine to drop charges against a given inmate in anticipation of filing a superseding or amended set of charges against the individual. The court will duly record that all charges against the inmate have been dropped, thereby alerting the Sheriff's Department that the inmate should be released. Later in the day, the superseding set of charges will be filed, and a hold will be placed on the inmate. Unless the documentation reflecting the new charges and the hold arrive relatively simultaneously and are coordinated, a possibility of an erroneous release is raised. Given the heavy paper flow and the volume of inmates flowing in and out and around the jail and the courts on a given day, the potential for human error is large.

In the absence of automation, as noted earlier, the short-term solution has been to throw clerical bodies at the problem and attempt to better control the flow of paperwork at the jail. It is a testament to the persistence and effort of Captain Betkey that erroneous releases have been held to a minimum and over-detentions better managed through an intense effort to control and double- and triple-check the paperwork. But just because Captain Betkey has shown that for the moment he can stanch the flow of erroneous releases and over-detentions does not mean the problem is fixed for good. Automation will at least contribute to a long-term solution.

The Committee has proposed as a first step automating the entry of court orders with respect to pre-trial inmates. Forms for the input of the data will be standardized county-wide. Entry of the information by the courtroom clerk will be transferred automatically to the jail, thus allowing the inmate's status to be determined before the bus carrying the

individual arrives at the jail. This in turn will allow the Sheriff's staff to make speedier and better determinations concerning continuing incarceration versus release. Similarly, the DA's office has agreed to give more timely notice of superseding charges and holds to reduce the chances that inconsistent orders respecting the same inmate are received. This automation should be completed by mid-Spring 1998.

Another element to reduce the risk of erroneous releases and over-detentions is enhanced automation of information about pending warrants and holds. Currently, the Sheriff's Department must make critical decisions in the absence of complete and accurate warrant information. Warrant checks must be capable of being made automatically at all key processing points. The risk that an inmate could be released from custody when wanted for a serious crime in another jurisdiction must be reduced.

The proposed solution will automate the generation of warrant checks from county, state, and federal databases at three critical processing points: (i) as the inmate first enters the county jail system at the time of booking; (ii) at the time during the initial processing of inmates when they are positively identified and prior to classification; and (iii) when an inmate is about to be released. According to the schedule proposed by the Committee, this automation should be accomplished by March 1998.

## *Systems to Track the Location of Inmates*

An average of about 1600 inmates go to and from the courts and the jails on a daily basis. Courts and jails are scattered throughout the County, and the logistical issues are complex. The Inmate Reception Center, or IRC, is the funnel through which substantially all inmates are brought from the jails for dispersal to the various courts and are returned at day's end from the courts for dispersal to the jails. IRC also receives and processes all incoming newly-arrested and newly-convicted inmates and releases those who have served their time or are otherwise being released.

Throughout the process of moving inmates to and from the courts, the inmate

and paperwork respecting the individual must be coordinated, accounted for, and tracked. Three arms of the Sheriff's Department — Custody and Court Services, along with its constituent Transportation bureau — share responsibility for transporting, tracking, securing, and protecting the inmates as they move back and forth from the jails to the courts. Information with respect to a given inmate's security status and special handling needs must be passed between and among Custody, Transportation, and Court Services: For example, inmates who are mentally unstable or pose a high risk of escape or have been designated to be kept away from all other inmates for security reasons must be kept separate on the buses and in court lockups for their own protection and for the safety of other inmates and LASD and court personnel. As might be expected, the current system to handle all these logistical issues are on lists and slips of paper.

In the **Seventh Semiannual Report,** we described instances in which the failure to specially handle an inmate led to serious injuries. In one instance, a female inmate in a holding cell at a courthouse was attacked by a mentally ill inmate for whom a special handling card had been prepared. But because of communication snafus between the jail and court services, the mentally ill inmate was not identified by the court services personnel and was not kept away from other inmates.

The Committee has proposed as a first step to automate several phases of the process, including the generation of lists of inmates scheduled to appear in court along with new bookings and court-ordered remands to custody; the automation and frequent updating of data concerning inmate location; the addition of a query capability so that the computer can be asked to set forth the current location of an inmate; and the automation of data concerning an inmate's status, segregation requirements, security, and special handling status updated with new court developments or incidents so that IRC can be alerted to security incidents that may have occurred during the day prior to the inmate's return. If approved, the inmate tracking system should be in place by the end of 1998.

## *Systems to Better Identify and Classify Inmates*

The most critical decisions concerning inmates after they are booked are made in the classification process. As described at length in our **Sixth** and **Seventh Semiannual Reports,** the goal of classification is to positively identify and learn as much as possible about a given inmate in the shortest amount of time. Based upon the classification decision, an inmate is assigned a level of security risk, placed in housing appropriate to the risk, given special protection if necessary to avoid being victimized or the target of violence, and assigned special housing if the inmate presents mental or medical problems. In Los Angeles County, the sheer number of incoming inmates every day dictates that the classification process must be completed in minutes.

As commonplace as it may seem, one of the most difficult tasks in the classification process is to positively identify the inmate. Incomplete identification means that information vital to the safety and security of the jails is not taken into account during classification. Inmates may arrive with many aliases and long criminal histories. They may be repeat offenders who have spent time previously in the county jails or in state or federal prisons. They may have had previous health problems as inmates in the county jail. They may have been disciplinary problems during their previous stays. Even if they are currently being jailed for a relatively minor offense, they may be the subject of outstanding warrants for other serious offenses elsewhere. They may have a long history of violence that is apparent from prior convictions.

Currently, a significant number of inmates arrive at the jail without a fingerprint-based number that ensures positive identification. And for those that do arrive with that information, the data is captured manually, if at all, and at a point that may be too late to be useful for classification purposes. The problem is exacerbated because not all law enforcement agencies within LA County participate in the County's uniform booking and arrest system, leading to missing data on various arrests and bookings that do not otherwise come to the attention of the Sheriff's Department.

The solution to the identification problem is to connect the Sheriff's Department's arrest and booking databases with dispersed information captured through a computerized system called Livescan that provides the most reliable fingerprint-based positive identifications and can be used to collect information about a given inmate under the individual's real name as well as any aliases. Livescan is currently located at all booking locations throughout the County, and the Committee has proposed this further automation to assure that data gleaned from Livescan is transferred automatically to the County's uniform booking and arrest system. The proposed solution should insure that all incoming inmates have positive identification that can be linked to criminal history, warrants, court data, and institutional history data. This automation should be accomplished in late 1997 and early 1998.

Once an individual is positively identified, the person's prior disciplinary history must be available to assess security risk. There is currently no mechanism to permit the Sheriff's Department to access an inmate's recorded disciplinary history during prior incarceration in the LA County jails. The proposed solution is to establish an automated system that will record and track inmate incidents such as prior violent episodes or attempted escapes, as well as disciplinary hearings and their outcome. The data will be maintained and updated throughout multiple stays in the jails by the same inmate. This system should come on board at IRC and Twin Towers by the end of 1997 and be implemented at other sites in early 1998 if the Committee's Plan is accepted by the Supervisors.

In addition, the Three Year Plan contemplates that five years' worth of historical data that is currently on computers, but is cumbersome and difficult to access, will be replicated in a computer environment that will make it easier to get to and more responsive to queries and trend analysis. The replication of the historical data should be completed during the Spring of 1998.

The Three Year Plan additionally contemplates rewiring the various jail facilities to support personal computers and a local area network. The wiring will be done in phases. In the first phase, scheduled to be completed by June 1998, Central Jail will be wired and the computers installed. The outlying jail facilities will be complete by early 1999.

Finally, the Three Year Plan contemplates an overhauling and re-writing of the County's current, out-moded automated jail information system that currently cannot adequately meet the needs of the jails. The project will be take longer than the other pieces of the Three Year Plan and is not anticipated to be completed until early in 2000.

In sum, the Committee has constructed a series of projects that should help substantially to aid the County and the jails in those areas in which automation is a principal part of the solution. Automation is not, however, the sole answer, as demonstrated in our chapter on mental health issues.

# 3. The Inmate Reception Center

A year ago, in our **Sixth Semiannual Report,** we described serious concerns about one custody facility in particular — the Inmate Reception Center. A year later, it is good to report that our concerns have begun to ease in some areas. In previous reports, we have often described the Inmate Reception Center, or IRC, as the linchpin of the entire Los Angeles County jail system. It is the first stop for inmates entering the system, the last stop for inmates leaving the County jail system, and the place that most inmates pass through going to and from court appearances.

The numbers of inmates processed by IRC on a given day are substantial. During week days, between 1600 and 2000 inmates pass through on their way to and from court. As a result of weekend arrests, as many as 1000 new inmates may flow into the jails. During slower periods during the week, more than 500 new inmates enter the jail system each day, and a similar number leave. IRC is where inmates are first processed and classified according to security risk and are assigned to the general jail population or to one of 43 special housing categories. It is during the classification process that inmates suffering from physical or mental illnesses are supposed to be identified and treated by the Sheriff's Medical Services unit or by the County's Department of Mental Health.

When IRC fails, there are repercussions throughout the jail system. Mistakes in identifying and classifying inmates enhances the possibility of jail disturbances and riots, inmate-on-inmate violence, inmate-on-staff assaults, and lapses in inmate protection and care. Although not the direct responsibility of IRC, inmates are screened during the intake and classification process for mental or physical disease, and errors here have enormous consequences for the jail system and the Sheriff's Department as a whole. As is described more fully in Chapter One of this report, medical and mental health services remain the Achilles' heel of the entire jail system.

Those serious problems notwithstanding, during the last six months, there has been progress in many areas under the direct control of IRC. Erroneous releases have all but halted. In 1996, there were 32 erroneous releases, including individuals in major offender

categories. In the first three quarters of 1997, there have been eight erroneous releases, five of which occurred in the first quarter of the year. There has not been an erroneous release since June. All eight mistaken releases in 1997 were of minor offenders, all of whom were found and returned to custody within hours.

Although data for periods prior to 1997 are to be read with caution, we believe that enough data have been assembled to permit us to report at least tentatively on some positive trends in use of force within IRC, historically a facility where force was exerted frequently and at times brutally. The total number of force incidents at IRC in 1997, projected from mid-year figures, will in all likelihood be at least 10% fewer than in 1996. In almost all sub-categories of force, IRC experienced a sharp drop in force incidents since January, when new management took over the IRC. In some but not all categories, the drop in force incidents has been maintained through August, the last figures available to us for this report. The number of suspects upon whom force was used, for example, dropped from 35 in January to 19 in February and has not exceeded 18 in any subsequent month. Individual uses of significant force dropped from 19 in January and has not been as high as 19 in any subsequent month, although there were three months in which there were 16, 17, and 18 significant force incidents respectively. Despite this evidence of progress, however, the ratio of force incidents overall to average daily inmate population in IRC remains high as compared to other custody facilities.

In other areas, results are mixed. It appears, for example, that there will be more inmate-on-inmate assaults in IRC in 1997 than in 1996 as well as greater numbers of inmate-on-staff assaults. But when the numbers are broken down by month, however, the trend again is encouraging. Whereas in January 1997, for example, there were 44 inmates who were the victims of assaults by other inmates, the number dropped to 17 in May, 11 in June, and 7 in August. Similarly, whereas 9 staff were the subject of inmate assaults in January, the number dropped to 2 for July. As new management has been able to assert control, the numbers appear to be dropping in general.

Overcrowding in the jails — a problem managed by IRC — has eased. Within the Custody Division as a whole, the Sheriff's Department has been under its mandated population caps for August and September 1997. The one facility that has remained chronically overcrowded is Men's Central Jail (MCJ). The problem in that facility could move toward resolution if MCJ's use as a temporary warehouse for inmates could be reduced or substantially eliminated.

Currently, we are told that MCJ temporarily houses as many as 1000 inmates daily who have been classified but are awaiting transportation to their ultimate custody destination. MCJ also continues to house large numbers of state prison-bound inmates on any given day, although the numbers are beginning to drop. The state is currently picking up about 30% more male inmates bound for state prison on a weekly basis than at the beginning of the year. State prison-bound female inmates, however, are not moving out any more quickly. At the beginning of the year, the backlog of state prisoners still in County jail was approximately 1500 on a given day. As of mid-September, the number has dropped substantially to approximately 300.

The assignment of inmates to community-based alternatives to custody (CBACs) — which include work release programs, weekender programs, home confinement, and electronic monitoring programs — has started once again to expand after having almost ground to a halt earlier in the year. A snapshot as of mid-September 1997 discloses nearly 2000 inmates in CBACs, including more than 800 in work release, approximately 800 on electronic monitoring, and more than 300 in weekender programs. IRC estimates that it may have as many as 1000 inmates placed in work release by the beginning of November 1997. So far in 1997, approximately 500 individuals have completed their assignments to a CBAC. The non-compliance rate for work release, which had been up at the 33% level on a cumulated annual basis, has leveled off at approximately 12% on a cumulated annual basis, or an acceptable average of approximately 1.3% per month.

Because of better overall population control, the percentage of a sentence that a given

inmate currently serves has risen substantially during 1997. As of the end of 1996, except for some narrowly-restricted crime categories for which inmates were kept in jail longer, male inmates were serving approximately 35% of their sentence and females approximately 25% of their sentence before being released. As of mid-September, both male and female inmates are serving 60% of their sentences, and the goal for October 1997 is to have inmates serving 70%. Moreover, the categories of individuals who do not qualify for early release has expanded to include greater numbers of persons convicted for violence offenses — including armed robbery and family violence crimes, for example.

As the percentage of sentence served continues to rise, the incentive for low-risk inmates to seek to be placed in a CBAC will also rise. Earlier this year, the incentives were upside-down: Inmates would serve less time overall if they stayed behind bars than if they went into a CBAC. Now, it works the other way — inmates successfully completing CBAC programs serve less time than those who remain in jail. Additionally, there are two strong disincentives for inmates to flee from a CBAC: There is an increasing likelihood that absconding inmates will be returned to jail by the IRC compliance enforcement team and when they are jailed again, they not only will serve 100% of the original sentence but will be disqualified from participation in CBACs on subsequent arrests. The news that absconders will be caught and suffer the consequences seems to be getting out: Initially, several female inmates assigned to electronic monitoring left the jail, cut off the electronic ankle bands, and tossed away $2000 worth of tracking equipment. As they were picked up by the enforcement teams and returned to custody, the word spread quickly throughout the jail and the rate of would-be absconders dropped quickly.

There are nonetheless areas of substantial concern that remain. Although not the direct responsibility of IRC, the screening of mentally and physically ill inmates remains substandard, as is more fully described elsewhere in this report. The revised inmate classification test — which has undergone a significant overhaul to include a more

complete analysis of individual inmates for risk of becoming either perpetrators or victims of violence in the jails — is not yet being applied in substantial numbers to male inmates, although female inmates are currently subject to the wider analysis. IRC estimates, however, that it will have the classification system fully in place for male inmates by the end of October 1997. Although the Probation Department has been unable to perform risk assessments on a large number of entering inmates, as was initially hoped, the Sheriff's Department and the Probation Department have met on a number of occasions to attempt to work out the difficulties.

In other areas, the results are mixed. The processing of inmates for release continues to be slow. Although the IRC at Twin Towers has substantially better storage equipment for inmates' clothing and property than existed at the MCJ's IRC, staffing is so meager that inmates awaiting release cannot be reunited with their street clothing and belongings in a timely manner and there are substantial backups and delays. Misplaced and unclaimed property continues to accumulate in trash bins near the property room.

We are pleased to report, however, that our recommendations that inmates be supplied tennis shoes has been implemented. Noting that jailhouse knives were often made from metal shoe shanks in street shoes, we urged the Department to take away the street shoes and substitute tennis shoes. The better storage equipment at Twin Towers permits the storage of street shoes that apparently could not be stored at the old facility in MCJ.

In sum, there has been a rapid turn-around in the last six months in several key areas of concern at IRC. The challenge now is to expand the fuller classification system to all incoming inmates. Captain Betkey and his staff at IRC have done an excellent job of reducing erroneous releases and over-detentions. They have done so thus far without the benefit of automation, which, as described elsewhere in this report, should significantly ease the problems and reduce the risks. At this point, the progress has come about by the assignment of extra clerical help. Although it is useful and necessary to undergo the added expense of extra clerks in order to reduce the risk of error, the solution in the long

run is not a practical one. Greater automation combined with better-trained, more highly qualified clerical help is the cheaper and more efficient way to proceed. We are encouraged by what we have seen happening in IRC over the last six months.

We will continue to watch this important custody facility carefully. We will keep our eyes on force trends, inmate-on-inmate violence, inmate-on-staff assaults, classification, and the other issues which have in the past made IRC a poorly-managed area. As we have noted before, it is vitally important that improvements be institutionalized and not simply reflect the personality of a particular manager. At our urging and as a result of erroneous releases and over-detentions, the Sheriff put a number of his best people in charge at IRC with a mandate to bring the facility up to standard. Captain Betkey and his staff have turned things around, but at a facility as critical as IRC, progress can erode rapidly, and hard-won gains in reduction in force can dissipate with astonishing speed under a laissez-faire manager. Six months of good results is admirable, but we will not rest easy about IRC until we see the current trends solidified, fortified, and expanded over the next several years.

## *The Data Analysis Unit*

In our **Sixth Semiannual Report,** we raised troubling questions about the integrity of the data being collected and disseminated by the Custody Division, and recommended that the LASD address those questions by creating a risk management unit devoted exclusively to custody issues. In our **Seventh Semiannual Report,** we reported that the LASD had taken the first steps toward implementing this recommendation by replacing the old planning and research unit in the Custody Division with the Custody Support Services Risk Management Unit, which is divided into three subunits: Standards and Compliance, Risk Analysis, and Data Analysis. The purpose of the Data Analysis Unit, which began operating in April 1997, is to ensure the reliability and validity of the raw data collected at the facility level; to analyze that data and "translate" it into information that can be used by managers to reduce risk; and disseminate the data both within the LASD and to outsiders, such as the press. We are pleased to report that, barely more than a year after we reported on the primitive state of the Custody Division's collection and analysis of data, the Data Analysis Unit is in the process of creating a state-of-the-art data collection and analysis system.

The name of this system is, appropriately enough, the Facilities Automated Statistical Tracking system, or "FAST." According to Sergeant Rick Myers, who heads the Data Analysis Unit, FAST should be up and running completely by February 1998. FAST will have the following components:

- Each facility will receive a computer terminal on which data may be inputted and transmitted to the Data Analysis Unit on a daily basis. At present, the facilities input data on a monthly basis. Much of this information is transmitted directly to the Department-wide Risk Management Bureau, where it is compiled into the end-of-the-month Command Accountability Reporting System (CARS) report. The fact that this information is inputted only once, at the end of each month, has a number of negative consequences:

(i) managers are limited to making month-to-month comparisons, and thus do not have the "real time" data needed to make daily or weekly comparisons or to spot a developing trend and stop it before it becomes a full-blown problem; and (ii) the facilities appear to engage in an end-of-the-month scramble to input all of the data, and such a scramble poses a risk that data will be missed or inputted incorrectly. Under FAST, data will be inputted on a daily basis, and will be transmitted directly to the Data Analysis Unit. This should prove a boon to managers not only because it will provide more accurate and "real time" data with which to make decisions, it should also save the precious resources previously lost in the end-of-the-month scramble. According to Sergeant Myers, computers should be installed in each of the facilities by the end of October 1997, and the software to allow the inputting of all relevant data should be installed and operational by February of 1998. The Data Analysis Unit intends to install the separate "modules" incrementally over the next 5 months (e.g., the "suicide and attempted suicide module" was recently tested at one facility, CRDF, and should be operational at all of the facilities shortly).

- Each Facility will have a Statistical Coordinator, whose sole function will be data collection and input. In the past, no one person was responsible for collecting and inputting data at each facility. This lack of continuity (and accountability) probably contributed to problems with the integrity of the data. The Data Analysis Unit requested that each facility chooses a Statistical Coordinator, and each has done so (most have chosen a civilian). Among other things, the Statistical Coordinator will be responsible for inputting the data into the FAST system, and for ensuring that the deputies and sergeants at the facilities are accurately recording the data that are to be inputted into the FAST system. In January 1997, the LASD promulgated a Guide to Management Information, which provided uniform definitions of the types of events (e.g., "inmate v. inmate assault") being recorded at the facility level. Thus, one job of the Statistical Coordinators will be to ensure that deputies and sergeants are using the definitions found in the Guide to Management Information.

- The Statistical Coordinators will receive training from the Data Analysis Unit and will attend monthly meetings to ensure that the data are being collected accurately. The Data Analysis Unit intends to train the Statistical Coordinators on the FAST system and to meet with them on a monthly basis to ensure that the data continue to be collected accurately and to obtain feedback on how the FAST system is working on the facility level (e.g., the Data Analysis Unit will attempt to determine if the forms currently being filled out by deputies and sergeants can be made more "user friendly" to ensure better capture of relevant data). To this end, the Data Analysis Unit has already held one training session for the Statistical Coordinators, and other sessions are planned. In addition, the Data Analysis Unit has already held two meetings with the Statistical Coordinators.

- The Data Analysis Unit will perform audits of the facilities to ensure the integrity of the data. In the past, because of under staffing, the planning and research unit did not have the resources to perform regular audits of the facilities to verify that data were being collected and inputted accurately. With additional staffing (the Custody Support Services Risk Management Unit has a staff of 19; the old planning and research unit had a staff of 8), the Data Analysis Unit intends to conduct regular audits of the facilities. For example, the Data Analysis Unit intends to audit the reports and logs kept by the facilities to ensure that there is back-up documentation for each of the events reported by the facilities.

These are ambitious goals, but it appears that the LASD has provided the Data Analysis Unit with the resources it needs to achieve those goals. By resources, we are referring not only to computer hardware, but also (and more importantly) to the staff of the Data Analysis Unit itself, who appear to have the dedication, intelligence and enthusiasm to achieve the Unit's ultimate goal: to provide managers not just with the raw data, but also with the interpretive tools needed to allow the managers to use that data to reduce risk. As Sgt. Myers says, the goal of the Data Analysis Unit is to "collect information, not numbers." We intend to follow the Unit closely in the coming months to see if it achieves this goal.

## *Preliminary Analysis of 1996-97 Data*

As noted above, the FAST system is being implemented in an incremental fashion and will not be fully operational until February 1998. In the meantime, the Custody Division continues to collect and disseminate data that are plagued by many of the same problems and caveats that made FAST a necessity. Nonetheless, so long as these problems and caveats are understood and acknowledged, the existing data raise provocative questions, the answers to which may enable managers within the Custody Division to better identify, and hence eliminate, areas of risk.

In preparation for this report, we reviewed data for 1996 and the first 5 months of 1997. While these data appear to offer themselves up to a straightforward comparison between 1996 and 1997, several significant caveats are in order. First, because the Data Analysis Unit did not become operational until April 1997, and FAST will not become fully operational until next year, the reliability and validity of the data for both 1996 and 1997 must be considered somewhat suspect. Second, care must be taken in extrapolating year end figures for 1997 from the data for the first 5 months of that year, in part because certain events (e.g., disturbances) tend to occur more frequently at different times of the year.

Second, in January 1997, the Department circulated a Guide to Management Information, which contains definitions of all of the events for which data are being collected in the Custody Division in particular and in the Department as a whole. One of the laudable goal of the Guide was (and is) to create uniform definitions to ensure that all of the deputies and sergeants recording and reporting such events are actually recording and reporting the same thing. However, the absence of these definitions before January 1997 obviously complicates comparisons between 1997 and 1996 (or any earlier year). In addition, the Manual includes definitions of events — or aspects of events — that had not been previously tracked by the Department. In particular, the Department is

now tracking many more aspects of the use of force than it had previously. For example, the Department is now tracking the number of individual uses of force, and the number of suspects upon whom force is used, in addition to the number of force incidents. Again, we believe this further delineation of force represents progress, but it also further complicate year-to-year comparisons.

Finally, comparisons between 1997 and 1996 are complicated by the fact that there are gaps in the data for 1996 (for example, we do not know how many service complaints were received for either East or North facilities). It is our understanding that the Data Analysis Unit has requested the missing data from the various facilities, who eventually will collect the data and report the results to the Data Analysis Unit. The unavailability of these data severely hamper any attempt to make comparisons between 1996 and 1997 for many events. In addition, the unavailability of these data further highlights the importance of getting FAST up and running as quickly as possible. Once data are being inputted at the facility level — and transmitted to the Data Analysis Unit — on a daily basis, the data for 1997 and beyond will be available instantly at the touch of a keystroke. Besides making it infinitely easier to make year-to-year comparisons, this will also free the facilities from the time consuming task of generating data for prior years at a moments' notice whenever a request is received from someone within the Department or from someone outside the Department, such as the press or Special Counsel.

With these significant caveats in mind, we can turn to the data. In the critical area of use of force, there were 316 force incidents from January through May of 1997. This projects out to approximately 759 for the whole year, which would represent a 25% decrease from 1996 (1012 force incidents). It appears that most of the decrease has occurred at the Pitchess facilities. Similarly, there were 11 excessive force complaints from January through May of 1997. This projects out to approximately 26 for the whole year, which would be a 42% decrease from 1996 (45 excessive force complaints). It should be noted, however, that the number of excessive force complaints at North

facility for 1996 was not available. This simply means that there may be an even greater decrease in 1997 than is suggested by the available data.

Similarly, there were a total of 106 personnel complaints (which include excessive force, discourtesy and dishonesty among other kinds of conduct) from January through May of 1997. This projects out to approximately 254 for the whole year, which would represent a 23% decrease from 1996 (329 personnel complaints). Again, 1996 data for North facility were not available, and thus there may be an even greater decrease in personnel complaints for 1997.

These data suggest positive trends in use of force and the kinds of conduct, like the use of force, that lead to personnel complaints. However, not all of the trends appear to be so positive. For example, there were 85 service complaints from January through May of 1997. This projects out to approximately 204 for the whole year, which would represent a ten-fold increase in service complaints from 1996 (22 service complaints). However, the 1996 data for service complaints for both East and North facilities were not available, and thus the increase for 1997 is undoubtedly less pronounced than the available data suggest. Nonetheless, this trend appears to be real, because all of the facilities for which data are available for both 1996 and 1997 appear to be facing an increase in service complaints. For example, there were 26 service complaints at IRC from January through May of 1997. This projects out to approximately 62 such complaints for the whole year, whereas there were zero in 1996. Similarly, there were 12 service complaints at Men's Central Jail from January through May of 1997. This projects out to approximately 29 for the whole year, which would represent an almost ten-fold increase in service complaints from 1996 (3 service complaints). This is a perplexing and disturbing trend, and one that demands the Department's attention. This is especially the case because the increase in service complaints is threatening to overshadow the decrease in personnel complaints, to such a degree that the Custody Division may actually see an increase in the total number of complaints.

On a positive note, the data suggest that some of the steps recently taken by the Custody Division to reduce risk may in fact be having the intended effect. For example, the data suggest a decrease in drug law violations. There were 158 drug law violations from January through May of 1997. This projects out to approximately 379 drug law violations for the whole year, which would represent a 21% decrease from 1996 (478 drug law violations). This may, at least in part, reflect the imposition of the "shoe exchange," given that inmates were known to smuggle drugs in shoes. Similarly, there were 51 robberies from January through May of 1997. This projects out to approximately 122 robberies for the whole year, which would represent a 29% decrease from 1996 (173 robberies). This, too, may in part reflect the "shoe exchange," in that shoes were the object of robbery attempts (it may also reflect the fact that the Department adopted a cashless system in the jails). Finally, the "shoe exchange" may be partly responsible for the apparent decrease in assaults with handmade weapons. There were 54 assaults with handmade weapons from January through May of 1997. This projects out to approximately 130 assaults for the whole year, which would represent a 57% decrease from 1996 (302 assaults).

Another explanation of this apparent decrease may be an increase in housing area searches, and a corresponding increase in the number of handmade weapons recovered. There were 607 handmade weapons recovered from January though May of 1997. This projects out to approximately 1457 weapons recovered for the whole year, which would represent a 57% increase from 1996 (929 weapons recovered). In particular, many more weapons are being recovered at NCCF and North. This suggests that the Custody Division is in fact being more aggressive in searching for such weapons, but the data for housing area searches are not complete and thus no comparisons can be made between 1996 and 1997.

The data on inmate complaints are also provocative. For example, there were 600 inmate complaints at CJ from January through May of 1997. This projects out to

approximately 1440 complaints for the whole year, which would represent an increase of more than 100% from 1996 (676 complaints). Similarly, there were 618 inmate complaints at East from January through May of 1997. This projects out to approximately 1483 complaints for the whole year, which would represent a ten-fold increase from 1996 (150 inmate complaints). We have been told that this increase reflects not a dramatic increase in the actual number of inmates who have complaints, but rather a dramatic improvement in the complaint process: new metal complaint boxes have been installed in the modules, and an effort is now being made to make sure that complaint forms are available to all inmates who have complaints. While these efforts are laudatory, it does suggest that in the past many inmates with complaints were not able to register them.

The data on assaults are also provocative. Overall, there were 1261 inmate-on-inmate assault "incidents" from January through May of 1997. This projects out to approximately 3026 incidents for the whole year, which would represent a 47% decrease from 1996 (5743 incidents). Because of highly suspect 1996 numbers, it is difficult to be definitive with respect to apparent increases in such assaults in 1997 at CJ and IRC. We recommend, however, that the possibly disturbing trends with respect to such incidents be tracked with care.

There were 96 inmate on staff assault "incidents" from January through May of 1997. This projects out to approximately 230 incidents for the whole year, which would represent a 28% increase from 1996 (180 incidents). The increase at IRC and CJ appears to be even more pronounced if the 1996 numbers are correct, and we suspect they are not. Again, in light of a possible increase, we again recommend careful tracking.

The data raise myriad other provocative questions. For example, there were 54 civil claims related to IRC from January through May of 1997. This projects out to approximately 130 claims for the whole year, and would represent a 140% increase from 1996 (55 claims). One explanation offered for this increase is the slew of "over detention" claims filed in 1997. However, there also appears to be an upward trend at CJ, where

there were 44 civil claims related to CJ from January through May of 1997. This projects out to approximately 106 claims for the whole year, and would represent a 26% increase from 1996 (84 claims).

We do not have the answers to all the provocative questions raised by the data nor know the reasons for these apparent trends; indeed, because of the caveats noted above, we do not even know if these questions are legitimate or the trends real. Rather, we raise the questions as a means of illuminating the treasure trove of information that such data promise to offer to the managers who are willing to make use of them. For this reason, we intend to closely follow not only the Data Analysis Unit's attempts to provide facility managers with valid and reliable data, but the manner in which those managers use, or fail to use, such data as well.