The Los Angeles County

Sheriff's Department

14th Semiannual Report by
Special Counsel Merrick J. Bobb & Staff &
Police Assessment Resource Center (PARC)

October 2001

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Introduction

This is the fourteenth report assessing the Los Angeles County Sheriff's Department (LASD) for the Board of Supervisors, the Sheriff, and the general public. It describes the status of the LASD in mid-year 2001. Necessarily, in an institution as large as the LASD, there are hundreds of stories that should be told and hundreds of reports that should be made. In a season where we are grateful more than ever for those who concern themselves with our public safety, we acknowledge our appreciation for all the fine work the men and women of the LASD perform every day. In a season where hundreds of New York fire and police workers lost their lives in the performance of their duties, we acknowledge heart wrenching losses like that of Deputy Jake Kuredjian within the LASD family. In a season where destruction and fear awaken a propensity in some to think they must sacrifice rights and freedoms for safety, we acknowledge our admiration for LASD officers whose respectful and effective policing carefully protects both our persons and our rights.

To some persons, therefore, it may appear odd that we focus, as we must in these reports, on problems and shortcomings of local law enforcement. In a season where we are overwhelmed with the magnitude of senseless and unnecessary loss of life in New York and Washington, it is difficult at times to keep in focus and perspective just why it is so enduringly important to discuss the rights of Los Angeles County residents to be free from unnecessary and unreasonable conduct by LASD officers. But it is just those rights and freedoms that those who practice terror want to see abased and destroyed. Thus our vigilance to protect our country and our safety necessarily must include vigilance to protect those very rights and freedoms that gives our country its unique and unmatched value.

As we have emphasized repeatedly, our semiannual reports on the LASD emphasize problems, risks, challenges, and shortcomings. We do not trumpet the Department's successes, although we consider both the positive and the negative in our critical work. We have noted that the LASD compares favorably with many other law enforcement

agencies we have investigated and seen from the inside. It still does. We have said that the LASD is a source of pride to the County. It still is. Nonetheless, as this report demonstrates, in the areas of our greatest concern – use of lethal and non-lethal force – there is troubling backsliding and emerging trends that are causing us to move beyond simple concern to real worry. The leadership of the Department speaks eloquently and convincingly about civil rights and the centrality of those rights to the LASD's core values and mission. The creation of the Office of Independent Review, discussed in this Report, is a shining example where the Department's vision and its action are indistinguishable and point in the same positive direction. But the use of force trends and the Evans case, also discussed in this Report, show that vision and performance are also moving in contrary directions.

Chapter One of this report deals with the unnecessary and avoidable death at the hands of the LASD of Kevin Evans, a 33 year old African-American man who suffered from serious mental disease, Cerebral Palsy, a scarred and enlarged heart, and homelessness. He died during or shortly after a struggle with LASD personnel who were tying both his arms and both his legs with leather straps to a bedframe – a manner of immobilizing an inmate called four-point restraints. From the moment Mr. Evans was stopped by the LASD to the moment he died, the Sheriff's Department had sole custody of Mr. Evans and committed many errors. Each single mistake, mishap, or misjudgment along the way, taken alone, may not have foreshadowed Mr. Evans's death, yet their sum led inexorably to a lethal conclusion.

The plain truth is that Kevin Evans died because LASD personnel intermittently cut off his breathing in violation of LASD use of force policies, in violation of California law, and in derogation of any reasonable correctional or medical procedure. But when called upon to examine the LASD's actions to determine if it had done anything wrong, the internal LASD investigations were careless to the point of slipshod; self-justifying and rationalizing to the point where their credibility vanished. Our investigation of the

Evans case seriously shook our prior belief that the LASD was making steady if slow progress.

We do not believe, however, that the chances of a substandard investigation like the Evans case are as great today as they were in 1999 when Kevin Evans died. That is because there is now a functioning Office of Independent Review. Chapter Two of this report discusses this unprecedented and exciting new mechanism for meaningful civilian oversight and involvement in LASD internal investigations. The Office of Independent Review (OIR) is a bold experiment that holds great promise. If it succeeds, and we are certain it should, the OIR will become the gold standard — a national model, incorporating all the strengths of civilian review and civilian participation without the weaknesses. The OIR is headed by Mike Gennaco, who is regarded as one of the nation's finest civil rights lawyers. Chapter Two describes this newly-created office, offers some suggestions and recommendations about how it should function, and details further reforms and areas for inquiry to strengthen the office and improve the integrity of internal LASD investigations.

In Chapter Three, we return to a subject that is at the heart of our responsibilities as Special Counsel – the examination of officer-involved shootings and other uses of force. In our last semiannual report, we noted a welcome decline in deputy-involved shootings and an unwelcome uptick in other uses of force. In this report, we find, unfortunately, that deputy-involved shootings are up sharply in Field Operations Region II, and specifically at the Century Station. This development is particularly troublesome in that Century Station had for a time sharply reduced the number of such shootings. Turning to force other than shootings, we are distressed to report that the uptick we noted in our last report continues.

Our investigation over the last six months underscores our concerns that the LASD is not spotting these trends quickly enough and then reversing them to the extent that they are within management control. The LASD has not, on a regular basis, been producing

the management reports to spot these trends and is not coming to grips with these issues in a concerted and meaningful way. The result may very well be the alarming increases in shootings and force in Region II and at Century.

Chapter Four deals with litigation. In our last report, we discussed litigation during fiscal year 1999-00 and noted potentially troublesome trends. After seven years of declining numbers of excessive force lawsuits, we noted an increase. We also pointed out a general rise in the number of active lawsuits involving the LASD. With regard to excessive force cases, the trends have continued.

On a final note, we point out that this report differs from its thirteen predecessors in that Special Counsel's staff has been augmented with the assistance of the Police Assessment Resource Center, or PARC, a newly-formed organization to advance respectful and effective policing.

PARC was formed in 2001 under the auspices of the Vera Institute of Justice with funding from the Ford Foundation. Vera is a nonprofit organization based in New York City that for 40 years has been working closely with government leaders to improve the services people rely on for safety and justice.

PARC's mission is to support the oversight of police departments to advance effective, respectful, and publicly accountable law enforcement. Through its assistance, PARC helps monitors like Special Counsel and others charged with oversight, including police officials, to evaluate police systems to identify problem officers and stations, document and investigate the use of force, review disciplinary decisions, measure community satisfaction, assess the risk of litigation, and track, analyze, and respond to citizen complaints. By assisting monitors and others involved in police oversight around the country, PARC is developing a better sense of the emerging field of police oversight than anyone could acquire independently and is therefore in a position to share and adapt the most promising techniques.

PARC's Board is chaired by John Dunne, the former Assistant Attorney General for

Civil Rights in the first Bush administration. In addition, PARC's Board has noted police leaders, including a former New York City Police Commissioner; the former Chief of Police of Houston and Austin; and a former Assistant Sheriff of the Los Angeles County Sheriff's Department. PARC's Board also includes leaders of the civil rights community, including the head of the Urban League in a large city whose police department has been the subject of federal monitoring, the head of a New York-based civil rights advocacy organization, and the Executive Director of the Leadership Conference on Civil Rights. The Board also includes the Dean of the Annenberg School for Communication at the University of Southern California, a former Senior Vice President of Community Relations for the *Los Angeles Times*, and the former United States Attorney for the Eastern District of New York who was responsible for the prosecution of the Louima case.

1. The Death of Kevin Evans

On October 20, 1999, shortly after six in the evening, in the Lancaster-Palmdale area, a Los Angeles County Sheriff's Deputy stopped Kevin Evans, a homeless, mentally ill 33 year-old African-American with Cerebral Palsy who had been in and out of the Los Angeles County jails at least four times in recent years for minor offenses.

This time, Mr. Evans was stopped for having taken a shopping cart from a supermarket lot. Two other Deputies soon joined the officer who had stopped Evans. As the Deputies prepared to issue a citation, they discovered that Mr. Evans had an outstanding bench warrant for failure to appear on a 1998 citation for public intoxication. The officers then placed Evans under arrest and held him overnight at the Lancaster Station lock-up. The next day, a judge ordered that Evans be taken to Twin Towers in downtown Los Angeles until October 25, when he was to re-appear in court.

During the evening of October 21, as Mr. Evans was processed over a period of approximately five hours through the Inmate Reception Center (IRC) in downtown Los Angeles, officers found him to be withdrawn and giving inappropriate responses. They observed him mumbling unintelligibly to himself and hallucinating. No one, however, stated that Mr. Evans was violent, or threatening, or dangerous, or combative that evening. Nonetheless, he was twice ordered into restraints -- first, into three-point restraints by a jail physician, and next, a couple of hours later, before the first order had been carried out, into four-point restraints by a jail psychiatrist who had never seen him and relayed the order over the phone to a nurse. The second restraint order was assertedly for "threatening behavior." But just what that threatening behavior was, if there was any at all, is a mystery: There is nothing in the LASD records indicating that Evans acted in a threatening way that evening. Even more perplexing, neither of the two doctors who prescribed restraints, nor the nurse who called the psychiatrist on the phone, was interviewed by LASD investigators, much less asked to describe the basis, if any, for their findings and orders.

A few hours later, in the early morning hours of October 22, 1999, on the third floor

of the Medical Services Building (MSB) at Twin Towers, Mr. Evans was placed in four-point restraints, a procedure in which an inmate is strapped down as he lies on his back on a low bed. Each leg is secured with a leather strap at the two lower corners of the bed. One arm is secured with a leather strap at the inmate's side; the other arm is secured at an upper corner of the bed. The LASD's internal rules require that restraining an inmate must be performed in the presence of medical personnel, but none were summoned or present when Mr. Evans was strapped down.

After a sandwich he had been clutching was taken from his hand by one of the deputies, Mr. Evans began to kick and struggle. It took approximately eight minutes to strap Mr. Evans down. Nine LASD officers were involved at one point or another in restraining him. Another Deputy recorded the event on a video camera. By the time Mr. Evans was strapped to the bed, or within moments thereafter, he was dead.

The Deputy Medical Examiner, Dr. Carpenter, who conducted Mr. Evans's autopsy, concluded that Mr. Evans died from "a combination of asphyxiation due to some form of compression against the throat, and the strain against an enlarged and scarred heart." [1] Yet the struggle alone was not enough to have caused his death, even given the enlarged heart. Indeed, Dr. Carpenter "opined that the strain of the struggle alone most likely would not have been enough to cause the heart, even in this weakened condition, to fail, thereby causing Evans's death." [2]

The Medical Examiner's conclusion was supported by two findings from the Evans autopsy. First, the Medical Examiner discovered several dark and distinct bruises on the back of Evans's pharynx, the topmost part of Evans's air passageway. The bruising suggested that pressure was applied to Evans's throat with enough force to

1 Letter of October 30, 2000 to Captain Frank Merriman from Deputy District Attorney Marcia Daniel, p. 7.

2 *Id.*

cause the back of the pharynx to be pressed against Evans's spinal column - the solid bone structure behind the pharynx. That amount of pressure would have cut off Evans's breathing altogether. The multiple bruises gave rise to an inference that the severe compression occurred more than once; an inference corroborated by Evans's intermittent but repeated gasping and gurgling heard on the videotape. Second, the Medical Examiner also found compression trauma to the muscles covering the front side of Evan's lower trachea, located just above the chest. This trauma also suggests compression of the airways.

Although the Medical Examiner did not specifically state how the trauma to the neck and throat came about, careful review of the videotape demonstrates that it was caused by the actions of two or three deputies. Here are two examples:

- About five seconds after Evans began to struggle with the officers, the videotape shows Deputy W placing his left knee in the vicinity of Evans's throat. After maintaining that position for about 12 seconds, Deputy W used a hopping or slipping motion to switch legs and to forcefully land his right knee in the vicinity of Evans's throat. About 15 seconds later, Deputy W can be observed to press his knee even more forcefully down. Two seconds after that, Deputy W uses both hands to pull Evans to him, increasing the pressure exerted by his knee. Immediately there after, the videotape picks up the first sounds of Evans's gasping for air. The Coroner's Investigator, upon viewing this section of the video, concluded that Deputy W must indeed have blocked Evans's airway by putting his knee on Evans's throat or upper chest.
- The videotape also shows that at critical moments throughout the entire struggle, Deputy C2 shifted his body weight forward and pressed down on Evans's chest with his hands. That Deputy later conceded to investigators that he was pressing on Evans's diaphragm. He knelt on top of Mr. Evans, with his knees on Evans's thighs up near his groin. The video shows yet another officer, Deputy G,

pressing firmly down on Evans's face and throat. In the same shot, Deputy W's hand is also visible pressing against Evans's throat. The shot follows several seconds of gurgling and gasping sounds from Evans. Later, Deputy G spends seven seconds kneeling either on Evans's face or throat. He later told investigators that he had knelt on Evans's cheek.

As the LASD should have known, asphyxiation is the single greatest cause of death in the use of restraints. As reported by the United States General Accounting Office to Congress, "[r]estraint . . . can be dangerous to individuals . . . because restraining them can involve physical struggle, pressure on the chest, or other interruptions in breathing. [The Joint Commission on the Accreditation of Healthcare Organizations] reviewed 20 restraint-related deaths and found that in 40 percent the cause of death was asphyxiation, while strangulation, cardiac arrest, or fire caused the remainder." *Mental Health: Improper Restraint or Seclusion Use Places People at Risk*, GAO/HEHS 99-176. A 1998 study by the Hartford, Connecticut newspaper, the *Courant*, reached similar conclusions in a study of 142 cases over 10 years drawn from across the country. The Hartford *Courant*, Oct. 11-15, 1998.

I. SUMMARY OF CONCLUSIONS.

From the moment Mr. Evans was stopped by LASD deputies to the moment he died, the Sheriff's Department had sole custody of Mr. Evans. During this brief time, the LASD committed many errors. Where it had adequate internal policies to prevent these errors, the LASD violated its own policies. To the extent it lacked policies, or the policies it had were inadequate, the LASD acted in a negligent, even perhaps reckless, way. To the extent that the Sheriff's personnel were trained to put someone in restraints, the training fell significantly below reasonable standards in either a correctional or a mental health setting. To the extent that Sheriff's personnel did their jobs correctly, it was not enough. Each single mistake, mishap, or misjudgment along the way, taken

alone, may not have foreshadowed death, yet their sum led inexorably to a lethal conclusion.

Even more dispiriting, when called upon to examine the LASD's actions to determine if it had done anything wrong, the internal LASD investigations were careless to the point of slipshod, self-justifying and rationalizing to the point where their credibility vanished, and insensitive and defensive to the point where reason and good judgment flew out the window. Stripped of the rhetoric and obfuscation, the Department's position boiled down to this: The force employed putting Mr. Evans in restraints was reasonable because the LASD personnel in question did not lose their tempers and did not angrily beat Mr. Evans or knock him around as they might have ten years or so ago; this was "no Rodney King."

The LASD's position does not hold water. As soon as the Deputy Medical Examiner let it be known that Mr. Evans had been asphyxiated, the LASD should have acknowledged that the force used to place Mr. Evans in restraints was out of policy, or, at the very least, it should have re-opened or expanded the investigation. Any restraint causing asphyxiation is per se out of policy absent justification for lethal force. Moreover, it was equally clear that California law had been violated: "Physical restraints should be utilized **only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior.**" California Code of Regulations ("C.C.R.") § 1058. (Emphasis supplied). No less restrictive alternatives were even attempted, even though, as will be shown below, Mr. Evans had not engaged in any violent behavior and had complied, albeit at times grudgingly and with some "mouthing off," with all instructions given him.

Evans's family sued the County. When the $600,000 settlement came before the Board of Supervisors for approval, it came out that there was an LASD videotape of Mr. Evans's being placed in restraints. Supervisor Molina asked to see it and was sickened by what she saw. Although assured by the LASD that what she witnessed on the tape was a standard, run-of-the-mill restraint, and that it perhaps looked worse to her than it

might to others because she was seeing it with an untrained eye, the Supervisor remained skeptical. Supervisor Molina and the rest of the Board, asked us to conduct a special investigation, which we recently concluded.

We collected and gathered all the evidence we could, consistently finding that the Department's assurances that we had been given all the evidence and documentation were hollow - the more we persisted and insisted, the more was found. Files and records that we were told did not exist suddenly turned up; files we were told had been copied for us in their entirety turned out to be incomplete; requests we made were ignored; deadlines we attempted to impose were disregarded; phone calls were not returned. We had to go all the way to the Undersheriff himself to break the logjam. For the first time since 1993, when we started monitoring the Department for the Board of Supervisors, we felt that good faith cooperation was not consistently forthcoming. In the end, however, the truth was inescapable and plain - Evans died because officers had intermittently cut off this breathing in violation of Department use of force policies, in violation of California law, and in derogation of any reasonable correctional or medical procedure.[3]

Then was it murder? No. We are convinced that none of the LASD personnel acted with specific intent to do Evans in or to harm him for its own sake or with malice. [4] If it was not murder, could the DA nonetheless have charged sworn personnel involved in the restraint with other crimes? Possibly, at least in theory. Then did the DA abuse his discretion

3 At times, the LASD appeared to argue that placing Mr. Evans in restraints was not a "use of force" but rather a medical procedure. Our medical experts were shocked by the notion: No one with medical training would have compressed Mr. Evans's chest, diaphragm, or throat. The LASD should make clear, if there is any doubt whatsoever, that the application of restraints is a use of force and should be reported as such and reviewed as such. If it is to be done by custody personnel at all - a proposition we question because of the medical risks - it should be performed by individuals given medical training and under medical supervision.

4 What we witnessed on the videotape was the playing out of a group ethos to incapacitate a combative inmate in response to an order to put Evans in restraints. Whether that order was wise or foolish was not their concern; whether Mr. Evans should have been in jail in the first place was not their place to question. They did what they were told to do in the manner in which they were trained to do it and according to an implicit set of rules: Overcome the resistance the inmate puts up and get him in restraints. Don't act in anger or be gratuitously violent or punishing; we will discipline you for that. But if in the midst of a difficult struggle you mistakenly use more force than in retrospect may strictly have been necessary, or if in the heat of the moment you apply that force in a dangerous way - say by cutting off an inmate's breathing - the organization will back

by deciding to decline prosecution? No. The DA made a reasonable judgment that to prove a crime, much less prove it beyond a reasonable doubt, was more than this set of facts, however painful and sad, could bear.

But were crimes committed by others? Yes. One nurse deliberately falsified the medical records to make it appear that Evans was alive when another nurse had come in to Evans's room, shortly after the restraints were applied, to give him a shot of a sedative. But Evans's heart had stopped pumping; the tranquilizer simply pooled in Evans's arm, giving lie to the nurse's story. Did the DA take appropriate action on this falsification? Yes.

Was the internal investigation by the LASD's Homicide Bureau full, fair, thorough, and complete? No. Did Internal Affairs do its job in a responsible way? No. Internal Affairs did not conduct a separate, complete, and independent investigation as it should have, either at the time Mr. Evans died or later, after the Deputy Medical Examiner had concluded that Mr. Evans had died by asphyxiation.[5] Were the medical decisions by the doctors that led Evans to be put in restraints reasonable? No.

Should supervisory personnel who permitted the restraint to go forward in the absence of medical personnel be disciplined? Yes. Did the supervisors know, or should they have

you up. As a Homicide investigator put it, "I know many people have reviewed that videotape many times and have seen other things. But, you know, what we saw was a very controlled thing. This was not a brawl. This was not a free-for-all like you'd see back when I was in Custody . . . . They had the guy, he resisted, they immobilized him. It all looked very controlled to us. . . . No one was losing their head on that tape. It was all very controlled."

5 It is mandatory that Internal Affairs roll to the scene of any death following an altercation with any Department member. Here, a mandatory roll-out was called for. Evans died following a struggle with Department members who were trying to put him in restraints; clearly a death following an altercation. The LASD attempted to excuse IA's failure to roll on the grounds that the initial conclusion by the Homicide investigators on the scene was that Evans died of natural causes and not at the hands of another. The excuse is both facile and transparently wrong. Every human being ultimately dies of "natural causes" - the heart stops beating; the brain stops functioning. It is *how* the death came about that is important. Here, force, including lethal force, was applied to put Evans in restraints, and he died. Whether the force proximately caused the death is the question ultimately to be answered. Here, the investigators simply assumed it was not the case, apparently because Evans had a weak heart. But even if Evans had an abnormally weak heart and had died when a person with a normal heart would have survived, he still would have died at the hands of another because the force was a "but for" cause of the death. The questions then would be whether the LASD knew or should have known of the weak heart prior to the application of force and whether the amount of force employed was justified in any event. Because the videotape clearly discloses that lethal force was employed, the Homicide Bureau should have conducted a fuller investigation, and IA clearly should have done so as well. But even if it did not at the time Evans died, Internal Affairs should have opened a full investigation at a later time when the Deputy Medical Examiner's report came out and it was clear that Mr. Evans had been asphyxiated. This is one of the rare instances in the several years we have monitored the LASD that Internal Affairs has failed so completely.

known, that the pressures being applied to Evans's head, neck, throat, diaphragm, and chest were putting his life at risk? Yes.

As for the sergeant in charge and the deputies who got on top of Evans or otherwise applied pressure to his chest, neck, and throat, and thereby intermittently cut off his breathing, did they know or consciously realize that Evans was dying? No, we do not believe they did. Each was acting in the heat of the moment; each was responding ad hoc. Should they have known? Yes. A reasonable person in the position of each of these deputies, even in the absence of specific training or teaching, should have known from life experience, if not from general instruction at the Academy, that it is dangerous to apply substantial pressure to someone's neck, throat, chest, and diaphragm. They were negligent to ignore Evans's gasping and gurgling, and to continue interrupting his breathing.

There were three supervisors present for most of the restraint - a sergeant from MSB, a sergeant from IRC, and a senior deputy. They were there to make sure what happened here should never have occurred. Although they were acting in good faith and without an intention to see Mr. Evans suffer harm, they were nonetheless negligent in two respects. First, none of them should have allowed the restraint to go forward until medical personnel arrived on the scene so that they could monitor Mr. Evans's condition at all times. Second, at least one of the supervisors, probably the sergeant from MSB, should not have participated actively in the struggle to restrain Mr. Evans. Although the sergeant's desire to help her fellow officers is understandable, she had a duty to act purely as a supervisor. Her task was to monitor Mr. Evans, to maintain an unimpeded line of sight, and to supervise and instruct from a position where she could see everything that was happening. [6]

6 The sergeant from MSB, Sergeant H, called us and volunteered to come in and speak with us about the incident. She answered all of our questions fully and truthfully, and we found her credible and trustworthy and believe she was trying to do the right thing during the Evans restraint. She trusted us enough to volunteer to talk. We commend her forthrightness. We also commend her willingness to learn from and deal constructively with this incident. She chose not to put the incident behind her, but rather had the courage to confront it. In doing so, she earned our respect. In addition, by coming forward and speaking with us, she was able to put her own role in the incident in a clearer light. She was able to point out things to us in the videotape and put the incident in context for us. Her suggestions and recommendations for improvement of the process were correct and coincided with our own.

Should some of the deputies be disciplined? Yes, in a way that sends a clear and fair message that each bears a personal responsibility to preserve a life entrusted to his or her care and that each had a personal duty to have intervened to stop the others when Mr. Evans was struggling for breath. But that's not all that should be done. They should watch the videotape in the presence of an expert so that they come to understand, if they have not already, that they needlessly took a life. Each act or failure to act that contributed to the death should be pointed out and explained.

Does the responsibility stop with the sergeants and supervisors? By no means. Although not involved in the specific circumstances of Mr. Evans's death, LASD executives, at each level of command, from the Captains of IRC and Twin Towers to the Commander to the Chief and on up, had general duties and responsibilities concerning the administration of the jails that should have been performed and would have prevented the tragedy that occurred. In the jails, there are many things that have been left undone, some for many years.

The Sheriff's Department has been on repeated notice from the Board of Supervisors, from the Department of Justice, from the Department of Health Services, from us, from the newspapers, from the ACLU, from inmates, from doctors, from psychologists, from nurses, from consultants, from experts, from lawyers, from judges who have been complaining openly for years that the Sheriff's Department ignored their orders for medical treatment of inmates, from lawsuits, from hefty settlements, and from present and former Sheriff's executives that health care to inmates, particularly mentally ill inmates, was substandard if not illegal; scandalous if not outrageous.

We turn now to a detailed discussion of certain critical events and seriously flawed decisions that were made during the course of Mr. Evans's arrest and detention. Thereafter, we set forth the flaws and deficiencies in the LASD's internal investigation. Finally, we offer our recommendations.

II. THE LASD'S COURSE OF CONDUCT CONCERNING EVANS CONTAINED MANY FLAWS.

A. There was an Inadequate Basis to Conclude that Evans Constituted a Danger.

October 20, 1999

6:10 pm. Palmdale Deputy Greg Schell stopped Kevin Evans, who was pushing a shopping cart. Deputy Cox and his trainee responded to the scene and prepared to cite Evans for stealing the cart. Evans was cooperative and sat uncuffed in the back of the radio car while Deputy Schell prepared a citation and ran a warrant check. Deputy Schell discovered an outstanding bench warrant for Evans's failure to appear in court on a 1998 citation for public intoxication (being under the influence of a controlled substance).[7] Deputy Schell then placed Mr. Evans under arrest and began driving back to the station. As he drove to the station, Deputy Schell realized that he had forgotten to handcuff Evans. He called for back-up, on a non-emergency basis, and then, when back-up arrived, he handcuffed Evans without incident.[8] None of the involved officers reported that they had to use any force on Evans or that he had acted in a belligerent manner.

6:45 pm. At the Lancaster Station where Evans was taken, Deputy Schell did not report that Mr. Evans was mentally unstable or that he appeared to be under the influence of drugs or alcohol. The station jailer completed a Jailer's Assessment of Evans, finding no apparent

7 The 1998 arrest was based upon the suspicion that Evans was under the influence of cocaine. To our knowledge based upon LASD records, he was not tested for cocaine in his system. Although the deputy who made the 1998 arrest may have observed physiological signs and behavior consistent with cocaine, those same signs and behavior were also consistent with Mr. Evans's physical and psychological disabilities. The line between schizophrenia and drug-induced psychosis is not one that a lay person is equipped to make, and there are instances in which a given suspect will present a dual diagnosis: he will both be mentally ill and using an illegal substance. For these reasons, there is a compelling need to divert these individuals, as described at greater length in the section of this chapter dealing with prevention of similar incidents in the future.

We also want to underscore that after Mr. Evans died in October 1999, the Medical Examiner's blood toxicology report revealed no traces of cocaine or any other illegal substances in Mr. Evans's bloodstream.

8 In calling for back-up, Deputy Schell was merely following good police practice. The decision to call for back-up in these circumstances is not evidence that he considered himself to be in danger. Indeed, Deputy

mental or medical problems. Without stating any reasons, he classified Evans as "aggressive" as contrasted to "passive" or "assaultive" on the Station Jail Prisoner Classification Questionnaire. No one in any subsequent investigation asked the jailer what his basis was for the classification and what Evans did, if anything, that led the jailer to label Evans "aggressive." Nor could we find any written guidelines explaining the basis for the jailer to choose among the categories. The jailer did not believe, however, that there was any reason to segregate Mr. Evans. Evans was then housed in a minimum security cell, and there were no reports of any problems with his behavior.

October 21, 1999

6 -7 am. A Lancaster Station deputy opened the cell to call the prisoners out for court appearances. He noticed Evans standing near the sliding door leading out of the holding area and told him to step back. Evans replied, "I'll do what I want, fool." Other prisoners laughed and told the deputy that Evans "was not all there." The deputy ignored Evans comment, and Evans stepped back into the cell. Evans was thereafter transported to the Antelope Valley Court without any incident noted.

Later that morning. The Courthouse lock-up deputy, Deputy B, reported that upon first seeing Evans, he "seemed a little slow mentally and physically" but nonetheless "seemed to get along fine in the [lock-up] in the morning." [9]

That afternoon. Mr. Evans, chained to four other inmates, was taken to his arraignment before Superior Court Judge Randolph Rogers. During the hearing, Mr. Evans began to act strangely. As the judge began to address him, Evans slowly bent over. Finding him "very odd" at this point, and unsure of what Evans intended, Deputy B called for backup, albiet on a non-emergency basis. The bailiff in the courtroom at the time, Deputy T, in a later interview,

Schell did not tell Homicide investigators or anyone else that heconsidered Evans to be dangerous. He also indicated on his arrest questionnaire that he did not consider Evans as a threat.

9 There is a conflict in the record regarding whether Evans, an African-American, was first put in a cell in the Courthouse lock-up that housed some white supremacists. One deputy stated that Evans was moved from the cell when another Deputy realized that it contained white power inmates. Another deputy suggests that Evans was diverted to another cell before he was put in with the white power inmates.

thought the call for back-up was premature: “He stated that he did not think there was a need to get back-up because Evans was controllable and became cooperative.” When two back-up officers arrived, Mr. Evans turned around, stared for a moment at the rear wall of the courtroom, and told the judge that he might as well be talking to the wall. Evans then began mumbling to himself. Nothing further occurred. The judge ordered Mr. Evans to be kept at Twin Towers in downtown Los Angeles. According to Deputy B, the chain of four inmates quietly left the courtroom.

Mr. Evans went back to the Courthouse lock-up and was placed in a holding cell. According to Deputy B, inmates in the holding cell asked that Mr. Evans be removed from their cell “because he was acting so odd.” Deputy H saw Evans being relocated to another cell because “he was causing problems in the cell.” Deputy H stated that “Evans did not have any problems with the Deputies” and “did not cause any problems with deputies in the lock-up.” Deputy A also was present. In a report to his supervisor, Deputy A said that a male black inmate from inside the cell asked A to “please get Evans out of the cell because he was talking crazy. I immediately placed Evans in the sally port of cell #3 and closed the gate behind him . . . . Approximately 5-10 minutes later, I . . . told Evans to come out because I was moving him. . . . I directed him down the hall towards cell #7 where other deputies were to receive him. He complied with no incident.”

Deputy L also had contact with Mr. Evans. In his report to his supervisor, L reported that Evans was “having some words with another inmate.” L pulled Evans out to ascertain what the problem was. L “was unable to get any information from him. When I attempted to put him back into the holding cell, he shrugged his shoulders and stated ‘I don’t want you to touch me. But I’ll let you put me in.’” The Homicide interviewer gave a somewhat different report of Deputy L’s interaction with Evans. He reported that Deputy L had told him that when Deputy L was escorting Evans to another cell, he placed his hand on Evans’s arm. Evans shrugged his shoulders and pulled away stating, “Don’t touch me!” Evans “appeared to be agitated” but did not cause additional problems, according to Deputy L.

Deputy B, however, interpreted Evans's gesture as hostile. She thought Evans had thrown up his arms, saying, "Don't touch me!" At that point, Deputy B wrote a "Keep Away" card on him "for everyone's information and protection."

Deputy B attempted to justify doing so stating, "Inmate Evans exhibited an aggressive demeanor toward deputies. The arresting deputy called for a Code 3 back-up to cuff him. Evans backtalked the judge and seems to be 918. He almost swung at a lock-up deputy. He can not get along with other inmates either. Recommend leg and waist [chains] when transporting to court." Some of Deputy B's characterizations, perhaps, are judgment calls; others, however, are exaggerations. One asserted fact was clearly in error: The arresting deputy had not called for a Code 3 back-up (i.e., that the back-up officers come on an emergency basis with lights flashing and sirens sounding).

In light of the event as described by others, it is hard not to find some exaggeration in Deputy B's statement that Evans "almost swung" at a deputy. The statement apparently refers to Evans's reaction when Deputy L earlier had touched Evans's arm and Evans had either shrugged his shoulders or threw his hands up. Neither Deputy L nor any other Deputy witness claimed that Evans swung at Deputy L, and Deputy B does not say so in her written memorandum to the Homicide investigator. In any event, "almost swung" is markedly different from "swung" and seems to be a make-weight characterization.

As strange as it may seem given the importance of Deputy B's observations and recommendations on the Keep Away card, it does not appear that investigators ever interviewed Deputy B in person or asked her to explain her decision to fill out the card. She was never asked to reconcile her account of Evans's conduct with the accounts of other deputies who said that Evans was not a problem. Nor did Homicide or Internal Affairs question why she decided to fill out a Keep Away card when it had not occurred to any of the other deputies who dealt more directly with Evans to do so. It is important to note both the inaccuracy regarding the Code 3 and the relatively sparse justification for the Keep Away card. The Keep Away card

will have a profound impact on how others perceived and later dealt with Evans.

Later in the Afternoon. Later, Deputy A placed a waist chain and handcuffs on Evans, who behaved calmly during this procedure. He then began walking with other inmates to the bus destined for Twin Towers. Deputy B saw that Mr. Evans was acting strangely and bent over at the waist. Deputy C also noticed and told Deputy B that she thought Evans was suffering from Multiple Sclerosis. Deputies A and L thought (correctly it turns out) that Evans had Cerebral Palsy. When Evans was about 20 feet from the bus, he stopped abruptly. Deputies C and M ordered him to keep moving, and Evans began repeating, "Don't touch me" and "I don't have a case." He spoke unintelligibly and then talked to Deputy M, who had responded to the scene, saying he would not get on the bus because the court did not have a case against him. At that point, Deputy Q walked over and asked Evans to get on the bus. He agreed and boarded the bus without further incident. There are no reports in the record indicating that Evans engaged in any disruptive behavior while he rode the bus to the Inmate Reception Center at Twin Towers.

B. Evans was erroneously ordered into restraints.

That evening.

7:35 pm. Evans arrived in downtown Los Angeles at the LA County Jail's Inmate Reception Center ("IRC.") Watch Sergeant H2 reviewed Deputy B's "Keep Away" card and classified Evans as "D" dangerous. [10]

It is at this point that the failure of the LA County jail to have computerized records about inmates began to have tragic consequences. Had the Watch Sergeant or anyone else who saw

10 The classification of Evans as "dangerous" appeared to be based solely on Deputy B's "Keep Away" card. If, as we believe, Deputy B's classification was not based on adequate or accurate evidence, the error is compounded by Watch Sergeant H2's classification of Evans as "dangerous." The Custody Division Manual states that the dangerous classification is appropriate for "inmates who have physically assaulted other inmates or who have resisted officers. May also be used for inmates who, for any reason, may become dangerous. The circumstances must be considered." No one interviewed the IRC employee who decided that Evans should be classified as dangerous. Moreover, the last sentence of the Custody Division policy is open-ended: It is hard to see how anyone's discretion is meaningfully bounded by a phrase like "inmates who for any reason may become dangerous." It could apply, in theory at least, to any person at any time. Clearly, the definition needs tightening so that the jailer must articulate a basis for the conclusion that someone has the potential to be dangerous.

Evans earlier had access to or had reviewed the Department's records on Evans's previous stays at the jail, such as his visits in 1998, they would have learned that Evans's peculiar affect (*e.g.*, hallucination, mumbling to himself, failing to respond to external stimuli) had never resulted in him trying to injure himself or others. Nor had he ever tried to escape. Although Evans occasionally backtalked some of the people he encountered, Evans had otherwise behaved himself.

Moreover, and more crucially, the LASD personnel who dealt with Evans during this arrest and incarceration would have known from the very beginning that medical personnel in the LASD had previously diagnosed Evans during his prior incarcerations as having Spastic Cerebral Palsy, which produces extraordinary body rigidity (spasticity) and abnormally tight muscle tone (hypertonia). For example, in August 1998, the LASD noted in its records that it knew at that time that Evans's condition was so severe that he had once undergone surgery to release his hamstring muscles, which had locked up on him. This previously-acquired information would have gone a long way toward explaining why Evans had, on October 21, 1999, behaved so "bizarrely" by bending deeply at the waist while in court and later when he stood in the bus line. There is every reason to believe that Evans had done so at least in part because he was suffering from severe muscle tension. Had his previous history of compliance and his medical condition been known, noted, and taken into account when Evans was classified at IRC, he likely would not have been classified as dangerous. His odd behavior and bizarre manner would have been clearly linked to his mental and physical diseases, and the behavior which Deputy B, had misinterpreted as aggressive or dangerous would have been more accurately evaluated in light of his disabilities.

7:35 - 9 pm. There is no record that Mr. Evans caused any problems or was disruptive.

9:00 pm. Mr. Evans was questioned as his name was entered into the IRC database. The interviewer noted that Evans knew that he was in jail but did not know when or where he was first incarcerated. Mr. Evans denied mental illness and said that the interviewer was "asking dumb questions." Evans denied substance abuse or being on medication. The interviewer

noted that Evans appeared to be responding to internal stimuli and requested that he be moved to the "psych line" at IRC for evaluation by medical staff and either a psychologist or psychiatrist. [11]

9:12 pm. A physician, Dr. S, examined Evans and diagnosed him as a 33 year-old with Cerebral Palsy. He jotted down on the medical chart that Mr. Evans was "Withdrawn with inappropriate responses. Tottering gait. IMPRESSION: Chronic Cerebral Palsy." He ordered tests to rule out drug-induced psychosis. He also sent Evans to the Psych. line. And finally, Dr. S. ordered that Mr. Evans be placed in 3- point restraints. He did not state any basis for the order.

Again, it is tragic that prior medical and custody records about Mr. Evans were not available on-line. It would have been easy to see that Mr. Evans indeed had Cerebral Palsy, indeed had been mentally ill, but had never needed to be put in restraints and otherwise generally behaved himself during prior stays in the jail. It is puzzling why Dr. S's suspicion of Cerebral Palsy was not passed on to the custody staff that evening so that they knew, prior to dealing further with Mr. Evans, that he was disabled with the disease. As will be seen later, the officer's failure to ascribe his stiffness and rigidity were due to Cerebral Palsy may have led them to mistakenly conclude that he was resisting them or under the influence of powerful narcotics, such as PCP. [12]

Dr. S. was never interviewed by the LASD or questioned about the restraint order. If, as we suspect, the order was given because of the classifications made by Deputy B and Watch Sergeant H2, then Dr. S. compounded the prior errors by ordering restraints without having

11 The LASD claims that an inmate's medical records are, or will soon be, available through the Jail Hospital Information System (JHIS). We have not seen rules mandating that such records, if they in fact exist, be available and consulted during classification at IRC.

12 In her conversation with us, Sergeant H was clearly troubled that no one had bothered to inform the Restraint Team that Mr. Evans had Cerebral Palsy. She quickly realized the implications of the disease and said that had she known of his condition, she would have sought guidance from a lieutenant or other senior officer before proceeding. She pointed out that medical staff does not routinely share information about inmates that would impact how the inmate is handled. "They never tell you anything about the patients you have to strap. All you hear is, 'Lookout, this guy's nuts.'" Indeed, she suggested that medical staff affirmatively tries to keep custody staff away from medical records and charts.

independently established that the legal criteria for restraints had been met.

If Dr. S had done so, he might have decided to attempt less restrictive measures, inasmuch as there was no apparent reason to conclude that they would not have sufficed. It is important to note that the law mandates less restrictive alternatives. 15 C.C.R. §1058. The law permits the restraint of an individual *only* in narrow circumstances, and then only when less restrictive means of control would not be effective. The administrative convenience and efficiency of restraints are not lawful grounds for placing an inmate in leather restraints.

Custody officials have many options available to them when it appears that an inmate poses a danger of injury. One option is a Safety Cell (15 C.C.R. § 1055), a padded area in which the inmate can be secluded from others and prevented from using objects or hard surfaces to injure himself. [13] An array of additional alternatives was quickly put forward by the experts we consulted, ranging from simple counseling to leaving Mr. Evans in the wheelchair and putting him in a room where he could be observed and monitored.

9:35 - 10:59 pm. Mr. Evans spent this time sitting on a bench at the IRC nurses' station without incident.

C. There was no Apparent Basis for Upping the Restraint Order to Four-Points.

11:00 pm. Nurse A arrived for his shift and noticed Evans sitting on the bench next to the nurse's station mumbling unintelligibly to himself. IRC Nurse Cr telephoned on-call Psychiatrist Dr. M. at his home. The doctor ordered "4-point restraints for threatening behavior" and a psych evaluation in the morning. [14]

11:20 pm. Evans was still sitting on the bench. Nurse A wrote on Mr. Evans's medical chart that Evans was "actively hallucinating. Bizarre behavior noted." Nurse A did not try

13 Tellingly, there are no safety cells at MSB. By failing to have alternatives like safety cells available, the LASD has thoughtlessly, if not negligently, restricted the availability of reasonable, less force-intensive options.

14 Neither Dr. M. nor Nurse Cr was ever interviewed by the LASD. Dr. M did, however, participate in the death review. Even so, there is no explanation given for the conclusion concerning "threatening behavior." There is no basis given for upping the restraints from three to four points. Dr. M. never saw Mr. Evans and there

to describe the "bizarre behavior" he said he observed. Nor did he write that Evans was disruptive or combative.

11:21 pm to 12:20 am on October 22, 1999. Evans spent this hour sitting on the bench near the nurses's station without incident. [15]

D. The LASD's Manner of Restraining Evans Led to his Death.

October 22, 1999.

12:25 am. Beginning at approximately 12:25 am, Evans was transported in a wheelchair from IRC to the third floor of the nearby Medical Services Building (MSB). He was accompanied by four IRC officers and two nurses. At this point, videotape coverage began. Senior Deputy B2 pushed Evans's wheelchair across the parking lot separating IRC and MSB. Evans was quiet and motionless. No one else was close to the wheelchair.

Shortly thereafter, B2 wheeled Evans into the elevator for a short trip to the third floor of MSB. The camera pulled in for a close up of Evans, who was calm, quiet, and unemotional; seemingly inattentive. His eyes were downcast. He occasionally looked at a plastic-wrapped sandwich in his hand. [16] His right wrist was handcuffed to a waistchain. His left arm was unrestrained and rested across his legs. Neither B2 nor any others in the escort team spoke to Evans.

is no evidence that immediate authorization for restraints was necessary due to an emergency situation. Dr. M. apparently did not ask, or was not informed, that Evans had been sitting calmly for nearly 1 ½ hours and had been acting calmly since his arrival at IRC approximately four hours previously. Nor, apparently, did Dr. M. attempt to consult records about prior times Mr. Evans was incarcerated at the LA County Jail. He would have learned that although Mr. Evans was equally mentally ill on those occasions, there never was need for restraints and that he behaved reasonably.

15 At this point, Evans had been at IRC for five hours. No one had noted that he acted disruptive, combative, dangerous, or violent. Indeed, at no time since his arrest had he acted in a dangerous manner. It is critical, therefore, that to this point *he has never been directly observed by any qualified medical personnel to be dangerous and no medical personnel had any stated factual basis whatsoever for ordering restraints.*

There should clearly be a rule that a restraint order has to be reviewed and renewed by a mental health professional if more than an hour elapses between the giving of the order and the actual placement in restraints. The inmate may very well have calmed down, thereby eliminating any reason for restraints. Apparently, sending calm inmates to be restrained is not an infrequent occurrence. We were told by a restraint team member, "They've sent us calm people to put in points [before]. I wonder, 'What are we doing this for?' But we just do what we are told."

16 We were informed that it was contrary to policy to permit Evans to leave IRC with a sandwich. Everything is supposed to be taken away from the inmate prior to being transported to MSB.

Approximately 12:32 am. B2 wheeled Evans out of the elevator and down the hallway behind two nurses, neither of whom turned to observe Evans. Evans was wheeled easily down the hallway to Room 23 to be restrained. The MSB restraint team awaited him. There were four deputies: Deputies O, G, W, and C2. Room 23 is approximately nine feet wide by 13 feet deep. Next to its glass door is a safety glass window measuring roughly three feet by three feet. As Evans neared the doorway, the camera showed Deputy G holding a set of thick leather straps.

12:27 - 12:34 am. *[During this time period, we will measure time by the videotape counter and will indicate elapsed time in brackets]* Evans was able to see that he was to be strapped down. As the wheelchair was backed into Room 23, various officers discussed among themselves whether the order was for three-point or four-point restraints. [1:48] Evans remained quiet. Deputy G placed his right hand on Evans's left arm and asked, "Are you all right? Can you stand up? We need you to stand up." [1:58] Evans shied away from Deputy G and moved the sandwich away from him. Deputy G then placed both hands on Evans's left arm and began to raise him from the wheelchair. Evans mumbled words that sound like, "Why you gotta' tie me up for, man?" Deputy G did not answer the question but stated, "We need you to stand up." [2:01]. At this point, Deputy C2, who stood directly behind Evans, pushed Evans up out of his seat. Evans pitched forward slightly and regained his balance. He hunched slightly forward, but otherwise did not react. [2:02].

Deputies G, C2, and W gently walked Evans backwards and pushed him down on the bed. [2:13] Deputy W slowly grabbed Evans's shirt and he and Deputy C2 gently slid Evans up toward the head of the bed. [2:16] Evans did not react except to look behind himself so that his head did not hit the frame at the top of the bed. He then put his head flat on the mattress. [2:19] Officer W maintained a firm grip on Evans's left wrist. Evans did not attempt to pull away. He focused his attention on the sandwich in his left hand. [2:20] Deputy O grasped Evans's right ankle and began reaching for the first leather strap. Deputy

G lightly gripped Evans's right shoulder. Evans did not resist or otherwise respond to any of these actions. Deputy C2 moved from the head of the bed toward the foot to hold onto Evans's left foot. Just as Deputy C2 was about to complete his move, Deputy G reached over and, without speaking to or looking at Evans, snatched the sandwich out of Evans's left hand. [2:22].

Evans responded by jerking his arms and legs and kicking his left leg rightward, narrowly missing Deputy O's head with his slippered foot. [2:23] Deputy W maintained his firm grip on Evans's left wrist, and C2 raced around W to prevent Evans from trying to kick O. [2:24] C2 grasped Evans's left leg in both arms. He then climbed on the bed, landing his right knee on Evans's upper thigh or groin as he tried to pin Evans's left leg to the bed. O gripped Evans's right ankle with her left hand, while her right hand continued holding the leather straps. She and C2 pinned Evans's left leg to the bed. Deputy G pushed Evans's right arm, still handcuffed to the waistchain, down to the bed. [2:26-2:28]

Almost simultaneously, other officers entered the room. [2:26-2:27] The first three officers to assist were members of the IRC Escort Team: Sergeant E, Senior Deputy B2, and Deputy S. None of them seemed particularly familiar or experienced with restraint techniques.

For the next few moments, there was confusion. Restraint Team Sergeant H was not yet in the room because she was donning latex gloves. No one coordinated the use of force. Instead, the officers improvised. B2 moved left to help O restrain Evans's right leg. Sergeant E and Deputy S remained in the right foreground, focusing on Evans's left leg. Deputy G remained on the upper left side of the bed (Evans's upper right) and appeared to be pushing with both hands on Evans's head, neck, or right shoulder. C2 remained straddled across Evans's upper legs and pushed down on the center of Evans's chest with both arms. (He later told Homicide he had been pushing on Evans's diaphragm area.) W remained on the upper right side of the bed (Evans's upper left) and appeared to be using both hands to hold down Evans's left arm. [2:28-2:29]

A few seconds later, MSB Senior Deputy C3 entered the room and positioned himself on the right side of the bed (Evans's left) to pin down Evans's right arm and hand. [2:29-2:31] Shortly after C3 entered, either C2 or C3 calmly but firmly commanded, "Relax. Relax." [2:33] Another officer ordered, "Let's get those legs strapped first." [2:35]

The camera then slowly moved to the left to reveal the positions the officers had taken. C2 remained kneeling on Evans's thighs, leaning heavily on Evans's chest. W remained on the right side of the bed (Evans's left), bent over Evans's shoulder area. G remained on the left side of the bed near Evans's head. W put his left knee on the bed, possibly on top of Evans's left upper arm or chest. [2:27] Next, W changed legs, and slipped or hopped to place his right knee onto Evans. The point of contact is obscured, but W's knee landed in the vicinity of Evans's head, neck, and shoulder. [2:39]

After this maneuver, Evans seemed momentarily subdued and was completely pinned down by the four Restraint Team Deputies. W knelt in the area of Evans's face, neck, and left shoulder; the exact point of contact remaining obscured. W shifted his weight to press his knee down more firmly on Evans. [2:54] C2 remained on top of Evans, leaning heavily on his chest; his right leg has pinned down Evans's left leg. O, partially off-camera, pinned down Evans's right leg. G remained on the upper left side of the bed, pressing down on Evans's upper right arm or shoulder.

Evans, however, continued to wriggle his torso and legs, prompting the commands, "Relax, relax," from one of the officers. [2:54] Other officers reentered the room to provide assistance. W next pulled Evans's body toward himself, thereby increasing pressure from his knee down further in Evans's face-neck-shoulder area. [2:56] W's knee may have at least partially obstructed Evans's airway, because the maneuver caused Evans to gasp and grunt several times. At least one of the gasps clearly sounded like a strained effort to inhale. [2:57-3:02] S took hold of Evans's upper left arm, but Evans continued to struggle. He shook himself and let out a loud grunt. [3:08] A male officer said, "Relax." [2:57-2:58] Evans grunted again and said, "Get off." C2 then brought his left knee toward Evans's upper left

thigh or groin. [3:12]

Next, Deputy W moved off the bed and stood bent over by Evans's left shoulder. C2's right knee remained on Evans's upper right thigh or groin. [3:23-3:27] W then slowly lowered his left knee on the upper right side of the bed (Evans's upper left). The point of contact is obscured, but W's knee was clearly in the area of Evans's upper chest, shoulder, and neck. Almost simultaneously, Evans made a loud hacking or gurgling noise. [3:38] An officer responded, "Calm down. Stop fighting." C2 returned his left knee to Evans's lower right thigh. [3:41-3:43]

The camera then pulled back, lost focus briefly, and then displayed the entire room. [3:48] Deputy G remained positioned on the upper left side of the bed (Evans's upper right) with both hands firmly pressing down on Evans's head-neck-shoulder area. Directly opposite was W, his head almost touching G's. W appeared to be applying the same maneuver to the opposite side of Evans's body. [3:50] In the right foreground, to W's left, Senior B2 held Evans's left leg. Sergeant H was also in the foreground, to B2's left. She also attended to Evans's left leg. [3:52] C2 maintained his position on top of Evans and continued to lean on Evans's chest. C2's position appeared to prevent H from seeing Evans's head. [3:53] To H's left, evidently holding Evans's right leg down, was Sergeant E. Kneeling to his left was Deputy O, fastening the first leather strap to Evans's right ankle. Above her, and behind Deputy G, is Deputy S, who appeared to be pinning Evans's right arm down. G remained by Evans's upper torso and head. [3:53-3:56]

Deputy O next fully secured the first strap and moved to the right to work on Evans's left leg. Evans had become sufficiently calm to allow C2 to take both of his hands off Evans's chest and toss a leather strap to the floor. At the same time, Sergeant E released Evans's right leg, which was now strapped into place. Deputy O knelt down to work on Evans's left leg. After a moment, W released Evans and walked around the head of the bed to the left side (Evans's right). [4:08-4:14] Evans appeared to be completely under control; there was no

sign of struggle.

Over 10 seconds passed as O worked on Evans's left ankle. Evans then made more throaty, gasping sounds. [4:26-4:30] At this point, B2 and C3 leaned back from Evans's left side, affording a brief glimpse of G's hands. G's left hand appeared to push Evans's face to the left. His right hand appeared firmly pressed against Evans's throat. [4:28] As G maintained this hold on Evans's throat, Evans lets out his loudest gasp yet; sounding as if Evans's airway was partially constricted. [4:29-4:30]

Sergeant H interpreted Evans's throaty sounds to mean that Evans was preparing to spit. She asked if any of the deputies had a spit bag. [4:30] Deputy G replied, "Probably just get us a sheet." [4:34] H responded, "A sheet? Nurse, could you get us a sheet?" C2 pulled a spit bag out of his right rear pocket and handed it to G and W. [4:36-4:37] H then told the off-camera nurse to "Forget it." [4:45] [17] By the time, C2 had handed the spit bag to G. Evans had become quiet. Deputy C2 briefly took one hand off Evans's chest so that he could wipe his own face. Deputy G's left hand held the top portion of the spit bag firmly over Evans's forehead. Deputy G's right hand pressed the bottom of the mesh bag over Evans's throat. Deputy G appeared to be exerting some pressure to Evans's throat. At the same time, Deputy W's right hand also held the bottom of the spit bag in place. His hand was either on Evans's chin or the uppermost portion of his throat. Deputy W appeared to apply less pressure than G. Sergeant H appeared to be in a position to see Deputies G and W but did not comment on the pressure being applied to Evans's throat. [4:47-4:48]

Deputy C2 then shifted his weight and pressed harder on the lower center of Evans's chest, near his solar plexus or diaphragm. [4:50] Deputy O finished securing Evans's left leg [5:10] and moved to the head of the bed, where she retrieved a leather strap from the floor and began working on Evans's left arm. At the same time, H moved to the left foot of the bed (by Evans's

17 We asked Sergeant H if a nurse was actually present or in the area when she had called out for the sheet. Sergeant H said no, but that the nurses's room was nearby and within shouting distance. Sergeant H was critical of the nursing staff and their reluctance to attend, much less attempt to oversee, the placing of inmates in restraints.

right foot). A male officer told someone to start working on "this hand here." Sergeant H added, "One hand at a time." [5:12-5:20]

Although at this point Evans's left ankle was strapped to the bed, and his left leg pinned to the mattress by Deputy C3's right leg, Sergeant H returned to Evans's left ankle and held on to it with both hands. Rather than move to Evans's head to check on his condition, Sergeant H fixed her gaze on the officers' efforts to strap down Evans's left wrist. She remained in this position for nearly 40 seconds. [5:28-6:05]

Evans resisted C3's and B2's efforts to slide his left arm into position for Deputy O. [5:20-5:23] The officers nonetheless quickly moved the arm into place and Deputy O, now kneeling, began to strap Evans's left wrist down. Deputy G is visible as well, continuing to hold the spit bag down with noticeable pressure.

The officers next briefly discussed which of Evans's arms was to be strapped by Evans's waist. They decided that because Evans's left arm was already pinned down by his waist, the right arm would be secured in a higher position. [5:47] Evans remained under control. Deputy G removed his left hand from Evans's head to check his wristwatch briefly. [5:47] C3 then asked the officers to slide Evans's body a few inches toward the head of the bed. The officers accomplished this with no visible resistance from Evans. [6:04] After roughly 15 seconds, Deputy O fully secured Evans's left wrist. [6:20] At this point, Evans's two legs and left arm were fully secured by leather restraints. Evans's right arm remained handcuffed to his waist chain. Evans did not attempt to move his legs or left arm. His head and right arm were at this point obscured from view by Deputy C2, who continued kneeling on top of Evans's legs with both hands pressing against Evans's chest. O and W walked around the head of the bed to work on Evans's right arm. Senior Deputy C3 can be heard saying to someone, "Nah, he's fine. He's not getting out of there." [6:23]

The camera then panned to the middle of the room. [6:26] Deputy C2 continued to lean heavily on Evans's chest. C3 stood on the right (Evans's left) and appeared to be holding Evans's left hand or fingers in a compliance hold. Evans showed no reaction to this hold,

which was probably painful. [6:27] Evans's fingers appeared to be completely still for the next several minutes. Deputy G remained in the same position, firmly pressing the spit bag over Evans's face. Deputy S, on G's left, firmly holds Evans's right arm down.

Deputy O then moved over to Evans's right shoulder. [6:27-6:33] Deputy G moved over to the right side of the bed (Evans's left) while maintaining his hold on Evans, pressing down firmly with both hands. Although Evans did not appear to be struggling, G slowly raised his left leg and planted his left knee near Evans's head or throat. (He would later tell Homicide investigators that he had planted his shin on Evans's cheek.) [6:33] No one commented on G's maneuver. Evans did not appear to react to G's knee.

At this point, Sergeant H was positioned at the left foot of the bed, by Evans's secured right ankle. She was not standing in a place where it was possible to check on Evans's condition and did not comment on Deputy G's knee placement. [6:35] [18]

Next, Senior Deputy C3 asked which officer had a handcuff key so he could uncuff Evans's right hand from the waist chain. C2 raised his right hand from Evans's chest to reach into his right breast pocket. C2 then returned his hand to Evans's chest. Evans remained quiet and motionless. [6:38]

C3 then asked B2, who had moved over to Evans's right foot, to "bust these [the waistchains] out." [6:42] Deputy W responded by walking past the head of the bed (and past the kneeling G) to where C3 was positioned. [6:45] Deputy W attempted to unlock the waist chains. This effort failed, and he returned to the left side of the bed (Evans's right), between Deputies S and O. [6:46-7:22] During this time, Evans remained silent and apparently motionless.

The officers then engaged in some banter to relieve stress [6:58-7:07] which was interrupted by another throaty sound from Evans. [7:09] Sergeant H responded by moving

18 As we noted before, Sergeant H permitted herself to become too involved in the restraint procedure itself. Her instincts, however, were correct: She said that if she had seen a deputy's knee on anyone's face, "Hell yes, I would have told him to remove it."

along the left side of the bed (Evans's right) up to Evans's head, where she was in a position to see where G's knee was located. (This marked the first time since the struggle began that Sergeant H appeared to check on Evans's condition.) [7:14] B2, on the right side of the bed (Evans's left) likewise moved up to G's head to take a look. He moved calmly and slowly, his hands in his front pants pockets. [7:25] Neither H nor B2 said anything, although they appeared to be intently studying Evans's face. Meanwhile, the deputies were having a difficult time figuring out how to remove Evans's waistchain. Although Evans appeared to have stopped moving, Deputy C2 remained on top of him, pressing down on his chest. Evans then moved slightly, causing the officer to press down harder. A male officer told Evans, "Relax." [7:43] [19]

B2 next slowly bent down by Evans's head, appearing to place one or both hands near the top of Evans's head. To his left was G, who continued to kneel on Evans's face or throat. They remained in this position for several seconds. Evans was not moving or making a sound. [7:45-7:50] At this point, there was a long silence as H studied Evans's face. [7:52-8:06] C3 broke the silence by asking B2 if he had gloves on yet. [8:07]

The camera now clearly showed C2's knees resting on Evans's thighs with C2 continuing to press down on Evans's chest. [8:07] Two barely audible sighs escaped from Evans. [8:15-8:17] C3 asked an unidentified officer to start on Evans's waistchain. [8:20] Efforts to this end continued on the left side of the bed, where Deputies S, W, and O were standing. Evans grunted again but did not move. [8:28] For the next several moments, the deputies figured out how to remove Evans's waistchain. C2, still atop Evans, assisted with his right hand, his left hand continuing to press down on the center of Evans's chest. [8:29-8:58] He then returned his right hand to Evans's chest. [8:59] Senior Deputy B2 then disengaged from Evans's head and moved toward the foot of the bed, past C3, who maintained a firm

19 Sergeant H noted that there are no rules about when it is improper to straddle an inmate: "Sometimes you have to get on top of them just to keep them under control. Rules? Just common sense. I don't want to see [the Restraint Team deputies] get their knees on a guy's neck, but you know there's nothing written on it."

compliance hold on Evans's left hand. [8:52] Evans's fingers had remained motionless for several minutes. The officers then were able to remove the waistchain. [8:54] Evans's right hand had been secured sometime earlier, off camera.

Thus, Evans was at this point held down by four-point restraints. Nonetheless, G remained kneeling on Evans's face or neck. Sergeant H bent down, perhaps to examine Evans's face through the mesh of the spit bag. [8:57] She said nothing to G about the placement of his knee. C2 remained on top of Evans, pushing down on his chest. H did not remark about this either.

Senior Deputy C3 then calmly ordered, "Everyone except G and C2, out." [8:59] G's knee came off Evans face-neck area briefly, returned, and then came off again. [9:02-9:05] Sergeant H also left the room at this point. [9:07-9:11] Next, C3 ordered, "C2, out." [9:11] C2 hopped off Evans's body, landing both feet on the floor. To do so, C2 had to briefly place his full body weight on Evans's chest. [9:12-9:13] The maneuver drew no comment from C3 or G, the only two officers remaining. Deputy C2 later told Homicide investigators that when he climbed off of Evans, he noticed that Evans had urinated on himself.

C3 continued to maintain his compliance hold on Evans's fingers, and G continued pressing the spit bag over Evans's face. [9:14-9:17] As G released his grip, the camera showed that most of Evans's head appeared to be covered with a sheet. (The camera had not captured when or how the sheet came to be placed over Evans's head.) G then spent over 20 seconds reaching under the sheet, apparently so that he could remove Evans's spit bag. [9:19-9:41] Eventually, C3 had to assist G in this effort, and it appeared as if it was difficult to remove the spitbag, possibly because the sheet covering Evans's face, which in turn was covered by the spitbag, was tight and difficult to maneuver under. [9:39-9:41] Sergeant H suggested that another reason it took so much time was that the spitbag's rear handling snaps may have become knotted or tangled. C3 tossed the spit bag and G returned the sheet over Evans's head, obscuring Evans's face from view. (Sergeant H later told Homicide that she subsequently had to remove the sheet from Evans's face in order to check on his condition.) [9:42] Deputy G

then placed his hands on each side of Evans's throat, evidently checking for a carotid pulse. At the same time, C3 extended his right hand to the left side of left of Evans's throat, also as if to check for a pulse. [9:44] At this point, G and C3 were alone with Evans. Evans, now in plain, unobstructed view of the camera, was quiet and motionless.

A female voice near the door to Room 23 and close to the camera was then heard to say something like, "Unh." [9:46] It is unclear what prompted this sound, or what it denoted. The exclamation was immediately followed by H's order, "Somebody want to get a nurse in here?" [9:48] Roughly a second later, a female voice quietly exclaimed, "Wow." H turned away from Evans's room to face the officers in the hallway. She ordered in a calm, but commanding tone, "Kill the video. Kill the video." [9:52] [20] The video footage almost immediately stopped [9:54]. The tape stops at approximately 12:34 am.

Sergeant H's order to turn off the video camera was not intended to do so, but it nonetheless substantially impeded the LASD's investigation of what happened in the critical minutes after Evans had been restrained. Ordering the camera off proved particularly unfortunate because the witness accounts of those first crucial minutes vary dramatically, at least two witnesses were later proven to have lied about their actions, and others also appear to have fabricated at least some portion of their testimony. We will therefore set forth next what we believe to be the most likely sequence of events.

E. There was a Failure to Attempt Timely Resuscitation.

Approximately 12:34 am. Sometime after giving the order to "kill the video," Sergeant H went back into Evans's room. H told Homicide investigators that she removed the sheet from Evans's head and saw that Evans's eyes were staring straight ahead. She said she checked his

20 Some persons hearing the "kill the video" comment suggested that Sergeant H at that point knew Mr. Evans was dead and wanted to stop the cameras. Even before we interviewed her, we were convinced that was not the case. She was following then-standard procedure both by shutting off the camera and calling a nurse to check on the inmate. The standard procedures needed to be changed. Less than 24 hours after Evans's death, the LASD modified its policy to require that the camera should stay on at least until medical personnel have confirmed that the inmate is in stable condition. And, as stated before, medical personnel should be in attendance during the entire restraint procedure.

carotid and could not detect a pulse, although she also claimed at another point that Evans's neck was still warm and his chest was moving up and down. Finding no pulse, H claimed she called for Nurses C and D to examine Evans, because "he did not look good." In her interview with us, Sergeant H again emphasized how the fixed, blank stare caused her to realize that Mr. Evans was in trouble.

At about 12:30 am., while the restraints were being applied, the supervisor on duty, Nurse C, telephoned the only MSB physician on duty, Dr. M2. Nurse C told Dr. M2 that Evans was highly agitated and requested authority to give him a sedative. Dr. M2 authorized her to administer two milligrams of Ativan every six hours. Nurse C then asked Nurse D to accompany her to Room 23 and give the shot to Evans.

Approximately 12:35 am. By the time they arrived, Evans had already been restrained and the room was empty. Without checking Evans's condition, Nurse D administered the shot of Ativan. We know that by this point Evans's heart had already stopped beating, because the Medical Examiner found no detectable traces of Ativan in Evans's bloodstream.
D noticed that Evans did not flinch when he received the shot. She then shook him and found no response. Seeing that his eyes were open, Nurse D exited the room and asked for a flashlight.

Approximately 12:36-12:40 am. Seeing that Evans made no response to the flashlight to his eyes, she exclaimed, "My God, his pupils are dilated." D then left the room to find a blood pressure cuff. She returned with the cuff, checked Evans's blood pressure, and found no reading. Deputies G, W, and C2 asked Nurse D if she wanted them to contact paramedics. Nurse D ignored them.

Approximately 12:41 am. Dr. M2 was called to render assistance.

Approximately 12:42 am. At Deputy C3's request, Twin Towers Control called the paramedics. Why the paramedics had to be called is also somewhat of a mystery: One would expect that all personnel in MSB, both custody and medical personnel alike, would be trained in CPR.

Approximately 12:45 am. Dr. M2 arrived and, seeing that no one was performing CPR, he began chest compressions and asked Nurse C to call Dr. Hill, who, unlike Dr. M2, had Emergency Room experience.

Crucial moments were thereby lost in which it might have been possible to save Mr. Evans's life. Even more disturbing, however, is that CPR was not performed in the critical minutes that followed discovery that Mr. Evans was not responding. The record is in conflict about what happened, and the LASD's internal investigation did not clear it up. It appears likely that the crash cart with the CPR equipment was not fully stocked when brought to Evans's room. There is a suggestion in the record that the personnel present were reluctant to perform CPR on Evans because the crash cart was missing a mouthpiece. [21] Regardless of whether the personnel had a legitimate reason not to perform mouth-to-mouth resuscitation, there is no reason why chest compressions were not commenced, and the American Heart Association has noted that chest compressions, even without mouth-to-mouth, saves lives. It is undisputed (and we re-confirmed the fact with the LASD) that none of the sworn personnel present performed CPR.

Approximately 12:50 am. Dr. Hill arrived from IRC. The paramedics arrived nearly simultaneously and commenced CPR.

12:55 am. Evans was pronounced dead.

III THE INVESTIGATION OF EVANS'S DEATH WAS SERIOUSLY FLAWED.

We found the investigation by the LASD's Homicide and Internal Affairs Bureaus deficient in many respects. First, investigators failed to interview many witnesses who had dealt with Evans from the time he was arrested until the time he was pronounced dead.

21 Deputy W told Homicide, "I don't understand why, why they [the nurses] didn't start [CPR] earlier, why the nurses didn't start earlier, I know when they wheeled the crash cart out they were not prepared, they didn't have a breathing mask with the little apparatus, the breathing apparatus for CPR . . .and so I, I waited, I didn't want to . . . endanger myself so we're waiting for the mask and still nothing was there, the crash cart wasn't prepared, I saw the nurses come in and their saying, 'Oh, we need saline,' 'Oh we don't have saline on this crash cart, ' just the crash cart was a complete mess . . . " Transcript at 10:17-28.

A. Failure to Interview.

Homicide and Internal Affairs failed to interview:

- Three of the four deputies who had first encountered Evans the evening of October 20, when he was spotted with the stolen shopping cart; [22]
- The station jailer who made the initial assessment of Evans's behavior in custody;
- The station watch sergeant who had approved the arresting officer's and jailer's assessment of Evans at the time of booking;
- Any of the prisoners housed with Evans in the station jail cell;
- Deputy S2, who had witnessed a verbal outburst from Evans as prisoners were being called out of their cells for court;
- Any of the prisoners housed with Evans in the courthouse holding cell, particularly those who had complained about Evans's behavior;
- The judge who had witnessed Evans's courtroom behavior and ordered transported to Twin Towers;
- Any of the prisoners who accompanied Evans on the trip from the courthouse to Twin Towers;
- Deputy B, the courthouse officer who had written up a "Keep Away" card warning IRC to isolate Evans from others;
- The IRC Sergeant who decided upon the basis of Deputy B's "Keep Away" card, to classify Evans as a "dangerous" inmate;
- The individual(s) in IRC who first conducted a mental screening of Evans at 9:00 p.m. the evening of October 21;
- Dr. S, who first examined Evans and recommended that he be placed in three-point restraints;
- The social worker who had briefly interviewed Evans within hours of his death;

22 In addition, investigators failed to conduct a formal, tape-recorded interview of the fourth officer, Deputy Schell, who had arrested Evans and drove him to the station. Instead, one investigator merely telephoned this deputy and interviewed him "for several minutes."

- Two nurses involved in communicating the decision to restrain Evans to MSB;
- Nurse Cr, who telephoned the on-call psychiatrist, Dr. M, to report on Evans's behavior at 11:00 p.m.;
- Dr. M, who, upon receiving a call to his home from Nurse Cr, ordered that Evans's restraint be modified from three-point to four-point restraints;
- The unidentified male lab worker seen in the videotape to be peering into Room 23 after Evans had been restrained to the bed; and
- The individual paramedics who had arrived at the scene in order to assist in resuscitation efforts.

Perhaps more significantly, investigators neglected to interview Deputy B2, who pushed Evans's wheelchair over to the Medical Services Building and subsequently assisted the Restraint Team in subduing Evans. Deputy B2 was allowed to go home after the incident without providing a statement to anyone, and investigators did not call him back for an interview. This investigative failure was particularly troubling given that videotape of the incident plainly shows that Deputy B2 not only used force on Evans, but also actually bent over Evans's head at one point to check on his condition. In this respect, Deputy B2 was a key witness.

We discussed this issue with the Department on many occasions and received many conflicting stories. Initially we were told that investigators decided not to interview Deputy B2 because he was "too peripheral." Later, those same individuals told us that Internal Affairs had in fact interviewed Deputy B2. When we then asked for the interview tape, the Department admitted over a week later that no one had interviewed Deputy B2 after all. Still later, one of the key investigators told us that the investigative team had not interviewed Deputy B2 because he was assigned to the Inmate Reception Center and thus was not part of the group from the Medical Services Building that was under investigation. When we then pointed out that Homicide investigators had interviewed all of the other officers at the scene, including those assigned to IRC, the investigator offered a different explanation. He stated

that Deputy B2 was not a high priority witness because "[H]e was not one of the officers applying any significant force to Evans." But this excuse likewise failed to hold water because Homicide and Internal Affairs had interviewed other personnel who had witnessed the restraint but had never touched Evans. Finally, the investigator stated that "someone" was supposed to "get around" to interviewing Deputy B2, but evidently neglected to do so. As we stated earlier, the Department's failure to interview Deputy B2 was inexcusable.

B. Failure to Analyze.

Second, department investigators did not at all scrutinize any of the decisions that lead up to the actual restraint procedure. They did not question:

- whether Deputy B was accurate when she stated on Evans's "Keep Away" card that the arresting officer had requested a Code-3 backup (she was not);
- whether IRC had sufficient information to classify Evans as a "dangerous" inmate (it did not);
- whether Dr. S. had good cause to order Evans into three-point restraints (he did not);
- whether Dr. M had good cause to increase the order to four-point restraints without ever examining Evans (he did not); and
- whether, given that Evans had sat quietly at the IRC nurses's station for over an hour after Dr. M. had given his restraint order, it would have been appropriate to reassess the need for restraints (it was).

Instead, the investigators - many of whom are highly-regarded for leaving no stone unturned when it comes to investigating street crimes - never considered these critical issues or, worse, assumed that the decisions of the health care personnel were not subject to further scrutiny. For example, we were surprised to hear one investigator tell us matter-of-factly, "I mean, someone, a doctor or someone says that this guy needed to be in three-point or four-point restraints - you have to take that at face value."

C. Failure to use Available Evidence.

Third, although the videotape of the incident plainly showed three officers using highly

questionable force and restraint "techniques," Department investigators failed to use this evidence to their advantage when they interviewed the officers at the scene. For example, although the videotape clearly showed Deputy W thrusting his knee onto what appears to be Evans's throat, investigators did not ask Deputy W to account for this unusual maneuver. Indeed, investigators did not ask about this high-risk use of force in *any* of their interviews.

By failing to adequately utilize the videotaped evidence at their fingertips, Department investigators hamstrung their own ability to cross-examine the officers effectively. Accordingly, the Department never learned the answer to many critical questions such as:

- Why, when Sergeant H thought that Evans was going to spit, did she and other officers ask a nurse for a sheet instead of a spit mask, particularly when particularly when the Department has never authorized the use of sheets to restrain inmates?
- What did Deputy B2 see when he bent over to peer at Evans's face just as the last leather restraint was being strapped into place?
- Why did Deputies G and W press their hands firmly against Evans's throat? Did they learn this "technique" from the Department? [23]
- Why did Deputy C2 continue to press both hands firmly against Evans's diaphragm for several minutes *after* other officers had subdued Evans's arms and legs? Did he learn this "technique" from the Department?
- Why, after Evans had been fully restrained, did Deputy C2 press down heavily on Evans's chest one final time so that he could hop off the bed? Did the Department teach him this dismounting "technique" as well?
- Why did Deputy G, after placing a spit mask over Evans's face, later decide to place a sheet over Evans's face? Who told Deputy G that he could use a sheet in the first place?
- Why, given the fact that the spit mask was not torn or otherwise damaged, did Deputy

23 The answer appears to be that no special training was provided. As Sergeant H told us, "They don't provide us any special training about what to do whey they fight. You just rely upon your general training on how to take someone down . . . . You just take them down as best you can, with the minimal amount of force."

G remove it after Evans was fully restrained and then slide the sheet back over Evans's face? [24]

Instead, the investigators sailed quickly through their interviews, spending roughly 10 minutes to question each officer, including those who had used force on Evans. The following exchange illustrates the superficial nature of the questioning:

Investigator:	O.K. Did you see anyone punch this inmate?
Sergeant H:	No, absolutely not.
Investigator:	Did you see anyone kick this inmate?
Sergeant H:	Absolutely not.
nvestigator.	Did anyone do anything, uh, that was out of the ordinary as far as restraining is concerned?
Sergeant H:	At …. No.

A competent, inquisitive investigator would have used his knowledge of the videotape footage to ask more specific questions at this point:

- Did you see anyone kneeling on Evans?
- Did you see any force applied to his face, throat, or chest?
- If you did see such force, did you consider it to be "out of the ordinary?" Why or why not?
- Did you say anything to the officer(s) when you saw such force being applied? If so, what did the officer(s) say or do in response?

Given that these Homicide investigators surely knew enough to ask such obvious questions, we wonder whether they simply had already determined that since Evans had not been struck gratuitously or in anger, there was no need to conduct an in-depth thorough investigation. Indeed, having heard many other tape-recorded police interviews, we were left with the distinct impression that most, if not of all of the investigators were simply going through

24 Sergeant H acknowledged that she could not think of a reason, under these circumstances, why it would be appropriate to replace the spitbag with a sheet.

the motions.

D. Failure to Intensify or Re-Open Investigation.

Fourth, although the Coroner's office had reported that asphyxiation had played a role in Evans's death, this critical fact did not spur the Department to intensify or re-open its investigation. For example, when the Deputy Medical Examiner (DME) who had performed the autopsy told investigators that he did not know how Evans had been asphyxiated, investigators failed to take the next logical steps: (i) Sitting down with the DME and carefully reviewing the videotape with him, or (ii) conduct their own investigation of the videotape and witnesses to determine, as our medical consultants did, that Evans was asphyxiated because of the actions of sworn personnel.

E. Failure to Re-Interview Witnesses.

Fifth, the news that Evans had been asphyxiated should have prompted investigators to re-interview each of the officers present during the restraint procedure. Specifically, they should have sat down with each officer and gone through the videotape frame by frame. One of the investigators informed us that the investigative team did not even consider taking this step.

These investigative failures are particularly disturbing given that the videotape clearly showed (i) that Deputies G and W used force that likely caused Evans's throat trauma; (ii) that Deputies, G, W, and C2 used force and restraint "techniques" that likely cut off or restricted Evans's breathing; and (iii) that Evans was gasping for air when such force was applied.

IV. RECOMMENDATIONS FOR AVOIDING FUTURE EVANS CASES.

Our recommendations fall into two categories. The first includes steps that the LASD should take immediately to remedy the problems that led to Mr. Evans's death - the systemic failures at each stage of the proceedings. The second set of recommendations are steps the County should consider so that the tragic circumstances that led to Mr. Evans's death do not get triggered in the first place.

A. Recommendations for Reform of LASD procedures.

1. Immediately Implement the Recommendations we made in June 2000 in our Twelfth Semiannual Report.

Our semiannual reports have highlighted for many years the failings of the LASD in the provision of medical and mental health services. We have repeatedly made several recommendations. These recommendations have largely been ignored. We strongly recommend immediate implementation of them on a tight time schedule ordered by this Board. The most important of them are:

a. Immediate licensure as a Correctional Treatment Center for the Medical Services Building (MSB) at Twin Towers. Although preliminary steps in this direction have been taken, the process must be speeded up on a tight timetable.

b. Immediate independent Title 15 inspection and immediate response thereto to bring medical and mental health services into compliance, and implementation of adequate mechanisms for external monitoring and oversight to be in place. If the ACLU can no longer effectively monitor, replace that organization with another independent organization that can do so.

c. Seek immediate IMQ accreditation of all out-patient facilities in the Los Angeles County Jail system as the minimum jail health care services delivery standard.

d. Transfer the provision of emergency, inpatient and outpatient specialty visits to MSB under a contract with a university hospital, be it UCLA or USC.

e. Contract immediately with USC for the provision of services at IRC pursuant to a plan devised years ago by Chief Moorehead and Lieutenant Moak.

f. Contract out all or part of the remainder of medical and mental health services to USC or UCLA.

g. Immediately computerize all medical and jail records relating to inmates.

2. The LASD should revise its Station Jail Prisoner Classification Questionnaire and Overhaul its Procedures for Dealing with Mentally and Physically ill Individuals.

It should give specific guidance and direction to the jailer concerning how and why a particular individual should be classified. The categories of "passive and compliant," "aggressive demeanor," and "assaultive behavior" should be abolished. Instead, the questionnaire should ask whether any *specific* behavior has been observed by the arresting officer or the jailer that gives rise to a concern that the individual poses anything greater than a minimum security risk or poses any cognizable risk of danger to himself or others. If so, then the specific factual basis must be specified in detail and the individual housed and classified appropriately.

- If the basis for the specification, or the observed behavior, consists of possible mental illness, strange or odd behavior, or possible drug-induced psychosis, the arrestee must be evaluated within one hour by a medical professional on call or on site at each station. Such medical professional for these purposes shall include a psychiatrist, a psychologist, or any other licensed mental health practitioner certified as capable of recognizing and classifying mental disease. It may also include sworn personnel who are specially trained and certified by a psychiatrist as capable of recognizing and classifying mental disease. If the individual is determined to be suffering from mental impairment, whether organic or drug-induced, he or she shall be specially housed and handled with the goal of stabilizing the individual and protecting him from any risk of danger to himself or others until such time as the individual is released, arraigned, or transported to IRC. He shall be classified as "ill."

3. Any individual so classified as "ill", or any individual ordered by any court to be put in psychiatric observation, given a mental evaluation, or given medical attention of any kind, should be specially so classified and specially accompanied and given special expedited processing at IRC so that he or she is in the psych or medical line and actually sees a mental health or medical professional within no more than one hour of arrival at IRC.

For these purposes, a "medical professional" means an MD and a "mental health professional" means a psychiatrist or licensed psychologist certified as capable of recognizing and classifying mental disease. Each such inmate must be evaluated in person by the mental health professional.

4. The Inmate Special Handling Request (the "Keep Away" card) shall be revised to include a special handling classification of "ill." Such classification shall override any other classification and shall invoke the procedures specified in (2) above.

5. All inmates so classified shall be mandatorily assigned to a paid or volunteer independent patient advocate detailed to IRC to assist in the timely, efficient, and proper processing of mentally and physically ill inmates.

6. New policies regarding restraints should be adopted.[25] Our recommendations in that regard are:

a. The use of three- and four-point restraints is abolished for all purposes except emergencies involving unanticipated severely aggressive or destructive behavior posing an immediate

25 Our recommendations are influenced by, and, in some instances, the words or phrases or concepts are taken verbatim or in paraphrase from the following sources: Breggin, Peter, M.D., *Principles for the Elimination of Restraint*, prepared for the Joint Commission on Accreditation of Health Care Organizations (April 1999); Commonwealth of Massachusetts, Department of Correction, Health Services Division, 103 DOC 650, Regulations for Mental Health Services, (April 1999); Louisiana State University Health Services Center at Shreveport, Policies and Procedures re Restraints, Policy No. 5.15 (December, 2000); National Institute of Health (NIH) Clinical Center Nursing Department, SOP: *Management of the Patient in Restraints*, (January 2000).

threat to the physical safety of the inmate or others and only when alternative methods would clearly be ineffective or have failed. Under no circumstances shall restraints be used as a disciplinary measure or as a convenience for custody or medical staff.[26] Alternative measures should include "verbal de-escalation, communication using non-threatening body language and tone of voice, more frequent observation, environmental change" (including safety cells and quiet surroundings), orientation of the inmate to his or her surroundings and what is taking place, verbal calming techniques, and if, absolutely necessary, handcuffing or other low-level force options. [27] To avoid the use of restraints, to create a positive environment, and to maintain a high standard of ethics, all sworn and civilian personnel must aim at eliminating behavior towards inmates that is calculated to humiliate or encouraging disrespect. Breggin, supra.

b. **Any order for restraints must be preceded by a face-to-face face-to-face assessment of the patient by a mental health professional specifically trained in the use of restraints and alternatives thereto. Adequate medical and psychiatric personnel shall be present and available 24 hours a day, seven days a week.** The psychiatrist or physician may not order

26 The LASD uses restraints far too often. As one staff member from custody put it, "On weekends we can have 4 to 5 restraints a night. I mean its restraint-o-rama around here. You get tired struggling with these guys. . . . They've also sent the wrong guy to restrain. That's happened before, too." Regarding the practice of psychiatrists to prescribe restraints over the phone, the same individual noted, "They always do it over the phone. That's standard."

27 Quoted passage from Louisiana State University Hospital, supra.

restraints unless, after personally observing and examining the patient, he or she is clinically satisfied that: (i) the use of restraints is *immediately* necessary to prevent the patient from placing himself or others in *imminent* danger of unanticipated severely aggressive or destructive behavior, and (ii) all reasonable alternatives have failed or would clearly be ineffective. Furthermore, the mental health professional must specifically state in writing the factual basis for this conclusion.

c. An initial restraint order by any psychiatrist or physician should be valid only for one hour. If more than an hour has transpired before the order has been carried out to completion, a new face-to-face assessment as set forth in (b) above must be performed. Once the inmate is restrained, the restraint order shall be valid only for the next four hours. Any new restraint orders must be preceded by a new face-to-face assessment as set forth in (b). All inmates in restraints must be observed by medical personnel at 15 minute intervals or more frequently if medically advisable.

d. The placement of any individual in restraints shall occur only under the direct command and personal supervision of a physician. All sworn personnel performing restraint procedures shall be under the command of the physician for the duration of the restraint procedure. The physician shall monitor the physical condition of the inmate at all times. [28] Prior to leaving the presence of a restrained inmate, the physician must examine the

28 Sergeant H put it this common sense way, "What you need is medical personnel standing at the head of the bed to monitor from the diaphragm up. If they see something that might be a problem, they have to pipe up and get it under control."

inmate and affirm that he or she is in a stable condition. There shall be staffing by DMH mental health personnel at MSB 24 hours a day, seven days a week. [29]

e. All personnel performing a restraint procedure shall be specifically trained in best medical practice for accomplishing the restraint and must be certified as competent to perform restraint according to best medical practice by a psychiatrist or medical expert in such. Such training must include the ability to determine if the inmate is undergoing breathing difficulties or loss of consciousness. In this regard, staff shall be alert to issues of obesity, alcohol and drug use, or psychotic behavior. In no instance shall any personnel performing a restraint perform any maneuver or take any action whatsoever that risks asphyxiation. Even if an inmate struggles or resists or is combative, no person may apply pressure or weight to an inmate's face, throat, neck, chest, diaphragm, or abdomen.

7. The LASD's videotaping procedures should be revised to require:

a. Where feasible, videotaping of the face-to-face assessment by the psychiatrist or physician specifically trained in the use of restraints and alternatives thereto.

b. In all instances, the videotaping must begin immediately after the restraint order has been given and be on continuously until the inmate has been fully secured, evaluated by the physician, and

29 Custody staff who work in MSB spoke in the harshest terms about DMH's shortcomings. Noting the absence of mental health workers at MSB, one noted, "You won't find nobody from DMH here after 8 pm. That's been a problem for years." Another complaint dealt with the unwillingness of DMH personnel to pitch in: "See, there will be times when I got a guy who's threatening to kill himself - cut himself all up, what have you. And the DMH people tell me in this pissy ass voice, 'That's not my client,' and turn their back. So it's up to me to handle him - me and some young, young, deputies. . . . I'm telling you this has been going on for years."

declared to be medically stabilized.

c. In addition to a hand-held video camera, each room in which an inmate is restrained shall be equipped with an overhead camera providing an unobstructed view of the inmate at all times during the restraint procedure. The videotaping shall continue thereafter until the inmate is released from restraints and leaves the room.

8. CPR Training. All personnel working in any capacity in Custody, sworn or not, shall be specifically trained in CPR and shall be required immediately to perform CPR in all instances in which CPR is indicated. All personnel working in any capacity in Custody, sworn or not, shall be provided with a breathing mask or device that will permit mouth-to-mouth resuscitation to be performed safely. All personnel working in any capacity in Custody, sworn or not, shall be trained or re-trained within the next six months in control techniques with specific reference to avoiding positional or other asphyxia and the application of weight to an individual's face, throat, neck, chest, diaphragm, or abdomen.

B. Long Term Recommendations.

We believe that the long term solution is a diversion program that permits mentally-ill individuals detained by the police to be independently assessed as to their mental status and diverted from the criminal justice system into treatment if appropriate. The analogy is Drug Court. The County's current Mental Health Court is likely the place to start.

An article in the December 1999 edition of *Psychiatric Services* magazine succinctly describes a jail diversion program for the mentally-ill: [30]

> "Jail diversion generally refers to specific programs that screen detainees in contact with the criminal justice system for the presence of mental disorder; they employ mental health professionals to evaluate the detainees and negotiate with prosecutors, defense

30 Steadman, et al., *Psychiatric Services*, December 1999 Vol. 50 No. 12 p.1620.

attorneys, community-based mental health providers, and the courts to develop community-based mental health dispositions for mentally ill detainees. The mental health disposition is sought as an alternative to prosecution, as a condition of reduction in charges, or as satisfaction for the charges, for example, as a condition of probation. Once such a disposition is decided on, the diversion programs links the client to community-based mental health services."

The National GAINS Center for People with co-occurring Disorders in the Justice System published a fact paper in the Summer of 2000 that describes one apparently successful diversion program in Seattle that dealt with mentally ill individuals who also engaged in substance abuse: "Many offenders - both youth and adult - whose misdemeanor offenses are related more to the symptoms of mental illness and substance use than to truly criminal behavior are poorly served in a criminal justice system that offers little in the way of structured treatment." *Id.*

The paper concluded that the Seattle program **"demonstrates when there is political will, creative vision, and invested people, significant progress can be made in creating integrated systems of care to divert individuals with co-occurring mental health and substance use disorders from the criminal justice system.** ***Furthermore, these experiences demonstrate that the infusion of large amounts of new money is not the key.*** **Rather, it is a matter of joint planning, pooling resources, and more effectively managing existing resources toward new goals."** *Id.* (Emphasis supplied).

Whether or not the County goes forward with such a diversion program, the LASD must create a Crisis Intervention Team. It is by no means rare that law enforcement must deal with mentally-ill individuals. [31]

"The results from a national survey of major police departments in the United States (those serving populations of 100,000 or more), estimated that approximately seven percent of police contacts involve people with mental illness. Similarly, information coming directly from people with mental illness suggests that being arrested is virtually a normative occurrence. In a study that surveyed members of the Oregon chapter of the

31 We want to acknowledge helpful conversations and suggestions from individuals on the Los Angeles County Mental Health Commission, the Los Angeles County Task Force on the Incarcerated Mentally Ill, including the Minority Report of Ron Schraiber (April 1993); LAMP and its benefits coordinator, Gerald Minsk.

Alliance for the Mentally Ill, more than half the respondents reported that their mentally ill family member had been arrested at least once, and on the average it was more than three times." Borum, Randy, *Improving High Risk Encounters Between People with Mental Illness and the Police*, The Journal of the American Academy of Psychiatry and the Law, Vol. 28, No. 3 (2000).

In Seattle, the crisis intervention team was a "group of more than 100 volunteers from the existing ranks of the police force agreed to receive 40 hours of specialized training on dealing with persons with mental illness, drug/alcohol problems, and developmental disabilities. Training . . . offered officers new skills to recognize different types of illnesses and to intervene to de-escalate potentially dangerous situations without using force or making arrests. [These] officers are now regularly dispatched to calls involving persons with mental illness with a primary goal being jail diversion." National Gains Center, *supra*. The Memphis, Tennessee Police Department's Crisis Intervention Team is often cited as a model program.

V. CONCLUSION.

From time to time, we all run into people like Kevin Evans: poor, black, homeless, probably unkempt, talking aloud to themselves or to imaginary persons, perhaps on drugs, or drunk, or simply acting odd. They may suffer from Cerebral Palsy, they may have undiagnosed heart conditions, or other serious disease. Shop owners do not want them in or around their stores because they might pilfer or simply intimidate customers. They become too much for even well-intentioned relatives and friends to handle. They carry their few possessions in shopping carts and roam the streets. They go through the revolving doors of jails, in and out, in and out, time and again. The unluckiest of these unlucky people, like the diminutive Margaret Mitchell with her screwdriver, may get shot dead by the police or, like Kevin Evans, be asphyxiated as he is being placed in restraints.

They become the problem of the police or the LASD because of the trivial misdemeanors or other, more serious offenses they commit. But many of them do not really belong in jail.

It is instructive to focus on organizational dynamics as well as individual responsibility

in analyzing Kevin Evans's death. We tend as lawyers to think in terms of individual responsibility. Our initial mind set is to look at an incident like Kevin Evans's death in terms of individual legal rights and responsibilities; duties to act and breaches of duties; categories like "negligence" or "recklessness" or "intentional misconduct" or "malice aforethought." Our responses arise from a notion that what happened to Mr. Evans was unjust or unfair; a wrong that needs to be righted. We look at the individual actors - the deputy who classified Evans as dangerous; the doctor who ordered him in restraints in the first instance; the psychiatrist who upped the restraints to four-points. We focus on whether they made mistakes or failed to act when they should have. We expect each individual's acts to reflect societal norms about how reasonable people should act.

But in focusing on *individual* responsibility, we lose sight that organizations like the LASD - indeed any large bureaucratic organization, public or private - are simply not as capable of acting as intelligently, flexibly, and rationally as we expect an individual to act. Perhaps we mistakenly anthropomorphize organizations. Since they are composed of people, we expect the organization as a whole to act like an individual person would. When an organization does something that seems mindless and senseless, we respond as if an individual did something mindless and senseless. We forget that an organization itself is not a conscious entity and does not have the complex and often conflicting impulses and goals of an individual. Like a huge, lumbering animal, a large organization can only accomplish a relatively simple, straightforward mission or carry out well-defined rules. Individuals caught up in work in such an organization consciously or unconsciously further that simple mission, and individual decision making or action that might frustrate or complicate the mission is suppressed. In order therefore to minimize error, as in a hospital or laboratory, there are elaborate and meticulous rules governing all aspects of the operation. Licensure, certification, and accreditation are necessary to create the rules and establish minimum standards.

In terms of the LASD, we must keep in mind that most of the sworn personnel who work there think of the LA County Jail as merely a jail - not a mental hospital; not a homeless

shelter; not a drug treatment facility. A jail. What's its mission? To house people who have been arrested for crimes, are serving sentences of less than a year, or who have been convicted and are on the way to state prison. People who do not want to be there; people under great stress; people with pent-up rage; people who have poor impulse control; people who are, on occasion, dangerous. They must be processed, fed, housed, taken to and from court. There is a constant stream of inmates in and out. It is not an easy inventory to track. The time for processing is short; inmates cannot be left hanging around unattended. It is hard to render individual attention to each inmate or make nuanced decisions about a given person's potential for danger.

But the LA County Jail, in the final analysis, is in reality more than just a jail. Sheriff Baca has called it the largest mental health facility in the state, and in a sense he is right. It must be recognized more generally that the institution is more than just a correctional facility. It does and must provide medical and mental health care. It must therefore do so in a responsible way. It can no longer evade or avoid licensure and accreditation. But that is not the entire answer.

Our recommendations for change are calculated to make it harder for the LASD to fail to treat the Kevin Evanses of this world in a more humane, nuanced, careful, and intelligent way. But we are not so naïve as to believe that this is an easy or straightforward thing to do. That is why, when all is said and done, the Kevin Evanses of this world should be diverted before they even reach the jails and be put into treatment facilities or shelters.

2. The Office of Independent Review and the Integrity of Internal Investigations

The Office of Independent Review (OIR) is a bold experiment that holds great promise. If it succeeds, and we are certain it should, the OIR will become the gold standard — a national model, incorporating all the strengths of civilian review and civilian participation without the weaknesses. Its genesis was the confluence of ideas from the Sheriff, the Board of Supervisors, and the Kolts recommendations. Each sought to sharpen and bring greater integrity to the LASD's internal investigative process. The OIR is headed by Mike Gennaco, who is regarded as one of the nation's finest civil rights lawyers. This Chapter will describe this newly-created office, offer some suggestions and recommendations about how it should function, and describe further reforms and areas for inquiry to strengthen the office and improve the integrity of internal LASD investigations.

I. THE OIR AND SPECIAL COUNSEL.

We first take a moment to distinguish the OIR from Special Counsel. The roles do not overlap and in fact reinforce each other. Our role as Special Counsel is an outgrowth of the Kolts investigation. Our mission is to help the Board of Supervisors and the LASD to reduce police misconduct and the attendant liability — be it excessive force, corruption, failure to protect inmates, or other events giving rise to exposure to County taxpayers. In doing our job, we scour and test LASD policies, procedures, and practices to see if they in fact are up to the job of preventing misconduct. We propose and advocate new policies and practices where the old ones fail the test. We bring to bear best practices from other law enforcement agencies and attempt to put the LASD in the context of American policing in general. We look to see whether the LASD uses lethal and non-lethal force appropriately and how it compares to other law enforcement agencies. We check whether the LASD is costing the taxpayers of Los Angeles County more or less than taxpayers in other similar jurisdictions. We are curious how the LASD's jails compare to similar large urban jails, as in New York City or Chicago, in the provision of health care to inmates and the rate at which the LASD is sued for medical malpractice or failure to treat illness or injury. We try to sniff out problems

in their inception and catch them early. [1] Although we are not always the bearers of glad tidings, we hope we give the Board, the Sheriff, and the public honest, well-researched, and trustworthy information about the LASD.

At times, we review completed investigations by the LASD — we have commented upon Homicide, Internal Affairs, Internal Criminal, and station level investigations. We generally do not involve ourselves in pending investigations unless requested to do so by the Board. We report on how well or poorly the LASD investigates misconduct, but we do not influence the outcome of any given investigation. The OIR, however, will do so.

Acting in a complementary way to Special Counsel, the OIR has specific responsibility to involve itself in and scrutinize ongoing investigations. OIR's contract with the County makes clear beyond peradventure that OIR is to assist the LASD in the initiation and development of investigations and participate in ongoing investigations. The OIR also works with Special Counsel and establishes and maintains liaison with the DA, County Counsel, the employee unions, the US Attorney, and others. [2]

II. THE OIR'S KEY RESPONSIBILITIES AND HOW IT CAME INTO EXISTENCE.

The OIR will assure that the LASD internal investigations are full, fair, thorough, and reasonable. The OIR will make specific recommendations to the Sheriff regarding the outcome of such investigations, including recommending specific discipline. Sheriff Baca has set an important and praiseworthy precedent by holding weekly meetings with Mike Gennaco, thereby giving the head of OIR unfettered access in order to communicate recommendations directly. Importantly, however, the OIR does not displace the ultimate accountability of the

1 When we read about the escape of an inmate suspected of attempted murder who got out of jail wearing a badge with Eddie Murphy's picture on it, we cannot help looking back to our calls for action on mistaken releases in 1996. When we see the County has put up $27 million to pay inmates who have been over detained, we look back at our 1997 report on the County jail system and over-detentions. When we see yet another avoidable death in the jails, we pull our reports from 1994 on and are saddened.

2 Because of the importance of the office and its unprecedented nature, and for the benefit and guidance of other cities, counties, and law enforcement agencies that receive these reports and may wish to emulate this promising new model, we set forth the entire contract with the Chief Attorney of the OIR in Appendix A to this Chapter.

LASD itself. The LASD is not stripped of power to investigate, adjudicate, and discipline police misconduct. Nor should it be: The LASD, in the main, has responded to recommendations to improve internal investigations. But it is important to keep in mind that self-policing is not an inalienable right of the LASD's or any other law enforcement agency. Rather, it is a rare privilege afforded only to certain highly trained and disciplined professionals — be it university faculty, lawyers, doctors, or CPAs.

The privilege comes with heavy obligations to demonstrate upon demand in any individual case, or in general, that the results reached are fair, reasonable, and grounded in thorough and dispassionate investigation. If the LASD cannot, then the privilege is no longer merited and should be taken away. The privilege comes with an obligation to open the books and records fully to responsible public representatives, including elected officials, monitors like ourselves, and the staff of the OIR. If not, the privilege again is no longer merited. How the LASD investigates itself and conducts its business in general must be an open and transparent process; not hidden behind a stone wall or a blue curtain. In our semiannual reports, we help open up internal LASD process and subject it to the light of day.

Under the OIR model, unlike more radical solutions to biased internal investigations and lax discipline, where the police chief executive is stripped of investigatory and disciplinary power, the buck will still stop at Lee Baca's desk. That is appropriate – not only because it is good public policy in this instance, but also because it was from Sheriff Baca's desk that the idea for the OIR first gained currency.

A coalition of civil rights advocacy groups met with the Sheriff to complain about the Department's failure to adequately handle an embarrassing case of racially offensive conduct by LASD officers directed against an Asian-American officer in the Department. Reflecting on the merits of a Seattle PD experiment where the head of Internal Affairs was a civilian, Sheriff Baca suggested that something similar might work in the LASD, particularly if the individual in charge had expertise in civil rights. The advocates took the Sheriff up on the idea and continued in the months that followed to push it. They lobbied the offices of the individual

Supervisors where it met with general approval.

The Board of Supervisors has the ultimate responsibility to approve lawsuit settlements paid from County revenues. From time to time, a given matter is settled when pre-trial discovery has disclosed weaknesses in the LASD's defenses. On occasion, individual Supervisors have had a concern that the misconduct giving rise to the settlement was poorly investigated or trivialized by the LASD. In theory, the weaknesses in a given case should be apparent from the earliest stage when the LASD investigates the matter. If those weaknesses are not rationalized or swept under the rug and are faced forthrightly, litigation can be avoided. The matter can be resolved at far less cost.

One of the principal Kolts recommendations in 1992 was that LASD internal investigations needed to be full, fair, thorough, and objective. At the time, many investigations were anything but that. All too often, the LASD:

- failed to interview key witnesses who had already been identified by the LASD officers or the complainant,
- made no serious attempt to identify readily available witnesses,
- failed to ask key questions or only attempted to elicit information favorable to the charged officer,
- failed to name additional officers as subjects of investigation when information implicating them came to light,
- made biased and incomplete presentations of evidence,
- unfairly discredited witnesses giving information damaging to the officer or called all close cases in favor of the officer without resolving credibility disputes, and
- imposed lax discipline.

More recently, in our October 1999 **Eleventh Semiannual Report,** we examined sexual harassment investigations between 1995 and 1999 and found most of these same problems persisted. [3] In the last few months, our confidence in the LASD's investigations has once again

3 A second look in our December 2000 **Thirteenth Semiannual Report** found that investigations of sexual harassment cases, in the main, had improved.

been undermined. In our intensive review at the request of the Board into the in-custody death of Kevin Evans, we found all, or nearly all, the deficiencies in investigation first noted in the **Kolts Report**. We turn, then, to describe pressures on the LASD that cause internal investigations to be less than fair and thorough. By so doing, we suggest ways in which these pressures can be counteracted by the LASD with the help of the OIR.

III. PRESSURES DISTORTING THE INTEGRITY OF INVESTIGATIONS.

A. Criminal Investigations.

Pressures from all sides come to bear on internal investigations of an officer-involved shooting, a death in the jail, or a serious use of force on the street. The first hot-potato question is whether there was criminal misconduct by any LASD employee. It is useful to take a deputy-involved shooting as an example.

A deputy sheriff may lawfully use deadly force if the officer has probable cause to believe that the suspect poses a threat of death or serious physical harm either to the officer or others. Probable cause is not judged from the officer's subjective perception of the danger; rather, the officer's conduct must be "objectively reasonable given the totality of the facts and circumstances known to the officer at the time of his actions." Michael Avery, David Rudovsky, and Karen Blum, *Police Misconduct: law and litigation,* 3rd. ed. (2000). In theory, under California state law, if a police officer is reckless or grossly negligent, the officer could be criminally prosecuted; in practice, prosecutors routinely decline cases unless the officer acted with intent to do harm, intent to deprive another of civil rights, or with malice.

Usually, the determination as to whether there was criminal misconduct in an officer-involved shooting case is made by the District Attorney based upon an investigation by the Sheriff's Homicide Bureau. In the vast majority of cases, the prosecutor declines to go forward with a criminal case.[4] Homicide detectives are trained to investigate crimes involving death

4 A prosecutor's declination to proceed criminally is often misread to mean that the officer was exonerated and the shooting was lawful from all perspectives – criminally, civilly, and administratively. But all the prosecutor is usually saying is that for whatever reason, its not worth pursuing the case – often, because it will be tough

and thus are deemed to have particular expertise in analyzing and investigating a shooting. At least, this is the common rationale offered for why shootings by officers are investigated by Homicide in contrast to the LASD's Internal Criminal Investigations Bureau (ICIB).

In the past, we found certain Homicide Bureau investigations to be biased in favor of the officer. The bias may show up in a number of different ways: The investigation may be half-hearted – not all relevant witnesses are interviewed, and only minimal efforts are made to locate witnesses who might give testimony unfavorable to the officer. Interviews of the officer himself may be tainted: Investigators may simply pitch soft-ball, open-ended questions to the officer, allowing the officer to give a narrative answer that is not given rigorous cross-examination. More troubling still, investigators at times use leading questions which seem to signal to the officer what he is supposed to say in order to get off the hook: "You were in fear for your life, weren't you?" "You thought your partner was about to be shot, correct?" "You saw the suspect reach for his waistband and withdraw a black, shiny object you thought was a gun, right?"

In some police departments, the bias and incompleteness have led to Homicide's losing the authority to conduct the investigations. Certainly, charges of bias surrounded the operations of the LAPD's Robbery Homicide Division for many years. The recent Consent

to prove the case beyond a reasonable doubt. But what the criminal law requires in terms of both the persuasiveness of the evidence and the kind of evidence presented is far different from what is necessary to show to prove civil liability or make out a case for administrative misconduct. For these purposes, it is often sufficient to show by a preponderance of the evidence that a given police officer was negligent or reckless in firing his weapon.

It used to be the case that if the prosecutor declined, the LASD's Internal Affairs Bureau would rarely, if ever, proceed administratively to discipline an officer for negligent or reckless conduct that was out of policy. Indeed, IA would not commence an investigation in earnest until after the declination. A landmark Kolts reform was intended to cause IA to begin an earlier investigation and to look at the incident from a different perspective than Homicide. The Homicide bureau is, in some sense, the prosecutor's eyes and ears. A good Homicide officer knows what the DA needs to prove a case beyond a reasonable doubt and considers a possible crime from that perspective.

A great Homicide investigation, however, has only limited relevance to a good IA investigation. Although it certainly looks at the same event, Homicide sees it very differently from IA. That is in no way a criticism of Homicide. It has a different job. A key insight reached in joint discussions and planning between the Kolts staff and the LASD was that it was necessary to get IA to the scene early, have it work in parallel with Homicide, and then have it present its own conclusions from its differing perspective quickly to a commander's panel focused on whether there were administrative or policy violations.

Decree between the federal government and the City of Los Angeles takes investigatory power for serious use of force cases away from the LAPD's Robbery Homicide and Detective Headquarters Divisions and gives them to a new unit assigned to the Operations Headquarters Bureau. *U.S. v. City of Los Angeles, et al.*, Consent Decree, p. 23, ¶55.[5]

In the past, our disappointment with the LASD's Homicide Bureau brought us close to recommending that it lose the right to conduct investigations of deaths of suspects at the hands of LASD officers. In response, the Department implemented reforms we had recommended to counter the lack of accountability and accuracy in Homicide investigations. As noted above, the most important such reform was to empower Internal Affairs to conduct a simultaneous, parallel, independent investigation focused on possible policy violations, civil litigation risks, and tactical and strategic issues posed by the death in question.[6]

A set of guidelines dividing the turf between IA and Homicide gave IA the power to attend and participate in all interviews of LASD witnesses with the exception of the shooter in a shooting case.[7] But the Homicide interview of the shooter has to be tape-recorded, and the tape recording has to be turned over to IA within a specified number of hours so that IA can listen to the tape, glean information from it, and check whether Homicide had compromised the integrity of the interview by asking biased or leading questions, turning the tape recorder on and off, or coaching the shooter or giving him untoward opportunities to change his story or come up with the magical phrases to reduce the risk of prosecution. We recommend that the Office of Independent Review make this scrutiny of the integrity of Homicide interrogations

5 The Consent Decree further requires that in conducting serious force investigations, the LAPD must tape or video record interviews of complainants, involved officers, and witnesses. It prohibits group interviews of officers and requires that the LAPD "collect and preserve all appropriate evidence, include canvassing the scene to locate witnesses where appropriate" and "identify and report in writing all inconsistencies in officer and witness interview statements." *Id.* at pp. 32,33 ¶ 80.

6 In addition to Internal Affairs, LASD risk management personnel also roll to shooting scenes pursuant to LASD policy. These individuals begin to assess the incident's civil liability risks. LASD Area Commanders also are generally present at the scene of a shooting in order to be debriefed early on concerning the incident. Both Risk Management and Area Commanders play important roles at the scene, and we strongly support their continuing participation.

7 Recently, an internal debate took place in the LASD regarding whether Internal Affairs investigators should continue to have the ability to attend and question LASD witnesses other than the shooter in a shooting case. Wisely, the LASD commanders resisted efforts to change the rule.

of LASD officers a standard part of its investigatory efforts, and we will continue to do the same.

Another reform to bolster the integrity of investigations was the District Attorney's roll-out. Started under District Attorney John Van de Kamp, shuttered under District Attorney Gil Garcetti, and only recently revived, the program calls for early notification of the DA that a police shooting death has occurred. Representative of the DA then come to the scene to observe the investigation. Although the DA's representatives complained from time to time that the law enforcement agencies kept them behind the yellow tape, did not give them timely walk-throughs, and otherwise frustrated their efforts, the theory behind the DA roll-out was a good one. We recommend that the OIR, which also is empowered to roll to the scene, be vigilant not only with respect to its own rights of access but also monitor the Department's cooperation with the DA and other prosecutorial authorities, including the United States Attorney's Office.[8]

Despite the reforms described above, problems with the integrity of internal investigations persist. Some have to do with interviews of the shooter. A deputy sheriff who shoots a suspect has the same constitutional protections as any other person not to give self-incriminating testimony. It is nonetheless the case that officers can be compelled to give a statement upon penalty of possible loss of their job for failure to cooperate. Any such compelled statement, however, may not be used in connection with a criminal investigation or prosecution of the officer. Some police agencies routinely compel statements and in so doing prejudice criminal investigations and prosecutions, sometimes fatally so. Although some may argue that the real-life likelihood of prosecution is so low that no real harm is done, the

8 The current DA has restructured his office to bring greater specialized resources to bear at the scene of shootings. The DA wants to put an end to conduct by some law enforcement agencies (other than the LASD) that has been construed by some observers to obstruct or impede criminal investigations or referrals of possible criminal misconduct by police officers. We commend the DA for doing so. There's plenty of room for the DA, Homicide, IA, Risk Management, Area Commanders, and the OIR to perform their different and distinct jobs at a crime scene. No one of these parties "own" the investigation and no one's job is more important than another, although each must coordinate its efforts so that one party's way of doing its job does not prejudice another's.

practice of routinely compelling statements does make it more difficult for prosecutors. It also places substantial power in the hands of law enforcement to influence the outcome of officer-involved shooting investigations.

To its credit, the LASD does not routinely compel statements. The LASD in general has been reasonably respectful of the prosecutors' role. But another reason is that the Homicide Bureau has generally been successful at getting a voluntary statement from the involved officer soon after the shooting, and thus the question of compulsion has not had to be reached. This is a double-edged sword: On one hand, the officer's voluntary statements speed up and facilitate resolution of the investigation. This is good for the officer as well as for the Department. On the other hand, it causes some to wonder why LASD officers involved in shootings feel safe enough to talk to the Homicide investigators in circumstances where they would refuse to talk to IA.

Skeptics quickly reach the conclusion that officers talk to Homicide because they know that Homicide will be a sympathetic audience and will, except in the most blatant instances of wrongdoing, resolve doubts about a given shooting in the officer's favor. In the view of such skeptics, an officer involved in a questionable shooting has more to fear from an internal administrative investigation than from a criminal investigation. Those who are less skeptical concede the latter point, but argue further that the consequences of a successful criminal prosecution, however remote, are so far-reaching that it is in the officer's interest to clear the air as soon as possible. Thus, they would argue, an officer has an incentive to give Homicide a voluntary statement that does not exist with IA.

Whoever is correct, LASD officers involved in shootings tend to give Homicide investigators a voluntary statement. This is generally viewed as a good thing, being both in the officer's self-interest and in the LASD's interest in quickly resolving the matter.[9] Accordingly, the LASD is very sensitive to suggestions or reforms that might tend to lessen the chances that an

9 The DA is also strongly supportive of this practice because voluntary interviews from the shooting deputy makes it easier to undertake a prosecutorial assessment of the case.

officer will give a voluntary statement.

At times, this sensitivity may be taken too far, and to increase the chances that the officer will give a voluntary statement, the LASD at times tolerates conduct that raises ethical concerns. The LASD is in a difficult position: It must constantly calibrate the benefit of a voluntary statement against the possibility that the voluntary statement is so massaged as to be less than completely reliable.

It cannot seriously be questioned that an officer is entitled, if he or she wishes, to legal counsel prior to giving a voluntary statement that might tend to be self- incriminating. But it is one thing for a lawyer to confer with and counsel an officer one-on-one. It is different when the lawyer interviews all LASD witnesses collectively, both the shooter and the others involved. The opportunities to smooth away inconsistencies in recollections or to fashion a collective story are simply too great. Conflicts of interest between individual officers that might give rise to a need for separate representation are not given sufficient weight. Group interviews should clearly be banned.

It is not much better when the lawyer goes from witness to witness and back again – the same opportunities exist to convey signals about what to say and not to say. The LASD, however, usually turns a blind eye. The LASD could easily sequester the shooter and other witnesses from each other, thereby at least reducing the likelihood of dubious group or round-robin interviews. We recommend that the OIR take into consideration the possible detrimental impact of group or serial interviews on the integrity of Homicide investigations. Ultimately, the OIR is to be the public's mechanism for insuring that all internal LASD investigations are fair and thorough. To the extent that an investigation is compromised before it begins by improper coaching or preparation of LASD witnesses, it is very difficult to remedy or give the subsequent investigation real integrity.

We recently learned to our surprise that officers involved in shootings are not asked to fill out routine incident reports on shootings. Nor do their supervisors take information from them to fill out routine use of force forms. No one in the LASD asks the officers to write down their

version of what happened. Again, this seems to be a voluntary accommodation by the LASD to the officers and their representatives and lawyers. In essence, it gives them "first crack" at the officer. The implied threat is that if this "first crack" were not afforded, then officers would routinely refuse to give voluntary statements, thereby forcing the LASD to compel statements or find that investigations were less easy to resolve. Whether this is a idle threat or not remains to be seen. Given that the officer's self-interest is usually served by a voluntary statement (the investigation doesn't drag on; there is not a cloud over the officer's head; most officer involved shootings are justified), it might just be in the LASD's interest to call the union's bluff and see whether officers refuse to give voluntary statements. If the officers decide to clam up, then the LASD should impose a requirement that all involved LASD witnesses, including the shooter, be immediately isolated and made to complete a written report on the incident. Because these considerations impact heavily on the integrity of investigations that the OIR will participate in and monitor, we strongly recommend that the OIR keep a watchful eye on these issues.

B. Administrative Investigations.

Other and different pressures come to bear on administrative investigations. Even if a given incident does not have criminal implications, the officer may have violated internal departmental policy and require discipline. It used to be the case in nearly all circumstances that if the DA or United States Attorney declined to prosecute an officer involved in a shooting, no further administrative action would be taken. That is still the case in many police departments across the country. We have argued strenuously from the *Kolts Report* onward that a shooting may pass muster criminally but nonetheless be out of policy. As noted earlier, the criminal law tends to look at the matter in the split second before the officer fires the gun to ask if a hypothetical police officer, knowing the facts then available to the officer in question, could reasonably have concluded that he or others were under immediate threat of death or serious harm. In contrast, an administrative review of a shooting should step back farther from the moment when the shot was fired to examine the strategy, tactics, options,

and alternatives available to the officer. It should also examine the training the officer was afforded.

Reverence for human life is a core value of the LASD. The LASD prohibits the use of any force that is not objectively reasonable. While it may not be fair to second-guess every decision that ultimately leads an officer to fire a gun, it is fair to ask if the use of deadly force could have been avoided without subjecting the officer himself to greater risk.

A significant number of shootings we have reviewed in the past several years have been, in the Department's parlance, "awful but lawful" — lawful in the sense that they were not criminal; awful in that they involved grossly negligent or reckless conduct, tactics, or strategy. Assuming that the officer had received proper training, shootings of that kind should routinely be held to be out of policy. All too often, they are not. We have cited examples in prior reports where the taxpayers of Los Angeles County paid hefty sums in litigation over grossly negligent and reckless shootings that the LASD itself should have found out of policy.

There is a natural, predictable, human impulse involved: No law enforcement officer can examine an officer-involved shooting without at some level saying, "There but for the grace of God go I." The trauma of having to kill another person, even if very few police officers have to face it, is nonetheless so great that it is difficult for one police officer to question another's decision that he had to do so. Who's to say that if faced with the same situation, one would not have pulled the trigger? The empathy one police officer has for another is entirely understandable. But it cannot be allowed to go so far as to cloud judgment or reach unjust results.

As noted earlier, highly disciplined professionals, like doctors and lawyers, are allowed significant power to regulate themselves. The idea of being a "professional" carries with it the obligation to do one's duty even when one would prefer not. Doctors cannot refuse to treat patients they have taken on because they come to dislike the patient. A lawyer must zealously represent a client even if the lawyer would prefer not to. And the lawyer and doctor

are expected to judge the conduct of other lawyers and doctors from the perspective of the broad societal duty of professionals. Ultimately, the doctor or lawyer sitting in judgment of a counterpart must serve the duty to patients or clients, even if it means that sympathy or empathy for a fellow professional strongly tempts one to be faithless to it.

The same must hold true for law enforcement. The power to carry a badge and gun is no less awesome than the power of a doctor or lawyer when life hangs in the balance. It is no less awful when a police officer kills a suspect through gross negligence or recklessness than when a doctor kills a patient through malpractice or a lawyer sleeps through a death penalty case in which the client is convicted and condemned to die. If the police are to be allowed to police themselves, they must live up to the responsibility to steadfastly perform their duty to the public at large even if it means finding that one of their own was in the wrong.

The OIR is premised on the view that the discipline, objectivity, and legal training of its staff will give the LASD the breathing room to administer self-discipline more professionally. As noted before, the OIR does not displace the authority and accountability of the Sheriff to adjudicate and impose discipline. But the mere presence of the OIR, and the quality of its objectivity, thoroughness, and fairness, should cause internal investigations to have more integrity.

The OIR, however, is not, and should not be, merely a passive agent waiting patiently for a completed investigation to be put before it. The OIR should be as active as it deems fit or necessary from the moment an incident takes place that may ultimately lead to an administrative investigation. Indeed, it should be actively involved at any and every stage where the exercise of unbounded discretion by Homicide, IA, or ICIB could irremediably impact an investigation. For example: If an Internal Affairs investigator is failing to ask all the probing questions that need to be asked of a witness, a member of the OIR must ask the questions lest the witness get away and not be able to found at a later time. The OIR should be involved at an investigation's inception, helping to shape it so that it will turn out to be thorough and fair.

The consequences of a bold OIR may be that various oxen get gored, and the Board of Supervisors, the Sheriff, and Special Counsel will need to be vigilant and willing to protect the OIR. One predictable consequence of better investigations with more integrity is that in the short run, more Sheriff's personnel may be subject to discipline. So be it. Another predictable consequence is that in the short run, better internal investigations will lead to greater civil litigation exposure. Again, so be it. Ultimately, as proven with implementation of the Kolts recommendations, the overall impact over time will be to steeply lessen exposure. An accountability system must ultimately reduce risk. Any upticks in exposure before accountability measures take hold are dwarfed by the savings once the measures are firmly in place.

C. Our Hopes for the OIR.

Earlier, we described the potential of the OIR to become the gold standard; a model for civilian review and oversight that has all the strengths and none of the weaknesses of other systems. Civilian review boards and police commissions often lack the resources and expertise to do the job effectively, and sadly at times wind up being captives of the very police department they are supposed to investigate or manage. Here, the OIR has an extremely capable and savvy staff. All are lawyers with experience in the right arenas, including individuals who have served with distinction in the District Attorney's Office, the United States Attorney's Office, and on our staff. They each know how to investigate, how to probe, and how to be dogged and unrelenting.

Make no mistake, however: The pressures on them will be severe. The careers and reputations of LASD personnel will ride on the outcome of their deliberations. All the pressures that tend to distort or compromise internal investigations will be applied to the OIR. Its one and only effective and reliable shield will be its credibility. If it refuses to cut corners, stands up under pressure, and acts in a thoughtful and deliberative way, the quality of its work product will be its best defense. The Board of Supervisors and the public at large, as well as the LASD itself, must know that when the OIR speaks, it is giving an honest, thoughtful, and

factually accurate report. Factual accuracy is the keystone of credibility: Get the facts right and the conclusions drawn therefrom are self-evident; spin the facts, and the conclusions will be suspect. We anticipate that under Mike Gennaco's direction, the OIR will have impeccable integrity.

AGREEMENT FOR SPECIAL LEGAL SERVICES OFFICE OF INDEPENDENT REVIEW

This Agreement for Special Legal Services ("Agreement") is entered into as of April 27, 2001 by and between the County of Los Angeles ("County") and Michael J. Gennaco (hereinafter referred to as "Chief Attorney") for the purpose of providing for the services of a Chief Attorney for the Office of Independent Review ("OIR").

RECITALS

WHEREAS, the Sheriff has requested the addition of resources for the Sheriff to fulfill his duties and obligations to investigate allegations of intra-departmental misconduct, including that which constitutes criminal conduct which he, as the Sheriff, has the duty to investigate; and,

WHEREAS, the Sheriff wishes to ensure that the allegations of intra- departmental misconduct are investigated and reviewed in a fair, thorough, and impartial manner; and

WHEREAS, the Board of Supervisors has endorsed the concept of utilizing such resources to accommodate and to further these goals; and,

WHEREAS, pursuant to Government Code Section 31000 the Board of Supervisors has the authority to contract for specialized services to assist the Sheriff in the performance of his statutory duties;

WHEREAS, the Chief Attorney has been determined to be uniquely qualified to serve as such a resource,

NOW THEREFORE, the County and Chief Attorney agree as follows:

1. Scope of Services - Chief Attorney, OIR

The Chief Attorney, shall, during the term of this Agreement, serve as Chief Attorney for the OIR, shall oversee and coordinate the independent review process and functions of the OIR, and shall perform such specialized services as are necessary to accomplish such oversight and coordination, including the following:

- Providing periodic status reports on all investigations and significant matters within the purview of the OIR to the Board of Supervisors, the Sheriff, the Executive Planning Council, and the Special Counsel.
- Assisting in the initiation, structuring, and development of ongoing investigations conducted by the Office of Internal Affairs, the Office of Internal Criminal Investigations, the Homicide Bureau, Sheriff's Department unit investigations, and any such other investigation falling within the purview of the air to ensure that investigations are complete, effective, and fair.
- Participating as necessary and appropriate, in ongoing investigations including interviewing witnesses, responding to crime scenes, and reviewing tangible evidence and relevant documentation.
- Monitoring all ongoing and reviewing all completed investigations conducted by the Office of Internal Affairs, the Office of Internal Criminal Investigations, the Homicide Bureau, and Sheriffs Department unit investigations, and any other such investigations falling within the purview of the OIR to ensure that content, disposition of employment issues, and recommended discipline are appropriate.
- Making recommendations of disposition and discipline, if founded, for all investigations falling within the purview of the OIR

- Establishing and maintaining liaison with the District Attorney, Sheriffs Department Executives, Special Counsel, LA. County Ombudsman, Department Units, County Counsel, employee unions, the United States Attorney, the Federal Bureau of Investigation, civil rights organizations, community based organizations, and other outside entities.
- Interviewing and selecting the five other OIR attorneys for recommendation to the Board with input, counsel, and advice from County Counsel and Special Counsel.
- Working with Special Counsel in performing thorough analyses and reviews of selected Departmental investigations to determine whether Departmental policies, practices and procedures should be reexamined to prevent the future occurrence of similar allegations of misconduct, and when warranted, developing and proposing recommendations for revisions of the implicated policies, practices, or procedures.
- Working with Special Counsel in reviewing selected Departmental investigations and studying best practices from other law enforcement departments in order to develop and improve policies, practices and procedures to ensure that investigations of intra-departmental misconduct and disciplinary procedures are more effective, fair, thorough and impartial.
- Devising and recommending mechanisms to provide positive recognition and incentives to employees who perform duties in an exemplary fashion with regard to use of force, integrity, conduct, and other issues that frequently are the subject of discipline.
- Setting the operational philosophy of the Office of Independent Review to ensure that the needs and goals of the community, the Department, and the staff are met.
- Working with the Office of the District Attorney and the Office of the United States Attorney to promote effective investigative strategies in order to ensure effective, appropriate and timely prosecutions

2. Term

The term of this Agreement shall be for a period of three (3) years, unless otherwise amended or terminated earlier as provided herein, commencing June 4, 2001, and extending to and including June 3, 2004.

Either party may at its sale option and discretion, cancel or terminate this Agreement, for any or no reason, by giving the other party 30 days written notice of such termination.

3. Compensation and Expenses.

Chief Attorney shall be paid an annual amount of $200,000.00 for all services performed, plus actual and necessary expenses incurred by Chief Attorney pursuant to this Agreement. Reimbursement for necessary expenses shall be paid for such items, at the same rates and on the same terms as for County employees pursuant to Chapter 5.40 of the Los Angeles County Code.

Payment of the annual compensation amount by County to Chief Attorney shall be made in twelve (12) equal monthly installments within ten (10) working days after the first day of each month during the term of the Agreement. Reimbursement of actual and necessary expenses shall be payable on a monthly basis within ten (10) working days after submission to and approval of an invoice by the Office of County Counsel.
Such invoices shall specify in detail the dates and reasons for incurring each item of expense for which reimbursement is claimed. Invoices shall be mailed or delivered to the Office of County Counsel, 648 Kenneth Hahn Hall of Administration, 500 West Temple Street, Los Angeles, California 90012.

4. Access to Records and Confidentiality.

As special counsel to the County of Los Angeles, Chief Attorney shall have access on an attorney-client basis to such confidential records of the County, its departments and officers as may be material and relevant to performance of his services and responsibilities pursuant to this Agreement.

All communications and reports to the County, including the Board of Supervisors and Sheriff, shall be made or submitted on a confidential attorney-client basis. Any public reports by the Chief Attorney which are authorized by the County shall preserve all statutory and constitutional requirements of confidentiality with regard to records and individuals. All such information will be information acquired in confidence by a public employee in the course of his or her duties and not open, or officially disclosed, to the public within the meaning of Evidence Code Section 1040.

The confidentiality of all records and materials collected and used by Chief Attorney shall be preserved consistent with the terms of this Agreement, and shall within ten (10) days from the date of expiration or termination of this Agreement be delivered to the Office of County Counsel for confidential retention in the manner and for the periods required by law for confidential records of the County Counsel.

5. County's Contract Managers.

The County's Chief Administrative Officer and/or County Counsel will serve as County's contract manager for purposes of this Agreement.

6. No Assignment or Delegation.

This Agreement shall not be assignable by Chief Attorney, in whole or in part. Any attempt to assign shall be void and confer no rights on any third parties.

All services and duties of the Chief Attorney pursuant to this Agreement are solely the responsibility of the Chief Attorney, and may not be delegated without the prior written consent of County. Any person not employed by the County whose services are utilized by Chief Attorney, with such prior written consent, to assist in the performance of Chief Attorney's services pursuant to this Agreement shall, prior to performing any such services, execute an addendum to this Agreement, approved as to form by County Counsel, agreeing to the terms of this Agreement, including all requirements of confidentiality.

No person assisting Chief Attorney shall have a criminal record of conviction of a felony or any crime of moral turpitude. Chief Attorney shall be responsible for all assisting staff who are not County employees. All communications and reports to County pursuant to this Agreement shall be made or submitted only by Chief Attorney, not by his assisting staff.

7. Independent Contractor Status.

Chief Attorney is not, nor shall he or any of his employees or agents be deemed for any purposes, an employee of the County; nor shall Chief Attorney, his employees or agents be entitled to any rights, benefits, or privileges of County employees.

Chief Attorney shall comply with all federal, state, and local statutes, laws, and ordinances related to the payment of any employer, income, disability, or other tax which may be due by virtue of any compensation received by Chief Attorney under this Agreement. Chief Attorney represents and warrants to County, and County relies on such representation and warranty, that Chief Attorney has the necessary skills, competence and expertise to fully and completely perform the specialized legal services called for under this Agreement. County and Chief Attorney understand and agree that Chief Attorney is wholly responsible for the meansand methods of performing these specialized legal services and accomplishing the results, deliverables, objectives and/or purposes as specified and/or requested by County pursuant to this Agreement

8. Indemnification.

In consideration of the benefit to County of the specialized legal assistance and independent review services to be provided by Chief Attorney pursuant to this Agreement, County agrees to indemnify, defend and hold Chief Attorney harmless from claims of liability resulting from acts and omissions of Chief Attorney in the performance of services provided within the scope of services required pursuant to this Agreement to the same extent as if Chief Attorney was a County employee under

Sections 995 et seq. of the California Government Code.

Except as specifically provided herein, Chief Attorney agrees to indemnify, defend and hold County harmless from any and all other claims of liability for damages of any nature whatsoever arising from or connected with acts or omissions of Chief Attorney, including any workers' compensation claims, liability or expense arising from or connected with services performe by or on behalf of Chief Attorney by any person.

9. Office Space, Equipment and Staff Support.

County agrees to provide Chief Attorney. at no cost to Chief Attorney, such office space, use of related equipment, and staff support and assistance during the term of this Agreement as may be mutually agreed upon by Chief Attorney and County's Contract Managers. Any and all other office space, equipment and/or staff support and assistance utilized by Chief Attorney in providing services pursuant to this Agreement shall be the sole cost and responsibility of Chief Attorney.

10. Notices.

Notices required or permitted pursuant to this Agreement shall be given in writing by personal delivery or deposit in the United States mail first class postage prepaid addressed as follows:

To County: Office of County Counsel

648 Kenneth Hahn Hall of Administration
500 West Temple Street Los Angeles,
California 90012

With a copy to:

Chief Administrative Officer
713 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

To Chief Attorney: Michael J. Gennaco
4900 S. Eastern Avenue
City of Commerce, CA 90040

The address for notice may be changed by County or Chief Attorney, as the case may be, by written notice to the other party as provided herein.

IN WITNESS WHEREOF, County and Chief Attorney have executed this Agreement as of the date first set forth above.

COUNTY OF LOS ANGELES	CHIEF ATTORNEY
By _____	_____
Michael D. Antonovich, Mayor	Michael J. Gennaco
Board of Supervisor	

APPROVED AS TO FORM:

LLOYD W. PELLMAN

County Counsel

By _____

Deputy

3. Shootings and Other Uses of Force

In the Thirteenth Semiannual Report, we reviewed shootings and other uses of force, noting a welcome declining trend in deputy-involved shootings and an unwelcome uptick in other uses of force. In this chapter, we return to those subjects. Unfortunately, deputy-involved shootings are up sharply in Field Operations Region II, and within the Region specifically at the Century Station.[1] This development is particularly troublesome in that Century had for a time sharply reduced the number of deputy-involved shootings, a number once so high (three times as high as any other station) that we were moved to undertake an in-depth review of the station in our Ninth Semiannual Report. Turning to force other than shootings, we are distressed to report that the uptick we noted in our last semiannual report continues.

Such trends shed light on whether the Department is managing risk appropriately in Region II in general and at Century Station in particular. But they do not tell the entire story. Before drawing a conclusion that the LASD is falling down on the job, we need to consider whether the increased use of force, deadly and otherwise, is due, at least in part, to circumstances beyond the ability of LASD management to control. From a risk management perspective, then, the critical questions are not simply whether uses of force are trending upward, but also whether:

- the Department was able to spot these trends through management reports and an early warning system and then alert management to them quickly; and
- the Department is aggressively determining if these trends are within management control and, if so, if they can quickly be reversed.

Our investigation over the last six months raises concerns on both of these points. The Department has not been producing the relevant management reports regularly. It currently seems to lack the capacity and will to act on them rapidly, and, despite LASD

1 The County of Los Angeles is divided into three Field Operations Regions by the LASD. Region II is the western and southern ends of the County - encompassing West Hollywood, Marina Del Rey, Carson, Compton, Lynwood, Lennox and Lomita. Century Station is located near Imperial and Alameda boulevards.

protestations to the contrary, is not institutionally coming to grips with issues in a concerted and meaningful way. The result may very well be the alarming increases in shootings and force in Region II and at Century.

I. SHOOTINGS.

As noted in the **Thirteenth Semiannual Report,** the number of hit shootings by deputies, as well as the total number of shootings by deputies for the LASD as a whole, has dropped substantially over the last decade. See Tables 1 and 2. If the trend in the first six months of 2001 continues, there will be approximately 35 deputy-involved shootings in 2001, consistent with the downward trend over the last 3 years: Between 1998 and 2000, there was an average of 33 shootings.[2] In contrast, in 1991 and 1992, there was an average of 51 **hit** shootings alone.[3] Another positive trend is that the number of deputies killed or wounded in the line of duty fell considerably from 1991 to 2000, and 2001 appears to be consistent with this trend.[4]

Buried within the generally positive long-term trends on deputy-involved shootings, however, are ominous short-term ones. First, Region II accounts for an increasing percentage of all deputy-involved shootings -- in fact, Region II has been responsible for a higher percentage of the shootings in 2001 than in any of the previous five years. See Table 3.

2 Since the second half of 2001 includes the summer months of July and August, there may be a slight increase in shootings and other uses of force, concomitant with the increase in violence that is said to occur during the hot summer months. However, this hypothesis has not been tested, and, in any case, it is unlikely that there will be such a surge in shootings that 2001 will be inconsistent with the recent trend.

3 The number of non-hit shootings for these two years was not available.

4 We must take note of the recent death of deputy Hagop "Jake" Kuredjian a few weeks ago. He was the first deputy killed by gunfire since 1997. The positive trend does not diminish the tragedy of his death.

1

DEPUTY - INVOLVED SHOOTING INCIDENTS

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

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001(Jan-Jun)
# Incidents	56	47	29	28	34	25	35	20	22	18	12
# Suspects Wounded	40	31	12	11	24	11	17	8	12	6	6
# Suspects Killed	23	18	22	17	10	14	20	11	10	12	7

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

	NA	NA	14	21	26	19	20	15	8	15	5

Deputies Shot (Does not include accidental discharges)

# Wounded by Gunfire	10	6	4	4	2	2	8	4	6	3	2
# Killed by Gunfire	0	2	0	0	2	0	2	0	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
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

01-15-98	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

02-06-00	SEB	#SH2005203
09-05-00	NWK	Schaap
10-08-00	TEM	Adams

2001(Jan-Jun)

04-13-01	NWK	Dominguez
06-08-01	MCJ	Contreras
08-31-01	SCV	

*** 3 deputies

** 2 deputies

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

Source for 1994-2001 figures is Force Review Committee database, Internal Affairs Bureau and Homicide Bureau.

2

TYPES OF SHOOTING

	1996			1997		
	On Duty	Off Duty	Total	On Duty	Off Duty	Total
Hit [5]	22	3	25	33	2	35
Non-Hit [6]	15	4	19	17	3	20
Accidental Discharge [7]	24	2	26	7	1	8
Animal [8]	38	0	38	31	5	36
Warning Shots [9]	0	0	0	0	0	0
Tactical Shooting [10]	3	0	3	1	0	1
Total	**102**	**9**	**111**	**89**	**11**	**100**

	1998			1999		
	On Duty	Off Duty	Total	On Duty	Off Duty	Total
Hit	15	5	20	21	1	22
Non-Hit	15	0	15	8	0	8
Accidental Discharge	11	2	13	4	0	4
Animal	36	1	37	33	1	34
Warning Shots	0	0	0	1	0	1
Tactical Shooting	6	0	6	1	1	2
Total	**77**	**8**	**85**	**68**	**3**	**71**

	2000			2001(Jan-Jun)		
	On Duty	Off Duty	Total	On Duty	Off Duty	Total
Hit	18	0	18	12	0	12
Non-Hit	15	0	15	4	1	5
Accidental Discharge	11	1	12	6	2	8
Animal	35	2	37	17	0	17
Warning Shots	2	0	2	0	0	0
Tactical Shooting	0	0	0	0	0	0
Total	**81**	**3**	**84**	**39**	**3**	**42**

5 **Hit Shooting Incident**: An event consisting of one instance or related instances of shots (excluding stunbags) fired by a deputy(s) in which one or more deputies intentionally fire at and hit one or more people (including bystanders).

6 **Non-Hit Shooting Incident**: An event consisting of one instance or related instances of shots (excluding stunbags) fired by a deputy(s) in which one or more deputies intentionally fire at a person(s), but hit no one.

7 **Warning Shot Incident**: An event consisting of an instance of a deputy(s) intentionally firing a warning shot(s), including instances in which someone is hit by the round. *Note: If a deputy fires a warning shot and then decides to fire at a person, the incident is classified as either a hit or non hit shooting incident.*

8 **Animal Shooting Incident**: An event in which a deputy(s) intentionally fires at an animal to protect himself/herself or the public or for humanitarian reasons, including instances in which a person is hit by the round.

9 **Accidental Discharge Incident**: An event in which a single deputy discharges a round accidentally, including instances in which someone is hit by the round. *Note: If two deputies accidentally discharge rounds, each is considered a separate accidental discharge incident.*

10 **Shooting Incident - Other**: An event consisting of an instance or related instances of a deputy(s) intentionally firing a firearm but not at a person, excluding warning shots (e.g., car tire, street light, etc.) *Note: If a deputy fires at an object and then decides to fire at a person, the incident is classified as either a hit or nonhit shooting incident.*

3

	1997	1998	1999	2000	2001 (Jan - Jun)
Region I	17	8	11	13	2
Region II	20	17	10	10	12
Region III	12	8	7	9	3
Total	49	33	28	32	17
Region II %	41%	51 %	36 %	31%	70%

Moreover, as Table 3 demonstrates, Region II has had more shootings in the first six months of 2001 (12) than in all of 1999 or 2000 (10), and, if the trend in 2001 holds true, will have more shootings in 2001 than in1999 and 2000 **combined.**[11]

More worrisome still, the increase in shootings in Region II appears to be due to increases at two stations, Century and Lennox, where the **four** shootings in all of 2000 contrast strongly with **11** shootings in the first six months of 2001 alone. In other words, Century and Lennox stations accounted for all but one of the shootings in Region IIduring the first six months of 2001. Table 4 demonstrates the trends at Lennox and Century stations.

4

	1997	1998	1999	2000	2001 (Jan - Jun)
Century	14	11	1	4	7
Lennox	5	4	5	0	4

Thus, if the trend in 2001 holds, both Century and Lennox stations will account for a substantial increase in deputy-involved shootings over the last few years. Century Station

11 Conversely, both Region I and Region III are below "historical" levels in 2001 (i.e., together they represent 30% of all shootings in 2001, down from previous years (a high of 69% in 2000 and a low of 49% in 1998)). Moreover, the absolute numbers appear to be trending downward in 2001 (Region I averaged 12 shootings per year from 1997-2000, but is on pace for 4 shootings in 2001. Region III averaged 9 shootings per year from 1997-2000, but is on pace for 6 shootings in 2001).

had already had more such shootings in the first six months of 2001 than in 1999 and 2000 combined.[12] Moreover, the shootings at Century Station represent 41 percent of all of the deputy-involved shootings in the Department in 2001, reversing a trend and establishing a new all-time high for the last five years. See Table 5.

5

	1997	1998	1999	2000	2001 (Jan - Jun)
Century	14	11	1	4	7
LASD	55	35	30	33	17
Percentage	14 %	31 %	3 %	12%	41%

We find these trends alarming. But as the LASD has hastened to point out to us, it claims it, too, identified these trends early in the year, shares our concern, and is trying to determine their underlying causes. At the station level, Century Station Captain Eric Smith is studying each of the shootings in detail.[13] At the Department level, we have been told that Commander McSweeney has been asked to analyze all of the shootings in Field Operations Region II in 2001, including those at Century and Lennox Stations. We look forward to reviewing his analysis.

Although LASD managers, too, await the results of these analyses, the most frequent "educated guess" that we have heard is that the increase reflects more violence and firepower in the Century area. The "educated guess," at first blush, however, does not hold water. Part I crime statistics in the Century area do not evince a meaningful increase in violent crimes.[14]

12 Although our analysis is based upon the first six months of 2001, we also must note that there have been two additional deputy-involved shootings at Century since the end of June 2001, bringing the year-to-date total to 9 as of mid-September.

13 Eric Smith became Captain of Century Station about three months ago, succeeding Ken Brazile who has been promoted to Commander. It was during Brazile's incumbency at Century that the number of deputy-involved shootings plummeted in the wake of our **Ninth Semiannual Report.** We have in the past singled out Ken Brazile, his operations lieutenants, and his other senior management for having demonstrated that management can impact the shooting rate. We expect that Captain Smith, with the assistance of Operations Lieutenant Paul Denny, will do the same, and we look forward to monitoring and reporting on their efforts to do so.

14 Part I crimes are generally the most serious crimes against persons - e.g., criminal homicide, forcible rape, robbery, aggravated assault, burglary and larceny.

See Table 6. Although homicides may be up slightly from the two previous years, both rape and aggravated assaults are trending downward.[15]

6

	1997	1998	1999	2000	2001 (Jan - Jul*)
Part I crimes	8,900	8,125	8,007	7,820	3,891
Homicides	73	60	51	47	27
Rapes	77	83	60	81	23
Ag. Assault	2,177	2,043	2,124	2,005	807

*The July 2001 numbers have not been verified by the Department.

Nor does it appear that Century deputies are arresting more people or having more contacts with the public. See Table 7.

7

	1997	1998	1999	2000	2001 (Jan - Jun)
Total arrests	12,547	13,079	10,596	9,642	4,614
Total incidents (field activity)	137,908	132,157	136,496	130,815	62,301
Arrests per 100 contacts	9.1	9.9	7.76	7.37	7.41

To be sure, there are problems in using Part I crime statistics, particularly homicide numbers, as an appropriate surrogate for the asserted violence faced by deputies on a day-to-day basis, as we discuss in greater detail below. In Century's case in particular, we were told that a special task force detailed to Century may have successfully "suppressed" homicides in the area. Thus, the argument goes, but for this task force, the number of homicides at Century in 2001 would have been much greater, and our reliance on the "artificially low" homicide crime statistics makes it appear that Century deputies face less of a threat of violence than is really the case. We acknowledge the theoretical force of the argument, but

15 It should also be noted that Compton Station, another station within Region II, has Part I crime statistics that are very similar to those of Century Station but had no shootings in the first six months of 2001. In addition, the data provided by the Department do not show an increase in "field duty" injuries at Century Station; such an increase might have been taken as evidence of an increasingly dangerous working environment for the deputies.

absent persuasive evidence, we are not convinced.

Another theory the LASD has been put forward, if supported by the facts, may prove to hold more promise as an explanation. Captain Smith and Lieutenant Denny hypothesize that there has been an increase in gang shootings in the area in 2001. This raises the possibility that the "mix" of homicides has changed in 2001. If the thesis is correct, the asserted higher proportion of gang-related shootings in the overall mix (as contrasted to a lower proportion of other shootings, such as ones related to domestic disputes), might reflect a greater incidence of street violence and hence threats to the deputies than the homicide statistics, taken alone, would suggest. We will be interested to see if this theory is grounded in fact and, if so, can explain why Century has such a disproportionately higher number of deputy-involved shootings than in other patrol areas experiencing upticks in gang shootings. It will also be interesting to see if Century accounts for a disproportionately high number of guns seized or arrests of armed suspects.

In this vein, Century management asserts repeatedly that seven of the nine shootings to date involved armed suspects, implicitly suggesting that the fact that suspects were armed is ipso facto proof that the shootings were justified. And if the District Attorney declines to prosecute, that too is often treated as proof in and of itself that the shooting was justified. We do not necessarily see it that way. Although a deputy who faces an armed suspect pointing his weapon may have a legitimate, objectively reasonable belief that his life or that of others is endangered, and thus may be immune from criminal prosecution, the shooting may prove to be unjustified or improper from other perspectives. A shooting that fails to give rise to criminal liability may nevertheless create civil liability or be out of policy for a variety of reasons, including that the shooting took place as a result of deplorable tactics and strategy or poor training. A flat statement that the suspect was armed, therefore, does not end the inquiry.

Similarly, a flat statement that the Century area is uniquely violent and therefore will necessarily have a higher number of deputy-involved shootings does not overly impress us, in part because we have heard this argument before. Not many years ago, the LASD

commissioned a study to explain the high number of Century shootings by claiming that the area patrolled by Century Station was unique in terms of the ambient violence in the area. The explanation did not hold water, as our in-depth review of Century Station in the **Ninth Semiannual Report** revealed.

Giving further grounds to our skepticism is that the argument does not work in reverse. For example, homicides in the Century area **decreased** between 1999 and 2000 but the number of deputy involved shootings actually **increased**. We did not hear the LASD arguing that the number of shootings was too high given the decreased ambient violence. Thus, even assuming that the number of homicides bears a correlation to the level of ambient violence, it is far from clear that the level of ambient violence correlates to the number of times that deputies fire their guns at suspects. To their credit, those in the Department who are investigating the shooting trend appear to trying in good faith to uncover the cause or causes of that trend. Moreover, the managers at Century Station have shown a willingness to take decisive action with respect to shootings when they believe that they are unjustified. For example, after two shooting incidents at the beginning of this year involving unarmed suspects, deputies at Century received on-site supplemental training on firearm use.

We should make clear that we do not reject out of hand, at least as a theoretical matter, that the number and mix of homicides, in particular, or the level of ambient violence, in general, have predictive force on the number of deputy-involved shootings. But to assert it is not to prove it. The LASD must thoroughly investigate the shooting trend instead of simply accepting by default an explanation that reinforces gut instincts and allows it to avoid a deeper analysis that may implicate Department policies, personnel, or management failures in the increased number of shootings. In any case, we will continue to monitor the situation at Century Station, particularly since, as noted in the next section, Century Station is increasing its other uses of force as well.

II. USE OF FORCE.

As we noted in the **Thirteenth Semiannual Report**, after years of a significant decline in the use of force, there was a discomforting rise 1999 and the first part of 2000. Ominously, this trend is continuing in 2001. Even more unfortunately, this trend is particularly pronounced at Century Station.

As Table 8 demonstrates, use of force rate has risen fairly steadily throughout all the patrol regions over the past five years. While the use of force remains rare (only 1.41 times per 100 arrests), the rate has increased 32 percent since 1997. Table 8 also demonstrates that the largest increase has occurred in Region II, where the rate increased 64 percent between 1997 and 2001.

8

	1997	1998	1999	2000	2001(Jan - Jun)
Region I	336	390	373	375	186
Per 100 arrests	.95	.99	1.09 (1.10)*	1.22	1.24
Region II	344	329	445 (428)	504	284
Per 100 arrests	1.09	1.03	1.39 (1.42)	1.67	1.79
Region III	365	319	288	350	173
Per 100 arrests	1.18	1.04	.97 (.96)	1.16	1.18
Total	1,045	1,038	1,106	1,229	643
Per 100 arrests	1.07	1.02	1.15	1.35	1.41

*The numbers in parentheses represent slightly different ones given to us recently as contrasted to numbers provided in connection with our Thirteenth Semiannual Report.

Even more worrisome, the Department-wide use of **significant** force in the patrol areas is increasing at even a faster rate than the use of force overall: Whereas the rate of force increased 32 percent between 1997 and 2001, the rate of significant force increased 67 percent during that same time period. See Table 9.

9

	1997	1998	1999	2000	2001 (Jan - Jun)
Regions I, II & III	473	553	583	663	365
Per 100 arrests	.48	.54	.61	.73	.80

These general trends are magnified in the case of Century. For example, the Department-wide increase of 32 percent in the overall rate for use of force in the patrol areas between 1997 and 2001 is dwarfed by Century's **149 percent** jump in that time period.[16] See Table 10.

10

	1997	1998	1999	2000	2001 (Jan - Jun)
Total force incident	111	123	148	165	101
Per 100 arrests	.88	.94	1.40	1.71	2.19

Even worse, Century's **253 percent** increase in the use of significant force overshadows the worrisome 67 percent increase in the rate of the use of significant force Department-wide in the patrol areas between 1997 and 2001. See Table 11.

11

	1997	1998	1999	2000	2001 (Jan - Jun)
Total sig. force	43	61	86	105	54
Per 100 arrests	.34	.47	.81	1.09	1.20

But that is not all. There are other disturbing trends in the force data from Century Station. The rate of significant force with visible injury has skyrocketed, up **85 percent** between 2000 and 2001 to date and up **154 percent** since 1998. See Table 12.

12

	1998	1999	2000	2001 (Jan - Jun)
Century				
Total sig. force w/ visible injury	32	37	32	28
Per 100 arrests	.24	.35	.33	.61
Field Operations Regions				
Total sig. force w/ visible injury	263	285	296	169
Per 100 arrests	.26	.30	33	.37

16 We have focused on Century Station for two reasons; (1) the increase in the use of force in the Department appears to be largely due to an increase in Region II, and the increase in Region II appears to be largely due to an increase at Century Station; and (2) Century Station has been an area of particular concern in the past. This focus should not be interpreted to mean that no other stations within Region II are worthy of attention. In particular, the West Hollywood Station has seen a significant increase in its use of force rate (54 percent) since 1997, and its rate in 2001 (2.27 uses of force per 100 arrests) is higher than the rate at Century Station.

Moreover, Century Station experienced more uses of force leading to hospitalization or death in the first six months of 2001 *than in the three previous years combined*. Although the total number of such incidents remains small, the increase is inconsistent with the trend seen Department-wide in the patrol areas. Overall, the LASD's Field Operations Regions are on track to record fewer such uses of force in 2001 than either 1999 and 2000. See Table 13.

13

	1998	1999	2000	2001 (Jan - Jun)
Century				
Total sig. force w/ hosp. / death	0	0	2	3
Field Operations Regions				
Total sig. force w/ hosp. / death	10	21	20	5*

*The numbers are so small that no ratios were calculated. We cannot completely account for the jump between 1998 and 1999. It appears that it was due to activity at the Lennox Station and in the Special Enforcement Bureau. Lennox's number of significant uses of force resulting in hospitalization or death dropped in 2000 to zero, but the East Los Angeles Station went from zero to seven such uses of force.

These force trends greatly concern us. They represent an increased safety risk to deputies, an increased risk of harm to suspects, and an increased litigation risk to the Department.[17] Unlike the uptick in deputy-involved shootings - which, as noted above, is receiving attention at both the station level and above - it is our distinct impression that at least some Department executives and managers in Region II and elsewhere were unaware of these trends until they heard about them from us.

This brings up the Department's virtual abandonment of a useful risk management tool that had been used to uncover, track, and attack such trends. In the **Twelfth Semiannual Report,** we first reported our disappointment at the discontinuation of the Department-wide risk management meetings, called the Sheriff's Critical Issues Forum, or SCIF, that had been devoted to quickly spotting and eliminating worrisome trends. In that report, we also

17 Civil claims are also trending upwards at both Century Station (on pace for a record year in 2001 for both the number of claims (35 in the first six months in 2001 versus 18 in all of 2000 and an average of 35 in the years 1997-2000) and the rate of claims as measured per 100 arrests (.76 in 2001 versus .19 in 2000) and the Field Operations Regions as a whole (285 in the first six months of 2001 versus 337 in all of 2000 and the rate of claims as measured per 100 arrests (.63 in 2001 versus .37 in 2000). While we do not know if these increases reflect an increase in **force** related claims (but intend to research this issue in the near future), they are nonetheless a cause for concern.

encouraged that the SCIF meetings be resumed. After noting a continuation of worrisome trends in the **Thirteenth Semiannual Report,** we repeated our view that SCIF should be resumed. Since that Report was issued in December 2000, the SCIF process has been resurrected, but only in a fashion. Each Field Operations Region conducts its own SCIF on its own schedule; presently, it appears that the Regional SCIFs are occurring on a quarterly (or even less frequent) basis.

While we acknowledge the resumption of SCIF process in some form, and we intend to closely follow the division-level SCIFs to gauge their contribution to risk management at the Department, it is a tepid and unsatisfactory response. By devolving responsibility to regional chiefs, the LASD's top executives are not participating in and communicating Department-wide concerns and values. There is no single executive, and no corps of dedicated experts scouring SCIF and CARS data on a daily basis, keeping a finger directly on the Department's pulse with respect to use of force.

In the past, the former Undersheriff and one of the Assistant Sheriffs had a group of the LASD's best and brightest doing just that. Whatever criticisms might be leveled at SCIF concerning whether it was conducted in a respectful manner toward the managers involved, it cannot be argued that it was ineffective in keeping use of force in check.

The importance of the SCIF process to meaningful risk management cannot be over-stated. Indeed, most of the trend data cited in this chapter were gleaned from "SCIF Indices" generated by the Department.[18] We believe that the Department ignores such trends at its peril.

When we attempted in our **Thirteenth Semiannual Report** to point out worrisome force trends, the LASD in response was quick to trivialize our observations by noting that

18 In a positive development, the Department's MIS department will shortly begin posting the SCIF Indices on the Department's intranet site on a monthly basis. This will obviously make it easier for the SCIF data to be viewed on a regular and frequent basis. The MIS department should be commended for its work on this project, which has included automating the generation of the SCIF data. It should be noted, however, that for the past months the SCIF data were only available upon request, and that it appears that few requests were ever made. This in itself appears to reflect the Department's failure to adequately use all of the existing risk management tools in its possession.

although the rate of force has clearly been increasing, the overall incidence of force per each 100 arrests remains low. We acknowledge that force is used in less than two percent of arrests. But that's not the point.

Lest there be any doubt, let us state our concerns in the frankest possible way:

- The precipitous rise at Century Station in shootings, force leading to hospitalization, death, and visible injury, as well as use of force in general, is a matter of grave concern. It needs to drop equally precipitously if, after careful review, the Department determines that it is due to causes within its control. Century's apparently disproportionate use of lethal and non-lethal force revives concerns we thought we had been allayed regarding whether Century Station's culture and performance are out of step with respectful, effective, and community-oriented policing. The failure to aggressively investigate these trends reflects poorly on the Department as a whole and raises questions about the determination of the LASD to control force. It is one thing to talk about a kinder and more sensitive approach to law enforcement issues. It is another to tolerate, without inquiry, Century's 253 percent increase in the use of significant force.
- The apparently poor performance of Region II in force matters is a matter of deep concern for the same reasons and similarly must be addressed.
- The markedly reduced emphasis of the LASD on risk management, accountability, controlling force, and use of early warning and trend data is ill-serving the public and the taxpayers of Los Angeles.

4. Litigation

In our last report, we discussed litigation during fiscal year 1999-00 and noted potentially troublesome trends. After seven years of declining numbers of excessive force lawsuits, we noted an increase. We also pointed out a general rise in the number of active lawsuits involving the LASD.

With regard to excessive force cases, the trends have continued. During fiscal year 2000-01 ending June 30, 2001, the number of new excessive force lawsuits filed rose to 67, an increase of nearly 25 percent over the prior fiscal year. The number of such cases pending at the end of the fiscal year was 102, an increase of approximately ten percent over the prior fiscal year. On the other hand, the total number of active lawsuits declined from 435 to 422 from fiscal year 1999-2000 to 2000-01. See Table 1. Nonetheless, the LASD received a somewhat greater number of lawsuits and claims last year as compared to the fiscal year before: In fiscal year 1999-00, the LASD received 282 new lawsuits; in fiscal year 2000-01, it received 287. In fiscal year 1999-00, the LASD received 1028 claims; in fiscal year 2000-01, it received 1151.

The total amount of judgments and settlements in fiscal 2000-01 was $19,221,435.[1] Of that amount, however, nearly $14 million related to the settlement of a 1984 case where the plaintiff had alleged that he had been falsely imprisoned and maliciously prosecuted for child molestation. Taking this settlement out of the picture because of its age, the total of judgments and settlements in fiscal 2000-01 came to $5.2 million, down from $7.3 million the year before. Force-related judgments and settlements totaled approximately $2.9 million in fiscal year 2000-01, down from $4.6 million in 1999-00. See Tables 2 and 3.

The most significant force-related settlements both involved deaths in the jails. Both involved 33 year-old inmates who suffocated as deputies attempted to restrain them. Both had enlarged hearts. The first case is that of Kevin Evans, discussed at length

1 This figure does not include the $27 million settlement of the over-detention class action that was widely reported a few weeks ago. That settlement will be part of fiscal year 2001-02 statistics.

earlier in this report. The second case is that of Mark Philyaw.

The Philyaw case settled for $1.5 million. Mark Philyaw either was physically unable to comply or else refused to permit himself to be strip searched upon return from court. A fight then broke out as deputies attempted to force him to comply. At least three deputies then struggled to restrain Mr. Philyaw by getting on top of him. As the coroner's investigator told *The Los Angeles Times*, "He died of traumatic and positional asphyxia. . . . His death was partially caused by someone lying on top of him and partially caused by the position his body was in."

The Philyaw and Evans cases point to serious litigation risks in the LASD's techniques for restraint of combative or disruptive inmates. Both cases deteriorated into free-for-alls in which the suspect died from lack of air. Any restraint techniques which run the risk of cutting off an inmate's ability to breathe should clearly be banned, including putting substantial weight on an inmate's chest, diaphragm, throat, neck, and face. We recommend that the LASD consider wholesale revision of its techniques for swarming inmates or suspects to eliminate any maneuvers that interrupt breathing.

1

LASD Litigation Activity, Fiscal Years 1992-2001

	FY 92-93	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01
New Force Related Suits Served	88	55	79	83	61	54	41	54	67
Total Docket of Excessive Force Suits	381	222	190	132	108	84	70	93	102
Lawsuits Terminated									
Lawsuits Dismissed	79	90	60	42	39	27	20	24	34
Verdicts Won	22	9	10	6	3	6	1	1	4
Verdicts Against LASD	3	7	3	5	2	1	2	2	0
Settlements	70	81	103	82	41	45	32	13	21

Lawsuits Terminated Fiscal Year 2000-2001

	Dismissed	Settled	Verdicts Won	Verdicts Against	Totals
Police Malpractice	130	84	8	6	228
Medical Malpractice	9	3	0	0	12
Traffic	12	23	0	1	36
General Negligence	2	1	1	0	4
Personnel	3	8	1	1	13
Writs	1	0	2	1	4
Total	**157**	**119**	**12**	**9**	**297**

Activity Lawsuits by Category

	7/1/98	7/1/99	7/1/00	7/1/01
Police Malpractice	224	247	341	299
Traffic	47	43	37	50
General Negligence	7	8	3	12
Personnel	19	22	16	16
Medical Malpractice	22	28	25	30
Writs	8	6	13	15
Total	**327**	**354**	**435**	**422**

2

Fiscal Year 2000-2001 Department Financial Summary

	Department Funded	Contract City Funded	MTA Liability Funded	Totals
Lawsuits				
Police Liability	$17,656,117.00	$292,820.00	$0.00	$17,948,937.00
(Portion of Total for Alleged Excessive Force)	*$2,689,500.00*	*$174,800.00*	*$0.00*	*$2,864,300.00*
Personnel Issues	$487,000.00	$0.00	$0.00	$487,000.00
Auto Liability	$278,343.00	$170,500.00	$10.000.00	$458,843.00
Medical Liability	$57,750.00	$0.00	$0.00	$57,750.00
General Liability	$500.00	$0.00	$0.00	$500.00
Writs	$0.00	$0.00	$0.00	$0.00
Lawsuit Total	**$18,479,710.00**	**$463,320.00**	**$10,000,00**	**$18,953,030.00**
Claims				
Police Liability	$97.855.00	$4,585.00	$525.00	$102,965.00
(Portion of Total for Over Detentions)	*$0.00*	*$0.00*	*$0.00*	*$0.00*
Personnel Issues	$0.00	$0.00	$0.00	$0.00
Auto Liability	$138,496.00	$24,222.00	$0.00	$162,718.00
Medical Liability	$0.00	$0.00	$0.00	$0.00
General Liability	$2,360.00	$362.00	$0.00	$2,722.00
Claim Total	**$238,711.00**	**$29,169.00**	**$525.00**	**$268,405.00**
Incurred Claims/ Lawsuits Liability Total	**$18,718,421.00**	**$492,489.00**	**$10,525.00**	**$19,221,435.00**
FY 1900/00 Total	$7,002,511.00	$479,227.00	$387.00	$7,481,738.00
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	2000-01
	$17 million*	$3.72 million	$1.62 million	$27 million**	$4.6 million***	$2.9 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.

4

Inmate Over Detentions

Fiscal Years	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01
Over-detentions	301	339	712	495	267	191