The Los Angeles County

Sheriff's Department

13 th Semiannual Report by

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Introduction

This is the thirteenth report ordered by the Board of Supervisors to review the performance of the Los Angeles County Sheriff's Department (LASD). Our orders are to provide an independent perspective on the LASD, to report problems, and to assess progress in a forthright manner. We do not serve a public relations function—as much as we respect the genuine effort, hard work, and daily heroism of sworn personnel and civilians in the LASD, we do not tout accomplishments simply for their own sake, although we factor in the good as well as the negative in our critical analysis. Nonetheless, as our responsibilities over the last decade have exposed us to more law enforcement agencies, we remain impressed by how the LASD compares favorably to many others.

Without trying to minimize the problems in the LASD—and, as this Report demonstrates, there are some serious ones—we would not feel comfortable failing to note that we see the LASD moving toward the forefront of American law enforcement. When we are asked to cite model policies and procedures, we turn to the LASD policy manual and general orders. When police agencies develop an interest in a tracking system, they ask us to arrange a visit to the LASD to see the PPI. When law enforcement groups call for advice on how to structure thorough internal reviews of shootings and use of force, we share with them what the LASD has accomplished by implementing the Kolts recommendations.

Our focus in this Report is once again in part on problems and chronic difficulties challenging the LASD. Some are serious, and others seem intractable. They require focused attention, resources, and oversight. They require that we remain involved and vigilant. But it is important not to get so enmeshed in the LASD's problems and challenges that one forgets that the LASD is a source of pride to the County. Our Report discusses some of these areas of solid achievement, as well as problems.

Chapter One focuses on shootings and other serious uses of force, concluding that the LASD is doing a fine job in controlling the number of deputy-involved shootings, both in

general and particularly at the Century Station, where in the past we expressed great concern. At the time we did our last intensive study of Century in 1998, the LASD was adamant that the high crime rate and the ambient violence in Century's service area accounted for the high number of shootings by deputies, which, the LASD argued, would not drop until the crime rate came down. Nonetheless, even though the external factors—crime rate, violence—have largely remained the same, the number of officer-involved shootings at Century has plummeted. Nationally, there are some cities (Detroit, for example) which consistently have substantially higher officer-involved shooting rates than others. The Century experience may be evidence that even in heavily crime-ridden cities, the number of police shootings can be powerfully impacted by management practices without compromising the safety of police officers.

In contrast to the good news regarding shootings, however, we see signs that the LASD's progress for several years running in reducing other uses of force is coming to a halt, or, at the very least, the trends are pointing in the wrong direction: There are more uses of force, driving up the ratio of force used per each 100 arrests. The numbers are beginning to point to a possible Departmental step-down in vigilance with respect to use of force. We disavow that we are hugely alarmed, but now is time to nip the problem in the bud. This administration appears not to be as consistently and single-mindedly focused on keeping force in check as its predecessor, and our concerns are beginning to mount. Chapter Two builds on those concerns.

Chapter Two discusses corruption controls and risk management, topics we broached in our last Report, written with the Los Angeles Police Department's Rampart scandal very much in mind. Here again we are worried about the rust building up in the LASD's risk management machinery. On one hand, we were pleased to find that the LASD had taken a hard look and shored up weaknesses regarding informants, intelligence-gathering, search warrants, and evidence handling. On the other hand, we were dismayed that only slim progress has been made on our broader recommendations for reducing risks of corruption or scandal, particularly in key specialized units.

Chapter Three deals with medical care to inmates in the Los Angeles County Jails. To deepen our understanding, we evaluated more than half of the 7181 inmates complaint forms submitted in 1999 relating to medical services. Although we could have made do with a smaller sample, we wanted to get as wide a picture as possible. We also wanted to make certain that our conclusions were grounded in fact, especially since the sources of the complaints were inmates themselves: Because of skepticism within the LASD (and in the world at large) about the truth of what inmates have to say, we took particular care that we had objective corroboration of the substance of an inmate's complaint. Our review confirmed previously identified problems: serious delays in access to doctors and dentists; delays in prescription renewals, leading to medication lapses; interruptions in medical treatments due to transfers of inmates within the jail; and disconnections between diagnosis of a problem during an initial screening and follow-up care. At the same time, we saw the every-day heroism of the nursing staff. Although overwhelming volume does not excuse substandard performance, it would do disservice to the self-sacrificing and steadfast performance of the nurses to gloss over the difficulty of their jobs and how well they in general do it. The Chapter concludes with a largely pessimistic review of the status of our prior recommendations on improving medical care in both the short term and the long term.

Chapter Four is an update on sexual harassment issues. We reviewed approximately 75 sexual harassment investigations conducted by Internal Affairs over the past 18 months. As a group, LASD supervisors are responding more quickly and forcefully to reports of possible sexual harassment. Internal Affairs has largely eliminated the substantial former backlog of pending cases and reduced the average time to complete inverstigations. We saw evidence of improvement in the overall quality of the investigations themselves. Finally, we saw some preliminary signs that the LASD is beginning to correct its historical reluctance to impose appropriate discipline where violations of the LASD's sexual harassment policy are established.

Chapter Five is devoted to the difficult issue of racial profiling and the differential racial impact of law enforcement. It is very much to the credit of the Sheriff's Department and Lee

Baca that the LASD has begun to collect necessary data on the pedestrian and traffic stops. It is even more impressive that the LASD has done so voluntarily; not in response to litigation or the threat of litigation. We review the LASD's efforts and offer suggestions. We attempt to penetrate the thicket of painful issues surrounding race and law enforcement but we do not provide definitive answers. We do, however, suggest ways to think about the issue in advance of the data flowing in.

Chapter Six describes litigation. After seven years of declining numbers of excessive force suits, the trend reversed itself in fiscal year 1999-00, leading to an increase from 41 to 54 of such lawsuits filed and a jump from 70 to 93 of such lawsuits pending. We reviewed a sample of significant settlements, and we describe patterns and trends we noted. We will continue to keep our eye on litigation to see if the trend of more excessive force suits continues.

1. Shootings and Other Use of Force

This Chapter reviews shootings and other uses of force, concluding that the LASD has done a fine job controlling deputy-involved shootings, particularly in Region II and at the Century Station.[1] Ironically, however, we see signs that the progress of the Block years in reducing other uses of force is coming to a halt, or, at the very least, the trends are pointing in the wrong direction: more uses of force, driving up the ratio of force per each 100 arrests. Here, in reverse to the case with shootings, Region II stands out as the biggest problem.

I. Shootings

A key question for police reform is whether law enforcement can be more judicious and restrained in the use of force, with fewer shootings and serious injuries and greater trust and respect for law enforcement, without putting officers themselves at greater personal risk. In order to make this assessment, among other measures, since 1991 we have been tracking the number of persons killed or wounded by LASD deputies and the number of LASD deputies killed or wounded by suspects. As the tables on the next pages demonstrate, the number of hit shooting incidents by LASD deputies has dropped substantially over the last decade.[2]

1 The County of Los Angeles is divided into three Field Operations Regions by the LASD. Region I encompasses the northern part of the County, from the Antelope Valley to East Los Angeles and Temple City. Region II is the western and southern ends of the County—from West Hollywood and Malibu to Carson, Lynwood, Lennox, and Lomita. Century Station, located near Imperial and Alameda, is in Region II. Region III covers the eastern end of the County, from the City of Industry, Lakewood, Norwalk, and Pico Rivera to Walnut and San Dimas.

2 As is also interesting to observe, the LAPD has experienced a similar drop. Both of these law enforcement agencies produce similar numbers of shootings per each 1000 officers. See Tables 1 and 2. It is also interesting to compare the LASD to the other large urban law enforcement agencies on the basis of fatal police shootings per 100,000 residents. According to figures calculated by a newspaper, Detroit led the nation at 0.92 fatalities per 100,000 residents. Houston was second at 0.68. New York was 0.39. *Detroit Free-Press*, "Detroit cops are deadliest in U.S.," May 13, 2000. Using 1999 figures and an estimated LASD resident population of 2.7 million, the LASD ratio is 0.37. Los Angeles on an assumption of 3.8 million residents would be 0.38 for 1999.

1

Los Angeles Police Department Officer-Involved Shootings 1996-99

Year	Total # of OISs	# of Hits	# of Suspects Injured	# of Suspects Killed	# of Non Hits	# of Accidental Discharges	# of Animal Discharges	Other
1996	122	54	27	27	29	11	29	1
1997	114	41	17	24	23	11	35	4
1998	98	23	10	13	12	13	45	5
1999	97	23	9	14	16	16	42	1

Source: Los Angeles Police Department as of November 8, 2000.

2

LASD Hit Shooting Incidents (Deputy intentionally fired at and hit a suspect)

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000 (Jan-Sept)
Number of Incidents	56	47	29	28	34	25	35	20	22	12
Number of Suspects Wounded	40	31	12	11	24	11	17	8	12	3
Number of Suspects Killed	23	18	22	17	10	14	20	11	10	9

LASD Non-Hit Shooting Incidents (Deputy intentionally fired at a suspect but missed)

	NA	NA	14	21	26	19	20	15	8	7

Deputies Shot (Does not include accidental discharges)

Number Wounded by Gunfire	10	6	4	4	2	2	8	4	6	2
Number Killed by Gunfire	0	2	0	0	2	0	2	0	0	0

Incidents in Which a Deputy(s) was Shot

1994

06-18-94	CAR	#7918
09-10-94	CAR	#8198
11-29-94	SSB	#8518
12-10-94	WAL	#8647

1995

05-12-95	SSB	#9069
07-18-95	CSB-C	Geuvjehizian
11-24-95	NWK	#9804
12-26-95	CAR	#9885

1996

08-02-96	LCS	#10654
11-30-96	LKD	#11061

1997

01-05-97	LNX	#011171 01-15-98
05-14-97	LCS	#1072778
06-10-97	SEB***	#1084850
08-14-97	PDC-E	York
09-03-97	LKD	#1132696
10-30-97	CEN	#1166136
12-09-97	ELA**	#1184392

1998

04-12-98	SSB	#1193601
04-12-98	IDT	#SH1205611
04-25-98	PLM	#SH1208071
09-08-98	CEN	#SH1226479

1999

01-10-99	CEN**	#SH1240801
04-24-99	ELA	Monarrez
06-13-99	SCV	#SH1257917
09-19-99	WAL	Burton
11-21-99	TEM	#SH2001693

2000 (Jan-Sept)

02-06-00	SEB	#SH2005203
09-05-00	NWK	Schaap

*** 3 deputies

** 2 deputies

NOTE: Source for 1991-1993 figures is Homicide Bureau.

Source for 1994-2000 figures is Force Review Committee database, Internal Affairs Bureau and Homicide Bureau.

3

LASD Hit Shootings by Station

	1997	1998	1999
Number of Incidents	**35**	**20**	**22***
Altadena Station	NA	NA	0
Carson Station	1	0	2
Century Station	7	7	1
Court Services Bureau	1	1	0
Crescenta Valley Station	NA	NA	0
East Los Angeles Station	2	0	2
Lakewood Station	2	2	2
Lancaster Station	7	2	0
Lennox Station	1	2	4
Lost Hills Station	NA	NA	1
Marina del Rey Station	NA	NA	0
Mira Loma Facility	0	1	0
Miscellaneous Units	0	2	0
Narcotics Bureau	0	0	1
Norwalk Station	3	1	0
Palmdale Station	0	1	1
Pico Rivera Station	NA	NA	1
Safe Streets Bureau	1	1	0
Santa Clarita Valley Station	NA	NA	1
Special Enforcement Bureau	2	0	2
Temple Station	6	0	2 *(1 off duty)*
Walnut Station	1	0	0
West Hollywood Station	1	0	2
Number of Suspects Wounded	17	18	12
Number of Suspects Killed	20	11	10

* In the Temple Station shooting (11-21-99), two suspects were wounded; in the SCV Station shooting (06-13-99), no suspects were killed or wounded but one deputy was hit by friendly fire.

LASD Non-Hit Shootings by Station

	1997	1998	1999
Number of Incidents	**20**	**16**	**8**
Carson Station	1	0	1
Century Station	7	4	0
Crescenta/Altadena Station	0	1	NA
East Los Angeles Station	0	3	3
Industry Station	1	2	NA
Inmate Reception Center	1	0	NA
Lakewood Station	1	1	NA
Lancaster Station	1	0	NA
Lennox Station	4	2	1
Men's Central Jail	1	0	NA
Narcotics Bureau	NA	NA	1
Norwalk Station	0	1	1
NORSAT	NA	NA	0
Palmdale Station	1	0	NA
Pico Rivera Station	NA	NA	0
Safe Streets Bureau	0	1	1
Special Enforcement Bureau	1	0	0
Temple Station	1	0	0
Walnut Station	0	1	NA

Incidents Resulting in Force/Shooting Roll-Out	**126**	**112**	**86**

In 1991, there were 56 such incidents, leading to the death of 23 suspects. Ten deputies were wounded by gunfire, none were killed. In 1999, there were far fewer—22 hit shooting incidents, resulting in ten deaths. In that same year, six deputies were wounded; none were killed. Looking more closely at the patterns among the stations and field operations regions for 1997-1999, we note a substantial reduction in the number of shootings in Field Operations Region II in 1999. There was a similar reduction in shootings in Field Operations Region III in 1998 and a further modest reduction in 1999. Although Field Operations Region I achieved a very significant drop in 1998, its numbers crept up again in 1999. See Table 4.

4

LASD Total Hit and Non-Hit Shootings

	1997	1998	1999
Field Op Region I	17	8	11
Field Op Region II	20	17	10
Field Op Region III	12	8	7

The statistics further demonstrate that Region II accounted for a declining percentage of the LASD's overall shootings.[3] During those same years, Field Operations Region II remained constant in terms of the percentage of all LASD arrests that took place in the region.[4] The ratio of total shootings to total arrests for the three years therefore revealed a declining percentage for Region II, from .00020 in 1997; to .00017 in 1998, to .00011 in 1999.

It is difficult to isolate from all the possible variables why it should be that a particular Region has fewer shootings in one year than another. Nonetheless, as demonstrated in this Chapter, leadership and oversight necessarily play an important, if not decisive, role. Accordingly, we credit the leadership in Region II with an effective job in gaining control of

3 In 1997, Field Operations Region II accounted for approximately 41 percent of all hit and non-hit shootings. In 1998, the percentage was 51.5. In 1999, it dropped to 35.7 percent.

4 In 1997, of a total of 97,801 arrests for all three regions, Region II accounted for 32.3 percent; 1998, of 101,813 arrests for all three regions, Region II accounted for 31.3 percent; and in 1999, of 94,324 total arrests, Region II accounted for 32.1 percent. We also want to note that the number of arrests in the three Field Operations Regions does not correspond to the total number of arrests by the LASD as a whole. We also note that pinning down the total number of arrests for 1997-99 was harder to do than we imagined it might be. According to data from CARS reports, in 1997, the LASD arrested 101,549 persons; in 1998, 105,302 persons; and, in 1999, 97,574 persons. But the number of arrests for 1997, 1998, and 1999 reported in the Department's *1999 Year In Review* was different. That study had the total arrests for 1997 at 98,706, 1998 at 98,782, and for 1999 at 90,943. As is further discussed in our Chapter on Corruption Controls, we cannot account for the difference in the figures. We note also that the differences in the two sets of numbers, particularly for 1998 and 1999, are not trivial - 9.4 percent for 1998; 9.3 percent for 1999.

shootings, and we therefore acknowledge the work of Chief Curtis Spears, Commanders Bill McSweeney and Gil Jurado, and the other commanders—Lee Kramer and (now Chief) Beth Dickenson—who have worked in recent years in Region II.

Century Revisited

Even more interestingly, when we examine the stations within Region II, it is apparent that the drop in the number of shootings at the Century Station accounts for the lion's share of the Region's progress. But before turning to these findings, it is useful for a moment first to step back and put Century, which we had seen for a long time as the LASD's most troubled station, in the context of the rest of the Department.

The Century Station patrols approximately 14 square miles of the south Los Angeles area—nine square miles of unincorporated territory and about five square miles of the city of Lynwood. Century's service area has a population of 191,100. The crime rate per 10,000 population for the most serious crimes, Part I crimes, is high: 425.17 in 1998 and 419 in 1999, a drop of only one percent[5]. Century is often said to be one the busiest stations in the LASD. That is correct. The busiest of all by a wide margin is the Lakewood Station, with about 35,000 cases and nearly 12 percent of all reported incidents for the entire LASD. Century is next with approximately 25,000 cases handled in 1999 and roughly nine percent of all reported incidents for the entire LASD[6].

The Field Operations Region of which Century is a part—Field Operations Region II—

5 Part I crimes are generally the most serious crimes and crimes against persons—criminal homicide, forcible rape, robbery, aggravated assault, burglary, larceny theft, grand theft auto, and arson. Part II crimes, while serious, are generally somewhat less harmful —drunk driving, vandalism, weapons offenses, narcotics offences, gambling, disorderly conduct, and the like.

6 "Reported incidents" are the sum of Part I crimes, Part II crimes, and incidents that are noncriminal in nature (i.e., missing person reports, traffic accidents, suicides and attempted suicides, and the like). For the LASD as a whole, there were 300,959 reported incidents in 1999: 77,678 Part I crimes, 107,902 Part II crimes, and 115,379 noncriminal incidents. Of total reported incidents at Century in 1999, the breakdown was 8,007 Part I crimes, 9,460 Part II crimes, and 7,195 noncriminal incidents.

has a total service area of 81.23 square miles and a population of 585,700 persons. The Region as a whole had a 1998 crime rate of 402.70 per 10,000 population and a 1999 crime rate of 380.76. There was thus a five percent drop in the crime rate in the Region between those two years. The crime rate at Century was therefore higher than the Regional average for both years, and it dropped by the least amount—one percent—between 1998 and 1999.[7]

The LASD as a whole serves 3,152 square miles with a population estimated at 2.7 million. The Part I crime rate for the LASD service area as a whole was 433.82 in 1998 and 287.06 in 1999, a dramatic 34 percent drop[8]. Among the Part I crimes, the biggest drops percentage wise were with respect to aggravated assault (down 17 percent); burglary (down 15 percent); robbery (down 13 percent) and in criminal homicide and larceny theft (both down 11 percent).

As noted above, Part I crimes declined only one percent in the Century area from 1998 to 1999 as contrasted to the 34 percent Departmental drop. Within the Century area, the biggest drops percentage wise were in forcible rapes (down 28 percent); burglaries (down 21 percent) and criminal homicides (down 15 percent.)

With respect to shootings of suspects by deputies, Century had previously stood out as an anomaly: During 1995 and 1996, Century had three times as many shootings as any other station. We examined Century in detail in Chapter One of our **Ninth Semiannual Report.** As regards shootings, at least, the picture today is very different. See Table 5.

7 Century did not have the highest crime rate in the Region. West Hollywood had that dubious distinction, with a 1998 crime rate of 709.80 and a 1999 crime rate of 607.29. It must be kept in mind, however, these figures are based upon West Hollywood's permanent population base of 39,800. This base is probably far too small for accurate measurement, thereby driving up the apparent crime rate. It is estimated that the weekend population in West Hollywood is more like 100,000 people. If figured on that much larger population base, the crime rate in West Hollywood would be far more modest.

8 Coincidentally and interestingly, the drop was almost all in the contract cities area, where the crime rate dropped by 49 percent, as contrasted to the unincorporated areas, where the crime rate dropped three percent. The population in the contract cities is somewhat larger than in the unincorporated area—1.66 million in the contract cities; 1.05 million in the unincorporated areas. Also by way of comparison, the Part I crime rate for the City of Los Angeles in 1998 was 492 per 10,000. We do not have the 1999 figures. To put Century further in context, and putting aside the downtown area where the figures are distorted because of the extremely low permanent population base, the Southeast Station of the LAPD (which adjoins Century) had the City's highest Part I crime rate in 1998 at 693 per 10,000. The lowest crime rates in the City were in the area patrolled by the Northeast and Foothill LAPD stations, 359 and 360 per 10,000 respectively.

During 1997-99, Century accounted for a relatively stable percentage of the Region's arrests. In 1997, Century made 12,547 of the Region's 31,625 arrests, or 40 percent. In 1998, Century arrested 13,079 of the Region's 31,914 arrests, or 41 percent. In 1999, Century arrested 10,596 of the Region's 30,241 arrests, or 35 percent.[9] Thus, while remaining nearly as active a patrol station as measured by arrests, Century somehow managed over the three-year period to bring its total number of shootings down substantially. Again, the variables are many, but credit is due at least in part to station leadership—Captain Ken Brazile, Operations Lieutenant Jim Lopez, and all the other excellent lieutenants and sergeants—and to Region II management, particularly Chief Spears, and Commanders McSweeney and Kramer.

5

Comparison of Century Shootings to Region II Total Shootings

	1997	1998	1999
Century Station	12	9	1
Region II	20	17	10
Percentage Century to Region	60%	53%	10%

Although cause and effect are hard to figure out, it is worthwhile pondering why the number of shootings at Century declined so dramatically. At the time we did our study in 1998, the LASD was adamant that the high crime rate and the ambient violence in Century's service area was intractable and accounted for the differentially high number of shootings. Indeed, the LASD commissioned a study to explore whether four violence variables—criminal homicides, aggravated assaults, firearm seizures, and Part I crimes—correlated with the frequency of shootings. Although we found that the LASD's shooting study did not hold up to scrutiny, and the LASD itself conceded that the statistical correlation of the four violence variables to shootings was weak at best, it was nonetheless interesting to see just how far the Department was willing to go at that time to shift the inquiry to external factors rather than looking inward at management defects within the LASD. In essence, the Department argued

9 By way of further comparison, Century arrested a total of 12,977 in 1996 and 12,189 in 1997. *1997 Year in Review*. Again, there were disparities between the number of arrests reported in CARS reports and in the *1999 Year in Review*. The *Year in Review* reported a total of 12,770 arrests for the Century Station in 1998 and 10,443 for 1999.

that Century was fated to have more shootings, that the controlling factors were violence in the community, and, inferentially, that the quality of management made little difference.

It is ironic, then, that the Century shootings have dropped so impressively even though the external factors—crime rate, violence—have largely remained the same. What it suggests to us is that the number of officer-involved shootings may indeed be subject to a meaningful degree by management control. When cast against a national backdrop, where some cities in some years have substantially higher officer-involved shooting rates than others (Washington DC; Detroit), the Century experience may be evidence that the number of police shootings can be powerfully impacted by management practices.

The leadership at the Century Station certainly believes this is so. Indeed, Century management cites its crackdown on foot pursuits as a key step in managing shootings. Management also points out that for the first time in recently memory, the Century Station has a full complement of lieutenants and sergeants. Sergeants are spending much more time out in the field. According the Century's Operations Lieutenant, the sergeants are rolling on routine as well as "hot" calls. Whereas the deputies were at first resistant to having sergeants showing up all the time, the Operations Lieutenant believes that the resentment has died down and that the deputies are now expecting to see sergeants on their calls. Combined with other concerted efforts described below to tighten up on questionable arrests and probable cause and to change the standards for selection of training officers, the leadership at Century has tried to run a far more carefully managed operation. They conclude that their efforts have paid off in terms of the reduced number of shootings.

Before leaving the Century Station, however, we would be remiss if we failed to take into account a possible counter-explanation to management's put forward by some deputy sheriffs when we asked their views and theories about the drop in shootings at Century. Noting the numerous personnel changes at the station at both the deputy and supervisorial levels, these individuals suggested that good, aggressive, hard-working deputies were either being suppressed by their supervisors and were less productive or were replaced by a "wimpier" or less hard-

6

Century Station Part I Crimes, 1998 and 1999

Part I Crimes	1998 Reported Incidents	1998 Total Arrests	1999 Reported Incidents	1999 Total Arrests
Criminal Homicide	60	28	51	14
Rape	83	19	60	23
Robbery	1047	417	1027	289
Aggravated Assault	2043	911	2123	978
Burglary	1535	450	1214	426
Larceny	1762	245	1913	252
Grand Theft Auto	1458	394	1421	308
Arson	137	6	197	3
Total	**8125**	**2470**	**8007**	**2293**

7

Century Station Part II Crimes, 1998 and 1999

Part II Crimes	1998 Reported Incidents	1998 Total Arrests	1999 Reported Incidents	1999 Total Arrests
Forgery	139	51	164	53
Fraud;nsf checks	49	19	73	8
Felony sex crimes	140	78	126	77
Misdem. sex crimes	75	35	87	34
Nonaggravated assaults	529	76	679	86
Weapons laws	520	377	350	257
Family crimes	20	4	19	5
Narcotics	2,980	2,739	1,947	1,691
Liquor laws	682	59	396	28
Drunk/alcohol/drugs	68	76	108	102
Disorderly conduct	163	33	138	15
Varancy	0	15	4	11
Gambling	3	23	4	5
Drunk Driving	194	217	161	176
Vehicle laws	3,534	3,165	3,144	2,822
Vandalism	708	127	695	109
Warrants	25	951	35	871
Receiving stolen property	109	260	69	160
Federal offenses w/o money	9	1	2	1
Federal offenses with money	40	0	16	0
Felonies, misc.	418	162	611	265
Misdemeanors, misc.	795	1,717	632	1,269
Total	**11,200**	**10,185**	**9,460**	**8,045**

Source: *1999 Year In Review*

working group. While these persons did not suggest that the current deputies at Century were reluctant to fire their weapons if necessary, they suggested that less active and aggressive policing on the deputies' part might have reduced the occasions when a shooting might have occurred and thus brought down the overall number of shootings.

We decided to probe a little deeper into Century to see if we could shed some additional light on this issue by seeing if productivity, at least as measured by arrests, was down. What we concluded was although there had indeed been a drop in arrests, particularly narcotics arrests, it turned out, perhaps ironically, to be a good thing and a mark of progress: The drop seemed to be traceable to Century leadership's being more vigilant in making sure there is really probable cause for the arrests. To pinpoint where the drop in arrests came from, we studied the Department's *1999 Year in Review*. Tables 6 and 7 compare the number of reported incidents in each Part I and Part II crime category with the number of arrests in each crime category for 1998 and 1999.

Based on the foregoing, it appears that with respect to Part I crimes, the drop in arrests, expressed as a percentage of reported incidents, was greatest with respect to criminal homicides and robberies, the same categories of Part I crimes experiencing the largest drop between 1998 and 1999. The picture with regard to Part II crimes showed a very substantial drop in the absolute number of reported narcotics incidents in 1998 (2980) compared to 1999 (1947). Similarly, there was a drop of note in weapons law violations, 520 in 1998; 350 in 1999. Overall, there was a drop in reported incidents of Part II crimes of 15 percent between 1998 and 1999 and a drop in arrests of 21 percent between 1998 and 1999. Of that, the largest single drop was with regard to reported incidents of narcotics violations.

We asked the Century Station management to account for this drop in narcotics arrests, and in particular whether they believed it reflected less activity on the part of the deputies. They attributed it to better, more careful arrests that were standing up better in court. In 1998, in connection with the court survey described at page four of our **Twelfth Semiannual Report,** the leadership at Century realized that as many as one in four arrests, particularly narcotics-

related arrests, were questionable: Prosecutors were either refusing to press forward on the cases or suppression motions were being brought successfully by defense counsel.

In response, management began substantially tightening up of supervision for probable cause. As noted earlier, sergeants have been rolling on routine as well as hot calls. The sergeants are putting pressure on deputies to justify stops, detentions, and searches of suspects, particularly those detentions where a suspect is placed in the back seat of a patrol car while the suspect's car is searched. Additionally, the leadership in the station is attempting to better manage the deputies's so-called "unallocated time." Whereas in the past some deputies would routinely defer routine paperwork and low-level radio calls (taking a burglary report, for example) in favor of "hunting"—running suspicious plates; making stops and searches—the deputies are now apparently being more actively directed in how to prioritize their activities and manage unallocated time.

Thus, in a strange way, the reasons put forward by management and the reasons put forward by deputies for the decrease in shootings at Century converged: management and supervision at Century were much tighter. The spin put on it from the perspective of some of the deputies was that this was a bad thing: hard-working, productive deputies were being suppressed by intolerant management. The spin from management's side was that this was a good thing: the station leadership was cracking down on questionable arrests and searches that would not stand up in court.

In conclusion, we cannot account for the dramatic drop in the number of shootings at Century based solely upon drops in the crime rate, drops in the numbers of reported incidents, drops in arrests, or ratios constructed from the foregoing. Therefore, and admittedly by process of elimination, we conclude that better management at the Regional and Century station levels is the most powerful explanation, particularly by first line supervisors—sergeants and lieutenants.

Ironically, however, when we look at other uses of force, the picture for Region II, and the Department as a whole, is less comforting.

II. Use of Force

As we will demonstrate in this section, after many years of significant progress, there has been some erosion between 1998 and 1999. As shown in Table 8, there were slightly more force incidents in 1999 as compared to 1998. Somewhat more worrisome, though by no means alarming, was a Department-wide rise in the number of uses of force per each 100 arrests, from 1.01 in 1998 to 1.13 in 1999.[10] Somewhat more worrisome still, we forecast another Department-wide rise in the number of uses of force per 100 arrests in 2000. See Table 9. Paradoxically, given its enviable record on reducing the number of shootings, Region II presents the greatest concern in that regard.

When we looked at all patrol stations for the years 1997, 1998, and 1999, shown in Table 10, we found an overall increase in the uses of force per 100 arrests in each of those years successively for Field Operations Region I. Field Operations Region III had a successive overall *decrease* in uses of force per 100 arrests in each of those three years. Field Operations Region II rose overall, with 1997 being slightly higher than 1998, but 1999 being higher than either 1997 or 1998. For 1999, Field Operations Region II had the highest overall uses of force per 100 arrests at 1.42, as shown in the Table 10.

When we looked more deeply at the varying performances of the patrol stations within Region II, we found that each station experienced a rise in the ratio of force to 100 arrests (with the exception of the Lomita Station) over those three years. Thus, Region II tended to account for more of the downward trend that either of the other Field Operations Regions: Gains in Region III were more than offset by losses of ground in Regions I and II, in particular in II.

To get a sense whether these Region II trends are continuing in the year 2000, we looked at all the stations for the period January-August 2000[11] and compared their performance to

10 There was a rise in the most serious uses of force per each 100 arrests also: in 1998, there were 0.01 uses of force per 100 arrests that led to death or hospitalization of the suspect; in 1999, 0.02. Similarly, in 1998, there were 0.25 uses of force per 100 arrests that led to visible injury of the suspect; in 1999, 0.29.

11 August 2000 was the latest set of figures the LASD could give us as of mid-October 2000 when this section of this report was drafted.

January-August 1999. See Table ll.

Each of the Region II stations in operation for both of those years reported fewer overall arrests in the equivalent period in 2000 as compared to 1999. With the exception of the Lennox Station, each station by contrast reported more use of force incidents in the equivalent period in 2000 as compared to 1999. And each of those stations reported a rise, therefore, in the ratio of use of force per 100 arrests.

When we aggregated the Region II stations and compared them as a whole with the aggregated statistics for Regions I and III stations for January-August 2000 as compared to January-August 1999, we found that arrests as a whole went down in Region II and force incidents went up, leading to an increase in the ratio of uses of force per 100 arrests. In Region I, arrests went up but uses of force went down, leading to a drop in the ratio of uses of force per 100 arrests. In Region III, arrests were up and uses of force were up, leading to an increase in the ratio. Overall for the three Field Operations Regions, comparing January-August 1999 to January-August 2000, arrests went down, uses of force went up, and the ratio went up to 1.22. If the trends hold, then the year 2000 will likely produce fewer arrests for the LASD as a whole, more uses of force, and a third year in a row of an increase in uses of force per 100 arrests.

As Table 11 demonstrates, there is further cause for concern in that the Region II stations of Carson, Century, Lennox, and West Hollywood all have use of force ratios in excess of 1.35 per 100 for 1999. Those same stations will have even higher ratios in 2000 if trends continue. No other stations in the rest of the LASD have use of force ratios that high with the exception of Palmdale and San Dimas[12]. There were months in 2000 when some of the Region II stations were in excess of 2.0 uses of force per 100 arrests, including Carson, Century, and West Hollywood.[13]

12 The Avalon Station also had a higher ratio, but it is so small with so few arrests that we believe the numbers are distorted when compared to other stations.

13 The Lomita Station did also. But as with Avalon, the smaller numbers it generates tend to magnify the statistical variations.

8

LASD Force Statistics 1998-99

Force	1998	1999
Total Force Incidents	1918	1997
Total Force/100 arrests	1.01	1.13
Significant Force: Deaths and Hospitalizations/100 arrests	0.01	0.02
Significant Force: Visible injuries/100 arrests	0.25	0.29
Significant Force: Complaints of pain/100 arrests	0.14	0.14
Significant Force: no visible injury or complaint of pain/100 arrests	0.13	0.14
Less significant force	0.27	0.24
OC spray/100 arrests	0.20	0.30

9

LASD Force Statistics for Three Field Operations Regions: January-August 1999 vs. January-August 2000

Field OP. Region I	Jan-Aug 1999	Jan-Aug 2000
Arrests	24,280	25,263
Force Incidents	253	231
Force Incidents/100 Arrests	1.04	0.91

Field OP. Region II	Jan-Aug 1999	Jan-Aug 2000
Arrests	20,407	18,342
Force Incidents	273	319
Force Incidents/100 Arrests	1.34	1.74

Field OP. Region III	Jan-Aug 1999	Jan-Aug 2000
Arrests	20,132	20,592
Force Incidents	180	233
Force Incidents/100 Arrests	0.89	1.13

Field OP. Region Totals	Jan-Aug 1999	Jan-Aug 2000
Arrests	64,819	64,197
Force Incidents	706	783
Force Incidents/100 Arrests	1.09	1.22

Source: CARS reports.

10

Force/100 Arrests All Patrol Stations 1997-1999

Station	1997	1998	1999
Crescenta Valley	1.37	1.35	0.55
East LA	0.62	0.67	1.03
Lancaster	0.99	1.16	0.93
Lost Hills/Malibu	0.68	0.63	1.00
Santa Clarita	1.36	1.10	1.33
Temple	0.94	1.05	1.08
Palmdale	NA	1.17	1.64
Field OP. Region I Totals	**0.95***	**0.99***	**1.10***
Carson	1.31	1.29	1.35
Century	0.88	0.94	1.40
Lomita	1.33	1.12	0.89
Lennox	1.13	0.86	1.82
Marina del Rey	NA	NA	1.34
West Hollywood	1.47	1.46	1.75
Field OP. Region II Totals	**1.09***	**1.03***	**1.42***
Avalon	3.09	3.35	2.29
Industry	1.17	1.18	0.69
Lakewood	1.45	1.47	1.27
Norwalk	0.81	0.71	0.90
Pico Rivera	0.78	0.68	0.47
San Dimas	NA	NA	1.40
Walnut	1.77	0.77	0.86
Field OP. Region III Totals	**1.18***	**1.04***	**0.96***

*Includes specialized units as well as patrol stations
Source: CARS reports.

11

LASD Force Statistics for Region II Patrol Stations: January-August 1999 vs. January-August 2000

Station	Jan-Aug 1999	Jan-Aug 2000
Carson		
Arrests	2557	2372
Force Incidents	38	47
Force/100 Arrests	1.49	1.98
Century		
Arrests	7556	6377
Force Incidents	95	106
Force/100 Arrests	1.26	1.66
Lomita		
Arrests	955	763
Force Incidents	10	18
Force/100 Arrests	1.05	2.36
Lennox		
Arrests	3968	3247
Force Incidents	55	53
Force/100 Arrests	1.39	1.63
Marina del Rey		
Arrests	153	466
Force Incidents	2	4
Force/100 Arrests	1.31	0.86
West Hollywood		
Arrests	2336	2275
Force Incidents	273	319
Force/100 Arrests	1.34	1.74

When we put these statistics together with trends we note in our Chapter on Litigation regarding a rise in the number of force-related lawsuits received in fiscal year 1999-2000 over the prior fiscal year, and an increase in the total number of excessive force lawsuits pending at the end of fiscal 1999-2000 as compared to fiscal 1998-1999, we wonder whether the progress experienced during the Block years has come to a halt and that trends are beginning to reverse themselves.[14]

In our **Twelfth Semiannual Report** of June 2000, we included in pages 36-38 a long discussion of why we deplored the demise of Department-wide meetings, called SCIF, that were devoted to spotting and quickly eliminating worrisome trends in risk management. We advocated strongly for its return and urged that it should be reinstated in a manner that "encourages the willingness of all concerned to holding each other mutually accountable and responsible." *Id.* at 38. We once again, with more urgency, advocate a return to a monthly Department-wide SCIF-like process. The numbers are beginning to point to a step down in vigilance with respect to use of force. Again, we disavow that we are hugely alarmed. But now is the time to nip these problems in the bud, and the Sheriff and his senior executives should act quickly to do so. Our concerns that this administration is not as focused on keeping uses of force in check as the Block administration are beginning to mount.

14 We recognize that litigation statistics tend to deal with behavior in years past whereas the other statistics we rely upon in this Chapter relate to current activity. We concede, therefore, that we are looking at things that are not entirely equivalent. Nonetheless, we believe the litigation trend legitimately reinforces our concerns about trends overall.

2. Corruption Controls & Risk Management

We are concerned that key programs within the LASD to measure and manage risk of corruption and other misconduct have, to all appearances, been all but abandoned and fallen into disuse. Key reports that were the foundation for analysis of risk are no longer being routinely produced. As noted in Chapter One, and, in all likelihood, as a result of the rust building up in the LASD risk management machinery, trends are beginning to show a reversal of progress that had been made in earlier years. This Chapter will describe why.

In the **Twelfth Semiannual Report,** we examined whether the LASD was adequately prepared to avert a scandal within the Sheriff's Department of the dimension of the LAPD's Rampart scandal or similar ones in the NYPD. In both those police departments, internal review and audit procedures, at the departmental and station or precinct levels, failed to detect patterns of police misconduct. Both scandals resulted from breakdowns in accountability among managers and supervisors and, from there, all the way up the chain of command.

In comparing the LASD to those two troubled departments, we concluded in our last semi-annual report that the LASD was in somewhat better shape: It had reduced its own corruption risks by its implementation of self-critical recommendations flowing from its own Big Spender scandal in the 1980's and its progress since **Kolts.** We nonetheless had concern in two areas: (i) the LASD's COPS teams were operating without adequate controls in high-risk activities, and (ii) the Department had not yet fully implemented several crucial recommendations left over from Big Spender or from study of similar scandals in other law enforcement agencies. In this Chapter, we return to the latter topic.[1]

In our investigation for this report, we followed up on the key recommendations we made in Chapter Two of our last **Semiannual Report.** On one hand, we were pleased to find that the LASD had taken a hard look and shored up weaknesses in procedures regarding informants, intelligence-gathering, search warrants, and evidence handling. On the other hand, we were dismayed that only slim progress had been made on our broader recommendations, even though

1 We have not, as yet, re-audited the COPS teams. We will do so for an upcoming report.

Commanders McSweeney and Scaduto had completed a review of ethical and corruption issues, including our recommendations, and had prepared a useful list of proposals for the LASD to consider. Before turning to those unfulfilled recommendations, we will first highlight those areas in which there has been good progress.

I. The Specialized Units Review

Since our **Twelfth Semiannual Report,** Commanders Soderberg and Sewards, with the hard work of Lt. Jim Whitten, completed a review of a selected group of specialized units, including the Asian Crimes Task Force, the COPS Bureau's "Hi Impact" teams at three selected stations, the Safe Streets Bureau's programs at five selected stations, and the Gang Enforcement Teams for selected areas and stations. The Specialized Unit Review also examined three station-based specialized units at the Lancaster, West Hollywood, and Pico Rivera Stations.

These various units were examined for compliance with Department policies and procedures in three areas: (i) use of informants; (ii) search warrants; and (iii) intelligence gathering. The Commanders also looked at a fourth area—the handling of money, narcotics, and firearms as evidence—in the Asian Crimes Task Force and the COPS Bureau.

The Specialized Units Review identified weaknesses in each of the areas and made a series of recommendations to address them. Responsibility for following up on implementation of the recommendations has devolved to Commanders Betkey and Sewards, and they are doing an effective job of doing so.

The net of the recommendations on informants is to generalize successful Narcotics Bureau policies and make them applicable to the Department as a whole; to standardize forms and procedures for informant management; to restrict or prohibit use of juvenile informants; to provide specialized training on use of informants for deputies, sergeants, and lieutenants; and to create special accounts in each of the field operations regions to facilitate non-narcotics investigations and informant payments.

The recommendations on search warrants require more precise articulation of probable cause, more clearly define the scope of permissible seizures, amend and reconcile conflicting Department policies, and shore up procedures for retention of search warrant documentation. Narcotics Bureau forms and checklists are mandated for use by the LASD as a whole, and random audits will assure compliance with search warrant procedures. Similarly, there are good recommendations regarding separation of intelligence and investigative functions, separation of gang intelligence records from organized crime records, more widespread training in the law regarding entry of records in the state's gang database, and quality control measures to improve gang intelligence field investigative reports and files. Evidence-handling procedures are tightened and conflicting policies reconciled.

As we had noted in our sidebar discussion at page 19 of our **Twelfth Semiannual Report,** the Narcotics Bureau had elaborated excellent procedures in the wake of Big Spender that were worthy of emulation throughout the LASD. The Specialized Unit Review team made good use of Narcotics Bureau expertise, including that of Lieutenants Whitten and Werner, and the resulting report and recommendations were well-conceived. The full implementation of the recommendations of the Specialized Unit Review team will substantially improve things in a nuts and bolts sense.

We only wish equivalent progress had been made on the overarching issues, including our recommendations on fighting corruption and Departmental safeguards.

II. Corruption Controls

A. Risk management

We made three key recommendations in our last report, none of which have been adopted. The first was to revive a flagging commitment at the highest executive levels to risk management by reinstating monthly Department-wide meetings where captains, commanders, chiefs, and the top executives review trends in all relevant risk categories, including shootings and other

use of force, citizen's complaints, and lawsuits. The LASD regularly did so during Sheriff Block's administration. The meetings were called SCIF (pronounced "Skiff"), an acronym that stood for Sheriff's Critical Incident Forum. SCIF was not uniformly popular, and the egos of some captains were publicly bruised in sessions where they were called to account for increases in risk parameters.

After the divisive campaign in which Lee Baca challenged Sherman Block, newly-elected Sheriff Baca wanted to establish an atmosphere of greater comradeship and mutual respect at all levels of his command staff and abolished the Department-wide SCIF, while nonetheless encouraging Chiefs to conduct mini-SCIFs on a regional or divisional basis. Although sympathetic to the Sheriff's goals of fortifying morale among the command staff, we nonetheless were sufficiently worried about shifting focus away from risk management that we strongly recommended reinstating a Department-wide SCIF "in a manner that encourages the willing consent of all concerned to holding each other mutually accountable and responsible." **Twelfth Semiannual Report,** p. 38.

The Department has repeatedly attempted to assure us that its commitment to risk management remains strong, with or without SCIF. We decided to test the contours of those assurances. We came away worried.

We focused on whether the LASD is paying adequate attention to risk management issues, with or without SCIF, by zeroing in on the monthly management reports that had provided the factual basis for the discussions at SCIF. We wanted to see if the reports were still being produced in an accurate, timely manner, and were being widely used by management on a voluntary, self-initiated basis, as contrasted to the somewhat more coercive use of the reports in the SCIF setting.

There are two principal monthly management reports in question—one is called the SCIF report, and the other is called the CARS report ("CARS" stands for Command Accountability Reporting System). CARS take data from the SCIF report and, among other things, constructs ratios and other measurements to compare and contrast performance between and among patrol

stations and other LASD units over time. The reports, if used actively, spot both favorable and unfavorable trends at a particular station, or group of stations, thereby allowing management to address them. Combined with the Personnel Performance Index, or PPI, the SCIF and CARS reports are powerful tools for early identification of possible problems and trends. The LASD's enviable reputation as the nation's leader in managing potential police misconduct and accountability rests entirely on these Block-era innovations and the Department's active use of them.

To our shock, SCIF and CARS reports have fallen into disuse and have been all but abandoned. The latest postings of SCIF and CARS data on the Sheriff's Intranet was nine months old: Nothing was available post-February 2000 when we had it checked in late November 2000. We investigated in a roundabout way to find out why there had been no postings. One answer, from the deputy in charge of producing the reports, as told to us by a reliable source, was that "no one was asking" for the data and therefore production of it on a timely basis had a low priority.[2] Another source very close to the matter was even more candid, telling us directly that the reports were now only produced upon request, and that apart from one captain and an occasional commander or chief, we were the only ones requesting, hence the delays in getting them to us.[3]

That admission coincided exactly with our own experience. When we asked for year-to-date and updated CARS and SCIF data, it incomprehensibly seemed to take a long time to get it.

2 We hasten to add that we have been working with this deputy since he was assigned to the Risk Management Unit, and we respect his good work and responsiveness. Indeed, his expertise in producing the CARS and SCIF reports was so high (and apparently unique) that he took the responsibility with him when he was transferred to Headquarters Bureau. None of the criticisms of the Department for its lack of interest in the data should be laid at his feet. Indeed, his hard work and devotion to the apparently thankless job was exemplary, and we commend him for it. The burden of the job is being moved finally from his shoulders. We now understand that the job of preparing the reports will go to Management Information Services, or MIS. MIS is already over-burdened and consequently slow in getting out reports. Indeed, its staff has been slashed in recent years. Perhaps it was thus understandable, but yet troubling, that as of late November 2000, the most recent crime statistics we could find on the LASD's Intranet were for December 1999. The Year in Review for 1999 came out late in 2000. We respect MIS and its manager, Wendy Harn, who has always seemed to us to be sharp and responsive. But she clearly needs additional staff. The transfer of the SCIF and CARS responsibilities to MIS thus signals a further downgrading of the importance of the reports.

3 When word got out in the Department in late November that we were concerned that no one was ordering or studying these reports, Assistant Sheriff Larry Waldie assured us that it wasn't so; in fact, he said, he had just ordered a set for himself.

Obviously, the LASD was cranking hard to enter and update the long-neglected data so that it could be produced for us. Equally obvious, no one else was requesting the data on a regular basis.

Further evidence that the SCIF and CARS data had become largely ornamental and not taken seriously was that the first batch of reports we got was wildly inaccurate. Many of the statistics and trend analysis flow from measuring a variety of criteria against the number of arrests. Use of force per 100 arrests is an example, and derivative statistical measures—hospitalizations and deaths per 100 arrests; use of pepper spray per 100 arrests; complaint of pain or injury by suspects per 100 arrests—all depend upon accurate arrest statistics.[4]

To our amazement, at least one station in Field Operations Region II had failed to report its arrests for April and June 2000, thereby throwing off all the statistics for the station, Region II, and the LASD as a whole that were based upon an accurate reflection of the number of arrests not only for those months but for the entire year. It meant that all the station-to-station or region-to-region statistics were essentially garbage. It fell to us to inform the LASD of this lapse when we discovered it in October. Obviously, since the previous April and again in June, no one had really looked at the numbers or given them any critical analysis—squaring, once again, with our information that no one except us was asking for the reports or apparently using or relying upon them. Upon learning from us of the errors, the LASD corrected the reports, and new data was produced. Combined with the admission that few in management was even asking for SCIF or CARS data, much less pounding the table for it and taking subordinates to task for errors they found in it, we were convinced that risk management in the LASD had largely withered on the vine.

4 As we noted in our Chapter on use of force, the LASD reported two sets of numbers for arrests which could not be reconciled and were substantially apart. From our conversations with MIS, we learned that in general the statistics in the *Year In Review* reports were likely the most reliable. The arrest numbers in those reports were consistently lower than in the CARS reports. This means that the ratios showed in CARS tend to understate statistics such as force per 100 arrests because in truth, there are fewer arrests than CARS reports. To be fair, the CARS numbers are rawer and more hastily assembled than the more precise numbers in the *Year in Review*. Because the difference in 1998 and 1999 in particular was large, the problem is not trivial, however.

Our chapter on use of force points to at least one of the consequences of this lack of attention: trends regarding force are pointing in the wrong direction. Accordingly, we renew our call for a Department-wide recommitment to risk management. Enough time has now passed so that whatever bad taste was left in the mouth of the command staff by Sheriff Block's SCIF meetings should have long ago dissipated. Sheriff Baca, Undersheriff Stonich, and Assistant Sheriff Waldie have adequately demonstrated to the troops and command staff that they are behind them. Having restored morale, it is now imperative that they show themselves capable of taking the best that the Block administration had to offer and putting their own stamp on it. That means reviving SCIF and holding command staff strictly accountable, whether or not egos are bruised in the process. That means paying attention to SCIF and CARS reports and the underlying data. That means doing more than paying lip service to PPI and risk management. It means getting real control of force and corruption-related risk.

B. Proactive Anti-Corruption Measures

The second recommendation that we made that has thus far not been adopted was the creation of a permanent anti-corruption unit that would include undercover officers to gather intelligence on corruption, excessive force, and search and seizure violations. While in the past it might have been adequate for the LASD to function passively—only responding to allegations of criminal behavior that somehow came to its attention—it is now necessary for the LASD affirmatively to use intelligence work to detect possible problems. We argued that the full panoply of law enforcement tools that are available for detection of criminal activity on the streets must become available for internal investigations, be it sting operations or other use of undercover officers.

Our recommendations were based in part upon the LAPD's review of national best practices for fighting corruption that was described in the March 1, 2000 Report of its Board of Inquiry into the Rampart Area scandal (BOI Report). The LAPD's Integrity Subcommittee considered the experience of four cities in the wake of major corruption scandals and the anti-corruption

policies and practices that were adopted:

Several cities have experienced major corruption scandals, and all have taken aggressive steps to deal with such problems. In the early 1990's, New York City conducted a 22-month investigation into a major corruption scandal [the Mollen Commission report arising from the Michael Dowd case]. More recently, serious ethics and integrity breakdowns in two community stations led to an investigation and a comprehensive set of remedial actions by the Chicago Police Department. In Chicago's corruption incident, officers in specialized units were found guilty of criminal activity very similar to the officers accused in the Rampart incident. In the last several years, both the New Orleans and the Miami Police Department have experienced serious episodes of police corruption and malpractice. BOI Report at 312.

The LAPD concluded that "the most dominant theme discerned from the lessons learned in all four departments was the importance of establishing aggressive anticorruption practices." *Id.*

To the credit of the Sheriff's Department, some of those recommended anticorruption practices were already in place, including having the PPI and the collection of SCIF and CARS data. (Parenthetically, then, it is even sadder, as described above, that the LASD is allowing these tools to become cobwebbed through disuse.) A key recommended practice, and one that we in turn advocated in the last semiannual report be adopted by the LASD, was targeted stings. As the BOI Report put it, discussing the NYPD:

The NYPD conducts over 1,000 stings annually in an effort to test their officers' integrity in the field. While command officers have the responsibility of ensuring integrity among their personnel and within their commands, internal affairs or public integrity divisions have the primary responsibility of rooting out corruption using gathered intelligence as well as random stings and drug testing procedures. In the NYPD, internal affairs [undercover officers] are used to provide intelligence on possible corrupt activities within commands and to check out rumors of corrupt or improper behavior. The clear lesson learned from all four of the departments studied is that constant vigilance is necessary to search for and find corrupt behavior. Id.

The experience of the NYPD is indeed instructive, leading us to question the efficacy of random stings but reinforcing our recommendation of targeted stings. We reviewed the 1999 Annual Report of its Internal Affairs Bureau. The NYPD relied upon two sources of information to gather intelligence on possibly corrupt officers. The first source was sting operations.

The 1999 Internal Affairs Annual Report noted that the NYPD in the two years past had conducted integrity tests or stings on more than 1800 members. In 1998, there were only 41 integrity test failures; in 1999, only 53. The second source of intelligence on possible corruption came from what the NYPD termed "EDIT" arrests. These arrests targeted narcotics and vice cases where the defendants were actively debriefed to determine misconduct by police officers. These targeted efforts produced better results. In 1999, 498 EDIT arrests generated approximately 100 Internal Affairs logs, misconduct cases, or corruption-related referrals. NYPD Internal Affairs Bureau 1999 Annual Report, p. 21.

Earlier this year, the LASD's Internal Criminal Investigations Bureau (ICIB) formally proposed the creation of permanent teams to conduct both random and targeted stings. We were disappointed that the proposal was neither adopted nor, to our knowledge, revised or re-tooled if LASD leadership had deemed it to be too expensive or too ambitious or housed inappropriately at ICIB. We were further disappointed that a proposal for stings did not make the final list of immediate and long-term recommendations from the Anti-Corruption Task Force chaired by Commanders Scaduto and McSweeney, even though, as we noted earlier, the recommendations of that Task Force generally were excellent.

We therefore repeat, with additional urgency, our recommendation that the LASD establish teams to conduct stings in areas prone to corruption or police misconduct or malpractice, including exposure to money and drugs, excessive force, and Fourth Amendment violations. We also repeat, again with added urgency, other unadopted key related recommendations from the **Twelfth Semiannual Report:**

- Those individuals who apply for or take jobs with the Narcotics Bureau or any other unit where they are exposed to large amounts of money or drugs should
  (i) waive any privacy rights that otherwise might apply to their financial status and financial affairs;

(ii) be required to submit and update complete financial disclosure information, including acquisition of substantial personal or real property;

(iii) be required to submit to regular monitoring of spending habits, credit card debts, and unusual purchases.

- There should be mandatory rotation from specialized units after reasonable time limits. We note that the LASD's Anti-Corruption Task Force picked up on this recommendation and itself urged that there be mandatory rotation of managers, supervisors, and team sergeants and a mandatory rotation program for specialized units. Anti-Corruption Task Force, Special Units Sub-Committee, long term recommendations nos. 6 and 7; Supervision Sub-Committee, recommendation 5.

- There should be clear standards for assignment to Narcotics or other specialized units that specifically test the applicant's honesty, integrity, and prior adherence to legal and Departmental norms. There should also be routine background investigations on applicants. Again, the LASD's Anti-Corruption Task Force apparently agreed with us and also recommended a background investigations unit to vet applicants for specialized units. The Task Force also recommended that selection for certain units—such as the Detective Division—be done at the divisional or higher level and that selection for other specialized units and details be reviewed at the Commander level. We agree. As we have argued for many years with respect to Field Training Officer selection, these positions should not be patronage for unit commanders to hand out but should be the result of Department-wide selection and assignment, based upon predetermined standards that eliminate candidates with imperfect records in important areas, including integrity and use of force.

C. Inspections and Audits

Our third key recommendation was that the LASD revive its ability to conduct regular, department-wide unannounced audits. We further sought reactivation of special project teams

(called the "Magnificent Seven" by the *Los Angeles Times*) that under the prior administration had been used for long-term probes, audits, and analysis and performance reviews that regularly followed up on individuals identified as possibly problematic by the PPI.

In language echoing provisions of the recently-signed consent decree in *U.S. v. City of Los Angeles, et al.,* C.A.00-11769 GAF(RCx), (C.D.Calif.), we advocate that the LASD conduct regular, periodic audits of warrant applications and supporting affidavits; use of force reports; arrest, booking, and charging documentation and reports; stops and searches; informant packages, gang database entries, and related documentation to test adherence to policy and procedure. Again, the Anti-Corruption Task Force concurred in our recommendations and itself advocated establishing an Inspectional Services Unit. Special Units Sub-Committee, long term recommendation 2.

Conclusion

As the foregoing discussion demonstrates, the LASD is running unacceptable risks by virtue of a dwindling commitment to risk management and a failure swiftly to adopt anti-corruption measures that have become standard procedure in other law enforcement agencies, either by voluntary adoption or through negotiated consent decrees. The LASD is otherwise in an enviable position. It responded well to **Kolts** and has, if it would only put it to good use, the best risk management program in the United States with the PPI, the SCIF process, and excellent underlying data and management reports. The LASD has not had a major scandal since Big Spender in the late 1980's. It studied and learned lessons from that scandal, even if it failed to adopt the best of its own recommendations that flowed from it. The LASD does not suffer from the blows to morale and reputation that the LAPD has suffered.

In other words, it is well-positioned, if it would only choose to do so, to vaccinate itself against a major scandal. Instead, it seems to have become overly complacent or forgotten how easily the contagion of scandal and misconduct can be transmitted to the unprotected. For what-

ever reasons, the LASD has relegated risk management and strict accountability for it, in the broader senses, to a low priority. It is nothing less than shocking that SCIF and the underlying management reports and information have gone by the boards. We strongly urge the LASD to give itself a strong booster shot of the vaccine it largely invented and patented. It should do so by taking the steps outlined in this Chapter and in our previous semiannual reports.

3. Medical Care in the Jails

Our semiannual reports have dealt at length with the problems of medical care to inmates in the Los Angeles County jails. We have set forth the problems and listed our recommendations repeatedly. It is dispiriting to find, as this Chapter will demonstrate, that acute problems persist. Notwithstanding the seriousness of the medical lapses described herein, we acknowledge incremental progress, albeit at a patience (and patients') wearying pace, on some issues. This Chapter will first describe our exhaustive review of medical services from the perspective of the inmates who receive—or fail to receive—medical care. Next we provide an update on the status of our prior recommendations for an overhaul of medical services.

Introduction

To deepen our understanding of the difficulties and problems in providing medical services to inmates in Los Angeles County jails, we undertook to analyze more than 3600 of the 7181 inmate complaint forms submitted in 1999 relating to medical services. Our previous examinations of the topic were based upon a study of litigation on medical malpractice and failure to treat allegations; our review and critique of expert reports and opinions issued after inspections of the County's jail medical facilities; our interviews with a spectrum of physicians, psychiatrists, psychologists, nurses, academics, and health care professionals with experience in the Los Angeles County jails; our interviews with the jail's medical and nursing staff; our interviews with sworn and civilian administrators and managers in the LASD's custody operations; discussions with the County's Risk Management Inspector General; consultation with experts in jail medical issues from outside California; and what we learned at conferences and meetings on LA County jail medical issues.

It appeared that we had covered all the conceivable bases in order to form judgments on the quality of medical services with one uncomfortable exception: we had not spent enough time gathering data from inmates themselves and from those in close contact with them. To close the gap, we undertook to contact medical personnel in the Los Angeles area with patients who were in the jails to hear a range of views on the specific difficulties their patients were facing.

Similarly, we followed up on efforts initiated by relatives or friends of inmates to alert us to specific medical lapses. We reviewed correspondence between the LASD and persons who wrote to the Department to complain about the medical treatment of their patients, relatives, or friends.

These efforts gave us a sense, based largely on individual cases and anecdotes, of the frustrations and anger generated by lapses in the provision of care. Notwithstanding the poignancy of many of the stories we heard, we nevertheless felt uncomfortable generalizing from them. Inmates who had been treated with due professional attention obviously did not feel the urgency to speak or initiate contact as those who had a grievance to get off their chests.

It is thus important at the outset to emphasize that there are tens of thousands of individual contacts between inmates and medical staff in the jails each year, most of which go without a hitch. This chapter focuses on problems and it cites many examples of untoward—and sometimes heartbreaking—things that have happened to very ill individuals.

Keep in mind throughout, however, that providing medical services in the LA County jails is not a day at the beach. Recall that nearly 200,000 individuals flow in and out of the jails every year. The inmate population is older, sicker, and in jail for a longer period of time than in the past, in large part because of the impact of the three strikes law. Putting aside for the moment the difficulties in a jail setting of providing diagnosis and treatment of disease and injury, one cannot fail to appreciate the sheer volume of routine service provided to inmates. On any given day, an average of approximately 6500 inmates receive prescribed medications by licensed nurses throughout the jails. That adds up to over two million instances a year in which medication is dispensed. Although overwhelming volume does not excuse substandard performance, it does disservice to the heroic efforts of self-sacrificing and steadfast persons on the medical staff to fail to take account of the difficulty and complexity of their jobs. But as we have noted before, our obligation is to provide the Supervisors with a candid appraisal of the LASD's problems and its efforts to cure deficiencies. Our semiannual reports therefore give greater emphasis to describing shortcomings than to touting successes. That does not mean

that we fail to admire and appreciate jobs well done throughout the Department, from hard work to heroism.

To understand the problems in the provision of medical services from the inmate perspective, we decided to undertake an complete review of all the inmate complaints about medical service for a whole year and follow up to see how the LASD had responded to them. The LASD was somewhat slow in processing and completing its work on the complaints. For example, as of March 15, 2000, disposition data was entered for less than half—3,526—of the more than 7181 complaints recorded in 1999.

At the time of our **Twelfth Semiannual Report,** issued in June 2000, we reported in summary form on a preliminary look at approximately 25 percent of those inmate complaint forms then available to us. Since that time, we completed our review of another 25 percent. Our initial goal was to look at all 7181 complaints. We could not do so. The LASD had not completed processing on about half of the 1999 complaints at the time we launched our study in the spring of 2000. We opted therefore to look at every completed file available at that time.

Although we perhaps could have made the same points with a more restricted sample, and although a smaller sample could have been constructed that would have been statistically valid, we opted to look very broadly at more than 3500 complaints. Our principal motivation was to get as wide a picture as possible. Another was to make certain that our conclusions were well grounded in fact, especially since the sources of the complaints were inmates themselves. Because of skepticism within the LASD and in the world at large, warranted or not, about the truth of what inmates have to say, we wanted to take particular care that we had objective corroboration of the substance of an inmate complaint. We took two approaches to the data. First, we read and analyzed all of the 1999 medical complaints we received. Then we reviewed statistical and other information maintained by the Department regarding the complaints and their dispositions for corroboration or amplification.

Our review confirmed that problems identified in our earlier reports persisted at least into the first quarter of 2000, despite genuine efforts by the Department to address them. These include:

- Serious delays in access to doctors and dentists
- Delays in prescription renewals, leading to medication lapses
- Interruptions in medical treatments for transferred inmates
- Lapses and disconnections after an initial screening discloses a medical problem and follow up care.

Our review also confirmed our belief that these problems will continue until their systemic causes are addressed. As we have pointed out in previous semiannual reports and thus will not repeat here at length, the roots of these problems are chronic understaffing, periodic but persistent provision of substandard medical care by physicians engaged by the LASD, and lapses in treatment and care because of difficulties of coordination, communication, and logistics. Some issues, such as interruptions in treatment regimes for transferred inmates, may be addressed in the long term by the Department's new Jail Hospital Information System ("JHIS"); but even the most sophisticated data management system cannot ensure adequate delivery of medical services when there are not enough physicians and nurses or planning and oversight.

This Chapter will next, by way of background, outline the complaint and complaint resolution procedures. We then discuss in detail the problems and trends we identified in our review. Finally, we report on the current status of our prior recommendations.

A. The Complaint and Resolution Process

According to Department representatives, Inmate Complaint Forms ("Complaint Forms") are available in each unit.[1] At the end of each shift (i.e., every eight hours), a custody officer with supervisory duties collects Complaint Forms from boxes within each unit. The officer reviews the forms immediately after collection; any Complaint Form that mentions a medical issue is immediately assigned an identification number, and is copied and delivered to the

1 Inmates complained that Complaint Forms were not always accessible, and that inmates sometimes wait three to four days to get a Form. Others complained that the only way to get treatment was via complaint form.

facility's nursing manager. The Custody Division retains a copy of the Complaint Form, from which information about the Complaint is entered into FAST, a computerized database system.

The nursing manager triages the complaints, interviews the inmates, and handles the complaints if possible; otherwise, the inmate is referred to an MD, dentist, or nurse practitioner for further treatment or evaluation. Department policy requires the medical staff respond to emergency complaints (e.g., chest pains) within one hour; to urgent complaints (e.g., pain, bleeding, toothache) within 24 hours; and to routine complaints (e.g., reading glasses, diet requests, and other non-urgent medical conditions) within seven days.

After the inmate is seen, the findings and action taken in response to the complaint are noted on a "Medical Services Complaint Disposition Data Form" ("Disposition Form"), which is then attached to the Complaint Form. Inmates are informed of the findings and then asked to sign the Disposition Form acknowledging they received a response to their complaint. The Disposition Form identifies who in the LASD responded to the complaint and records whether the complaint is "founded"or "unfounded" and if the response was "timely" according to department guidelines. Objective information concerning the disposition, including type of complaint, general disposition, and timeliness, is entered into the computerized FAST system by Medical Services Unit staff.

B. Common Issues Raised in Complaints

Although the specifics of medical complaints vary, a number of themes and issues emerged from our review, essentially confirming our previous concerns and conclusions regarding the state of jail medical services.

1. Delays in Access to Doctors, Dentists, and Specialists

The most frequent complaint—raised in more than half of the Complaint Forms we reviewed in detail—was that the inmate had requested medical treatment one or more times before, without success. Many inmates report that they had waited weeks, and sometimes

months, to see a doctor or dentist. In some cases, inmates report that nurses simply refused their requests to see a physician. However, in many cases inmates were "put on doctor's line" (signed up to see a physician or taken to wait for an examination), but were never called in, or were told that the physician had left before the inmate could been examined.

As we noted above, we wanted to proceed carefully in assessing the quality of medical care through an analysis of inmate complaints given that some will reflexively discount the accuracy or veracity of any complaints from those persons. LASD staff also point out that inmates sometimes—or even often—submit spurious complaints because they are bored and want a medical appointment as a change of pace or because they are simply looking to make trouble. For these reasons, we gave substantial weight only to those complaints where LASD staff confirmed in the Disposition Form that in fact the inmate did have unredressed medical needs.[2] The vast majority of the complaints we reviewed were corroborated in this way. Many involved serious and potentially life threatening situations. To be sure, we found a small number of complaints concerning rashes and colds, and an even smaller number for which the Disposition Form indicated the inmate's complaint was completely meritless. But that small group of complaints was more than matched by complaints concerning difficulty in gaining access to doctors or treatment for heart conditions, cancer, kidney disease, high blood pressure, prostate problems, seizures, and HIV-positive status.[3] Following are illustrative examples of serious lapses:

2 We rarely—if ever—saw Disposition Forms in which the LASD disproved or seriously disputed the inmate's claim of having previously requested medical care and having been refused or overlooked or ignored. This tended to establish that the inmate's allegation was probably true, although by no means conclusively. It is possible that the inmates' claims of prior refusals of care were never investigated as such or that the investigator deemed it an adequate remedy in any event if the inmate was put on doctor's line.

3 For example, of the 3,600 complaints reviewed, 52 concerned heart problems, 93 concerned high blood pressure; 24, kidney infections or disease; 45, seizures; and 148, HIV or AIDS. Although not all complaints of serious medical problems allege delays in getting to physicians, a significant number do. In addition, a number of these same complaints also allege lack of access to medications.

- Had been requesting MD consult for more than 3-1/2 weeks regarding heart condition. In response, inmate was seen by MD five days later, given heart medications, and given follow-up cardiology appointment.

- Fourth complaint regarding heart medication and removal of stitches in foot. Referred to doctor.

- Has been trying to see doctor for about two months re heart and sinus problems. Has not been getting blood pressure check three times a week, as was prescribed. Inmate was place on doctor's line, and blood pressure was checked.

- Has been trying to see a doctor to get medicine for cancer and hepatitis B & C.

- Signed up to see doctor nine days ago for brain cancer, but had not been called.

- Inmate seeking treatment for bone cancer submitted earlier complaint; nurse told inmate to "sign off" on previous complaint because inmate would see a doctor the following Monday; inmate still had not seen doctor.

- Had been asking to see a doctor for three past weeks regarding "nephritic syndrome" and kidney problems.

- Went to sick call twice regarding already-diagnosed renal problems, was unable to see doctor either time. Has blood in urine.

- Told three weeks earlier he would be put on doctor's line for his chronic prostate problem, but still had not seen a doctor.

- Requesting to see a doctor regarding high blood pressure and shortness of breath; nurse kept putting off request.

- Requesting nurses to put him on doctor's line for six weeks regarding high blood pressure.

- Requesting to be put on doctor's line for about a month, and submitted three prior complaint forms; has Hodgkin's disease and is in pain.

- Has been trying to see doctor because feels sick and is HIV-positive.

- Requested doctor's appointment for past ten days for AIDS-related emergency.

In addition to cases in which inmates had previously been diagnosed with a serious condition, there were numerous complaints alleging symptoms that could indicate serious medical conditions, including rapid weight loss, seizures, and neurological problems, or pain:

- Requested doctor's appointment twice in two weeks for rapid weight loss and fatigue.
- Had been trying to see doctor for last three weeks; experiences seizures and has hit his head.
- Losing feeling in right hand, but unsuccessfully tried for two weeks to see a nurse.
- Turned down from doctor's line three days in a row. Needs to have staples removed from head to avoid infection. Also was not taken to orthopedic appointment at USC medical center.
- Signed up six times for medical treatment for hernia, but has not seen MD.
- Had signed up for MD line for three weeks, but no response; has abscess on arm. Response indicates doctor ordered medication after examination.
- Has been complaining of abdominal pain at sick call for two weeks. In response, the inmate was placed on MD line.
- Has been denied medical attention for over two weeks for excruciating pain in lower right side because of gallstones. Ten days after complaint made, inmate was finally seen by a physician, and was order transferred to Central Jail to schedule a gall bladder procedure.
- Requesting to see doctor for more than three months regarding burning, sore, watery eyes.
- Signed up for sick call for "several weeks" regarding lower back pain, but had not seen doctor.
- Went to sick call five times regarding kidney stone, but still hasn't seen a doctor.

- Had been requesting to see doctor for a week because had not had bowel movement in two weeks, and is diabetic; stomach and back are aching. In response, doctor evaluates inmate and prescribes medications for constipation.

- Requesting to see doctor for more than a week regarding earache with "draining pus."[4]

The complaints evidence a particularly serious deficit of dental resources. Of the complaints we reviewed, 647—about 20 percent—complained about access to dentists. There were literally hundreds of complaints of severe toothaches and painful abscesses that had been left untreated for weeks and, in some cases, even months in the face of repeated inmate requests for treatment. In most cases, dispositions note that the offending tooth was ultimately extracted. Examples of delays in dental care include:

- Asked to see doctor or dentist every day for eight days during sick call for bleeding, infected gums.

- Has been trying to see dentist for 1 -1/2 months - bridge has fallen out and teeth exposed. Nerves hurt when exposed to cold. Disposition: Placed on dental line.

- Had submitted many request forms to see a dentist regarding exposed nerve in tooth.

- Trying to see dentist for more than four weeks. Disposition: antibiotics and pain medication prescribed, and referral to LCMC for difficult extraction.

- Made sick call line eight times to see dentist for bad toothache, with no success. Disposition: tooth extracted.

- Asked nurse two weeks earlier to put on dental line re toothache.

- Four trips to dental line did not result in treatment by DDS for bleeding gums. Duty officer told inmate that dental line takes up to a month.

4 In a number of cases, the Department's failure to promptly diagnose and treat these kinds of apparently non-urgent conditions have led to serious, permanent injuries, and even death. For example, in the Twelfth Semiannual Report, we described the facts in *Llamas v. County of Los Angeles*, where failure to treat an infected ear led ultimately to surgery and brain damage.

- Had been waiting three months to see dentist for painful wisdom tooth.
- Request for dental assistance unheeded for two weeks.
- Requested dental assistance for four weeks for abscessed tooth.
- Inmate has been waiting seven or eight weeks for broken tooth extraction.
- Six to seven weeks past due to see dentist re extraction; although tooth was medicated, tooth started to abscess for third time; complained to staff about 11 times.

The principle reasons for delays in access to doctors and dentists appears to be too few practitioners on staff, logistical difficulties, and efficiency problems. Several inmates complained that although they are put "on doctor's line," they left the clinic without having seen a doctor. Some inmates with serious medical conditions expressly reported that they were physically escorted to the doctor's line or had an appointment, but were not seen by a doctor. This confirms that there are too few physicians to meet the demand for medical treatment or that the physicians fail to allot sufficient time to their duties. For example,

- Diabetic inmate was escorted to doctor's line in response to complaint four days earlier, but never seen by MD.
- Scheduled to see doctor on Thurs re HIV-related symptoms, but not seen.

Some inmates reported that there was no sick call on weekends, and sometimes there was sick call only four days a week. Other inmates reported that during some weeks, only emergencies were addressed on sick call, and inmates with other problems were turned away.

2. Delays in Renewing Prescription Medicines

The next largest category of complaints concerns prescription medication (981 complaints). Prescriptions may not be renewed unless a physician examines the inmate and approves the refill. It appears that, at best, the current system requires inmates to initiate MD appointments for renewals (although a number of inmates expressed confusion concerning how

to obtain renewals). Nonetheless, even some diligent inmates who tried to anticipate their needs for renewals complained that they were stymied: They were refused appointments with physicians until after their medications had run out. Even after prescriptions had actually run out, some inmates reported serious delays in getting renewals.

We were particularly concerned with reports concerning difficulty obtaining HIV medication, the effectiveness of which can be destroyed by a lapse in taking it. We are also particularly concerned about lapses in psychiatric medications because of the danger not only to the inmate patient, but to other inmates and staff, as well. But even medications that treat non-life threatening conditions, such medications to treat pain and rashes, should be provided continuously, and as medically indicated. The complaints indicate that the bottleneck is the product of the dearth of physicians.

- Asked to see a doctor to renew prescription that had run out; inmate noted that he gets violent without medication. Was not seen by psychiatrist until six days later, when medication was ordered.
- Went to sick call to see doctor regarding HIV medication; two weeks later still had not seen a doctor.
- Inmate complained he had not been receiving medical or psychiatric medication for ten days.
- Has not received HIV medication in three weeks.
- Has not received HIV medication for two weeks.
- Has not received asthma medication for one week.
- Inmate complained of trouble getting prescription medication for "cryptococcal meningitis" related to HIV, because sometimes medication was out of stock, other times dosage was wrong. Claimed symptoms had returned, and nurses had not let him see the MD.
- Waiting four months for medication renewal.
- Has not been receiving medication for a month.

- Nurse at sick call told inmate to raise need for prescription renewal with pill call nurse; pill call nurse told inmate to raise issue with sick call nurse.
- Inmate's renewal of arthritis self-medication was overdue; difficulties renewing medication every time.
- Seizure medication not renewed.
- Inmate requested appointment with MD to renew back pain medication, but did not get to see MD.
- Inmate "lacking" psych medication for three weeks.
- Inmate told by RN that he could not see MD until his prescription expired.
- Psychiatric medication prescription expired, although inmate warned psychiatric assistant in advance the prescription was going to be up for renewal.
- Advised sick call nurse two weeks earlier that his pain medication was running low. Medication ran out.

3. Interruptions in Treatment Regimes for Transferred Inmates

Just under five percent of the inmate complaints reviewed (167) reported that their treatment regimes, such as prescription medications and special diet, were interrupted upon their transfer from one jail facility to another within the Los Angeles County jail system. As with inmates who complained about delays in seeing physicians, a good number of these inmates apparently suffered from serious or life-threatening conditions, such as cancer, heart disease, asthma, seizures, psychiatric conditions.

- Medication and chart did not accompany inmate upon transfer three days earlier; he needed his asthma medication.
- Since being transferred has not received his medications for high blood pressure or colon cancer. Nurses say they do not have his file. Disposition: Seen by nurse. Medical file found. Placed on MD line for follow up.

- Had not received ulcer medication since his transfer, and could not sleep because of severe pain. Had already submitted one complaint.
- Transferred from state prison with eye drops for glaucoma; eye drops taken away.
- Inmate transferred from Twin Towers did not receive seizure and psychiatric medications for three days. Disposition notes medical chart and record missing.
- Upon transfer from NCCF to MCJ inmate could not get prescription filled.
- Upon transfer to MCJ, psychiatric medication not administered; inmate suffered seizure.
- Medication not received after being moved to different floor.
- Inmate trying to get psychiatric medication, but told to wait because he moved cells.

4. Other Prescription Issues.

Inmates reported a number of miscellaneous complaints relating to prescriptions:

- Denied mid-day dose of medication for two days.
- Not getting full dose of heart medication. Original heart medication replaced because jail did not carry that prescription.
- Has not received medication prescribed seven days ago.
- Prescribed three medications, but none have been received.
- Missing medication for high blood pressure.
- Not receiving HIV medication because doctor on duty was from Tower II and did not "feel comfortable" prescribing HIV medication.
- Non-English-speaking inmate was refused medication at pill call because he was unable to answer nurse's questions.
- Not receiving medication for high blood pressure, heart condition, and seizures.

5. Disconnect Between Doctor's Orders Emanating From IRC Screening and Follow-up Treatment.

The Department has instituted a comprehensive screening program for incoming inmates, designed to systematically detect medical and psychiatric problems in all new inmates. Yet inmates complained that follow-up to initial diagnoses and orders is lacking. Inmate complaints also revealed a failure to deliver treatments prescribed to inmates examined by physicians outside the IRC context (such as medication, special diet, and even surgery). For example:

- An inmate complaint dated October 21 reported that the inmate needed psychiatric medication, and that he had tried to inform the staff and submitted prior complaints. The response confirmed that Medical Services screened the inmate at IRC one month earlier (on September 20, 1999) and referred him for psychiatric evaluation. Almost three weeks after he filed his complaint, the inmate finally saw a psychiatrist, who put the inmate on medication.
- Had submitted many complaint forms because was supposed to be on liquid diet. The inmate was referred to an MD, who "re-ordered" the diet.
- Inmate scheduled for hernia operation within one week, but after three and one-half weeks still had not been to surgery. His complaint was substantiated; new orders for surgery consultation were issued.
- Inmate had been diagnosed with hernia, and surgery prescribed, but no action taken. In response to complaint, inmate's chart was submitted to County Hospital for appointment.
- Had not received special diet ordered 3-1/2 weeks earlier. Response included special diet order.
- Soft diet had been ordered for inmate who had no teeth. Inmate had not received diet and had been "on MD line" for five weeks. Inquiry confirmed that diet had been ordered, and staff made second request.
- Blood test conducted two months earlier, but has not heard results, although has made many requests to see doctor. Disposition: lab results given to inmate, and medication prescribed.
- Was not taken to orthopedic appointment at USC medical center.

- Two MDs recommended radioactive iodine treatment, but five weeks passed since inmate had signed last consent form and no treatment had begun. Disposition: inmate was set for appointment at County Hospital.

- Inmate was scheduled for emergency medical surgery for "reverse colostomy" one month earlier, but nursing staff refused to authorize; advised inmate would have to wait until sent to State prison or release. Response to complaint indicates inmate seen by physician, and surgical appointment made for inmate at County Hospital.

6. Miscellaneous Issues

a. Delays in investigating complaints.

Of those complaints for which dispositions had been entered into the computer as of the time we initiated our study in the spring of 2000, responses were indicated as timely for over 90 percent of those complaints. For purposes of analysis, we have assumed the accuracy of the finding of timeliness and did not attempt independently to verify them. We also assume that the standards for when treatment is "timely" meet with accepted medical criteria, again without independently so verifying. Yet even with these favorable assumptions, an estimate of over 500 delayed responses is high enough to give pause. Some delays are relatively short; others, however, stretched into weeks and even months. As a result, individuals experienced pain and declining health; sometimes, inmates were released without treatment.

Some of the worst were:

- On August 18, an inmate's tooth broke; his complaint was marked received by custody on August 19. However, the disposition form does not reflect any action until more than two months later (on October 29), when an "abscess" is noted. The disposition form indicates the inmate was not treated for another month (until November 27), making it more than three months between complaint and treatment.

- Inmate complaint dated 11/11/99 reported that inmate had been waiting since 9/16 for appointment at County Hospital regarding tumor. Disposition noted on 1/11/2000 that Department was unable to resolve complaint because inmate had since been released and Department was unable to find inmate name or number on computer.

- Inmate complaint dated 11/24 reported that inmate had requested psych consult three weeks earlier, with no response. Disposition noted on 1/11/00 that Department could not resolve inquiry because inmate was released and Department could not find the inmate's name.

- Complaint dated July 27 noted that psychiatric medication prescription expired. No response noted until August 17.

- Complaint submitted on August 24 that inmate had been requesting dentist for two weeks for severe toothache. Response on October 12 noted that inmate had been released prior to the LASD getting around to investigate the complaint.

b."Disposition Codes" do not convey whole story.

We found that we could not rely wholly on the LASD's disposition of complaints as "unfounded" or "unsubstantiated." Even if an inmate was found to have requested to see doctors one or more times in the past without success, we found several examples where the complaint was deemed "unfounded" or "unsubstantiated" if the inmate was eventually put on doctor's line as a result of the complaint. Similarly, we could not rely upon a disposition of "unfounded" or "unsubstantiated" to mean that the alleged medical condition was found not to exist. There were instances where a complaint was held "unsubstantiated" despite care having been requested and given.

It appeared that the LASD was treating all inmate complaints as simply alleging a failure to provide treatment. The LASD deemed the complaint therefore to be unfounded or unsubstantiated if one of two results occurred: (i) some action was taken as a result of the complaint or (ii) the underlying medical condition complained of was spurious. In other words, even if an inmate with a legitimate medical condition had repeatedly requested treatment, the complaint would be deemed unfounded if he was put on the doctor's line, whether he ultimately got to see the doctor or not, and regardless of whether he had in fact repeatedly requested help. Although we can understand that with more than 7000 complaints a year, it is burdensome for LASD staff to exhaustively investigate each instance where delayed treatment is alleged, and although

we can appreciate that in a chronically understaffed and overwhelmed jail medical setting that it is simpler just to say "no harm/no foul" as long as some treatment is eventually ordered, we question whether the LASD is getting the benefit from a risk avoidance perspective by giving these complaints short shrift.

C. The Nursing Staff

In cataloguing the complaints, we were struck that there were very few complaints about the nursing staff or their treatment of inmates. To be sure, some inmates appear to blame nurses for their lack of access to doctors. A small number complain that nurses were intentionally rude or refused to assist patients (e.g., threw pills on floor; refused to give inmates medicine). Where such issues are raised by complaints, the disposition indicates that the nurse in question was approached about the complaint and reminded to be professional in dealings with inmates. Although few in number, a few of the complaints about the nurses were sufficiently serious that we point them out:

- Nurses ignored his requests to see a doctor regarding his HIV-positive status.
- Nurses denied inmate's request to see doctor regarding "full-blown" AIDS, liver problem, and other ailments. Nurse dropped medication on floor and made inmate take the medication anyway.
- Nurse took away asthma inhaler; was rude. Inmate was prescribed another inhaler in response to his complaint.

These instances of poor performance notwithstanding, the nursing staff often performs heroically, and we acknowledge and appreciate their loyalty and dedication. The normally stressful position of nurse has been made even more stressful by chronic staff shortages. While there may be a handful of truly difficult nurses, the balance appear to be caring and committed, although overworked. We note that the LASD recently approved the hiring of an additional 77 nurses, one additional physician and one additional dentist. We understand that

some 38 nurse applicants are currently undergoing background checks. Nonetheless, even if all 77 nurses and the MD and dentist were hired tomorrow, the LASD would still be 106 positions short of its authorized strength of 861 positions. The burden of the shortfall rests on the already overworked shoulders of a dedicated nursing staff.

D. Status of Prior Recommendations

The foregoing discussion, combined with our wider ongoing investigation of medical care that spans several years' worth of semiannual reports, demonstrates a chronic, serious, deep, and difficult problem. Nor are we in any way alone in sounding the alarm. The County's own Department of Health Services has done so. The ACLU has done so. The United States Department of Justice has done so. So have many inmates, their doctors, and their relatives and friends.

Through our dealings with the LASD since **Kolts,** we believe we have forged a consensus with the Department, at least in theory and general approach, about what needs to be done in the mid- and long-term. Sadly, the pace of implementation is agonizingly slow. Our last semiannual report summarized nine key recommendations that we have been advocating for a long while. We will now turn to that list and report on the current status.

1. *Immediately seek licensure as a Correctional Treatment Center for the Medical Services Building (MSB) at Twin Towers.* The LASD has to date only taken the first step in what will be a long march over rough terrain. The initial phase, approved by Sheriff Baca recently, is to call for a pre-survey of measures the Department will have to take in order just to be put in the ballpark to seek licensure. The license depends at least in part on ratios of medical staff to inmates. The Medical Services Building is currently understaffed and below those ratios. It has been estimated that it may take an initial outlay of $6- $6.5 million to hire staff and get ready to undergo the scrutiny and pass the tests that are preconditions to licensure. Money for

that has not been identified, much less earmarked. Once the license is obtained, it is estimated that it will cost $4- $4.5 million per year to stay in compliance on the staffing ratios. Accordingly, the end is nowhere in sight and the march has only barely begun.

2. *Make certain that the jail medical and mental health services fully conform to California Title 15 standards and that adequate mechanisms for external monitoring and oversight are in place to assure ongoing compliance.* Apart from an occasional visit by the ACLU and a yearly pass through by the State of California, where compliance issues are noted and the LASD promises to do better, there apparently has not been an exhaustive independent look at Title 15 compliance issues since the long-buried, never-issued, and now somewhat musty DHS study entitled *Recommendations Concerning the Provision of Health and Mental Health Services in the Los Angeles County Jail System.*

3. *Seek IMQ jail accreditation for all the outpatient facilities in the Los Angeles County Jail System in a structured and phased way.* This recommendation is currently going nowhere. It is frankly not a priority and will not even be broached until after the in-patient facility, MSB, is licensed. As we argued in our **Twelfth Semiannual Report,** there are a number of specific IMQ standards that should be adopted voluntarily as sensible risk management steps to reduce potential liability while waiting for IMQ certification in general. **Twelfth Semiannual Report,** p. 52. We continue to be convinced of the benefits and wisdom of IMQ accreditation and we continue to strongly urge that it be sought.

4. *Transfer emergency and specialty visits currently taking place at County USC Hospital or elsewhere to MSB under a contract with a university hospital.* The first step in this Long March was to put out a Request for a Proposal (RFP) for a consultant to help the LASD find yet another consultant who could then draft yet another RFP to solicit proposals to provide those emergency and specialty services. Those who have been patiently holding their breath

may now exhale: The consultant to recommend another consultant to write the RFP has been identified. But since no money has been earmarked to pay Consultant A to identify Consultant B, Consultant A has not been asked to go forward.

5. *To the extent that recommendation no. 4 cannot be speedily accomplished, at least implement already drafted proposals for USC Medical School to use medical residents to staff the Inmate Reception Center (IRC).* Because of purported difficulties of long duration getting Sheriff Baca and USC President Sample in touch with each other to discuss them, these already drafted proposals are apparently hovering between desk and wastebasket in a state of suspended animation known in the LASD as "permanent hold." Never ones to let moss grow on the soles of their shoes, the quick-footed in the LASD's Medical Services Unit have devised an alternative plan: Have the as-yet-unidentified Consultant B include these IRC services in the RFP that will be drafted once Consultant A, who has been identified, is paid money so that Consultant A can go find someone to be Consultant B.

6. *Examine the feasibility of contracting all or part of the remainder of medical services to a university medical school.* This apparently will happen the moment that recommendations 3-5 above have been completed.

In this connection, it is interesting to note that the City of New York recently changed providers of medical services for Rikers Island, the huge New York City jail. The new contract price is approximately $105 million per year. There are fewer inmates in Rikers Island than in Los Angeles County jails. Rikers Island has an average daily population of about 13,500; LA County is closer to 20,000. Unlike LA County, with far-flung facilities in the north of the County as well as downtown, Rikers is a small island in the East River. Whereas LA County jails medicate approximately 6500 inmates daily, Rikers medicates about 4000. It is also the case that the staffing ratios at Rikers of medical personnel to inmates are significantly more favorable than in LA County. Medical services to inmates in LA County currently cost on the

order of $70 million yearly. Thus, it would likely cost more than the yearly $105 million that New Yorkers are currently paying for Rikers Island to buy equivalent staffing and services in County jails. Admittedly, this is a substantial additional amount of money over what LA County is currently paying. The question then becomes, is it worth it?

The inquiry to get an answer to the question is several-fold: First, on a purely dollars-and-cents cost/benefit analysis, how quickly, if ever, would the substantial cost of licensing MSB, coming up to IMQ accreditation standards on the out-patient facilities, and contracting out all or part of medical services to a highly reputable and competent university hospital be matched or exceeded by anticipated liability and other costs associated with maintaining the status quo or making small incremental changes? Second, even if the benefits do not outweigh these costs over time, what are the chances that the County's freedom of choice in this area will be undercut by injunctive or other judicially-ordered relief, either from privately-initiated or governmentally-initiated litigation? If those chances are substantial, what is the value to the County to be able to decide when and how much money to spend? How much is it worth to the County not to have to reallocate money, in a crisis mode, from priorities established by the Supervisors to priorities mandated by judicial decree? Third, even if all the foregoing risks are worth running in a purely economic calculation, are there other societal costs that are harder to put a number on but are just as real? What is the benefit to public health in general if the transmissible diseases of inmates are attended to in the controlled environment of a jail rather than largely ignored in the uncontrolled environment of the streets? How much crime and injury to future innocent victims could be avoided by dealing with serious mental illness or drug dependency while the inmate is in a custody setting?

Finally, but in the end more important than any of these other considerations, what are the moral and ethical implications? Regardless of how high or low the bar imposed by constitutional or statutory or common law standards, it is a fact that a seriously ill inmate cannot take herself to a doctor or show up at an emergency room or ask her brother to call 911 or summon other help. Jail is loss of freedom. And it makes no difference, and the freedom is equally lost,

whether you are there because you cannot make bail, or are awaiting trial, or have already been acquitted or had your case dismissed and are awaiting release, or have served your time and are waiting to be let out, or have been convicted and are waiting to go to the state penitentiary. Your freedom to take care of yourself is gone. The jailer decides if and when you can see a nurse or a doctor; if and when and how you get your prescribed medication; whether or not there is someone available to transport you to a specialist to get the radiation prescribed for your cancer.

How we treat those who are powerless and utterly dependent may be the ultimate measure of our moral worth as individuals or as a society, regardless whether those who have become powerless or dependent somehow may have brought it upon themselves because they committed, or have been accused of committing, crimes and got thrown in jail. This is not to say that MSB has to become the Mayo Clinic. But it surely does mean that the County jails should meet state licensure and IMQ jail accreditation standards at a minimum.

7. *Computerize medical records and inmate tracking so that inmates can get their medication, do not miss scheduled doctor's visits, are taken to the hospital when the doctor has so ordered, and so that one doctor or nurse is aware of what another has prescribed or ordered.* This too is coming along more slowly that we had hoped. The necessary wiring and preliminary work has been done only in MSB. The LASD is "getting ready" to do the same in the balance of Tower I and Tower II of the Twin Towers. The wiring is not complete at Men's Central Jail or the north County facilities. It will be at least until the end of 2001 before there can be a roll-out of computerized medical charts to those facilities.

8. *Address and resolve conflicts and ambiguities in the respective roles, power, authority, and precedence of Medical Services, DMH, and the Custody staff in a way that elevates health-related concerns so that the logistical and other custody needs, which seem often—if not invariably—to trump health needs, are subordinated appropriately.* Our frank appraisal is that in a practical sense this cannot occur until health professionals are in a more advantageous bargaining position. Where, as here, all the Medical Services staff are employees of the

LASD, and where, as here, Medical Services is part of Custody operations and run by sworn personnel, it is largely unavoidable that sworn custody personnel will wield final authority and call the shots. That is not to say that sworn staff is not able and competent—at various times, we have praised the efforts of John Anderson, Taylor Moorehead, Richard Moak, and others. Nor is it to say that it should never be the case that medical personnel report to sworn personnel. Nonetheless, we are pessimistic that there can be a serious reordering of priorities to the benefit of health-related issues under current circumstances.

9. *Examine the feasibility of telemedicine as a way to avoid unnecessary transportation of inmates.* We stated this recommendation as a long-term goal, and so it remains.

In sum, medical care in the jails remains a difficult, chronic, unresolved problem. We nonetheless look forward to working with Marc Klugman, the newly-appointed captain of Medical Services, on all the issues raised in this Chapter with the hope that we can report good progress in an upcoming report.

4. Update on Sexual Harassment Issues

Introduction

Following a spate of costly legal settlements and troubling new allegations of employee misconduct in early 1999, the Board of Supervisors asked us to evaluate whether the LASD was effectively and vigorously enforcing its existing policies against sexual harassment, and whether it could reduce its exposure to civil liability.[1] The **Eleventh Semiannual Report,** published just over a year ago, features a detailed discussion of the evidence we collected during our initial investigation of the record. It also contains our preliminary analysis of the LASD's performance in addressing harassment-related concerns.

The **Eleventh Semiannual Report** focused primarily on cases that reflected the Department's *past.* Indeed, several of the cases we reviewed involved investigations conducted five or more years before and alleged misconduct that occurred even before that. In the rapidly evolving field of sexual harassment law and policy, such periods represent a virtual eternity. By current standards, few five- or ten-year-old investigations would receive a passing grade.

For this Report, we accordingly decided to conduct an extensive review of more recent developments.[2] The primary purpose of this Chapter is simply to share a number of observations that arose from our review of the latest round of sexual harassment

1 Between 1995 and mid-1999, the County had paid nearly $3 million to resolve what we called the eleven "Settled Cases." As we observed last year, "[t]he number and dollar amount of these settlements have led some observers to conclude that the LASD [has] tolerated sexual harassment, mishandled employee's complaints, and, even where misconduct was found, meted out inappropriately light discipline, if any at all." Indeed, our review of the Settled Cases confirmed that there was some basis for these conclusions. Notwithstanding the LASD's well-publicized "zero tolerance" policy, evidence from the Settled Cases established that sexual harassment had been overlooked or ignored by Department officials—if not accepted outright as an intractable part of workplace culture.

2 This report is based primarily on our recent review of approximately 75 sexual harassment investigations conducted by the IAB over the past 12 to 18 months. Of these 75 investigations, 22 were launched before October 1, 1999, all of which are now completed. The 53 remaining cases were filed between October 1, 1999 and September 30, 2000. Given the volume of paper at issue, we chose to focus our attention on 25 of the 75 recent cases, and to conduct a less detailed review of the remaining files. Although we did not attempt to create a representative sample in any scientific sense, we are satisfied the 25 files designated for thorough review typify both the variety of claims received and the Department's expected treatment of them.

investigations by the Department's Internal Affairs Bureau ("IAB"). In doing so, we highlight a number of areas in which the LASD has made remarkable progress over the past 12 months. We also flag several areas of ongoing concern. We turn first to signs of improvement in several key performance areas.

First, LASD supervisors, as a group, are responding more quickly and forcefully to reports of possible sexual harassment. Indeed, the files describe numerous cases in which supervisors refer such allegations directly to the LASD's Career Development Bureau ("CDB") for intake, or to the IAB for investigation.[3]

Second, not only has the LASD eliminated its substantial former backlog of pending sexual harassment cases, it has also dramatically reduced the average time within which such investigations are typically completed. The Baca administration has consistently emphasized its commitment to timely investigations—with good reason, as we explain below. This message appears to have been successfully received.

Third, we saw evidence of noticeable improvement in the overall quality of the investigations themselves. Although several investigators would clearly benefit from additional training and practice in the art of investigation, the files we examined are—for the most part—thorough, organized, and well documented. They reflect a common interest in fairly balancing a variety of competing interests, and occasionally reveal flashes of extraordinary insight and attention to detail. Of course, such improvements are bound to affect the credibility of the entire process.

3 The CDB was created in 1999 to oversee the Department's management of equity, discrimination and harassment issues, as well as to oversee the County's affirmative action initiatives. Under the leadership of Commander Nancy Malone, the CDB includes the Office of the Ombudsperson, the Affirmative Action Compliance Unit/Career Resources Center, the Educational Development Coordinator's Office, and the Consent Decree Compliance Unit. The Office of the Ombudsperson serves as the Department's primary intake unit for employee complaints of discrimination and harassment. Before the CDB was created, this function was performed by the Ombudspersons/Career Resource Center ("OCRC").

Finally, it appears the Department has begun to correct its historic reluctance to impose appropriate standards of discipline where violations of Department policy are established. In sum, the men and women who were disciplined over the past 12 months for violating the LASD's sexual harassment policies received generally stiffer average penalties than those who were disciplined in previous years. Taken together, this and the other evidence we identify suggest that the LASD is continuing to evolve from the past practices we identified among the Settled Cases. In short, the Baca administration's continuing commitment to the reduction if not elimination of workplace harassment has begun to yield measurable results.

Our latest review also highlighted a number of additional areas that appear to require additional resources and attention. As an initial matter, the steady volume of credible complaints filed each year suggests that too many LASD employees remain unwilling or unable to conduct themselves professionally at work. Others apparently lack even the most rudimentary understanding of the types of conduct that existing LASD policies prohibit. Employees in each of these two groups would probably benefit from further education and training on this topic. In fact, improving available training opportunities would not only increase popular understanding of the issue, but also signal the Department's stiffening resolve in the fight against workplace harassment.

Finally, we identified repeated examples in which the Department's investigative resources were inefficiently allocated. For example, a number of investigations appear to have consumed disproportionate shares of time and other resources in light of the surrounding circumstances. Although we hesitate to criticize an investigation as having been "too thorough," overworking an especially simple or shaky case not only risks scarce resources, but undercuts general confidence in the entire enforcement process.

We turn now to a detailed discussion of our investigation and its findings.

Observations from the Recent Investigation Files

Supervisory Responses to Complaints of Harassment

When we addressed this issue in the **Eleventh Semiannual Report** a little more than a year ago, we suggested that LASD supervisors deserved a generally mixed review for their overall responsiveness to employee reports of sexual harassment on the job.

Typically, the eleven Settled Cases referenced numerous instances in which supervisors had minimized or ignored allegations of harassment at significant risk to the complaining employee, and, ultimately, the Department itself. In fact, we concluded that the failure of line supervisors to respond to allegations in a timely and thoughtful manner was often "the most significant factor" in leading individual complainants to pursue litigation.

Many of the Settled Cases were brought by female deputies who had been with the LASD for several years. Some had experienced discrimination or harassment as rookies or early in their careers but decided against complaining; perhaps because they were trying to show that they were able to "just take it." Thus, harassing conduct was not brought to the attention of the supervisor until the Complainant's resilience was depleted and the situation became unbearable.[4]

Yet the unhappy picture we drew from the Settled Cases was tempered to some extent by results from more recent IAB investigation files. As we noted in the **Eleventh Semiannual Report,**

[e]arly evidence from current OCRC files we reviewed suggest that the supervisors are acting appropriately and are properly utilizing the resources of OCRC at an early stage. Our assessment cannot be complete, however, because it is too early to determine how many complaints of

4 In several instances, the incident under investigation was less severe than one or more earlier violations that had not been reported. As we observed, at the time, "[t]his unfortunate situation may, in some odd and again ironic way, account for the reaction of the supervisor: Unaware that the incident complained of was simply the last straw in a series of instances, the supervisor may have been perplexed by the vehemence of the Complainant in light of the apparent triviality of the incident complained of in isolation. Tragically, this may have led the supervisor to judge the Complainant as weak or inappropriately sensitive, thereby generating misplaced sympathy by the supervisor for the harasser."

sexual harassment have arisen since the Settled Cases that might have been ignored by supervisors. That will not be known until the Complainants report them to OCRC or Internal Affairs or file lawsuits.

Fortunately, our latest reviews confirm the encouraging preliminary assessment we began to draw from the files of a year or so ago.

Specifically, we identified a variety of reports describing instances in which supervisors, upon receiving a report of possible harassment, took immediate steps to touch base with the complainant, or to launch the Department's formal response, or both. Although we doubt that any group of IAB case files would reflect a representative array of supervisory practices, the files we examined reflected well on LASD practices.[5] In many cases, supervisors responded to reports of possible harassment by notifying their superior. Alternatively, some supervisors reported the allegations directly to the Office of the Ombudsperson or the IAB. In most cases, the appropriate referrals were apparently made within a matter of days. Most referrals were confirmed in writing—usually by way of a memo to the supervisor's superior(s), or perhaps as a note on the standard CDB intake form.[6]

Notably, the 25 files we reviewed in greatest detail appear free from evidence of Department employees having been ignored, rebuffed, or discouraged by one or more supervisors as they sought relief from alleged sexual harassment or gender bias. Yet several files did contain evidence of a roughly converse situation—in which reluctant complainants try to prevent their supervisor from acting on their allegations. Such

5 It would not be unreasonable to expect that any random review of IAB investigation files would reflect a disproportionately high level of supervisory initiative in reporting allegations of workplace sexual harassment. Indeed, the IAB is unlikely to learn of any individual cases that are not initially launched by either the victim or a direct third-party witness. In many cases, such initial reports are made to a line supervisor, who, upon receiving the report, has three primary options: (1) notify his superior, (2) report the allegation to the CDB or IAB, or (3) do nothing. In the event the extent the supervisor does nothing, the IAB may never learn of the charges. If the case is referred to the IAB, the supervisor's assistance will probably be noted.

6 The practice of drafting confirmatory memos has important consequences, as it becomes increasingly more difficult to hide or ignore a given case once it begins to develop a "paper trail."

"reluctant complainant" cases typically involve an employee who wants to discuss an issue in confidence, or "off the record." Some reluctant employees are merely unsure of their options; others may want some feedback about the relative severity of the conduct at issue. Some employees express concern about the effect a formal charge may have on their reputation. Surprisingly, many worry about possible harm to the harasser's career.[7]

Notably, among the IAB cases we reviewed, each reluctant complainant was told that while the matter would be treated with as much discretion as possible, LASD supervisors are required to disclose such allegations to designated authorities within the Department. This is an appropriate supervisor response. Indeed, allowing reluctant complaints to engineer their own cover-ups or frustrate reasonable investigation efforts may leave suspected harassers free to harm other employees. Should a later complainant discover that one or more supervisors were on notice about the possible misconduct yet did nothing about it, the Department may have been placed in a position of significant risk.

It is difficult to overstate the importance of appropriate supervisor responses to allegations of sexual harassment. Indeed, the overall quality of such responses affects individual cases and the general working environment on several different levels. As a matter of law, timely and appropriate supervisor responses can help protect the County from liability. Such responses can serve as evidence that the LASD has exercised reasonable care in combating workplace harassment and related misconduct. *See Burlington Industries, Inc. v. Ellerth*, 524 U.S. 742, 118 S. Ct. 2257 (1998); *Faragher v. City of Boca Raton*, 524 U.S. 775, 118 S. Ct. 2275 (1998). As a matter of *human resource policy*, an established record of effective response encourages prompt and accurate reporting. Not surprisingly, this works to discourage harassment in the first instance. Finally, as a matter of common sense, an appropriate response from one's supervisor helps assure the complainant that her concerns will be

7 Three of the 25 cases we reviewed in detail contained evidence that the complaining employee was reluctant to pursue formal charges against the alleged harasser for fear that it might injure his career in a manner that was disproportionate to the nature of the conduct.

taken seriously. This is an especially effective way to establish the Departmen's commitment to protecting the basic rights of all its employees.

Timely Investigation and Adjudication of Employee Complaints

The Department has also made significant improvement in the timeliness of its sexual harassment investigations. This is important for several reasons. First, laggardly investigations can be extremely frustrating to the parties who are directly involved. Not surprisingly, complainants are left to wonder if they were taken seriously, or whether the employer is willing to enforce its own policies.[8] Similarly, unexplained delays often send mixed messages to the subject and other would-be perpetrators, dramatically undercutting the employer's anti-harassment efforts.[9] Finally, timely investigations simply yield better results. Memories often fade with the passage of time. Evidence and witnesses can disappear. Regardless of the underlying causes, significant delays in investigating workplace misconduct can often affect the accuracy and credibility of the outcome.

LASD policy requires that most administrative investigations be completed within 90 days of the Department's discovery of the alleged misconduct.[10] Historically, however, this guideline was often ignored. In examining this issue a year ago, we noted that although

8 Of course, unnecessarily long investigations are especially unfair to those who are unjustly accused. At best, the subjects of such investigations are left to live and work under a cloud of suspicion for extended periods of time. Even where the subject is ultimately cleared, the mere duration of the investigation itself may cause some to conclude that the subject "got off on a technicality" or that "there must have been something there"—regardless of the result.

9 In fact, in mid-1999, the Department's Executive Risk Review Committee (the "ERR") refused to take any disciplinary action against two officers who were determined to have violated LASD policies in a case involving workplace sexual harassment based largely on unexplained delays in the IAB's investigation of the case. According to the ERR, such delay in the investigation and punishment of wrongdoing undermine the very purpose of corrective sanctions.

10 Section 3304 of the California Government Code prohibits punitive actions against public safety officers who have been charged with misconduct unless the agency for whom the officer works completes its investigation of the charges within one year of a public agency's discovery of misconduct by a person authorized to conduct investigations.

some sexual harassment investigations were completed within that time frame, it was not uncommon for them to take double that amount of time. Some took nearly a year to complete, and two took more than a year and a half. The LASD has conceded publicly that it took on average between 9 and 18 months to complete a sexual harassment investigation.

As of October 1999, the inventory of open IAB matters included at least four separate sexual harassment cases that had been under investigation for a full year or more. At that time, sexual harassment investigations took about three and a half months to complete, on average. Today, none of the IAB's open sexual harassment cases has been under investigation for even as long as six months. Moreover, the average LASD sexual harassment investigation is now completed in approximately 2.8 months—down 25 percent from a year ago, and comfortably within the 90-day limit. We applaud the Department for its progress in this area, and predict that it will yield significant dividends.

Having said this, however, we feel compelled to add at least one note of caution. Not unlike unnecessary delays, undue haste can also affect the quality of a complicated investigation. Although we found little evidence of this phenomenon in the files we reviewed, it is easy to imagine situations in which the pressure to meet an arbitrary deadline might tempt an otherwise careful investigator to cut corners needlessly. Although many sexual harassment investigations can easily be completed in 45 days—or less—the Department should take special care to maintain the overall quality of each investigation as the principal concern.[11]

Professional and Well-Documented Investigations

As we suggest above, speed alone is hardly determinative. One might naturally wonder whether marked decreases in the average completion time of IAB investigations may have come at the expense of quality. Fortunately, we found little evidence of such trade-offs among

11 Several reports have suggested the IAB has adopted an unwritten deadline of 45 days for the completion of sexual harassment investigations. In our view, a significant number of these investigations are too complex to be performed on that sort of timetable. Even where investigators enjoy relatively modest caseloads, it often takes several weeks simply to schedule various witness interviews. In the event a key witness is ill or out of town, investigators might be put to the unfortunate choice of foregoing the interview or incurring the cost of a "tardy" investigation.

the 25 cases we reviewed most thoroughly. Not surprisingly, the quality of the individual files we examined varied from one to another. This is probably the result of a range of factors, including the experience and skills of the assigned investigator, and the circumstances of the case itself. For the most part, however, the files we studied reflect relatively thorough and intelligent investigative work. Notably, we were able to identify a definite trend in the quality of the investigations—as a group, the latest files reflected significant improvements in quality. Although these improvements can fairly be traced to a combination of factors, the creation of specialized units within the IAB is perhaps primarily responsible.

Until recently, nearly all IAB investigators were seen as generalists; each investigator handled a wide range of cases, and, as a result, few were able to develop a particular area of expertise. In late 1998, however, the IAB was divided into several teams of investigators, each of which was assigned responsibility for an individual type of case. One such team, under the direction of Lt. Willa Glover, is responsible for investigating discrimination and sexual harassment cases. Sometimes referred to as the "Title VII team," it varies in size from five to ten investigators, each of whom maintains an active caseload of roughly three to five matters. Not long ago, many IAB investigators had caseloads that were three to five times larger, and which covered a wider array of substantive issues. Reducing average caseload size and encouraging substantive specialization appears to have had a noticeable effect on the quality of IAB investigations.

Like other internal inquiries in the LASD, investigations into allegations of sexual harassment typically follow the guidelines set forth in the Department's *Administrative Investigations Handbook*. First published in 1992, the *Handbook* presents a thorough blueprint for the investigative process—from the receipt of the initial allegation to the final resolution and imposition of discipline. The *Handbook* also contains an extensive collection of sample documents, including witness admonitions, notification letters and disposition worksheets. Nearly all the files we examined tracked the general procedures of the *Handbook*, and often borrowed extensively from its inventory of sample documents.

Among the most important documents in any IAB file is the disposition worksheet, which both sets forth the specific charges against each subject and provides a road map for the Department's case. Although the *Handbook* requires the Department's Advocacy Services unit to prepare disposition worksheets, we understand that they are often prepared by the IAB investigators themselves. Notably, the quality of the disposition worksheets we reviewed covered a much broader range than the files themselves—that is, while some of the worksheets were detailed and thorough, some were unacceptably poor.

As a general matter, investigation work requires a specific set of skills, which must be exercised and challenged on a regular basis. Chief among these are interviewing skills, and an ability to change the focus of an investigation in response to new developments.[12] A number of observers have suggested that IAB investigators have historically suffered from inadequate training. As a result, LASD investigators now typically receive 40 hours of general investigative training upon joining the IAB, and the members of Lt. Glover's special team receive additional training in discrimination- and harassment-related issues from the federal Equal Employment Opportunity Commission.

Finally, in reviewing the Settled Cases a year ago, we noticed a general reluctance to make credibility determinations among both unit commanders and IAB investigators. This compounded the difficulty of resolving a significant number of harassment allegations. As we observed at the time, a system

that effectively eliminates determinations of credibility in sexual harassment cases is out of touch with reality and with common practice. For instance, EEOC materials distributed by County Counsel to LASD personnel emphasize the critical role that credibility determinations play in sexual harassment cases.

12 In the **Eleventh Semiannual Report,** we noted that a number of IAB investigations were marred by an apparent reluctance to expand the inquiry to include subjects and misconduct uncovered during the course of a pending investigation. We have not yet collected sufficient information to offer an opinion on whether the investigators in Lt. Glover's unit have been appropriately aggressive in expanding the focus of ongoing investigations to include additional subjects and charges. We intend to explore this topic more thoroughly in upcoming reports.

Of the 25 recent files we examined in detail, exactly five—or 20 percent—were left "unresolved." In four of the five cases, this result was caused by the IAB's unwillingness to determine which of two conflicting witnesses appeared more credible:

- In the first of these four cases, a female trainee claimed to have been repeatedly harassed and mistreated by a male deputy. The case investigator interviewed 19 witnesses on the record, and a charge for "performance to standards" was ultimately founded based on over whelming evidence that the trainee was mistreated.[13] The trainee alleged that the mistreatment resulted from her earlier refusal to date the deputy, which the deputy allegedly proposed in several private conversations. Notwithstanding the overwhelming evidence of her mistreatment, however, the "sexual harassment" charge was left unresolved "because the allegation was on a one-on-one basis with an absence of witnesses and evidence to support either the subject or complainant."

- In the second case, a male former deputy alleged that a female LASD officer called his subsequent employer and made a series of false accusations against him in retaliation for his having filed a sexual harassment claim against her with the LASD. The retaliation charge was left unresolved "because the allegation was on a one-on-one basis with an absence of witnesses and evidence to support either the subject or complainant."

- The third case involved a female who alleged that a male deputy had touched her breasts repeatedly while the two of them rode in a crowded elevator. The deputy denied the charges, and no witnesses were able to corroborate the allegations. The case was left unresolved because it ultimately turned on a credibility determination between the female clerk and the male deputy.

- In the final case, a female phone operator alleged that a male volunteer had made a number of unwelcome sexual remarks to her, including a statement that he wanted to date her and visit her at her hotel. The volunteer denied the charges, and the case was left "unresolved" as there were no witnesses to corroborate either story.[14]

13 The deputy was ordered to undergo a two-day suspension for the founded "performance to standards" charge; however, this was reduced to a one-day suspension and ultimately waived in response to the deputy's grievance.

14 The investigation file for this case reveals that the operator made her allegations only after the Department denied her request to rescind her recent resignation from employment. She had resigned from the Department and she was unsuccessful in having her resignation rescinded so she could rejoin the Department.

Whether these cases should have been resolved by way of reasonable credibility determinations is a difficult question. In each of the four cases, however, the assigned investigator doggedly pursued a variety of leads before concluding that the case could not be resolved. Notably, several of the other matters we studied were resolved by weighing the credibility of two or more conflicting witnesses. In this area, too, we see evidence of significant progress.

Discipline-Related Issues

Perhaps the most striking flaw to emerge from our review of the Settled Cases was the Department's general propensity toward lenient discipline in cases involving sexual harassment. Two principal components to this issue were identified. The first involves "undercharging," which refers to the practice of filing less serious formal charges than the facts of a particular case might allow. In a number of cases, for example, officers accused of behavior that might easily constitute sexual harassment were charged instead with "conduct toward others" or "performance to standards"—less serious offenses that carry lighter standard penalties than violations of the Department's "sexual harassment and retaliation" policy.[15] The second component arises involves the basic appellate rights available to employees determined to have engaged in misconduct. By relying on his right to appeal, a harasser can not only delay the ultimate imposition of discipline, but also exert pressure on the Department to reduce his recommended discipline in exchange for his agreement to forego further appeals.[16] As we noted at the time,

[t]hese "settlements" not only result[ ] in lenient discipline, but also in tardy imposition of the discipline because of the passage of time between the initial complaint and the settlement of the matter. Ironically, the delay in itself increased the likelihood that the discipline would be made even more lenient. As time passes, the desire to exact an appropriate penalty wanes. In other instances, the Subject may have acted irreproachably in the interim, leading a seemingly compas-

15 According to the Department's *Guidelines for Discipline*, the standard discipline imposed for violations of "conduct toward others" or "performance to standards" policies can range from a written reprimand to discharge, depending on the overall circumstances of the case. The standard discipline in sexual harassment cases, by contrast, ranges from a ten-day suspension to discharge, and cannot be reduced below a five-day suspension.

16 The various avenues by which subjects can argue for reduced discipline and appeal both the findings themselves and the discipline imposed as a result of those findings are detailed at pages 30-34 of the **Eleventh Semiannual Report.**

sionate unit commander to conclude the Subject has learned his lesson and discipline is unnecessary. Whether or not such a determination is a just result in a given case, the failure to impose timely and appropriate discipline vitiates any effort to deter others, to make an example, or to show Complainants that sexual harassment will not go unpunished.

Unfortunately, our latest review suggests that these same factors continue to affect the manner in which discipline typically is imposed. Specifically, a number of subjects found to have engaged in sexual harassment were able to negotiate more lenient discipline by threatening an appeal or grievance. Others managed at least to delay the process by which discipline was imposed. On the other hand, there appears to be some evidence that the once-common practice of undercharging is less prevalent today. On the whole, the Department has demonstrated an increasing willingness to mete out harsher discipline than it did just a few short years ago. As we noted above, 53 sexual harassment investigations were opened by the IAB from October 1, 1999 to September 30, 2000—42 of which were completed within that same one-year period. Approximately half these completed investigations (20 out of 42) resulted in founded charges against at least one LASD employee. Indeed, this pool of cases yielded a total of 30 individuals who were found to have engaged in some form of sexual harassment. Of course, circumstances of each subject's situation were different. As a result, the ERR initially recommended the discipline shown in Table 1 in those 30 cases.

A number of these recommendations for discipline, however, will be modified significantly before discipline is actually imposed. Of the 30 individuals at issue, nine have already succeeded in having their recommended discipline reduced,[17] and three others are awaiting decisions on recent grievances. Two additional employees still had the option of grieving their discipline as this article is written.[18] The following individuals are among those whose

17 In three of the eight cases, the "reduction" consisted of allowing the subject to resign in lieu of discharge. Whether this is a meaningful reduction is open to debate. Such trade-offs are certainly common in the private sector. Moreover, the Handbook expressly provides that a subject is free to resign "at any time during an investigation."

18 Each of these two employees received "letters of intent" from the Department in the closing days of October notifying them that they will be suspended for ten days, in one case, and removed from consideration for a bonus, in another. Employees have up to ten days following their receipt of such a letter of intent within which to file a formal grievance.

recommended discipline has been or may be reduced:

1

Discharge	4
Allowed to Retire	2
Demotion	1
Suspension, 30 days	2
Suspension, 15 days	4
Suspension, 10 days	1
Suspension, 5 days	2
Suspension, 3 days	1
Suspension, 2 days	1
Suspension, 1 day	1
Removal from Bonus	1
Written Reprimand	10
Persons to be Disciplined	**30**

- A warehouse worker at the Men's Central Jail was determined to have repeatedly harassed a female co-worker and lied to his supervisor about the resulting investigation. He was allowed to resign in lieu of discharge.

- A female deputy who was found to have lifted up her shirt and exposed her chest to a male deputy in a stationhouse hallway is currently grieving her 30-day suspension.

- A female deputy who was found to have made false statements in connection with a sexual harassment investigation grieved her 15-day suspension, which was ultimately changed to a written reprimand.

- A male civilian employee was allowed to resign in lieu of discharge following a determination that he had repeatedly harassed and touched a female employee in the Department's gym.

- A mid-level manager who engaged in unwanted sexual banter with a number of Department employees was able to have a 30-day suspension put on hold by filing a grievance.

- A male sergeant who was determined to have touched and otherwise harassed a number of female employees was suspended for 25 days in lieu of demotion after grieving the initial discipline that was imposed.

To date, only 16 of the 30 subjects at issue were actually disciplined to the degree the ERR initially recommended—nine of whom received nothing more than written reprimands from the ERR to begin with. See Table 2. As this data demonstrates, the problem of bargaining-down discipline that we identified a year ago continues to exist.[19]

On the other hand, we also note that the Department has lately meted out significant discipline to individuals found to have violated one or more of the Department's sexual

19 We should emphasized that the handful of cases currently in the "grievance pipeline" may yet result in the imposition of significant discipline for the subjects at issue.

harassment policies. Consider the following examples:

- A male custody assistant was forced to resign after he inappropriately grabbed a female colleague in a chokehold and made a number of sexually suggestive comments.

- A male deputy was suspended for 25 days after making a series of sexually suggestive comments to a female court clerk.

2

Discharge	1
Allowed to Retire	2
Suspension, 15 days	1
Suspension, 3 days	1
Suspension, 2 days	1
Suspension, 1 day	1
Written Reprimand	9
Original Discipline Imposed	**16**

- A male sergeant was demoted after he called a female employee a "bitch" and repeatedly initiated discussions with her about women's breasts.

- A male lieutenant was suspended for 15 days for kissing a female colleague at a reception following an off-duty training conference.

- A male deputy was suspended for five days for telling sexually related stories to a female communications trainee and touching her leg while riding in a patrol car.

Of course, whether the discipline imposed in any of these cases is appropriate requires a thorough review the facts and circumstances of each case. But news of these and other disciplinary action is likely to have received significant attention among Department employees. Hopefully, this sends a serious message to potential victims and would-be perpetrators alike.

Conclusion

In sum, our review of a sample of recently completed sexual harassment investigation files suggests that the LASD is making continued progress in its attempts to eradicate sexual harassment from within its ranks. In particular, there have been noticeable improvements in the timeliness of the Department's investigations. The creation of a special team to investigate allegations of discrimination and harassment has led increasing thorough and professional investigations. Although a number of subjects were able to negotiate significantly reduced punishments after having been found responsible for sexual harassment, a number of

perpetrators received harsher discipline, which helps to communicate the general message that sexual harassment will no longer be tolerated within the Department.

Of course, there is room for improvement. Certainly, there is a need for continuing education, and to the extent that some employees feel they are "above the law," they must be dissuaded of this view.

Tables Three and Four display the current breakdown of the LASD by gender and ethnicity.

We look forward to re-examining the Department's record of progress in this area in future reports.

3

Los Angeles County Sheriff's Department Breakdown of Sworn Personnel by Division, Sex, and Ethnicity as of September 30, 2000

Division	Total	Male		Female		Caucasian		African-American		Latino		Native American		Asian		Filipino		Other	
Executive	99	79	79.8%	20	20.2%	59	59.6%	6	6.1%	24	24.2%	0	0.0%	9	9.1%	1	1.0%	0	0.0%
Office of Admin Services	5	4	80.0%	1	20.0%	3	60.0%	1	20.0%	1	20.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Court Services	1504	1196	79.5%	308	20.5%	746	49.6%	291	19.3%	396	26.3%	3	0.2%	54	3.6%	13	0.9%	1	1.0%
Custody	2036	1688	82.9%	348	17.1%	1050	51.6%	166	8.2%	698	34.3%	2	0.1%	93	4.6%	27	1.3%	0	0.0%
Correctional Services	278	223	80.2%	55	19.8%	119	42.8%	26	9.4%	117	42.1%	1	0.4%	12	4.3%	3	1.1%	0	0.0%
Detective	560	470	83.9%	90	16.1%	376	67.1%	39	7.0%	136	24.3%	0	0.0%	9	1.6%	0	0.0%	0	0.0%
Personnel & Training	442	334	75.6%	108	24.4%	249	56.3%	54	12.2%	116	26.2%	0	0.0%	21	4.8%	2	0.5%	0	0.0%
Technical Services	88	78	88.6%	10	11.4%	71	80.7%	3	3.4%	11	12.5%	0	0.0%	3	3.4%	0	0.0%	0	0.0%
Field Ops Reg I	1219	1121	92.0%	98	8.0%	881	72.3%	39	3.2%	264	21.7%	2	0.2%	23	1.9%	10	0.8%	0	0.0%
Field Ops Reg II	1421	1278	89.9%	143	10.1%	751	52.9%	242	17.0%	355	25.0%	3	0.2%	56	3.9%	14	1.0%	0	0.0%
Field Ops Reg III	1174	1059	90.2%	115	9.8%	819	69.8%	45	3.8%	265	22.6%	3	0.3%	32	2.7%	10	0.9%	0	0.0%
Total	**8826**	**7530**		**1296**		**5124**		**912**		**2383**		**14**		**312**		**80**		**1**	

Los Angeles County Sheriff's Department Breakdown of Sworn Personnel by Sex, Rank, and Ethnicity as of December 30, 2000

Class	Total	Male		Female	
Sheriff, U/C	**1**	1	100.0%		
Undersheriff, U/C	**1**	1	100.0%		
Assistant Sheriff, U/C	**2**	2	100.0%		
Div. Chief, Sheriff, U/C	**8**	7	87.5%	1	12.5%
Commander	**24**	22	91.7%	2	8.3%
Captain	**63**	56	88.9%	7	11.1%
Lieutenant	**311**	276	88.7%	35	11.3%
Sergeant	**976**	839	86.0%	137	14.0%
Deputy Sheriff IV	**23**	23	100.0%	0	
Deputy Sheriff	**7209**	6140	85.2%	1069	14.8%
Dep. Sheriff Trainee	**208**	163	78.4%	45	21.6%
Totals:	**8826**	**7530**		**1296**	

	Caucasian			African-American			Latino		
Class	**Male**	**Female**	**%**	**Male**	**Female**	**%**	**Male**	**Female**	**%**
Sheriff, U/C	0	0	0%	0	0	0.0%	1	0	100.0%
Undersheriff, U/C	1	0	100.0%	0	0	0.0%	0	0	0.0%
Assistant Sheriff, U/C	2	0	100.0%	0	0	0.0%	0	0	0.0%
Div. Chief, Sheriff, U/C	6	1	87.5%	1	0	12.5%	0	0	0.0%
Commander	14	2	66.7%	1	0	4.2%	6	0	25.0%
Captain	38	6	69.8%	7	1	12.7%	7	0	11.1%
Lieutenant	225	24	80.1%	17	7	7.7%	27	4	10.0%
Sergeant	627	92	73.7%	60	23	8.5%	129	20	15.3%
Deputy Sheriff IV	15	0	65.2%	4	0	17.4%	4	0	17.4%
Deputy Sheriff	3520	457	55.2%	558	212	10.7%	1731	367	29.1%
Dep. Sheriff Trainee	80	14	45.2%	12	9	10.1%	66	21	41.8%
Totals:	**4528**	**596**		**660**	**252**		**1971**	**412**	

	Native American			Asian			Filipino		
Class	**Male**	**Female**	**%**	**Male**	**Female**	**%**	**Male**	**Female**	**%**
Sheriff, U/C	0	0	0.0%	0	0	0.0%	0	0	0.0%
Undersheriff, U/C	0	0	0.0%	0	0	0.0%	0	0	0.0%
Assistant Sheriff, U/C	0	0	0.0%	0	0	0.0%	0	0	0.0%
Div. Chief, Sheriff, U/C	0	0	0.0%	0	0	0.0%	0	0	0.0%
Commander	0	0	0.0%	1	0	4.2%	0	0	0.0%
Captain	0	0	0.0%	4	0	6.3%	0	0	0.0%
Lieutenant	0	0	0.0%	6	0	1.9%	1	0	3.0%
Sergeant	1	0	1.0%	21	2	2.4%	1	0	1.0%
Deputy Sheriff IV	0	0	0.0%	0	0	0.0%	0	0	0.0%
Deputy Sheriff	12	1	2.0%	250	24	3.8%	68	8	1.1%
Dep. Sheriff Trainee	0	0	0.0%	3	1	1.9%	2	0	1.0%
Totals:	**13**	**1**		**285**	**27**		**72**	**8**	

	Other		
Class	**Male**	**Female**	**%**
Sheriff, U/C	0	0	0.0%
Undersheriff, U/C	0	0	0.0%
Assistant Sheriff, U/C	0	0	0.0%
Div. Chief, Sheriff, U/C	0	0	0.0%
Commander	0	0	0.0%
Captain	0	0	0.0%
Lieutenant	0	0	0.0%
Sergeant	0	0	0.0%
Deputy Sheriff IV	0	0	0.0%
Deputy Sheriff	1	0	0.1%
Dep. Sheriff Trainee	0	0	0.0%
Totals:	**1**	**0**	

On a national scale, the disparate impact of our criminal justice system on racial and ethnic minorities raises difficult societal questions about the cumulative effect of the way law enforcement, prosecutors, courts, and juries go about their jobs.[1] Those differences show up also in Los Angeles County.[2] One of our most important duties as Special Counsel to the Board of Supervisors is to consider whether the practices of the LASD pose a risk of potential liability.

Equally important duties are to recommend measures that will help quantify the scope of that risk and ultimately reduce or eliminate it. In recent years, old disparities in the impact of our criminal justice system have garnered fresh attention, and some of these practices present liability risk. The issue in the context of law enforcement activity is usually called "racial profiling." It focuses on whether traffic and pedestrian stops, and the searches of cars or individuals which follow, are discriminatory in their impact.

It would be foolish and unwarranted to leap from the mere fact that we are discussing this issue to a conclusion that we have found evidence or even believe, in the abstract, that LASD officers routinely engage in racial profiling. As we wish to stress throughout this Chapter, the question whether there is a disparate racial or ethnic impact in traffic and pedestrian stops by the LASD is entirely an open one. Moreover, the meaning and import of any such patterns, even

1 Whatever their cause, racial disparities are stark throughout the criminal justice system. A recent Justice Department study showed that 70 percent of the defendants facing the death penalty are black or Latino. As of the end of 1998, approximately 43 percent of all persons on Death Row in the United States were African-American men. *Capital Punishment 1998*, United States Department of Justice, Bureau of Justice Statistics (December 1999) (revised January 6, 2000) NCJ 179012. Black males comprise 49 percent of persons in prison. *Correctional Populations in the United States 1997*, United States Department of Justice, Bureau of Justice Statistics (November 2000). Black males comprise 42 percent of persons in local jails Id. Nine percent of all black adults over the age of 18 are in prison, jail, probation or parole, as contrasted to two percent of all white adults. Id. At current levels of incarceration, newborn black males in this country have greater than a 1 in 4 chance of going to prison during their lifetimes, while Latinos have a 1 in 6 chance, and white males a 1 in 23 chance of serving prison time. *Lifetime Likelihood of Going to State or Federal Prison*, United States Department of Justice, Bureau of Justice Statistics (March 1997) NCJ160092.

2 For example, the California Attorney General reports that blacks comprised 24 percent of adult and juvenile arrests reported in 1999 for Los Angeles County. *Criminal Justice Statistical Center*, *California Criminal Justice Project*, Attorney General of the State of California (1999). Yet blacks constitute only 10 percent of the population of the County. *County of Los Angeles Statistical Data*, www.co.la.ca.us/statistics/htm. A recent snapshot of the demographics of the 19,899 inmates in the Los Angeles County Jail system also makes the point. The percentage of inmates who are black stood at 35.5 percent. Black men represented nearly 30 percent; black females, 5.6 percent. Latinos were 45 percent, and whites were 16 percent. *LASD Racial Demographics for All Custody Division*, October 31, 2000.

if found, would merit further greater study and reflection. There can be valid reasons accounting for the disparities that do not derive from race-based discrimination, much less racial animus. But given the increasing litigation and potential exposure that has arisen regarding racial profiling issues, it would likewise be foolish for the County to wait until it is sued to probe whether these patterns exist and need to be addressed.[3]

As we demonstrate below, it is very much to the credit of the Sheriff's Department that Lee Baca has taken the first steps to do so. It is even more impressive that the LASD did it voluntarily; not in response to litigation or the threat of litigation. But it is also the case, as we argue below, that the LASD's would be in even better shape if it collected somewhat more data. In that regard, we advocate that the LASD consider and adopt measures that the San Diego and Sacramento Police Departments have already put into effect voluntarily and, interestingly, that the LAPD will initiate pursuant to the recent consent decree entered into with the Department of Justice. To do so will bring the LASD to its usual position at the forefront of law enforcement in California, in company on this issue with police departments in San Francisco, San Diego, Sacramento, and San Jose, as well as the CHP. It will also put the LASD in line with seven states that now require all their law enforcement agencies to collect similar data. In order to put the LASDís voluntary data collection efforts in context, it is useful to discuss racial profiling in greater detail.

The term "racial profiling" has been used loosely, and it lacks a universally accepted definition. The core notion focuses on the untoward, undesirable, and illegal consequences when police officers use race or ethnicity as a deciding factor in focusing suspicion. But to be precise, not everything that implicates the race of a suspect is racial profiling. It is not racial profiling to focus suspicion on an individual who has been described to the police as having committed a crime when an element of that description is the racial or ethnic identity of the individual. Nor is it racial profiling when the conduct of a black or Latino individual being

3 Litigation over racial profiling is proliferating. See, e.g., *United States v. State of New Jersey, et al.*, Civil 99-5970 (MLC), (D.N.J. 1999); *Wilkins v. Maryland State Police*, MJG 93- 468 (D.Md. 1993).

observed by the police gives rise to a legally sufficient basis for a stop or detention without regard to the individual's race or ethnicity. Yet on the other hand, it is racial profiling when mere stereotypes (i.e., a black man driving a BMW is a mismatch and thus grounds for the police to check it out), loose generalizations (a black man does not belong in this predominately white neighborhood and should be checked out), or even when known statistical correlations are used as a basis of focusing suspicion on a given individual (more black than white teenagers are arrested for street drug crimes therefore that specific black teenager in this high drug crime area should be checked out).

More generally, enforcement of certain laws may, in the aggregate, produce a disparate impact: Across a relevant mixed population, the proportion of blacks or Latinos stopped by law enforcement, or ticketed, or arrested, or frisked, or searched, may turn out to be higher than it is reasonable to expect, and, even more tellingly, there may be a dearth of convincing reasons, apart from the person's race or ethnicity, that adequately can explain or account for the stops. That kind of law enforcement activity produces a high level of "false positives" that falls more heavily on racial and ethnic minorities. The greater the level of generality employed to isolate particular individuals, the greater the number of persons who will be targeted repeatedly (the same black guy stopped again and again on his way home from work late at night) or erroneously (the correlation between having a busted tail light and having illegal drugs in the car is so weak that many innocent people will be stopped).

Dragnets are crude devices; they entangle porpoises even as they troll for tuna. The farther one moves toward generalities—let's pick up anything that swims in the hopes of catching tuna—the greater the chances that the net will ensnare many other species of fish and marine life. Whereas any police decision to detain an individual who is not visibly engaged in a crime may stir feelings of indignity and resentment, it is even more corrosive (and potentially explosive) when by virtue of wide sweeps the persons stopped believe it is because of their race or ethnicity alone, or because their race or ethnicity is too closely intertwined with an overbroad, over-generalized search: hence, the shorthand term "driving while black or brown."

Pretext stops add to the complexity of the question. In the traffic context, it is virtually impossible to drive any length of time without committing a vehicle code violation of some kind. Thus, the police have a high degree of choice about whom to pull over. It does not violate the Fourth Amendment when a police officer uses the "pretext" of a traffic or vehicle code violation to stop a motorist as long as probable cause exists to believe those laws have been violated, regardless of the subjective intent of the police officer in making the stop. *Whren v. United States*, 517 U.S. 806 (1996). We would venture, however, that the correlation between many "pretexts" and the underlying suspicion motivating the stop is often weak; a drug interdiction program using busted tail lights and minor traffic violations as "pretexts" for a stop will likely yield too few drug violators to justify the proliferation of stops and the inconvenience engendered. It is especially problematical when the "pretext" is so widely shared in the relevant population—there are so many illegal lane changes or rolling stops—that the police officer can pick and choose whom to stop, based on race or ethnicity or any other factor, legal or illicit, with relative impunity.

That does not, of course, mean that there must always be a one-to-one correlation between persons stopped by the police and persons found to have committed a crime. Nor does it mean that every time there is legal justification for a frisk or a pat-down, a weapon or contraband must be found. Neither does it mean that a sobriety check point—where scores of people, all of whom happen to be passing by the checkpoint, are stopped and inconvenienced without individualized suspicion—is necessarily unlawful or wrong even if the "hit rate" of persons found inebriated is low. Perhaps such stops can be rationalized on the grounds that drunk drivers pose an immediate, palpable, high risk of injury to other drivers.[4] The elimination of that risk is the immediate and predominant goal of the police; it is not that the checkpoint is being used pretextually to stop persons who may have committed other crimes or for purposes other than catching drunk drivers. Tacit consent to the checkpoint by those stopped, therefore,

4 The Supreme Court recently reiterated this rationale in *City of Indianapolis v. Edmond*, ___ U.S. ____ (2000), 2000 Daily Journal D.A.R. p. 12567.

might be easier to obtain or assume: We drivers agree you may stop us briefly for our own personal safety in order to take drunk drivers off the very road we are travelling because we know and understand that the stop won't be used as a ploy to conduct a fishing expedition for possible criminal activity and that we will be on our way as soon as you see we're not drunk.

A harder case, however, is where the motivation for a dragnet-like approach is crime suppression rather than an attempt to solve a specific, given crime or to eliminate an immediate threat to safety like the drunk driver. Assume that a given neighborhood, predominantly black, is experiencing an uptick in gun-related crime, with a predominance of black victims and black perpetrators. The police perceive that the area has become saturated with guns. They decide, therefore, to deploy massively to the area, to stop and search lots of cars, and to stop and frisk lots of individuals, with the goal of seizing as many guns as possible and making as many arrests for illegal possession of concealed weapons as possible. And if other contraband—drugs, for example—is found, arrests will also be made. Additionally, the police embark on a program of rigid enforcement of a wide variety of laws relating to otherwise petty or relatively trivial offenses that are often overlooked or not worth the effort to process—breaking a window, drinking beer from an open container on the corner, jumping turnstiles on the Metro. People detained for these offenses are then searched for contraband or weapons and arrested for those more serious offenses if the search produces a "hit." At the station house, they are then later questioned about criminals or other, more serious criminal activity of which they may be aware.

The net of all this police activity it is that in this predominantly black neighborhood, blacks—particularly young black males—are "tossed" and arrested in substantial numbers, and without the police having necessarily run afoul of the Fourth Amendment. Thus, even if each individual arrest seems to be properly grounded in probable cause and each stop grounded in articulable, reasonable, individualized suspicion—however pretextual or flimsy—it nonetheless happens that black male pedestrians and drivers are rousted repeatedly and unceremoniously and perceive themselves singled out by race. The number of "false positives" not only creates

widespread inconvenience, it appears to validate a suspicion that people are being stopped because they are black. Unlike the example of the sobriety checkpoint, there is not tacit consent on the part of those stopped. At the same time, however, the massive police presence, and the increased likelihood of being caught with a gun and arrested, as well as the number of guns seized, all taken together, produce the intended effect—gun-related crime plummets. In this example, the minor offenses and the pretextual traffic and pedestrian stops are essentially surrogates for better, more particularized suspicion. The correlations may be weak, and thus the overbreadth significant, but in the end the crime suppression goal is achieved.

Whether the residents of the neighborhood in question accept the crime suppression program is another question, and one that is hard to gauge. But it is clear that tolerance and forgiveness for serious police error, even if the result of negligence or recklessness rather than intentional misconduct, will predictably be low, as perhaps exemplified by the Diallo and Dorismond shootings in New York. Whatever goodwill the police may have banked will disappear, and generalized discontent and anger flowing from knowledge that the criminal justice system as a whole impinges disparately on blacks will be focused with laser-like heat and intensity on the specific controversial shooting. Even so, these may not be the hardest cases of all.

In the absence of a search for a particular criminal, or a targeted crime suppression effort, it becomes an even more difficult and complex a societal problem when the cumulative results and *compounded* consequences of uncoordinated, discrete, individual decisions by police officers about whom to stop and whom to search, over time, fall more heavily on racial and ethnic minorities. Thus, even if almost all police officers were to make decisions about whom to stop without intentionally or even consciously acting in a discriminatory fashion, it is still possible that the few who do use race improperly, combined with the prevalence of stereotyping and generalization that is simply "in the air," whether in society in general or around the police in particular, over time, will produce disparate results. So too when the targets of law enforcement are disproportionately those who are poor and where there is a significant overlap

in poverty and being black or Latino. Individual snowflakes falling slightly off vertical due to a barely perceptible breeze are trivial in isolation, but over time produce high drifts on one side of the road. Studies are beginning to validate that such a cumulative effect is taking place. What to do about it is another question.

For example, the Attorney General of the state of New York determined after a review of some 175,000 stops by the police in New York City that blacks were stopped six times more often than whites. *The New York City Police Department's "Stop & Frisk" Practices ("NYPD Stop and Frisk Practices"),* Office of New York State Attorney General Eliot Spitzer, Civil Rights Bureau (December 1, 1999), pp. 88 *et seq.* The report can be found on the Internet at http://www.oag.state.ny.us/press/reports/stop_frisk/stop_frisk.html. Whereas blacks constituted one-fourth of New York City's residents, blacks constituted half of the individuals stopped. *Id.*

Not all stops led to an arrest, however. The Attorney General then sought to discover if similar racial disparities existed when one examined just the stops that had resulted in arrests. They did: There were more "false positives" among blacks than among whites. The NYPD stopped 9.5 blacks to generate one arrest of a black person whereas it stopped only 7.9 whites to generate one arrest of a white person. *Id.* at 111.

It can be argued that looking solely to the differing proportions of the population that are stopped or arrested is overly simplistic: It might be the case that crimes are committed by blacks and Latinos in greater numbers than their proportion of the overall population, or it might be that the precinct in question is so heavily black or Latino that general population statistics, based upon the city as a whole, are essentially meaningless. In order to refine the analysis and take these arguments into account, the New York Attorney General tested whether the differing racial make-up of precincts, or the differing crime rates in precincts, explained the disparate rates at which minorities and whites were stopped. Yet even after accounting for the effect of the differing crime rates, it nonetheless was the case that blacks were stopped 23 percent more often than whites and Latinos were stopped 39 percent more often than whites across all crime categories. *Id.* at *x*. The results were similar after accounting for different

population mixes in different precincts. Indeed, blacks and Latinos were "significantly more likely than whites to be 'stopped' after controlling for race-specific precinct crime rates and precinct population composition by race." *Id.* at 121.[5]

New York's experience generally comports with a very recent study by the San Diego Police Department which, on September 21, 2000 issued its *Vehicle Stop Study Mid-Year Report ("SDPD Stop Study").* The study can be found on the Internet at http://www.sannet.gov/police/general-info/pdfs/stoprpt.pdf. San Diego started collecting data on traffic stops in January 2000. Officers fill out a paper form collecting the data set forth in footnote six below.[6] The form is a 4x6-inch card that is filled out in the field. "Completing the form for each stop takes less than 20 seconds." *SDPD Stop Study*, Preface, p. 5. During the first six months of data collection, the SDPD documented 91,522 stops. San Diego found that "both Hispanic and African American drivers [were] over-represented in vehicle stops in comparison to the characteristics of San Diego's driving-age resident population." *Id.*, Executive Summary, p. 8.

5 Studies in New Jersey of stops on the New Jersey Turnpike reached similar results: 13.5 percent of the individuals using the New Jersey Turnpike were African-American, and African-Americans comprised 15 percent of the drivers who sped on that Turnpike. Blacks, however, constituted 35 percent of the drivers stopped on the Turnpike and 73.2 percent of those arrested. Report of Dr. John Lamberth, Plaintiff's Expert, *Revised Statistical Analysis of the Incidence of Police Stops and Arrests of Black Drivers/Travelers on the New Jersey Turnpike Between Exits or Interchanges 1 and 3 from the Years 1988 Through 1991*, filed in connection with *State v. Pedro Soto*, 734 A.2d 350 (N.J. Super. Ct. Law. Div. 1996).

6 The San Diego PD collects for every vehicle stop:
Date and time of the stop;
Division where the stop occurred;
Primary reason for the stop (moving violation; equipment violation; radio call/ citizen contact; officer observation/knowledge; supplemental information on the suspect, etc.);
Driver's sex and age;
Driver's race;
Action taken (citation, written warning, verbal warning, field interrogation, other);
Whether the driver was arrested;
Whether the driver was searched, and if so:
- Type of search (vehicle, driver, passengers);
- Basis for search (visible contraband, contraband odor, canine alert, consent search; 4th Amendment waiver, search incident to arrest, inventory search prior to impound, observed evidence related to criminal activity, other);
- Whether a Consent Search Form was obtained;
- Whether contraband was found;
- Whether property was seized.

More interesting was the observation that "the vehicle stop data also indicate that, once stopped, Hispanic and African American drivers are substantially more likely to experience searches and arrests than Asian or White drivers." *Id.*[7] Less than two percent of vehicle stops resulted in arrests. About six percent resulted in searches. Vehicles were most often searched, followed by drivers and then passengers. Less than ten percent of the searches resulted in seizures of contraband or property. *Id.*, Preliminary Observations, paragraph 4, p. 11.

Importantly, the San Diego report stressed its preliminary nature and emphasized that it did not purport to explain why the disparities occurred. "Numerous hypotheses could be offered, ranging from intentional police discrimination to unintentional stereotyping to the unintended consequences of police deployment practices to actual differences in gang involvement by race/ethnicity, and so on." *Id.*, at p. 8. Rather than speculating about why, the authors of the report urged further analysis to get at the real answers. *Id.*

Because the implication of these studies is difficult to assess and, if looked at only cursorily, potentially inflammatory, it is not surprising that leaders in law enforcement diverge in their views concerning the wisdom of compiling statistics from which similar studies can be made.[8] Despite the risk that the answers might be uncomfortable, many cities in California have decided to collect such data: as noted earlier, San Diego, San Jose, Sacramento, and San Francisco, to name four of the five four largest cities in the state, along with the California Highway Patrol with its more than 6500 plus sworn employees.

7 If stopped, Latinos had a 10.6 percent chance of being searched; blacks a 10.2 percent chance; Asians and Pacific Islanders, a 3.4 percent chance, and whites, a 3.0 percent chance. If inventory searches of impounded vehicles were not counted, blacks had a 5.8 percent chance of being searched; Latinos, 2.8 percent; Asians/Pacific Islanders, 2.0 percent; whites, 1.5 percent. If stopped, blacks had a 3.0 percent chance of being arrested; Latinos, 2.7 percent; whites, 1.3 percent; Asian/Pacific Islander, 0.9 percent. *Id.*

8 Respected academics, including Professor Sam Walker of the University of Nebraska at Omaha, have also raised questions about how to interpret the data once collected and what is the appropriate benchmark to do so. Walker, Samuel (2000)(draft). "*Searching for the Denominator: Problems with Police Traffic Stop Data and an Early Warning System Solution.*" The challenge is to identify the right base against which to measure the disparate impact of traffic stops on minorities. Whereas it is relatively easy to do so on a controlled access Interstate highway, it is tougher— although doable— in a large metropolitan area. The US Department of Justice is in the forefront in attempts to do so.

The Los Angeles County Sheriff's Department, until recently, also did not keeping track. But that has now changed. On May 1, 2000, Assistant Sheriff Waldie and the Chiefs of the LASD's three field operations regions promulgated Field Operations Directive 00-04 which requires the Department to record and track all significant public contacts and activity. For purposes of the Directive, those contacts and activities are defined as:

- calls for service;
- self-initiated activity that results in arrest or citation;
- self-initiated activity which is enforcement/investigative in nature, but does not result in arrest or citation; and
- self-initiated activity, which is not enforcement/investigative in nature, but
- results in Department personnel taking some form of constructive action, i.e., requesting a tow struck for a stranded motorist.

For purposes of the Directive, each such incident must be logged and shall include "the name, sex, race, age/D.O.B. of the involved person, reason for the contact and a brief description of the action taken by deputies." New codes have been developed for traffic stops and pedestrian stops respectively. Captains at the various patrol stations in the LASD are given responsibility for "developing and implementing training and review processes to ensure strict compliance"
with the Directive.

By taking the action it has, the Sheriff's Department joins other law enforcement agencies that have had the courage to face facts directly, and Sheriff Baca deserves praise for it. In particular, the Sheriff's actions are especially worthy of recognition because the LASD will collect data both on pedestrian stops as well as traffic stops. To be sure, the Directive has only been policy for a few months, and it is far too early to draw any conclusions from any resulting statistics or data to date. Because it is in its inception, however, we wanted to see how the program was working thus far and to offer any observations we had while practices and habits

are still being formed. We do so fully cognizant that the LASD is taking an important step. Our suggestions and observations, then, should not be interpreted negatively as they are not criticisms.

The Field Directive as currently drafted is ambiguous in at least one crucial aspect: Do LASD deputies need to report searches, frisks and pat-downs, whether consensual or not, which they perform in the wake of a pedestrian or traffic stop? Does the factual and legal basis for any such search need to be noted? If a search was done, does the officer need to record what, if anything, was found? A commander with whom we spoke was confident that the Field Directive covered searches. But we then interviewed three patrol captains—one from each of the three field operations regions—and they told us that they did not interpret the Directive to require separate notation of searches and that their logs showed that searches did not appear to be reported.

As a matter of best practice, they should be, and thus we recommend that the LASD clarify existing policy and resolve the ambiguity that currently exists in favor of an explicit reporting requirement. By way of example, the Sacramento Police Department (SPD) has clear guidelines in this regard. The SPD'S July 2000 General Order 210.08 requires recording of search data, including the legal and factual basis for the search and the results of the search.[9]

9 SPD employs a Scantron form which has 17 different variables for the officer to fill in. The form is set up so that it can be filled out quickly after each stop by darkening an appropriate box in each category. The 17 categories and related choices are:

- Time of stop, with choices for am or pm and the hour and minute of the stop;
- Date of stop, with choices for date, month, and year;
- Reason for stop; with choices for:
  - Hazardous violation of the Vehicle Code
  - Violation of the Penal Code
  - Violation of a city ordinance
  - Call for service
  - Preexisting knowledge or information
  - Equipment or registration violation
  - Special detail (i.e., DUI checkpoint; narcotic suppression detail)
  - Other
- Race and gender of the driver

(continued next page)

The Consent Decree recently negotiated between the United States Department of Justice and the City of Los Angeles will require the LAPD to complete written or electronic reports each time an officer conducts a motor vehicle stop or a pedestrian stop.[10] The NYPD has also recently begun using two-sided forms that "require officers to provide more detailed explanations for the decision to stop and search a citizen on the street." *New York Times*, Jan. 5, 2001.

We strongly recommend, therefore, that the Sheriff's Department collect the same detailed search information as the SPD, the San Diego PD, and the LAPD. We further recommend that the address of the person stopped, as well as the place where the stop took place, be recorded. The LASD's service area includes large swaths of unincorporated territory in Los Angeles County and more than 40 contract cities. Much of the LASD's patrol area abuts other urban aggregations, be it the City of Los Angeles, Beverly Hills, Glendale, or Pasadena. The LASD stops drivers who live in Los Angeles, tourists from other states, and other people who happen to find themselves in an LASD patrol area. Where someone lives becomes

9 *(continued)*

- Driver's date of birth
- Driver's license no. and state
- Yes or no to whether the driver was asked to exit the car
- The number of passengers
- Was a search done, with choices for the driver, passenger, or the vehicle or no.
- Search authority, with choices for consent, Terry cursory (reasonable grounds to believe that the person may be armed and dangerous), incident to arrest, parole/probation, or tow inventory.
- What was discovered or seized, with choices for weapons, drugs, cash, the vehicle, alcohol, other property, or nothing
- the result of the stop, with choices for citation, arrest, etc.
- the stop location, by precinct
- the vehicle license plate and state
- the duration of the stop in total minutes
- the officer's badge number and the badge number of a secondary officer, if applicable
- whether the radio car was equipped with a video camera or not.

10 Like the SPD form, the LAPD will be required to note whether :

- the driver was required to exit the vehicle;
- whether a pat-down or frisk was conducted;
- whether a consensual search was requested and whether permission was given or denied;
- the source of authority for any warrantless search;
- what was searched; and
- what was discovered, if anything.

important in calculating the pool of persons at risk of being stopped by the LASD. It is thus important, and bears upon the relevancy of data, to be precise in this regard.

In recommending such data collection, we are cognizant that there are both risks and rewards to doing so. If the data reveals patterns similar to those in New York or San Diego, the LASD leaves itself open to arguments that it is simply creating bad publicity for itself, for use by persons with a political or ideological axe to grind or seeking a shocking headline. The contrary view, which we submit is the better one, is that lack of knowledge is a dangerous thing, and that a willful lack of knowledge, an attitude of "lets not ask because we don't want to find out," is far more dangerous still.

For one, facts are only facts; what they mean is often in dispute. As noted earlier, it is foolish and far too simplistic to leap to conclusions of racial animus or bias, or illegality, just because differential patterns emerge on racial or ethnic grounds. Second, forewarned is fore-armed: If the LASD should discover that its officers are lax or less than precise in assessing probable cause or reasonable suspicion to stop or to search, better to know it and institute remedial training than face the risk of ongoing liability.[11] Third, the tracking of the data—and the inclusion of its results in a law enforcement agency's early warning system, like the LASD's PPI—will allow the agency to spot patterns or identify particular officers whose conduct may require attention, counseling, or re-training before they become a public liability.

It continues to surprise us how often we hear repeated the thoroughly discredited argument has that collecting data is "only putting evidence in the plaintiff's hands." As lawyers, we can appreciate that the more facts one has to explain away, the harder the job is for defense counsel. In the short run, without the data, an individual case in question might even be dismissed or settle cheaper than it otherwise would, letting the lawyer appear to be a hero to the client.

11 The experience at the Century Station is noteworthy in this regard. As a result of a survey conducted by Lt. Jim Lopez, it was discovered that there were possible problems with seizures that were leading to an unusual number of successful suppression motions or declinations to prosecute. Armed with the data, Lt. Lopez was able to tighten procedures on searches and seizures, thereby improving the chances for successful prosecutions while at the same time lowering risk of liability for Fourth Amendment violations.

But as lawyers we also appreciate how ultimately specious such arguments are, and how in the long run the client is poorly served by the lawyer who advocates not collecting data. Clients who are ostriches with their head in the sand do not win lawsuits. More importantly, they lack the information to manage risk. In the business of law enforcement, people do the same things in the same ways in repetitive fashion day in and day out, year in and year out. New training and techniques may cause variations in how things are done, but the basic job—patrolling, responding to calls, making stops, questioning people, performing searches, making arrests, being on the lookout—do not change. Accordingly, law enforcement is a business that is paradoxically particularly vulnerable to loss and yet particularly easy to fix. It is vulnerable because if one officer is engaging in a risky pattern that may give rise to litigation, it's likely that many, many officers are doing the same thing. By the same token, if the risk can be analyzed and managed, the results can drop risk substantially. An example was the Century and Lennox stations' disproportionate number of officer-involved shootings. When our criticisms forced the LASD to analyze the problem, it turned out that there was a common pattern of partners splitting from each other and engaging in foot pursuits. When the LASD finally recognized the pattern and engaged in some retraining, the number of shootings dropped substantially, as noted elsewhere in this Report.

The same should occur if it should turn out to be the case that race and ethnicity are improperly entering into decisions about whom to stop or search. The way to avoid liability is not to be an ostrich. Rather, it is to look around and respond sensibly to problems that need to be addressed. Collecting data is the first step. We are pleased that Sheriff Baca has done so, and we hope the recommendations in this Chapter are adopted by the LASD in order to make the data even more useful and reliable.

Before leaving this subject, it is important to focus on the impact of data collection on the deputies who will be called upon to record the information. The necessity to collect the data cannot help but be perceived by deputies as an additional and unwelcome paperwork burden. Even if, as in San Diego, it takes no more than 20 seconds to complete a form, or,

as in Sacramento, the form is set up so that it can be rapidly filled out and fed into a scanner, there is no denying that the departments are asking officers to do something additional. There naturally will be grumbling about the added burden.

But it is more than just that. Deputies and line police officers also ask themselves what's in it for them? Is data collection simply another capitulation to appease the segment of the public that is angry and cop-hating to begin with? To create more opportunities to sue police officers? Will officers have to start defensively keeping track of whom they stop? If, by the end of the month, the percentage of blacks that they have stopped is more than the proportion of blacks to the overall population, should they start pulling over more whites to bring the percentage down? Or will they simply quit making stops? Will they simply "drive and waive?"

These arguments and fears have a familiar ring. We heard them immediately after the **Kolts Report** with respect to recording uses of force, making sure all citizens' complaints were written down and tracked, and initiating the PPI—the LASD's sophisticated early warning system. Although it was not borne out by arrest statistics, we constantly heard some deputies say, in a petulant tone, that if the consequences of doing their jobs was greater susceptibility to being sued, or disciplined by their superiors, or scrutinized from the outside, or subject to bogus complaints from citizens seeking revenge, then their response would be a reluctance to do their jobs. Better to be a mediocre cop who simply responds to the radio calls that cannot be avoided rather than an active enforcer of the law who engages in the rough and tumble and confronts the criminal element.

These arguments and attitudes did not seem to abate until the LASD's management let it be known that it would neither tolerate officers who failed to do their sworn duty nor unfair and baseless attempts by the public to smear the reputation of good officers. The ultimate answer to the question "what's in it for me?" when asked by a deputy sheriff being asked to record data on traffic and pedestrian stops should be: Everything. If you do your job well and professionally, and adhere strictly to legal and constitutional requirements, you will find that the Department will strongly back you when times get rough and similarly will reward you when

it is time to do so. The LASD leadership must both "talk and walk" this message. Some deputies are already too quick to see themselves as victims or to interpret events to match their freewheeling, corrosive cynicism about management. It is vitally important, in an area as inflammatory as data collection and race, that management stack the tinder carefully, lest unintended victims get scorched.

After seven years of declining numbers of excessive force lawsuits, the trend reversed itself in fiscal year 1999-00, leading to an increase from 41 to 54 lawsuits filed and a jump from 70 to 93 in lawsuits pending. The number of all active lawsuits pending at the end of the fiscal year increased from 354 to 435, with the largest jump—from 247 to 341—in police malpractice suits. In all, the Department received 282 new lawsuits and 1028 new claims. See Table One.

Force-related judgments and settlements for fiscal year 1999-00 stood at about $4.6 million out of a total of $7.3 million paid for all LASD lawsuits and claims. Of this total, $4 million represented a settlement in the widely-publicized 1992 Donald Scott case which resulted in a shooting at a Ventura County ranch during the service of a narcotics search warrant. The controversial 1997 Golden shooting, from the Century Station, settled for $275,000. See Tables Two and Three.

As is our practice, we reviewed a significant sample of settlements. We did not note any usual new patterns or trends, although we continued to see recurrent themes. In custody cases, we again saw substantial payments for over-detention of inmates; failure to provide medical care and prescribed medication; and failure to protect inmates.

In the latter connection, there were two significant settlements last Spring—one for $60,000 and the other for $100,000—both arising from similar fact patterns within a similar time frame at Men's Central Jail (MCJ). In the first case, the plaintiff alleged that on June 15, 1997, a deputy called him a child molester in front of other inmates, causing him to be physically assaulted by other inmates. In the second case, an inmate's mother alleged that the LASD has failed to segregate her son who had been charged with sex offenses, and that on July 11, 1997, as a result, her son was beaten and strangled to death.

At least two cases with similar allegations are pending. One alleges a beating in October 1997 after deputies at MCJ assertedly informed inmates that the plaintiff was charged with child molestation. A second case, filed by a pro per plaintiff, alleges that

1

LASD Litigation Activity, Fiscal Years 1992-2000

	FY 92-93	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00
New Force Related Suits Served	88	55	79	83	61	54	41	54
Total Docket of Excessive Force Suits	381	222	190	132	108	84	70	93
Lawsuits Terminated								
Lawsuits Dismissed	79	90	60	42	39	27	20	24
Verdicts Won	22	9	10	6	3	6	1	1
Verdicts Against LASD	3	7	3	5	2	1	2	2
Settlements	70	81	103	82	41	45	32	13

Lawsuits Terminated Fiscal Year 1999-2000

	Dismissed	Settled	Verdicts Won	Verdicts Against	Totals
Police Malpractice	83	55	9	1	148
Medical Malpractice	7	29	1	3	40
Traffic	17	5	0	0	22
General Negligence	4	1	0	1	6
Personnel	6	3	5	1	15
Writs	5	0	1	1	7
Total	**122**	**93**	**16**	**7**	**238**

Activity Lawsuits by Category

	7/1/98	7/1/99	7/1/00
Police Malpractice	224	247	341
Traffic	47	43	37
General Negligence	7	8	3
Personnel	19	22	16
Medical Malpractice	22	28	25
Writs	8	6	13
Total	**327**	**354**	**435**

2

Fiscal Year 1999-2000 Department Financial Summary

	Department Funded	Contract City Funded	MTA Liability Funded	Totals
Lawsuits				
Police Liability	$5,490,950.00	$391,476.00	$0.00	$5,882,426.00
(Portion of Total for Alleged Excessive Force)	$4,230,250.00	$345,400.00	$0.00	$4,575,650.00
Personnel Issues	$193,400.00	$0.00	$0.00	$193,400.00
Auto Liability	$390,585.00	$51,492.00	$0.00	$442,077.00
Medical Liability	$139,500.00	$0.00	$0.00	$139,500.00
General Liability	$1,282.00	$0.00	$0.00	$1,282.00
Writs	$0.00	$0.00	$0.00	$0.00
Lawsuit Total	**$6,215,717.00**	**$442,968.00**	**$0.00**	**$6,658,685.00**
Claims				
Police Liability	$704.206.00	$17,738.00	$237.00	$722,181.00
(Portion of Total for Over Detentions)	$120,725.00	$0.00	$0.00	$120,725.00
Personnel Issues	$0.00	$0.00	$0.00	$0.00
Auto Liability	$82,442.00	$18,521.00	$0.00	$100,963.00
Medical Liability	$0.00	$0.00	$0.00	$139,500.00
General Liability	$146.00	$0.00	$150.00	$296.00
Claim Total	**$786,794.00**	**$36,259.00**	**$387.00**	**$823,440.00**
Incurred Claims/ Lawsuits Liability Total	**$7,002,511.00**	**$479,227.00**	**$387.00**	**$7,367,899.00**
FY 1998/99 Total	$5,298,092.00	$27,926,889.00		$33,224,981.00
FY 1997/98 Total	$6,006,592.00	$2,856,734.00		$8,863,326.00
FY 1996/97 Total	$9,900,000.00	$2,600,000.00		$12,500,000.00

3

Force-Related Judgments and Settlements

Fiscal Years	1995-96	1996-97	1997-98	1998-99	1999-00
	$17 million*	$3.72 million	$1.62 million	$27 million**	$4.6 million***

* Includes $7.5 million for Darren Thompson paid over three years.

** Includes approximately $20 million for 1989 *Talamavaio* case.

*** Includes $4 million for *Scott* and $275,000 for *Anthony Goden.*

in November 1996, while at MCJ, deputies divulged that the plaintiff had been charged with child molestation. He further alleges that he was then assaulted by five inmates. We have no views on the merits of the two pending cases. We have some concern, however, at the similarity of the allegations in the four cases and that they all are alleged to have occurred within a relatively short time frame—between November 1996 and October 1997. Most striking is that the two settled cases allege incidents that were less than a month apart. We do not know whether the personnel involved in the four cases have been identified, whether they overlap, or whether they worked the same shifts or areas within MJC, and we are curious whether the LASD has explored these questions.

Another noteworthy case which settled for $100,000 involved a combination of an over-detention and a failure to provide medications that occurred in 1997. Due to a mistaken assignment of two booking numbers, an inmate was over-detained for 38 days during which he apparently requested but was not provided with his HIV medications. As we described at length in our **Tenth Semiannual Report,** the LASD has shown itself responsive to our concerns about provision of medication to persons living with AIDS and HIV, and we would not expect a repetition of the fact pattern described above, with a failure to provide necessary, life-sustaining medication to such persons. Over-detentions, however, still occur, although the numbers have dropped two fiscal years in a row, as shown in Table 4.

4

Inmate Over Detentions

Fiscal Years	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00
Over-detentions	301	339	712	495	267