The Los Angeles County

Sheriff's Department

17th Semiannual Report

by Special Counsel Merrick J. Bobb and Staff

and Police Assessment Resource Center (PARC)

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Introduction

This is the Seventeenth Semiannual Report of Special Counsel commenting on the Los Angeles County Sheriff's Department (LASD) for the Board of Supervisors, the Sheriff, and the general public. Special Counsel's reports describe the LASD's efforts to implement a wide variety of reforms and identify additional areas for improvement.

In this report, which reflects the status of the Department in the summer and fall of 2003, we focus on several aspects of the LASD's operation of the Los Angeles County jail system. That system, with an inmate population ranging from 17,500 to 22,000 over the past decade, is the largest in the country. In this report, we touch upon three particular areas of the LASD's custody operations.

Chapter One examines inmate violence and the use of force by LASD personnel. The Department undertook several violence management initiatives in the wake of inmate rioting in 2000. The following year violent disturbances declined substantially. However, some of these initiatives — which included a problem-solving "Liaison Deputy" program, and the segregation of younger, more violence-prone inmates — were subsequently discontinued because of budgetary constraints. And although several promising and commendable strategies are still in operation, a significant increase in violent disturbances began in 2002 and continues to the present. Moreover, inmate assaults on both inmates and staff also increased over the same period.

Our examination of recent trends in the use of force by LASD personnel found that significant reductions in the number of force events achieved in 2001 have since reversed, with uses of force rising steadily since 2002. Our review found that the LASD has been pursuing some positive force management strategies including promoting the use of OC spray in lieu of riskier force options; requiring a supervisory presence in certain high-risk scenarios; and conducting generally (although not universally) effective investigations and reviews of incidents where force is used.

An important component of the LASD's force management program is the training it provides to its employees in the use of force. However, gaps in the current training system allow lateral transferees and newly-promoted supervisors to work in custody facilities for substantial periods of time before they receive necessary force training — potentially leaving these staff members unprepared to defend against assaults or to appropriately control violent inmates. Moreover, no mechanism currently exists to ensure that all custody personnel receive in-service force training, while recent changes to the in-service program have led to deep cuts in the amount of training provided in this critical skill area. In addition, some custody facilities are providing "in-house" force training that is insufficiently regulated by the LASD.

Chapter Two addresses one of the LASD's principal tools in managing risk, the Facilities Automated Tracking System (FAST). FAST is a sophisticated relational database that tracks a broad range of custody-specific, risk-related data, from officers' use of force to inmate suicide attempts. The database enables Department managers and executives to conduct complex analyses of risk-related trends, from increases in particular types of inmate injuries, to identifying officers who may account for a disproportionate use of force.

While FAST is excellent, we found areas for improvement. FAST reports numerous details regarding inmate complaints, but does not provide

a way to identify Department employees accused of misconduct. A related concern is that FAST does not break down personnel complaints by category, such as excessive force, discourtesy, or discrimination. Accordingly, managers cannot examine trends about the officers who generate complaints or about the types of complaints lodged against their employees. In response to our proposals, the Custody Division agreed to modify FAST to capture this information. We also had concerns about the software application used for FAST, and the fact that there is only one person fully familiar with the program.

Another area of concern was quality control. After discussions with our staff, the Custody Support Services unit has agreed to increase the number of quality control mechanisms and therefore reduce the risk of tardy or inaccurate data entry.

Chapter Three focuses on the Department's Inmate Reception Center (IRC), which serves as the hub through which new prisoners enter the jail system, are sent to and from court appearances, and leave the jails when released or transferred to other facilities. We reviewed three aspects of IRC's operations: overdetention of inmates; erroneous releases; and use of force.

Overdetentions continue a sharp downward trend, with only 49 overdetentions for the first nine months of this year compared to 607 for all of 1997 and 249 for all of 2000. Much of the continued downturn appears to stem from the In-Court Release and Greenband Program, which reduces the risk of mistaken overdetentions by releasing inmates at the courthouse.

Erroneous releases have also recently declined, although the trend over the last several years has been inconsistent. We reviewed the erroneous release cases from the past several years and did not perceive any systemic or personnel problems that led to the mistaken releases. Beginning this year IRC has added a second layer of review designed to identify potential overdetentions and erroneous releases.

IRC has shown improvement in the area of force. Over the past four years, IRC has faced a steady increase in its average daily inmate population while its staffing has increased only slightly, resulting in an inmate-to-officer ratio today that is nearly double what it was in 1999. Nonetheless, when we control for the change in inmate population by looking at force incidents per 1000 inmates, there were only 1.47 such incidents for January – mid-September of this year, compared to 1.95 incidents per 1000 inmates last year, 1.54 for 2001, and 3.85 for 2000. In addition, we were encouraged to see this year two initiatives designed to better manage use of force: monthly force review meetings and supplemental, skills-based training regarding encounters with mentally ill inmates.

We audited roughly 40 percent of IRC's use of force incidents from January 2002 through September 2003 and found that, by and large, force cases were investigated and presented for decision in a thorough, balanced manner. In addition, we found that many of the cases appropriately identified issues of tactics and training that might assist officers to avoid future injury or even to avoid future confrontation altogether. Nonetheless, we found a small incidence of problems requiring closer attention.

Following Chapter Three is an Appendix with tables setting forth data we routinely collect and publish concerning LASD-related litigation and use of force.

Use of Force and Inmate Violence in Custody Facilities 1

Introduction

The task of managing the use of force by officials and the violence committed by inmates in the Los Angeles County Sheriff's Department's Custody Operations Division (hereafter referred to as "Custody Division" or "Custody") facilities[1] presents significant challenges at the best of times. These times, however, are far from the best: budgetary constraints have prompted reductions in the population capacity of the jails, with a consequent concentration of more serious offenders in the inmate population. Those same constraints have simultaneously caused cutbacks in authorization for overtime, leaving fewer staff to manage a more difficult inmate population and reducing the deployment of several promising violence-control initiatives. It is against this backdrop that we turn our attention to the use of force by LASD Custody Division personnel, inmate violence, and jailhouse disturbances. This chapter will examine recent trends in these areas and the strategies used by the LASD to manage the considerable risks associated with each.

1. The LASD's currently-operating custody facilities are: (1) Twin Towers Correctional Facility (TTCF); (2) Men's Central Jail (MCJ) ; (3) North County Correctional Facility (NCCF); (4) Century Regional Detention Facility (CRDF); (5) Mira Loma Detention Facility (MLF) (devoted exclusively to INS detainees); (6) Pitchess Detention Center- North, and (7) Pitchess Detention Center-East. Until early this year, the LASD operated an eighth custody facility, the Pitchess Detention Center-South. This facility closed due to budgetary cutbacks.

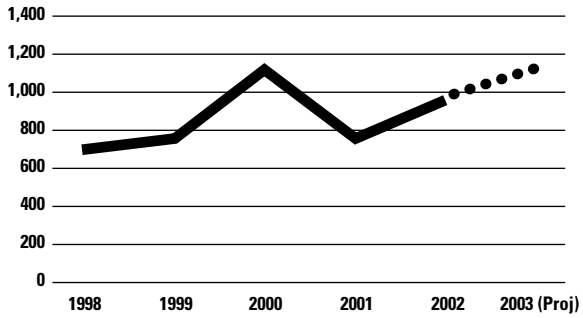
I. Trends in Use of Force and Inmate Violence

A. Use of Force

As Table 1.1 shows, the total number of force events occurring in Custody Division facilities rose to a peak in 2000. The following year saw a substantial decline, but by 2002 the downward trend had reversed itself to an upwards trend that continues to the present. Force events increased 31 percent in 2002 and are projected to increase an additional 16 percent in 2003.

The LASD classifies force as either "less than significant" or "significant,"[2] and Tables 1.2 and 1.3 divide the total number of force incidents into those

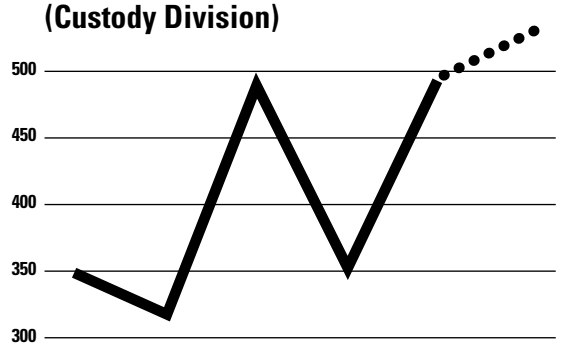
Table 1.1
Total Force Events (Custody Division)



1998	1999	2000	2001	2002	2003 (Proj)
709	736	1,157	749	979	1,140

Projection from data as of 9/1/03 Source: Custody Support Services

Table 1.2
Significant Force Incidents (Custody Division)



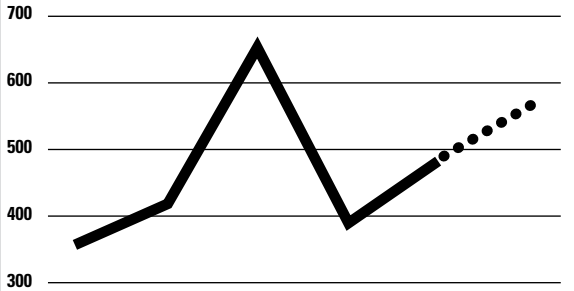
1998	1999	2000	2001	2002	2003 (Proj)
349	317	482	357	491	564

Projection from data as of 9/1/03 Source: Custody Support Services

2. Force is classified as "significant" whenever the force used results in injury to the inmate, a complaint of pain by the inmate (except when that pain is caused by OC spray), an indication or allegation of misconduct by the LASD employee, or where the force used is greater than a department-approved hold or come-along.

two categories. While less frequent use of force is always desirable, increases in the number of significant force events cause particular concern due to the greater level of associated risk. It is notable that the upswing in force that occurred in 2002 consisted disproportionately of significant force events, leading to more uses of significant force that year than of less than significant force. Significant force events increased 38 percent in 2002, while less than significant force incidents increased 25 percent.

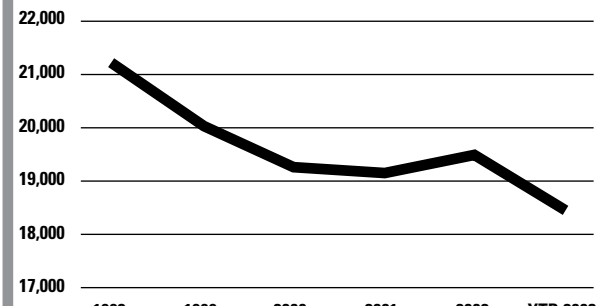
Table 1.3
Less Than Significant Force Events (Custody Division)



1998	1999	2000	2001	2002	2003 (Proj)
360	419	665	390	487	576

Projection from data as of 9/1/03 Source: Custody Support Services

Table 1.4
Average Daily Inmate Population (Custody Division)



1998	1999	2000	2001	2002	YTD 2003
21,302	20,221	19,297	19,136	19,508	18,423

YTD 2003: Data as of 9/1/03 Source: Custody Support Services

B. Inmate Violence

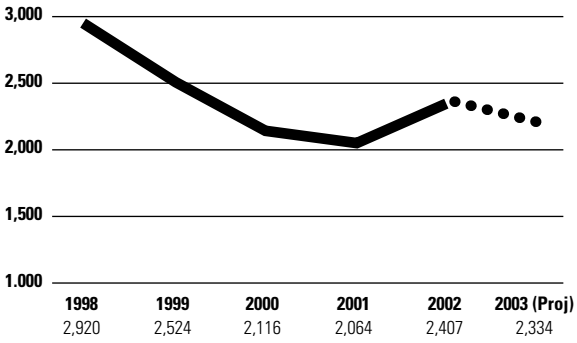
Custody facilities house difficult populations under circumstances that are often far from harmonious. The challenges involved in minimizing the incidence of violence among inmates are considerable. And, according to most LASD officials we interviewed, recent times have seen these challenges intensify.

Inmate violence ranges from individual inmates attacking one another to riots involving hundreds of inmates. Assaults may involve minor pushing and shoving or life-threatening attacks involving weapons. And while the

victims of inmate violence are overwhelmingly other inmates, LASD personnel, too, can and do become victims of inmates' violence.

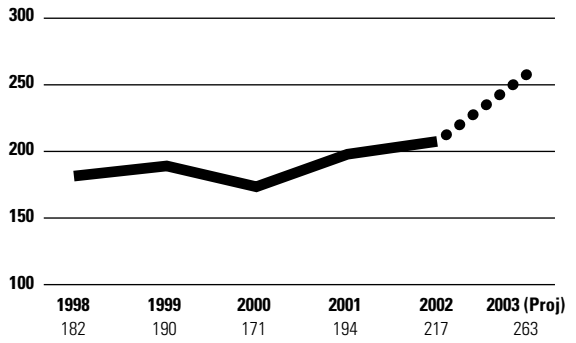
There was near unanimity among LASD officials we interviewed that the control of inmate violence has become more challenging as reductions in population capacity, combined with restrictions on overtime spending and staff attrition, have left fewer staff in charge of an inmate population with a higher concentration of serious offenders. As Table 1.4 demonstrates, the average daily inmate population has decreased 14 percent since 1998. Meanwhile, as Table 1.5 shows, inmate-on-inmate assaults declined from 1998 to 2001. That trend reversed in 2002 when such assaults increased 17 percent, at a time when the jail population increased only two percent. And, as Table 1.6 illustrates, custody facilities have become an increasingly dangerous place for LASD personnel as the number of assaults on staff by inmates has increased 54 percent since 2000.

Table 1.5
Inmate versus Inmate Assault Incidents (Custody Division)



Projection from data as of 9/1/03 Source: Custody Support Services

Table 1.6
Inmate versus Staff Assault Incidents (Custody Division)

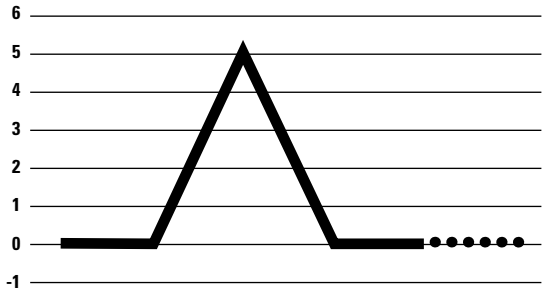


Projection from data as of 9/1/03 Source: Custody Support Services

While all inmate violence is undesirable, outbreaks of group violence are

particularly troubling due to their capacity to produce multiple casualties and to require substantial uses of force by LASD personnel. When group violence erupts in LASD custody facilities, it overwhelmingly takes the form of conflict between Latino and African-American inmates. According to all the officials we spoke to, only a small percentage of the disturbances[3] that occur are organized in advance. The great majority occur spontaneously — typically sparked by a minor altercation between individual inmates. When such altercations involve members of different races or ethnicities, they can quickly escalate as members of the respective groups take sides and join the fray.

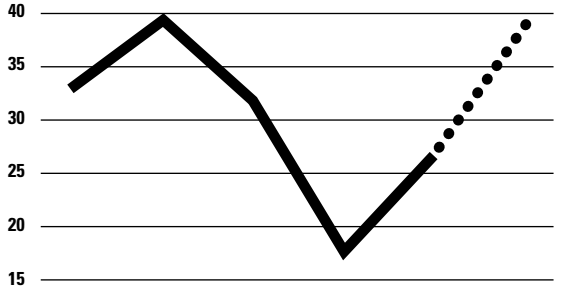
Table 1.7 **Riots (Custody Division)**



1998	1999	2000	2001	2002	2003 (Proj)
0	0	5	0	0	0

Projection from data as of 9/1/03 Source: Custody Support Services

Table 1.8
Major Inmate Disturbances (Custody Division)



1998	1999	2000	2001	2002	2003 (Proj)
33	39	32	17	26	39

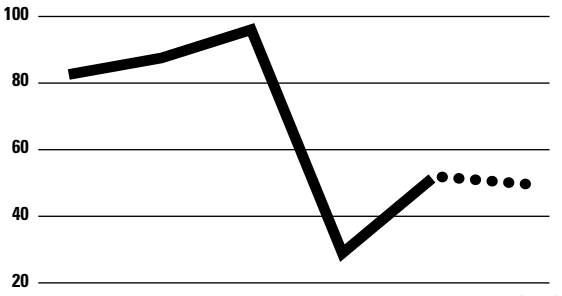
Projection from data as of 9/1/03 Source: Custody Support Services

The LASD classifies disturbances as minor, major, or riots. Riots — the most serious form of disturbance — are rare events. Between 1998 and 2003, there was only one outbreak of rioting,

3. The term "disturbances" captures a wide variety of incidents which can generally be described as violent altercations involving multiple participants. Not all disturbances result in injuries or uses of force.

involving large-scale interracial/ethnic violence at the Pitchess Detention Center in 2000. As Tables 1.7–1.9 illustrate, after the incidence of disturbances peaked in 1999 and 2000, a marked decline occurred in 2001. Major disturbances decreased 47 percent, and minor disturbances 70 percent. That decline reversed in 2002, and in 2003 the rate of disturbances combined has continued to rise. The number of major disturbances increased 129 percent from 2001 to 2003, and the number of minor disturbances increased 62 percent.

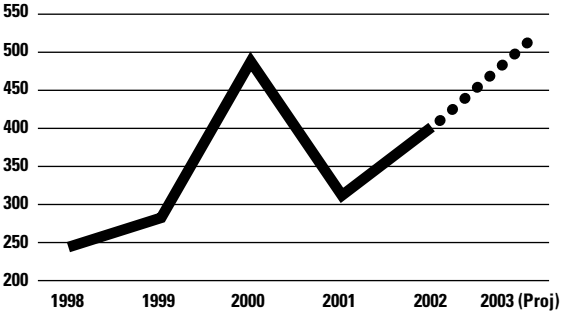
Table 1.9
Minor Inmate Disturbances (Custody Division)



1998	1999	2000	2001	2002	2003 (Proj)
82	85	96	29	51	47

Projection from data as of 9/1/03 Source: Custody Support Services

Table 1.10
OC Incidents (Custody Division)



1998	1999	2000	2001	2002	2003 (Proj)
244	279	481	310	400	516

Projection from data as of 9/1/03 Source: Custody Support Services

LASD officials attributed the significant reduction in disturbances in 2001 to an increased focus on the management of jailhouse violence in the wake of the rioting that occurred in 2000. The period immediately following the rioting saw the implementation of a number of initiatives designed to mitigate the underlying causes of jailhouse violence, as well as increased attention to existing strategies. Several initiatives were implemented only temporarily. Their cessation has coincided with a reversal of the downward trend in disturbances to which they likely contributed.

II. Force Management Strategies

As we have articulated in previous reports, the incidence of force events is likely to decrease if good management strategies are implemented.[4]

A. Monitoring Trends in Use of Force

We were encouraged to find that the captains in charge of the various jails actively monitor trends in use of force data as a means of identifying force-related management issues. The captains' monitoring goes beyond determining whether the gross number of force events is rising or falling, to examining who the individual employees using force are, the area of the facility in which the force was used, the type of force that was used, and a variety of other instructive facts. All but one facility captain told us that unit data are reviewed at least once a month, with the remaining facility conducting reviews on a quarterly basis. Several captains recounted how their trend analyses had enabled them to identify and remedy risk factors that could otherwise have gone unnoticed.

We encourage the Custody Division to require that all facilities conduct force trend analyses on at least a monthly basis.

B. Promoting Use of Incapacitant Spray

A variety of weapons, including pepperball launchers, stingball grenades, and Tasers, are available for use by custody personnel under appropriate circumstances. However, staff members typically engage with inmates while equipped with nothing more than a canister of incapacitant spray (OC, or a mixture of OC and CS) and their "personal weapons" (*i.e.*, hands, feet, and so on). Force incidents that occur in a custody setting typically involve the use of incapacitant spray or personal weapons, or a combination of both.

The resolution of relatively minor force incidents by the use of

4. See, for instance, **Fifteenth Semiannual Report** (July 2002), page 1.

incapacitant spray alone often represents the preferable option. The use of spray presents a minimal risk of injury to either the inmate or the staff member, and can facilitate the resolution of a violent encounter without any need for physical contact. The use of personal weapons, meanwhile, is riskier. Not only does the use of a personal weapon increase the risk of injury to the inmate, but it requires that the employee place him or herself in close proximity to the violent or resistive inmate. Moreover, an improperly-executed strike can injure the staff member. Similarly, other techniques requiring physical contact, such as takedowns, present an elevated risk to both inmate and employee.

Facility managers reported that they are actively encouraging their staff, whenever feasible, to use incapacitant spray in lieu of other force options. There are indications that these efforts have been effective: Division-wide, use of incapacitant spray has risen 111 percent since 1998. *See* Table 1.10. This increase has occurred at a rate that outstrips the growth in the number of force incidents, demonstrating that spray is increasingly being used in lieu of alternative force options.

C. "Recalcitrant Inmate" Policies

A number of facility captains attested to the value of their "recalcitrant inmate" policies as a means of avoiding or mitigating the need for the use of force when staff members encounter non-compliant or aggressive inmates.[5] These policies regulate the actions staff may take upon encountering a recalcitrant inmate and require a supervisory presence before such an inmate is engaged. Every custody facility operates with such a policy.

D. Force Packages

Whenever an LASD employee reports that he or she has used force, a

5. Twin Towers Correctional Facility's recalcitrant inmate policy is reproduced at the end of this chapter. (Note that the reference in the policy to "K-12" means mentally ill.)

Disseminating Lessons Learned

In the course of auditing force packages, we identified several cases that contained potentially valuable force management lessons. With the exception of the limited number of cases subject to review by the Executive Force Review Board or Disturbance Review panel, there is currently no formal requirement for facilities to disseminate such lessons, or to pass such information to a designated contact point. We discussed several instructive cases with Custody Training Unit staff members. These staff members were unaware of the cases our audit had identified, despite the potential value of those cases to their role as trainers. Both Custody Training Unit staff and senior divisional officials agreed that such information could be better managed by the designation of responsibility for the appropriate dissemination of such information to a particular LASD unit, along with a requirement that lessons of interest raised by incident reviews be forwarded to that unit. We recommend that a formal system of disseminating useful lessons from force packages be implemented, thereby enhancing the force management potential of the force package process.

supervisor is required to investigate and review the incident, and to report the outcome of that investigation and review. The supervisor's report is known as a "force package." Facility captains personally review all force events that occur in their jails by reading every force package. Most emphasized the key role force packages play within their systems of force management.

We have reviewed 232 custody division force packages, most of which involved 2002 force incidents and which constituted more than one fifth of the total force events that occurred division-wide that year. We were encouraged to find that most of the force packages we reviewed related to relatively straight-forward, non-problematic, and minor uses of force that had been adequately and appropriately reviewed by supervisors. However, we found a small but troubling number of cases where the potential for force management had been squandered. These cases were characterized by the failure either to identify clear problems with techniques or tactics used by staff members, or to make recommendations for appropriate remedial action concerning problems that had been identified. The following examples are representative of such cases.

Case 1. Deputies Y and Z were watching a group of seated, handcuffed, and waist-chained inmates while their housing area was being searched. Deputy Y was equipped with a pepperball launcher.[6] Deputy Z was equipped with a canister of MK 46 OC spray.[7] Both the pepperball launcher and MK 46 are classified by the LASD as "special weapons."[8]

One of the group of seated inmates, Inmate C, suddenly rose to his feet and began to assault Inmate D by kicking him. Deputy Z reacted by spraying Inmate C with OC from his MK 46 canister and ordering the inmate to lie on the ground. Inmate C did not stop the assault. Deputy Y then fired several pepperball rounds at Inmate C. Inmate C fell to the ground but continued to kick towards Inmate D. Deputy Y fired several more rounds. Inmate C then became compliant.

Inmate D was uninjured by Inmate C's assault. Inmate C was struck by nine rounds, and an uninvolved inmate was struck by a tenth. Inmate C was struck in the upper body, back, and head. He sustained injuries described as "bloody welts" on his head, chest, and back, along with a bloody nose.

In his review of the incident, the Watch Commander observed that the intended use of the pepperball launcher is to deploy OC into areas which cannot be reached using spray from a canister. He also noted that the projectiles may be fired at an inmate's lower body in cases where life is endangered and/or there is no other means of reaching an assailant to stop an assault. The reviewer correctly noted that these circumstances did not apply in this

6. The pepperball launcher is a weapon that fires projectiles that break and release a chemical irritant upon impact.

7. This type of weapon contains a greater volume of OC spray, and has greater range, than a regular canister of OC.

8. According to LASD Custody Division Manual, § 3-03/10.00 (Nov. 2003), the deployment of special weapons requires the authorization of a Watch Commander or Incident Commander, or higher ranking official. Authorization for the use of special weapons can only be given by a sergeant or senior deputy, although policy allows employees to use the weapon without direct supervision if an inmate's actions pose a substantial threat of serious injury.

event, and that Inmate C, or any other inmate, could have been seriously hurt by the use of pepperballs. No determination was made as to whether Deputy Y's actions were within policy. The Watch Commander recommended that the deputy "be scheduled for remedial training regarding the policy in the use of the pepperball gun." Deputy Z's use of the MK 46 OC spray was found to be justified and within policy.

We consider this force package to be troubling in the following respects:

- There is no indication why, or by whom, authorization for the deployment of special weapons had been given. Accordingly, the force package does not address whether the authorization that was given was appropriate.
- There is no indication that a supervisor was present when the force event occurred. The force package does not address the wisdom of leaving the deputies unsupervised while equipped with special weapons.
- The distance from which the pepperball launcher was used is neither indicated nor evaluated.
- The validity of Deputy Z's decision to deploy a special weapon absent supervisory direction is not explored.
- The force package does not indicate the precise number of pepperball rounds discharged, nor is there any indication whether the MK 46 canister was weighed to determine how much spray was used.
- Although the Watch Commander expresses clear dissatisfaction with Deputy Y's actions, he does not squarely address whether the deputy had violated Departmental policies regarding special weapons or the use of force.
- The remedial action recommended by the report is inadequate. In addition, there is no consideration of whether any remedial action should be taken with respect to the involved deputies' supervisor(s).

Case 2. Deputy A heard an inmate shouting from a row of disciplinary cells. Although the row was already under supervision by Deputy B, Deputy A entered — purportedly to provide whatever assistance Deputy B might have needed.

As Deputy A passed Inmate X's cell, Inmate X issued a profanity-laced demand that the deputy go and fetch the sergeant who had sentenced him to discipline so that he could "gas" him.[9] The deputy saw that Inmate X was holding a bag of liquid in his hand.

Fearing that he was about to be assaulted, Deputy A ordered Inmate X to drop the bag. Inmate X refused to comply and walked to the back of his cell before throwing the bag towards Deputy A. The contents of the bag hit Deputy A, who responded by spraying Inmate X with OC through the gate to his cell.

Deputy B joined Deputy A at Inmate X's cell, and both deputies ordered the inmate to submit to handcuffing. The inmate refused to comply, prompting both deputies to use their OC spray against him. The inmate then complied by placing his hands through a slot in his cell gate so that handcuffs could be applied.

The deputies removed Inmate X from his cell and sat him on a bench. Inmate X slid his handcuffed arms under his legs, stood up, and began yelling at the deputies. The deputies ordered Inmate X to sit down, and when he did not comply, they both sprayed him with OC. Inmate X then complied and was re-handcuffed without further incident. A sergeant was contacted by the deputies and advised that a force incident had occurred.

The supervisory analysis (with which the chain of command review concurred) presented in the force package read as follows:

> "The O.C. incident was a direct result of Inmate [X's] actions. He 'gassed' Deputy [A] and was sprayed with O.C. as a result. Due to his failure to turn and be handcuffed, he was sprayed again by Deputy [A] as

9. "Gassing" is jailhouse terminology for an assault using human waste.

well as by Deputy [B]. Additionally, because he slipped his handcuffs... and confronted deputies... he was again sprayed by both deputies. Deputies [A] and [B's] use of force was reasonable and justified and was within Unit and Departmental policies... I recommend that no further action be taken regarding this incident."

We consider this force package to be troubling in the following respects:

- Deputy A's decision to remain in front of Inmate X's cell gate was tactically unsound, given that he knew that Inmate X was non-compliant and that he was holding a bag of liquid. The force package did not address this issue.
- An important issue in this case was whether Deputy A's initial use of OC spray was a response to a continuing threat or whether it was a retaliatory act. However, this issue was not explored or evaluated in the force package. No one identified an ongoing threat and no one raised the possibility of retaliation.
- The deputies' decision to remove the inmate from his cell was tactically unsound because it unnecessarily increased the exposure of the involved deputies to the threat presented by the recalcitrant inmate. Moreover, the unit's recalcitrant inmate policy requires that this task should not have been conducted without supervision.[10] These issues were not identified.

Even though cases such as these represent a small minority of the force packages we audited, they nevertheless give cause for concern: each was subject to a unit-level chain-of-command review— a key component

10. The unit's "Confrontations with Hostile or Aggressive Inmates" policy reads as follows: "Aggressive or hostile inmates who are confined within their cell... and do not pose an immediate threat to staff personnel or other inmates SHALL not be removed from their location. The area floor sergeant SHALL be promptly notified... At no time, unless life threatening conditions are present, shall personnel make an attempt to remove an aggressive, hostile or armed inmate from a [cell] without the direction of a sergeant." (Emphasis in original.)

of the Custody Division's incident review process.[11] Given that force packages were consistently cited by LASD managers as playing a major role in the force management process, even a limited number of problematic cases is troubling.

E. Liaison Deputies

A program initiated after the 2000 riots that LASD personnel broadly cited as a success was the Liaison Deputy program. Liaison deputies performed a role inside Pitchess Detention Center facilities that could be likened to community policing. Liaison deputies would mix with inmates in order to identify and, whenever feasible, solve problems that might otherwise escalate and trigger violence. The kinds of problems liaison deputies would deal with were typically minor — *e.g.*, ensuring that inmates had equal access to telephones, or that toilet paper was being distributed properly. However, given the potential for minor disputes to trigger violent disturbances, efforts to resolve these seemingly insignificant issues could pay substantial dividends. Additionally, the program provided a means of promoting better relations between inmates and staff, and of keeping an official ear to the ground with respect to incipient problems in the facilities. The program was discontinued in late 2001 due to insufficient availability of staff resources.

F. Age Limits

Another initiative introduced in the wake of the 2000 rioting was the establishment of minimum age limits for inmates housed at Pitchess Detention Center facilities. The age limit was set at 30, with younger inmates being detained at Men's Central Jail where the physical

11. A senior official from the Custody Division has informed us that quality control is now bolstered by the review of all force packages at the commander level. The involvement of commanders in the force package review process began in February 2003, after the above-cited cases occurred.

environment presents fewer opportunities for large outbreaks of violence.[12] The imposition of age limits was seen by custody managers as a valuable means of controlling the potential for violent disturbances since younger inmates have a greater propensity to engage in violent behavior than their more mature counterparts. Despite the asserted success of this program, age limits were incrementally reduced, and were ultimately abandoned in April 2003 due to the inability of Men's Central Jail to accommodate all the younger inmates.[13]

G. Racial/Ethnic Balancing

An anti-violence strategy that is still being employed is the maintenance of racial and ethnic "balance" in housing areas. This strategy relies upon the premise that one racial or ethnic group will not attack its rival in the absence of a clear numerical advantage. The composition of each housing area is managed with the goal of ensuring that no group gains such an advantage. "Balance" is typically achieved with a 60:40 ratio of Latino to African-American inmates.[14]

A recent disturbance at Pitchess Detention Center-North demonstrated the need to consider factors beyond simple racial and ethnic designations when determining the ideal "balance" in a housing area. Departmental officials determined that the balance at Pitchess-North may have been upset by an unusually high concentration of Latino gang members, including some particularly physically imposing individuals. The consequent disequilibrium appeared to have facilitated an attack on African-American inmates.

12. The large dorms at Pitchess Detention Center jails facilitate major disturbances to a degree that the more tightly controlled environment at Men's Central Jail does not. By keeping the most violent-prone inmates in the more conrolled setting, the potential for violence was reduced.

13. One small exception to this is the maintenance of a dorm that exclusively houses older inmates at Pitchess-East. According to that facility's captain, that dorm is essentially trouble-free.

14. Various theories were offered by LASD officials as to why a 60:40 split, rather than 50:50, represents the ideal "balance." Whatever the explanation, no LASD officials we spoke to disputed the efficacy of such population management as a means of minimizing disturbances.

H. Disturbance Reviews

Another encouraging anti-violence strategy used by the Custody Division is the Disturbance Review. Implemented 18 months ago, the Disturbance Review process is initiated whenever a disturbance rated as "major" or higher occurs. Within five days of the disturbance, a meeting is convened to determine the causes of the event and to identify policy, tactical, or training issues, or other remedies. The review meetings are multi-disciplinary, involving the Division Chief, a commander, the captain of the facility where the disturbance occurred, Operational Safe Jails staff, Custody Support Services staff, and training staff. The meeting is followed by a secondary incident review by Custody Support Services staff. The two-stage review process is designed to identify both incident-specific and systemic issues so as to try to avoid future disturbances.[15]

I. Housing Area Searches

Housing area searches are a valuable means of reducing the potential for inmate violence and disturbances. The value of searches stems from their hindering inmates' capacity to possess both weapons and an alcoholic concoction known within custody facilities as "pruno."

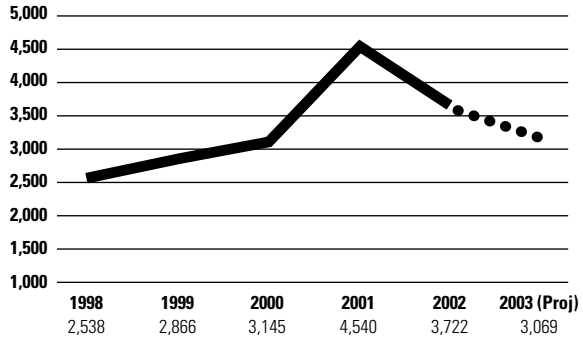
Keeping weapons out of the hands of inmates is a demanding and important task for Custody Division staff. Inmates' ingenuity in the jailhouse art of weapons manufacture is striking: newspaper is processed to make solid, heavy clubs, or shafts for spears; styrofoam cups are melted to produce sharp spikes; pieces of metal ripped from bunks are fashioned into daggers. Inmates with access to these improvised weapons present a significant risk to the safety of both their fellow inmates and LASD staff. The shorter the period of time an inmate is able to retain a weapon, the lower the chances the inmate will have the opportunity to use the weapon in an attack. Thus, the

15. Disturbances classified as "minor" are reviewed at the unit level.

greater the frequency of searches conducted, the lower the potential for armed assaults.

An experienced sergeant noted that, in his many years of working in custody facilities, he had "never seen a happy drunk." Indeed, there was near unanimity among the LASD officials that the availability of alcohol in custody facilities serves to fuel outbreaks of violence. Pruno is manufactured from everyday foodstuffs provided to inmates, and the manufacture of a batch of the intoxicant takes a day or two. Given this short production time, only consistent and frequent housing area searches can ensure that inmates' access to alcohol is minimized.

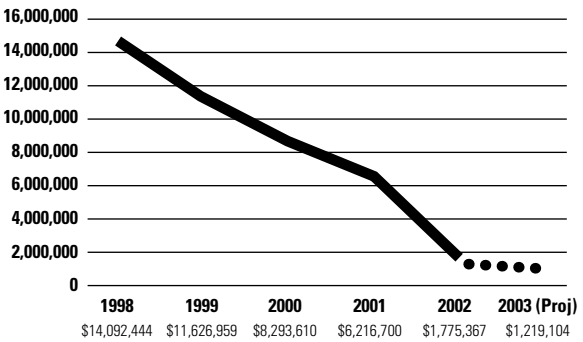
Table 1.11
Housing Area Searches (Custody Division)



1998	1999	2000	2001	2002	2003 (Proj)
2,538	2,866	3,145	4,540	3,722	3,069

Projection from data as of 9/1/03 Source: Custody Support Services

Table 1.12
Overtime Spending (Men's Central Jail)



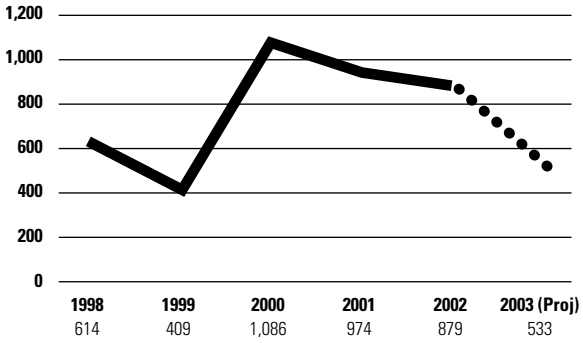
1998	1999	2000	2001	2002	2003 (Proj)
$14,092,444	$11,626,959	$8,293,610	$6,216,700	$1,775,367	$1,219,104

Projection from data as of 9/1/03 Source: Custody Support Services

We are concerned by the 32-percent decline since 2001 in the number of searches conducted — as shown by Table 1.11. Searching is a labor-intensive endeavor. According to several facility managers, staff shortages arising from the current limits on overtime have negatively impacted the frequency

with which searches are conducted. That impact is particularly apparent (*see* Tables 1.12– 1.13) at Men's Central Jail which had deployed dedicated search teams staffed entirely by personnel working overtime. Although facility personnel still conduct searches, they now do so in addition to their other duties and without the assistance of dedicated search teams.

Table 1.13
Housing Area Searches (Men's Central Jail)



1998	1999	2000	2001	2002	2003 (Proj)
614	409	1,086	974	879	533

Projection from data as of 9/1/03 Source: Custody Support Services

In light of the increased risk from less frequent searches, we urge the LASD to reverse the current decline in housing area searches.

J. Operation Safe Jails

Operation Safe Jails is a unit within the Custody Division that combats gang activities in the jails and investigates crimes committed by inmates. It is staffed by a sergeant and 16 deputies. According to its sergeant, Roger Ross, between one half and two thirds of inmates in the LA County jail system are gang members, a fact that increases the risk of organized violent crime within the facilities. As Sergeant Ross explained, not only do gangs sometimes play a role in orchestrating violent disturbances, they also order their members to attack individuals belonging to rival groups, or members perceived to have deviated from gang rules.

When a group or individual is targeted for assault by a gang, they are said to have been "greenlighted." An important Operations Safe Jails task is to identify and isolate greenlighted individuals from their would-be attackers. This involves the interception, through intelligence-gathering

methods, of greenlight orders from gang leaders within the jails (which can take the form of remarkably formal written instructions), along with other intelligence-gathering tasks. Operations Safe Jails staff also stay abreast of developments in the gang world outside of custody facilities, as events on the street can rapidly change relationships between gang members on the inside.

The value of Operation Safe Jails as a violence-prevention and incident-review resource was noted by several facility captains. Moreover, several officials pointed to the capacity of unit staff to establish the causes of violent outbreaks when they do occur, facilitating a more informed disturbance review process.

K. Conclusion

The discontinuation of several apparently successful violence-management strategies is disturbing, particularly since the data show that violence in Custody Division facilities is on the rise. Risk management strategies are being scaled back at a time when they are particularly needed.

While we readily acknowledge that budgetary restrictions create real difficulties for LASD managers, our role is to assess whether the Department's activities are consistent with the effective management of liability risk. It is not our role to determine how County budgets should be allocated, nor to examine the Sheriff's budget. Once our recommendations are made, it is elected officials who have the heavy responsibility of deciding what can or cannot be funded. Although we understand that the cutbacks in risk management activities we have identified are a response by the LASD to pressing budgetary difficulties, we are concerned that the short-term savings they facilitate may ultimately be outweighed by increases in liability exposure (and resultant County expenditure) arising from violence in the jails. Consequently, we urge the LASD to sustain existing programs and to consider how reductions in risk management efforts might be reversed.

Finally, without downplaying the importance of our concerns, we

recognize that the Custody Division's ongoing risk management strategies represent good work by Department officials and as such are worthy of commendation.

III. Force Training

Shortfalls in force training are always particularly troublesome: No matter how well force incidents are investigated, how thoroughly employees are held to account for their actions, or how carefully force trends are considered by managers, no law enforcement organization can expect its personnel to use force effectively and judiciously absent the skills required to do so. Training is the means by which such skills are furnished. As such, force training is critical to effective force management. With this in mind, we turn our attention to the current program of force training for LASD custody personnel.

Although the Custody Division employs several encouraging force management strategies, aspects of the force training program give us cause for concern that the LASD may not be optimally protecting (1) its own personnel from assaultive inmates, (2) inmates from avoidable injury, or (3) the County from the liability exposure that can result from mishandled or unnecessary force events.

A. Force Training Requirements

New LASD deputies receive 64 hours of force training at the academy. The 64 hours include training that is not directly applicable to the custody setting (six hours of training in the use of the side-handled baton, and two hours of training in firearm retention), but most of the skills taught relate to use of force generally and can be applied in a custody role.[16] Upon gradu-

16. The academy curriculum, including the force components, is determined by state regulation.

Standards and Training for Corrections

The Standards and Training for Corrections program, operated by the California Board of Corrections, sets state standards for the training of correctional officers. Those standards require that each employee receive 24 hours of Board-approved training annually. While certain topics, *e.g.,* racial profiling, are mandated, there is no requirement that any of the 24 hours include instruction in the use of force.

Since California's Standards and Training program does not mandate in-service use of force training, simple compliance with those standards will not ensure that members of the LASD staff are adequately trained in that skill area.

Until June 2003, the state provided local jurisdictions with funding support for Standards and Training-approved training. That funding has been discontinued.

ating from the academy, deputies attend Jail Operations School where they receive a further 16 hours of force instruction from the Custody Training Unit in the custody-specific topics of cell extractions, mechanical restraints, and safety cells. Custody Assistants receive similar training, with the Jail Operations curriculum taught as part of their six-week Custody Assistant Academy. Beyond Jail Operations School, the Custody Training Unit, a part of the Leadership and Training Division, offers a series of force training classes tailored for the custody environment to which the new recruits are headed. However, these classes are only provided "in-service," and do not constitute part of the recruits' initial training program.

Once an employee has completed initial training and has begun operational duty in a custody facility, no further training from the Custody Training Unit in the use of force is normally required. Employees may request to attend in-service training in a variety of force-related topics offered by the Custody Training Unit. Facility managers are ultimately responsible for determining whether employees attend force training classes.

The absence of a *requirement* that employees attend in-service training in use of force — an aspect of law enforcement expertise in which skills are perishable — is problematic. Since employees might work indefinitely without receiving any in-service force training, there is a risk that some employees' skill levels will deteriorate to a point where they cannot effectively handle a force incident, increasing the risks of excessive and/or inappropriate force, and of harm at the hands of an assaultive inmate. We recommend that all custody staff be required periodically to receive in-service training in the use of force.

A further gap in force training requirements involves lateral transferees to the LASD from other law enforcement agencies. Deputies hired as lateral transfers are not required to attend LASD force training *before* starting work in a custody facility.[17] Instead, employees may work in a facility for up to 120 days without receiving such training. Deploying staff with no LASD force training could prove difficult to defend if they were involved in a mishandled force incident. Such employees also face an increased risk of being injured during assaults they may not be sufficiently skilled to repel.

Even when lateral transferees do attend training — provided in the form of Jail Operations School and a Lateral Orientation course— the force training they are provided with is limited in scope.[18] This leaves this class of employees with limited LASD training in the basics of force, and thus potentially unprepared to deal with routine force encounters.

18. Transferees will typically be scheduled for the first available Jail Operations School. They are required by state regulations to attend that school within 120 days of their assignment to custody. Compliance with state minimum standards, therefore, does not eliminate the risk associated with the deployment of an untrained employee for a period of months.

19. Jail Operations School provides instruction in cell extractions, safety cells, and mechanical restraints. As with academy training, the content of Jail Operations training is mandated by state regulation. The LASD's 16-hour force component is double the state minimum requirement. The Lateral Orientation course provides eight hours of basic force training. As with Jail Operations School, transferees are not required to attend Lateral Orientation training before starting work in the jails. No Lateral Orientation training has been provided in the last year.

We recommend that the LASD close this gap by requiring that all lateral transferees receive LASD force training *before* they commence operational duties.[19]

An issue with parallels to the lateral transferee situation arises in relation to newly-assigned Custody Division supervisors. Sergeants and lieutenants may be called upon to supervise and direct staff involved in force incidents, as well as to conduct post-incident reviews that include consideration of tactical and training issues. As was noted in our prior discussion of force packages, these supervisory tasks constitute a critical element of the LASD's force management program. The optimal performance of these demanding roles requires a high level of skill and knowledge on the part of the supervisor. Without up-to-date training in force issues, a supervisor may struggle to perform effectively in this area.[20] Although most LASD supervisors will have worked in custody facilities earlier in their careers, considerable time may have passed since they received any force training. Training in force issues, including the supervision of force incidents, is provided as a component of Critical Incident Command School— a course that newly-promoted supervisors are required to attend within one year of appointment to their rank. Given the often distinct nature of the challenges presented by the custody environment, and the particular challenges of supervising force events, other use of force training received in intervening years and on non-custody assignments may not provide an adequate basis for effective performance.[21] We recommend

19. In commenting on the training provided to lateral transferees, we are aware that only a small percentage of LASD custody personnel fall into this category. While this fact limits the potential detrimental impact of the current "gap" in force training, it also limits the burden the recommended training reform would impose on the LASD.

20. Supervisors do cover force policy in their Supervisor School training, provided upon promotion. However, this training does not extend to the practical aspects of force management.

21. Several LASD policies designed to manage use of force require supervisory direction or presence. For instance, the use of certain special weapons requires supervisory direction, as does the removal of a recalcitrant inmate from his or her cell. It seems unlikely that the full force management value of such policies would be realized when supervisors lack training in such tasks.

that all Custody Division supervisors be trained for their force management roles *before* they start work in a custody facility.

B. In-House Force Training

In addition to training provided at the academy and by the Custody Training Unit, each custody facility has its own "in-house" training program.[22] These programs are organized and staffed at the unit level.

Unit-based training in force-related skills may have some benefits over a purely centralized program. The optimal response to events such as major disturbances, for instance, may be best trained for at the unit level, where the particular layout of the facility can be factored into the strategies and tactics to be deployed, and where it may be possible to perform drills in a realistic setting. Moreover, conducting training at an employee's regular place of work reduces the impact of training on other activities by eliminating the need for extra travel. However, aspects of the current system of unit-level training give some cause for concern.

The LASD cannot ensure that the current system of unit-level force training consistently and exclusively provides instruction in techniques and tactics compatible with effective and risk-conscious performance. The staff members who deliver unit-level training are selected from facility staff. The criteria for selection as a trainer are determined at the unit level, and unit-level training personnel are typically selected according to their enthusiasm for the role and experience in force-related fields. Unit-level trainers are not required to complete specialist force instructor training.[23] Determinations as to what will and will not be trained in-house are also ultimately made at the

22. Custody Training Unit staff provide force training at facilities. In this discussion of "in-house" training, we refer only to force training provided exclusively by facility staff, without direct involvement from the Leadership and Training Division.

23. Although some individual staff members may have received specialist training as force instructors before taking their current assignments at custody facilities, those who have not formerly been trained as defensive tactics instructors are not provided with this training.

Factors in Training and Certification

Departments should develop an annual training and certification program for officer safety. The program must include a written training description, syllabus, list of instructors, training dates, number of training hours, practical and written tests, and provisions for retesting. Departments should also apply performance measures to trainees. Unless we can document competence, we may be entrusting equipment inappropriately or assigning officers to tasks beyond their ability.

Budgetary constraints are not defensible in allegations of negligent failure to train. At the same time, however, training does not have to be expensive. A skilled bank of in-house trainers is cost-effective and can allow for flexibility in scheduling, remedial training, and assistance in policy and procedure development. In-house trainers can also be useful in reviews of use-of-force incidents. In addition, training does not have to be a full-time assignment. Many trainers maintain traditional or specialized caseloads, with training an ancillary or small part of their jobs.

Trainer credentials

Trainers need to have credentials. An officer who has a black belt in karate is not necessarily qualified to be an instructor.

Extract from 'Officer Safety The Core Issues,' *Topics in Community Corrections, Annual Issue 1996: Officer Safety,* U.S. Department of Justice, National Institute of Corrections. Full report available on-line at http://nicic.org/pubs/1996/period231.pdf

unit level. The force training that some facilities provide is not limited to a defined set of departmentally approved methods or techniques. Thus, the LASD appears to be failing to comprehensively regulate the force training custody personnel receive, raising the possibility that in-house force training that is inconsistent or inappropriate could be provided by staff who may have never qualified as force instructors. Indeed, in-house defensive tactics training includes instruction in techniques not taught by the force trainers of the Leadership and Training Division.

The LASD's closest approximation to a departmental guidebook on the use of force is its *Defensive Tactics Instructor's Manual*. Noting that the

law enforcement employee "needs a number of specific skills to do his [or] her 'job'," [24] the manual details the criteria for selecting which defensive tactics and techniques should be included in LASD training.[25] These include:

1. Techniques and tactics need to be practical, effective, and teachable.
2. Techniques and tactics should specifically fit a law enforcement environment.
3. Techniques or tactics that could place a deputy in jeopardy should be rejected.[26]

The use of sound selection criteria for tactics and techniques is an essential component of any effective law enforcement defensive tactics program. The criteria set forth above, while not exhaustive, all reflect robust principles. The current practice of in-house force training does not allow the LASD to assure itself that these criteria are being satisfied.

The unit-level force trainers are not held to the standards the Department has established for its force trainers. According to the LASD *Defensive Tactics Instructor's Manual*, a force training instructor must be certified. Certification requires successful completion of a Defensive Tactics Instructor course and annual refresher courses.[27]

According to criteria reported by the National Institute of Corrections of the U.S. Department of Justice, LASD custody facilities' in-house force training falls short in standards for both instructor qualification and lesson content. There is neither a written training description nor a syllabus.

24. Page 7, *Defensive Tactics Instructor's Manual.*

25. This manual is currently undergoing revision by LASD training staff.

26. Page 7, *Defensive Tactics Instructor's Manual.*

27. Page 17, *Defensive Tactics Instructor's Manual.* Similar standards are also reflected in a recent report on Los Angeles Police Department training: *Training the 21st Century Police Officer: Redefining Police Professionalism for the Los Angeles Police Department,* RAND, 2003. This report says that no LAPD instructor should be allowed to train officers "prior to his successful completion of the Department instructor development course" (page 240).

Additionally, trainers may not have the appropriate credentials.

Concerns about the unregulated nature of the custody facilities' in-house force training are not ours alone: a senior divisional manager and LASD Custody Training Unit staff stated that force training should not be provided by unqualified instructors. Such unregulated training with uncertified instructors unnecessarily exposes the County to potential liability for the use of an unapproved or inappropriately trained technique that results in harm to an inmate. Nor can this unregulated training be relied upon to effectively provide for officer safety.

We urge the LASD to ensure that only qualified instructors provide practical force training on techniques and tactics. We also urge that training be provided only in those techniques or tactics that have been departmentally approved.

C. Recent Reductions in Training

Our concerns with force training also extend to recent changes to the formal force training provided by Custody Training Unit staff.

Table 1.14 shows the number of Custody Training Unit force classes attended over the last three years.[28] Given that the LASD's custody facilities have a staff that totals around 3,300, the statistics presented in Table 1.14 show that in each of the last three years a significant proportion of custody personnel received no Custody Training Unit force training, which is problematic. However, since state financial assistance for the Standards and Training for Corrections program was discontinued at the end of June, the number of custody staff taking LASD's eight-hour force training classes has dwindled dramatically: 124 students

Table 1.14
Force Class Attendees

2000-2001	1,412
2001-2002	2,102
2002-2003	1,872

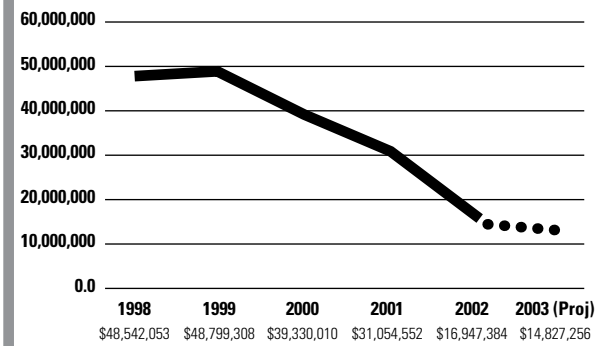
Source:
Custody Training Unit

28. It is possible that some employees attended multiple classes during the periods shown in Table 1.14, reducing the overall number of individuals trained.

attended eight-hour force classes in July, five attended in August, and none attended in September.

The reduction in eight-hour force classes corresponds with the introduction of Intensified Format Training in July 2003. Intensified Format Training, which has essentially replaced the more substantial classes previously offered,[29] consists of shorter training sessions provided at custody facilities. According to LASD officials, the introduction of Intensified Format Training resulted from the discontinuation of state funding for the Standards and Training for Corrections program which, in turn, has limited each facility's capacity to release staff for training. The discontinuation of Standards and Training funding occurred as overtime spending in the Custody Division had also plummeted (*see* Table 1.15, which shows overtime spending for the Division from 1998 – 2003).[30] Indeed, facility managers are not currently authorized to use overtime to "back-fill" the regular posts of employees released for training.

Table 1.15
Overtime Spending (Custody Division)



Projection from data as of 9/1/03 Source: Custody Support Services

Intensified Format Training was introduced to provide training that does not remove employees from their regular duties for an entire shift, thus reducing or eliminating the need to spend money replacing staff engaged in

29. Although the Custody Training Unit still offers eight-hour force classes, since July, 2003, most of these classes have been cancelled due to a lack of availability of students.

30. Until it was discontinued, Standards and Training for Corrections funding of $502 per employee covered between one half to two thirds of the cost of back-filling for staff engaged in training.

training. Since Intensified Format Training is a recent innovation, any long-term impact it may have upon the performance of Custody Division staff has yet to be seen. Nevertheless, initial indications are that the introduction of Intensified Format Training has led to a significant decline in the amount of training provided: In fiscal year 2002-2003, a monthly average of 1,248 hours of force training was provided to custody staff. In September 2003, the first month during which force training was provided exclusively through Intensified Format Training, 306 employees attended the new force classes. According to the Custody Training Unit, Intensified Format Training classes are designed to provide two hours of instruction. If two hours of training were provided to every employee who attended a class, September 2003's training would represent 612 hours of force instruction — a reduction of 51 percent from the previous year's monthly average. However, when we observed an Intensified Format Training force class at North County Correctional Facility one day in October 2003, we found that the actual time employees spent in training ranged from 15 minutes to one hour. The amount of time employees could spend with the trainers was limited by the competing demands of their normal work assignments.[31] And while the time we spent observing Intensified Format Training was limited, the trainers indicated that such restricted availability of trainees was not uncommon.

Early indications are that the introduction of Intensified Format Training represents a stark reduction in the amount of force training being

31. For example, one group of deputies was recalled from training by their sergeant after just 15 minutes because they were needed to fill-in for other deputies who were on a meal break. Another group was not released to attend training until 15 minutes before their shift ended.

32. Although the concerns expressed above relate to the significant reduction in the amount of time spent training employees, we are also concerned that the quality of instruction attainable under such severe time constraints may not match that possible with eight-hour classes. Our limited observation of Intensified Format Training revealed that insufficient time was available for instructors to address critical issues raised by force scenarios, or to discuss or remedy tactical or strategic shortfalls in deputies' performances.

provided to custody employees. It would be surprising if such a reduction in training did not prove to be detrimental to future performance.[33]

We caution the County and the LASD that discontinuing risk management efforts to save money may ultimately cost in judgments and settlements many times what had been saved. Consequently, we urge the LASD to reverse recent reductions in force training for custody staff, so as to obtain greater safety for both officers and inmates.

D. Conclusion

In summary, we make the following recommendations relating to the training of Custody Division personnel in the use of force:

1. The LASD should ensure that its custody staff receive in-service training in the use of force by requiring periodic attendance at force classes.
2. The LASD should require that all lateral transferees receive force training by LASD trainers before they commence operational duties.
3. The LASD should ensure that all Custody Division supervisors are trained for their force management roles before they start work in a custody facility.
4. The LASD should ensure that only qualified instructors provide practical force training. Training should only be provided in those techniques that have been departmentally approved.
5. The LASD should reverse recent reductions in the amount of force training provided to custody personnel.

Los Angeles County Sheriff s Department

Subject: Contact With Insubordinate Inmates

PURPOSE OF ORDER:

Past practice has revealed that movement of an insubordinate inmate(s) without a supervisor present has the potential for false allegations of unnecessary use of force to be made against personnel. This policy has been established to minimize the potential for such allegations.

SCOPE OF ORDER:

This order shall apply to all personnel assigned to and/or working in any capacity at Twin Towers Correctional Facility.

ORDER:

The primary concern when dealing with a recalcitrant, uncooperative, combative and/or an insubordinate inmate is the safety of the staff and inmates. Inmates who display such behavior pose the greatest danger to staff and other inmates. Personnel encountering such inmates shall be guided by the following:

- Whenever it becomes necessary to move a recalcitrant inmate to the outdoor recreation area, staging area, visiting area or any other isolated area because of the need to separate the inmate, it shall be the responsibility of the involved personnel to notify, via radio, either the assigned Floor Bonus Deputy or Floor Sergeant, who shall respond and monitor the contact prior to movement.

- However, if it becomes necessary to immediately move a recalcitrant inmate to prevent the escalation of the situation, involved personnel may move the inmate to the staging area outside the officer s booth, or the outdoor recreation yard. However, personnel shall **not** enter the outdoor recreation yard with the inmate for purposes of counseling. The inmate shall be left alone in the outdoor recreation yard until a supervisor arrives. All efforts should be made to videotape the movement. This movement may prevent other inmates from verbally encouraging the recalcitrant inmate.

- Recalcitrant, uncooperative, combative and/or insubordinate inmates shall be properly handcuffed and searched prior to movement. Inmates shall be kept in normal traffic areas.

- **When the inmate is, or appears to be, a K-12, personnel shall request a supervisor and a Mental Health Professional to respond and attempt a verbal intervention to minimize the need for the use of force, unless circumstances prevent such notification.**

- If an inmate becomes recalcitrant, problematic, etc., during a routine movement, custodial personnel shall immediately request for a supervisor and appropriate back-up or assistance via radio.

- Anytime an inmate is involved in a physical altercation they shall be escorted to the clinic for examination as soon as possible thereafter. All appropriate notifications shall be made and reports written.

NOTE: Personnel involved in an incident/altercation with a recalcitrant, uncooperative, or combative inmate shall not be part of the escorting team. Refer to CDM 5-05/090.00, Escorting Procedures for Combative or Uncooperative Inmates.

Inmates Confined Within Cells

Absent urgent circumstances (e.g., suicide attempt, rescue, etc.), recalcitrant, uncooperative, combative and/or insubordinate inmates who are confined within their cell should be left in their cell until adequate backup and the Floor Sergeant arrives. Personnel are reminded that time is on their side in these situations. A planned tactical approach to the situation will greatly reduce the possibility of physical confrontation or injuries. Tactical communications shall be employed whenever practical, to defuse the situation.

Should these efforts fail, the Watch Commander shall be notified and shall respond prior to any action being taken. Should the determination be made that a cell extraction is necessary, compliance with procedures contained in the CDM 5-05/080.00, Cell Extraction, shall be followed.

The Facilities Automated Tracking System (FAST) 2

Introduction

In past reports we have discussed at length the design and function of the LASD's early warning system, known as the Personnel Performance Index, or PPI. The PPI is a sophisticated relational database that tracks risk in a variety of areas, including use of force, citizen complaints, civil claims, discipline, and litigation. With a few keystrokes, LASD managers and executives can generate detailed reports that can help them spot at-risk officers and potential problems with Department policies or practices.

The PPI does not, however, cover many of the risks involved in the Department's operations of the jails. It does not track a broad range of risks that are found only in custody operations, such as inmate assaults, complaints, and injuries, attempted escapes or suicides.

For many years, we were concerned about LASD's inability to identify and cope with risk on the custody side. Not only did the Department lack a relational database to track custody-specific risk, but it also lacked uniform standards about how the jails were to report such risks.

That all changed in 1997, with the LASD's development of a state-of-the-art, custody-based computer program called the Facilities Automated Statistical Tracking System, or FAST. With FAST, Department managers and executives can, with a few keystrokes or mouse clicks, review trends in a wide variety of custody-specific areas of risk. In addition, FAST-generated statistics are seamlessly downloaded into a Department-wide risk and trend-tracking database, known as the Command Automated Reporting

System, or CARS,[1] which provides managers with monthly reports that present risk-related data in a clear, incisive manner.

Since FAST went on line, we have regularly reviewed data generated by the system to keep track of custody-related risk. We have not until now examined the functioning of FAST in any depth.

FAST is a sophisticated custody-risk tracking system — a model for jail systems throughout the country. Since 1997, FAST has continued to expand both the categories of risk tracked and its ability to sift and report data. On the other hand, we found several material deficiencies in the system and several areas where the system can be improved.

One serious deficiency is that FAST does not record the identity of employees accused of misconduct or specify the sort of misconduct alleged. Thus, while FAST can report that a given jail received 100 inmate complaints against its staff in one year, it cannot report whether particular officers accounted for a disproportionate share of those complaints. Nor can FAST report how many of those 100 complaints alleged excessive force, discrimination, or other high-risk misconduct.

A second concern relates to data integrity. The Department does not have sufficient quality controls in place and the existing controls are underutilized. The lack of adequate safeguards has affected the system: we found apparent data backlogs and instances where inaccurate, incomplete, or internally inconsistent data had been added to FAST.

A third concern relates to the computer program itself. FAST is on the verge of becoming too large for its current software application. Although serious system problems have not occurred yet, the Department risks losing years of valuable data and is currently vulnerable to security breaches. A related vulnerability is that there is only one person who knows the details of FAST's construction. The Department needs to take measures to ensure

1. For a discussion of CARS, see our **Seventh Semiannual Report** (April 1997) at 93-95.

FAST is well-documented and others are taught how to administer it.

We were encouraged to find the Department receptive to our analysis of the system and suggestions for improvement. As we discuss below, the Custody Division has already agreed to implement many of our recommendations and is in the process of evaluating the others.

I. Historical Background

To fully appreciate FAST for the achievement that it is, we will briefly trace the development of the system and show how it rectified the problems that existed in the Custody Division's information management prior to FAST.

A. Problems with Custody-Related Data

For many years the Department was encouraged to collect and track risk-related data on the custody side. For example, we reported in our **Sixth Semiannual Report** (September 1996) the substantial problems with the data collected and reported by the Custody Division:

> "The LASD lack[s] a solid basis for important statistics about [inmate] disturbances, assaults, and the use of OC spray in the LA County jails. Many of the numbers were haphazardly gathered and thus not useful for either historical or current analysis. The unreliability of the data has profound implications for the ability of the Department executives to manage the jails." [2]

In particular, we found that the LASD's collection of data suffered from three fundamental flaws:

2. *Id.* at 15.

1. The various jails did not use the same methods to record high-risk events, such as inmate assaults, and some methods employed were occasionally at odds with the methods advocated by the LASD Data Systems Bureau;
2. Many of the facilities changed their own data collection rules over time, presenting serious difficulties in tracking trends even for a single facility; and
3. Data were not input on a timely basis.[3]

We recommended that the Department standardize its data reporting by creating a single unit responsible for ensuring that data were input and reported in a consistent and timely manner.[4]

B. The Department's Response

Many current and former Custody Division officials viewed those critiques in the **Sixth Semiannual Report** as a catalyst for reform. The Department created a task force to overhaul Custody's reporting and information management systems in the following ways.

Standardizing Definitions. One of the first steps was to issue written guidelines standardizing treatment of certain critical events, such as inmate disturbances. Previously, each jail had formulated its own definitions and rules about when certain incidents should be reported. In January 1997, the Department published the first edition of its *Guide to Management Information*, a booklet providing standardized definitions of risk-related events. From that point forward, each facility was required to follow a single, Department-approved definition for events such as "inmate versus inmate assault" or "minor disturbance."

3. *Id*. at 16-18.

4. *Id*. at 19-20.

Custody Support Services. Three months later, the LASD formed a risk management unit devoted specifically to custody issues. The result was the Custody Support Services Risk Management Unit. The unit, now simply called Custody Support Services, or CSS, comprises these separate teams:

Standards and Compliance Team: Responsible for Title 15[5] compliance auditing: ascertaining whether the jails are functioning at minimum state and federal constitutional and statutory standards.

Data and Analysis Team: Responsible for (1) ensuring that custody-related data are input in a consistent manner and on a timely basis and (2) analyzing those data and presenting them to Department executives and, as appropriate, the public.

Risk Analysis Team: Responsible for identifying factual patterns that give rise to potential liability in the jails and recommending policy or operational changes to minimize such risk.

Sergeant Richard Myers was assigned to head the Data and Analysis Team. His immediate task was to eliminate reporting inconsistencies between the jails. He recently explained:

> "I'll give you a hypothetical about reporting an inmate versus inmate assault. When do you report it? One facility might do it every time. Another might do it [only] if one inmate is injured. Yet another might do it only if they are going to prosecute someone for the fight...We had to change all that."

A second critical task was to determine what additional risk-related information should be tracked. As Sergeant Myers stated:

> "A big part of the project was sitting down and figuring out just what kind

5. Title 15 of the California Code of Regulations sets forth minimum standards for operating jails.

of information was going to be useful. Take [jail housing] searches. Back then, all they reported was gross numbers: 'We performed 100 searches last month.' Our thinking was, 'Gee, that's not all that helpful. Maybe you want to tell us what [weapons or contraband] you found?' But then we took it a step further and thought, 'Well, maybe we should also start keeping track of what they [the inmates] are making the weapons out of—so you know if they are making shoe shanks or some other more exotic type of weapon.' So it was not only creating a database, but also designing new report forms to make sure relevant information was going to get captured in the first place."

The FAST Database. The next step was to design a database that would capture all of the information and report it in a format most useful to managers. Early on, CSS decided not to enlist the aid of the LASD's Data Systems Bureau, which was still struggling to bring the PPI on line. Instead, the decision was to build a "homegrown" database that could be up and running in a few months. Once the Custody Division was able to start using the data, the thinking went, CSS could go to Data Systems for additional software support.

Sergeant Myers decided to build the system on Paradox, a desktop database application. To assist him in the project, Sergeant Myers recruited Deputy Arlan Mulford, an officer at the Inmate Reception Center known to be familiar with Paradox and reputed to be highly competent. Together Myers and Mulford, both largely self-taught when it came to computer programming, built within a few months perhaps the most sophisticated custody-related risk tracking system in the country.

According to Sergeant Myers, the decision to make Deputy (now Senior Deputy) Mulford the principal designer and programmer worked well:

"Arlan not only knew how to put a big database together, but he knew how Custody operates because he worked the line — he knows the job.

He had great instincts about what sort of information managers would need to manage their facility and reduce risk. Arlan has expanded FAST to give managers more information than they ever asked for... [T]he information collected in FAST is needed and valuable to reducing liability within Custody."

The development of FAST within a matter of months is particularly remarkable given that neither Sergeant Myers nor Deputy Mulford could look to other agencies; there simply were no models.

II. System Design and Capability

A. Overview

FAST records and tracks information pertaining to 17 different areas: (1) officers' uses of force; (2) inmate complaints; (3) ACLU complaints;[6] (4) food complaints; (5) medical complaints; (6) inmate injuries; (7) inmate deaths; (8) attempted/actual suicides and requests for mental observation; (9) safety chair restraints; (10) inmate disturbances or riots; (11) escapes; (12) erroneous releases; (13) overdetentions; (14) facility searches; (15) facility tours; (16) civil claims; and (17) inmate property inventory. The first data module, Inmate Escapes, began operating in December 1997. The last data module, Civil Claims, became operational in February 2003. Within the next month or so, FAST will include an 18th data module devoted to tracking inmate assaults.

FAST contains a number of pre-programmed reports that allow managers to review data trends quickly. In addition, the data are stored in a manner allowing the system administrator (Senior Deputy Mulford) to generate dozens of specialized reports. For example, within minutes,

6. Pursuant to longstanding LASD practice, inmate complaints forwarded to the Department by the American Civil Liberties Union are handled on an expedited basis.

Mulford can produce a report showing how often officers injure their hands in fistfights with inmates, or showing how many times an officer's use of an impact weapon resulted in bruises or cuts. Moreover, FAST can not only provide the raw numbers, but also the factual details on each use of force case.

While the Custody Support Services unit is responsible for maintaining FAST, data entry is decentralized. Each custody facility has a designated Statistical Coordinator responsible for ensuring that the facility enters data into FAST on a daily basis. The Statistical Coordinator is accountable for his or her facility's FAST data. Prior to 1997, however, the jails did not give one person the ultimate responsibility for data entry, resulting in substantial data integrity problems.

FAST is a so-called "live data" system. Each day, the facilities input new data which become almost instantaneously available to managers. Thus, FAST not only provides managers with real time information, but also greatly reduces the need for last-minute scrambles to collect data for the monthly CARS reports. Once information is typed into FAST, it can be seamlessly transferred to CARS.

At the end of each month, the Statistical Coordinators review their FAST reports and compare them to CARS data in order to make sure the numbers match. Each month Custody Support Services likewise reviews the monthly FAST and CARS numbers for discrepancies.

B. Some FAST Modules Up Close

To better explain the strength and versatility of FAST, we describe several of its modules below.

1. The Use of Force Module

Although use of force is already tracked in the PPI, FAST contains its own Use of Force Module. Custody Support Services decided to add this module for two reasons. First, software incompatibility made it difficult to transfer

data from the PPI into CARS. Second, there were already some delays in getting force cases into the PPI. Such delays were deemed unacceptable by Custody, which wanted to place real time data at managers' and executives' fingertips.

For each use of force incident reported in a custody facility, FAST captures the following information:

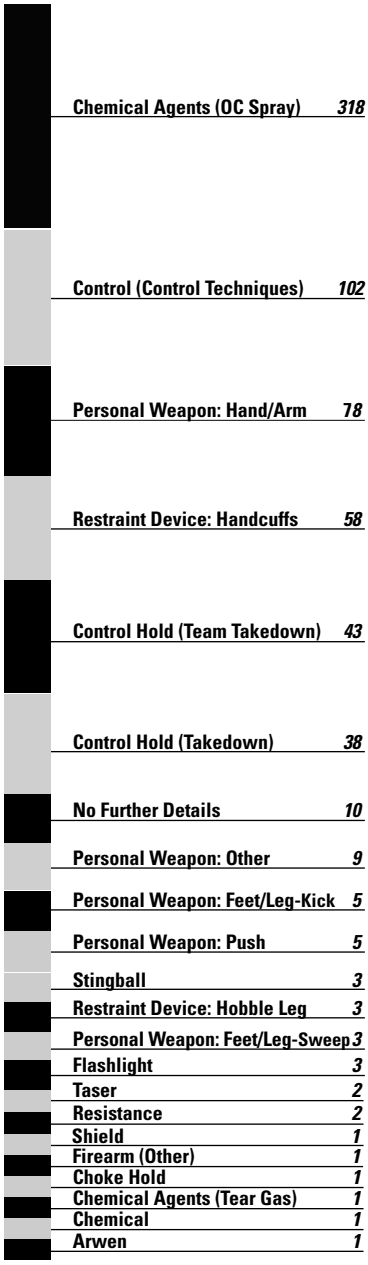
- The date, time, and location of the incident;
- The LASD shift involved;
- The specific location in facility (*e.g.*, clinic, search corridor) where the incident occurred;
- The inmate(s) and LASD employee(s) who used force;
- Whether each LASD employee used force at the command of a supervisor (*i.e.*, whether the force was "directed");
- Demographic (*e.g.*, sex, age, height/weight) information regarding each person involved in the incident;
- The type of force used by each of the involved parties, including classification of each use of force into one of the following six categories:
  - Significant Force[7] —Hospitalization or Death
  - Significant Force —Visible or Verifiable Injury
  - Significant Force — Complaint of Pain
  - Significant Force —No Injury or Pain
  - Less Significant Force — OC Spray
  - Less Significant Force — Other

7. LASD Manual of Policy and Procedure § 5-09/430.00 (Nov. 2003) provides:

> "[F]orce is significant when it involves any of the following: (1) Suspect injury resulting from use of force, (2) Complaint of pain or injury resulting from use of force, (3) Indication or allegation of misconduct in the application of force, (4) Any application of force that is greater than a Department-approved control hold or come-along. This includes the activation of the electronic immobilization belt or the use of the Total Appendage Restraint Procedure (TARP)."

The only exception to this rule is that the use of OC spray is deemed to be less significant force where the only injury or complaint of pain relates to eye or skin irritation normally associated with the spray. *Id.*

Table 2.1
Men's Central Jail–Use of Force by Weapon/ Method Jan.1–Sept. 30, 2003



Source: FAST, Custody Support Services

- The weapon(s), if any, used by each involved party;
- Whether each inmate involved was under the influence of drugs or alcohol;
- The criminal charge(s), if any, to be leveled at the inmate(s) as a result of the incident;
- Details regarding the type, location, and severity of any injuries sustained; and
- Whether the incident involved any commendable restraint exercised by LASD employees.

Unlike the PPI, the FAST Use of Force Module contains a wide variety of pre-programmed reports and charts designed to facilitate trend analysis. For example, with a few keystrokes, managers can obtain a breakdown of cases sorted by force used by LASD officers. *See* Table 2.1.

2. The Inmate Complaint Module

Like use of force reports, inmate complaints can provide Custody managers with valuable feedback regarding the operation of the jails. Before turning to the means by which

FAST captures and reports information regarding inmate complaints, we first describe how the LASD handles inmate complaints.

Overview of the Inmate Complaint System. Inmates may complain about any aspect of their confinement, such as medical/mental health services, misconduct by LASD employees, access to facility programs, food, clothing, and bedding, or other facility conditions. LASD policy requires that each custody facility make Inmate Complaint Forms and drop-off boxes available to inmates. At the end of each shift, a Custody supervisor collects the forms from the drop-off boxes. If the complaint concerns medical/mental health issues, the facility's Inmate Complaint Coordinator (typically a Sergeant) directs the complaint to Medical Services. Similarly, if the complaint concerns the food provided to inmates, the Coordinator forwards it to Food Services for handling. The Coordinator assigns all other complaints for investigation by the concerned Watch Commander (typically, a Lieutenant[8]) for the shift.

TheWatch Commander is responsible for recommending a disposition of the complaint to the Captain of the unit. Inmate complaints are concluded as follows: (1) Referral to Internal Criminal Investigations Bureau for investigation of a potential crime by LASD staff; (2) Referral to Internal Affairs for investigation of potentially serious violations of Department policy; (3) Commencement of a unit-level investigation of other potential violations of policy; (4) A finding that the inmate's allegations are "Founded" — *i.e.*, an LASD employee violated the law or Department policy; (5) A finding that the allegations are "Unfounded" — *i.e.*, that the allegations are found not true or when the actions of the Department member, which formed the basis for the complaint, are not violations of law or Department policy, and are otherwise not censurable; and (6) A finding that the allegations are

8. If the inmate does not allege serious misconduct, the Lieutenant often delegates the initial investigation to a Watch Sergeant. The Sergeant's report is then returned to the Lieutenant for review and comment before presentation to the Captain.

"Unresolved" — *i.e.*, that there is not a preponderance of evidence either to affirm or to refute the inmate's allegations. These findings and other information regarding the disposition of inmate complaints are recorded on an Inmate Complaint Disposition Data Form, a copy of which is set forth at the end of this chapter.

The PPI does not track inmate complaints, but instead tracks only those complaints (or commendations) made by the public. If, however, an inmate complaint is deemed sufficiently serious or credible to warrant the opening of an administrative investigation (*i.e.*, a formal investigation that carries with it the potential for discipline and thus triggers the subject officer's right to legal representation), details of that investigation are tracked in the PPI.

FAST began capturing inmate complaint data in July 1998.

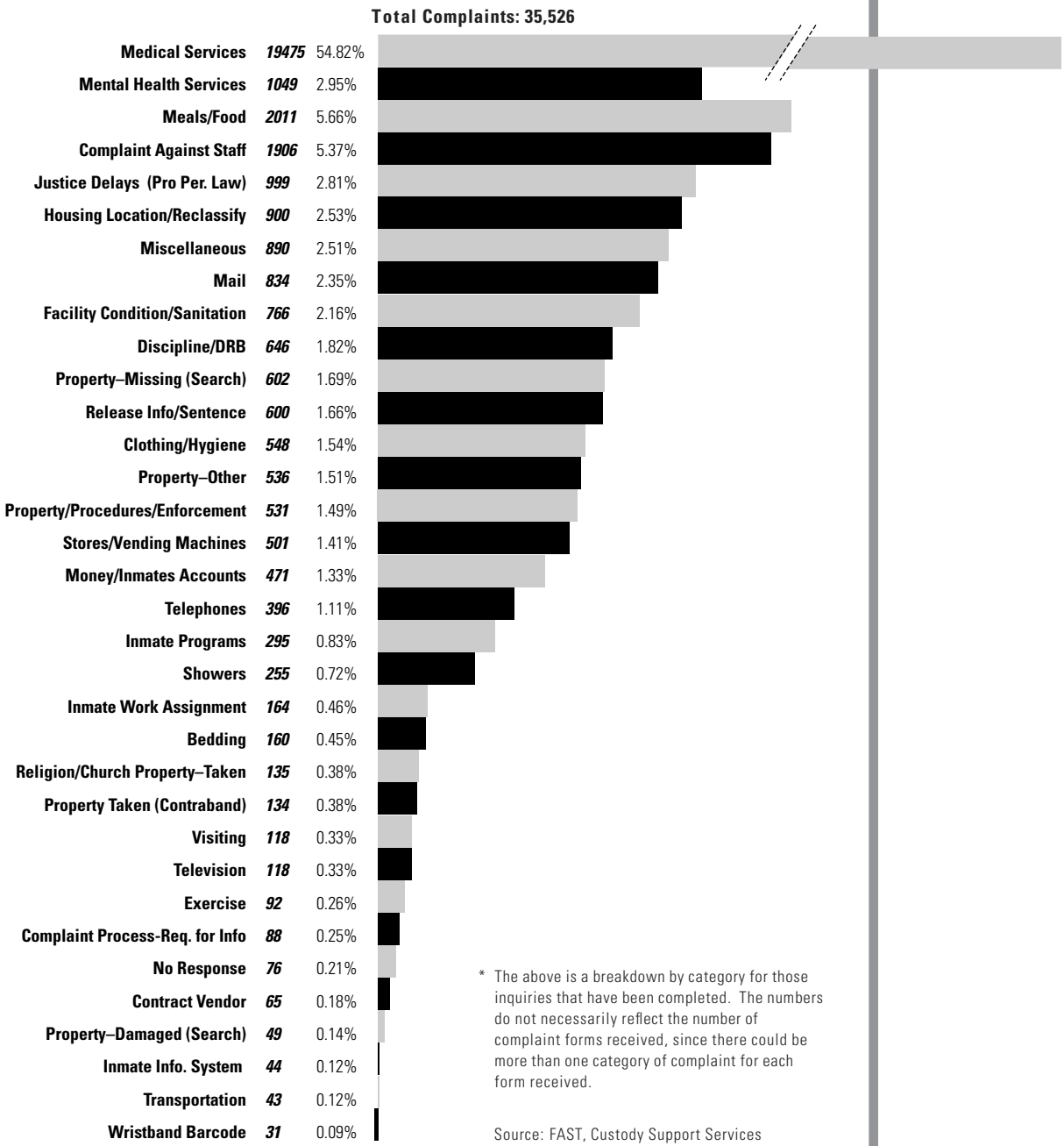
How FAST Tracks Inmate Complaints. FAST tracks inmate complaints in four different Modules: (1) Inmate Complaints, which tracks all complaints received; (2) Medical Complaints, which includes mental health-related complaints; (3) Food Services Complaints; and (4) ACLU Complaints, which tracks certain high-priority complaints forwarded to the Department by the ACLU.

For this review, we focused primarily upon the first module, Inmate Complaints, because it serves as a catch-all resource that tracks basic information on every complaint received, even if they are also included in one of the other modules. The Inmate Complaints Module reports the following categories of information:

- Whether the complaint was made by an individual inmate or a group of inmates;
- The name, booking number, housing location or assignment, and release date of the complaining inmate(s);

Table 2.2

Custody and Correctional Services Divisions
Number of Inmate Complaints by Category*
Jan.1, 2000–Sept. 30, 2003



Medical Services	19475	54.82%
Mental Health Services	1049	2.95%
Meals/Food	2011	5.66%
Complaint Against Staff	1906	5.37%
Justice Delays (Pro Per. Law)	999	2.81%
Housing Location/Reclassify	900	2.53%
Miscellaneous	890	2.51%
Mail	834	2.35%
Facility Condition/Sanitation	766	2.16%
Discipline/DRB	646	1.82%
Property–Missing (Search)	602	1.69%
Release Info/Sentence	600	1.66%
Clothing/Hygiene	548	1.54%
Property–Other	536	1.51%
Property/Procedures/Enforcement	531	1.49%
Stores/Vending Machines	501	1.41%
Money/Inmates Accounts	471	1.33%
Telephones	396	1.11%
Inmate Programs	295	0.83%
Showers	255	0.72%
Inmate Work Assignment	164	0.46%
Bedding	160	0.45%
Religion/Church Property–Taken	135	0.38%
Property Taken (Contraband)	134	0.38%
Visiting	118	0.33%
Television	118	0.33%
Exercise	92	0.26%
Complaint Process-Req. for Info	88	0.25%
No Response	76	0.21%
Contract Vendor	65	0.18%
Property–Damaged (Search)	49	0.14%
Inmate Info. System	44	0.12%
Transportation	43	0.12%
Wristband Barcode	31	0.09%

* The above is a breakdown by category for those inquiries that have been completed. The numbers do not necessarily reflect the number of complaint forms received, since there could be more than one category of complaint for each form received.

Source: FAST, Custody Support Services

- Whether or not the complaint was (1) made by a third party on the inmate's behalf or (2) forwarded to the Department by a third party, such as the ACLU;
- The date and shift on which the complained-of problem occurred;
- Data regarding how and when the complaint was received;
- A classification of each allegation in the complaint into one of 44 separate categories, from inadequate bedding to complaints against LASD staff;[9] and
- The disposition of the complaint.

LASD managers and executives can easily obtain a snapshot of how each facility's inmate complaints are broken down. Table 2.2 illustrates, for example, the breakdown of inmate complaints for the entire Custody Division between January 1, 2000 and September 30, 2003.

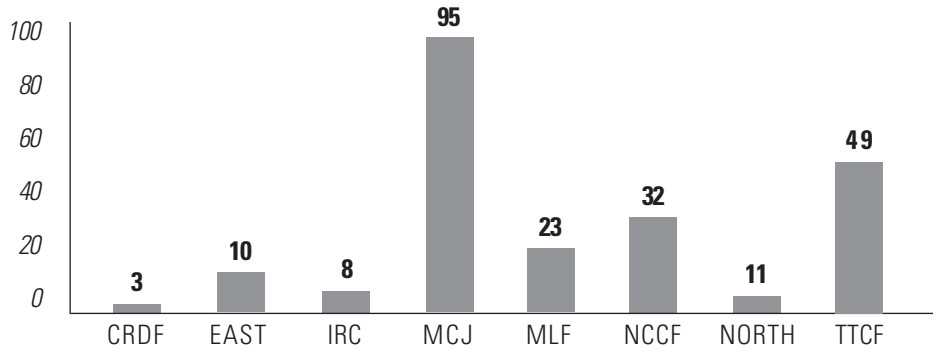
This breakdown, which the Department was unable to perform prior to the development of FAST, is telling in a number of respects. First, it shows that complaints against LASD employees ("Complaints Against Staff") account for a very small proportion (roughly five percent) of the total complaints filed by inmates. This figure appears to assuage the concern that inmates abuse the system by making numerous false complaints against Deputies. In addition, the figure contradicts the Department's claims that adding inmate personnel complaints to the PPI would "overwhelm" the PPI with data. To put the numbers in proper context, the PPI tracks roughly 2,000 new citizen complaints against LASD employees each year[10]— as compared to the roughly 600 inmate complaints against employees tracked by FAST each year.

9. The categories are set forth in the LASD's Inmate Complaint Disposition Data Form, a copy of which is set forth at the end of this chapter.

10. *See* **Sixteenth Semiannual Report** (February 2003) at 47, Table 2.

Table 2.3

Custody and Correctional Service Divisions
Number of Inmate Complaints Against Staff by Facility
Jan. 1–Sept. 30, 2003

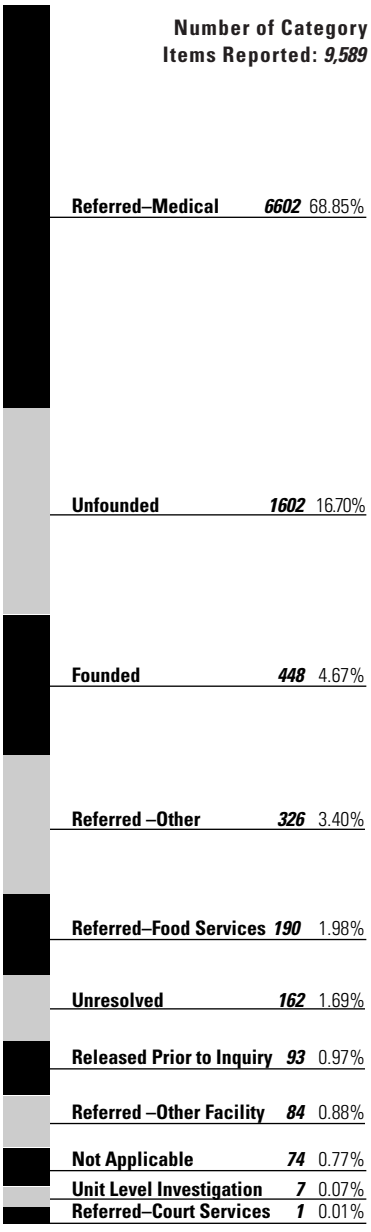


Source: FAST, Custody Support Serices

Another important fact revealed by Table 2.2 is that the largest number of complaints are medical- or mental health-related. Of the 35,526 complaints processed between January 2000 and September 2003, 20,524 (58 percent) pertained to medical or mental health.

Do all or even many of these medical or mental health complaints involve allegations of mistreatment or neglect? Unfortunately, FAST does not refine the data to that degree of detail. Audits we conducted during the current and previous review periods have consistently revealed that most of these "complaints" are merely requests for medical or mental health services. In one case — which was typical of many we reviewed — an inmate "complained" that he had a headache and needed some strong aspirin. In our view, this is not so much a complaint as a request for service. We have been informed, however, that a separate form for inmate requests is being developed. Hopefully use of such a request form will help the Department better determine how many medical or mental health complaints actually involve claims of inadequate or improper treatment.

Table 2.4
Custody and Correctional Services Divisions Number of Adjudicated Inmate Complaints by Disposition, 2002



Source: FAST, Custody Support Services

FAST can generate numerous useful breakdowns of inmate complaint data. For example, it can readily identify which jail facilities generate the most inmate complaints against staff. *See* Table 2.3. Within a given facility, FAST can provide a breakdown of personnel complaints according to shift or housing location.

In addition, FAST can inform managers about how inmate complaints have been adjudicated. *See* Table 2.4. This information can be provided at various levels of detail, including according to the nature of the allegation and the facility or shift involved.

Although there is room for refining the data further, the Inmate Complaint Module represents a quantum leap in the Department's ability to sort through inmate grievances about jail conditions and the performance of LASD personnel.

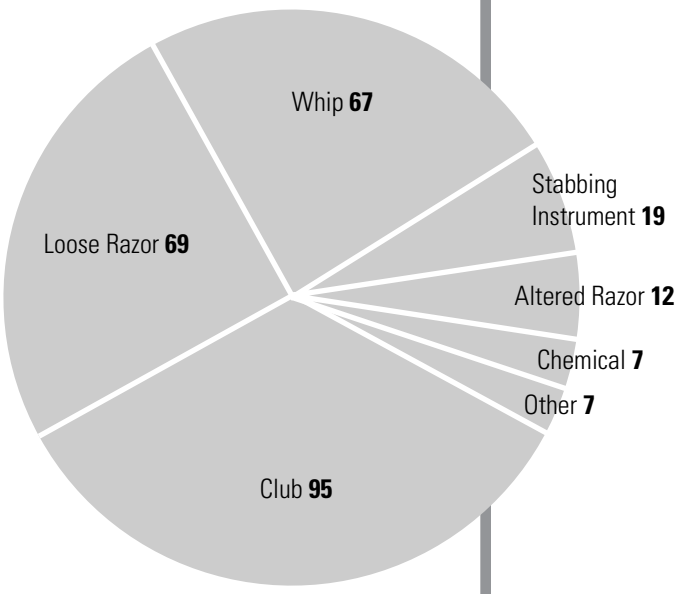
3. The Facility Searches Module

As we discussed in Chapter One of this Report, one well-established method of reducing the frequency and severity of jailhouse violence is to conduct regular searches of inmate housing areas for weapons and contraband. Prior to the

creation of FAST, Custody managers' information regarding the success of such searches was largely piecemeal and often anecdotal. Custody knew how many of the searches had occurred and what facilities or areas had been searched, but it lacked sufficient details to conduct meaningful trend analyses. The implementation of the Facility Searches Module substantially improved the Department's ability to deal with weapons and contraband. In addition to tracking when a particular housing area has been searched, the module also tracks:

Table 2.5
Twin Towers Correctional Facility Type of Weapons Recovered by Facility Searches Jan. 1–Sept. 30, 2003

Total Weapons Recovered: 276



Source: FAST, Custody Support Services

- The precise areas searched (*e.g.*, shower, closets, day rooms, etc.);
- The number of weapons or contraband recovered;
- The raw materials used to manufacture weapons or contraband;
- Whether the search was initiated by a particular officer or directed by a supervisor;
- For directed searches, the reasons for the search (*e.g.*, "recent riot/ disturbance," "racial tensions," "threats to staff," "lost kitchen utensil," etc.);
- Details regarding how the search was documented (*e.g.*, videotaping of the search); and
- Whether or not a special search team was involved.

Table 2.6

Twin Towers Correctional Facility
Composition of Weapons Recovered
Jan. 1– Sept. 30, 2003

	Altered Razor	Chemical	Club	Loose Razor	Other	Stabbing
Total	**12**	**7**	**95**	**69**	**7**	**19**
Bleach		6				
Bedding						
Cleaner		1				
Clothing						
Food in Sock			1			
Food Tray			7			
Glass					1	9
Misc. Metal						7
No Further Details	12		15	69	2	
Newspaper			30			
Other			40			1
Plastic						2
Rock			2			
Braided Sheet					1	
Piece of Cement					2	
Welding Wire					1	

Source: FAST, Custody Support Services

Accordingly, FAST enables managers not only to track the weapons and contraband by number and type, *see* Table 2.5, but also to track what materials are being turned into weapons or contraband, *see* Table 2.6.

The modules discussed — Use of Force, Inmate Complaint, and Facility Search — are but three of the database's 17 modules. FAST remains unmatched for the breadth and depth of risk-related data collected and reported within a custody environment. Nonetheless, as we discuss in the following section — and as the Department recognizes — there is room for improvement.

III. Areas of Concern and Suggestions for Improvement

Special Counsel is tasked not only with identifying areas where the Department lacks mechanisms to deal with risk, but also with critically examining existing mechanisms to determine whether they could function better.

We were greatly encouraged to find a high level of receptiveness to our suggestions. In every instance where we found actual or potential problems or room for improving the system, the response of Custody Support Services and others who work with the FAST system was consistently positive.

A. Concerns Regarding Inmate Complaints

There were two serious flaws in the program's ability to collect and report data regarding inmate complaints. First, while FAST collects much data regarding inmate complaints, it currently does not report the names of LASD employees accused of misconduct. Second, FAST does not specify the type of officer misconduct alleged.

When we brought these deficiencies to Custody's attention, Custody agreed to expand the database. Custody Division Chief John Scott has ordered CSS to modify the Inmate Complaint Module so that FAST can (1) identify those officers who are named in inmate complaints against staff, and (2) specify the type of allegation made against the officer (*e.g.*, excessive force, discrimination, and the like). A number of minor technical issues remain to be resolved and implementation is expected within a month.

One remaining issue is whether this information should be entered into FAST only on a prospective basis or whether the jails should also back-enter officer- and allegation-specific information from older complaints in the system back to the first of the year.

Currently, Custody does not plan to ask the jails to back-enter any old data. The stated concern is resources: data entry employees are already

busy, and entering older data would be taxing. There is some merit to this view: employees are indeed busy and the quality control changes we recommend in the next section undoubtedly will add to their workload. Nonetheless, we urge the Department to input officer— and allegation-specific information from at least the beginning of this year. By failing to enter historical data into the system, Custody will deprive itself of the ability to identify risks that may exist and need to be addressed *right now*. According to FAST, between January and September of this year there were only 231 inmate complaints against LASD employees. *See* Table 2.3 above. Given that these 231 complaints are spread among eight facilities (seven jails and IRC), it should not be difficult for data entry employees at each facility to pull the files in question, identify the officers' names and allegations against them, and type them into FAST. If experience is any guide, inputting this data is likely to identify a number of officers who may be at risk.[12]

In the coming weeks and months, we will continue to work with CSS to ensure that the modifications to the Inmate Complaints Module are implemented in a timely manner.

B. Concerns About Quality Control and Data Integrity

Because FAST is a de-centralized database, with information input from seven different custody facilities, the Department must take special care to ensure that information is input accurately and on time.

12. There is agreement among Department executives that reviewing citizen complaint data to identify potentially at-risk officers has been useful. There is no reason to believe that reviewing inmate complaint data would not be similarly helpful. Indeed, one custody facility recently proved this point. This past September, Captain Gary Sinclair of the Mira Loma Detention Center asked his own staff to go through all inmate complaints filed against officers that year and determine whether any officers had received an unusual number of complaints or had received multiple complaints containing similar allegations. When the project was completed, Captain Sinclair learned that while few officers had received more than one complaint, one officer had accumulated four complaints within a relatively short time span that alleged similar misconduct. Although this fact alone does not necessarily mean that the officer was guilty of misconduct, Captain Sinclair is now alerted to potential risk and has the opportunity to address any performance problems in a constructive manner.

During this review, however, we found that the Department is not meeting either the accuracy or the timeliness standards. In addition, we found numerous instances in which the lack of adequate controls has to some extent impaired the quality of custody data reported by FAST and CARS. However, many of the problems we identified can easily be remedied with some effort in the short term and careful planning for the long term. We were also encouraged to find the Department receptive to the critiques we offered and eager to remedy the problems we identified.

The Custody Division has agreed with our concerns, and so we will review here only the broader outlines of the problems we found and the solutions we suggest, leaving the details to our ongoing discussions with the Department.

1. Lack of Critical Quality Control Mechanisms

We found several instances in which Custody either overlooked or failed to institutionalize critical mechanisms to ensure data integrity.

Data Entered into FAST Is Not Regularly Checked for Accuracy. Because data entry into FAST occurs in eight different facilities (seven jails and IRC), there is an inherent risk that errors or inconsistencies will creep into the system. Accordingly, the Department must have in place certain checks to ensure that data entry employees do not mistakenly (or even intentionally) introduce erroneous or incomplete data into the system.

Ideally, each report typed into FAST should be checked by a second set of eyes. That is how the Department ensures quality control with respect to PPI data: each new PPI record input by a station or jail is checked by the Discovery Unit for accuracy and completeness. Discovery Unit employees go through each written report and compare the information in the reports to what has already been typed into the PPI. This safeguard has proven extremely useful, as internal audits conducted by the Discovery Unit have found station or jail error rates have spiked as high as 70 percent.[13]

13. *See* **Sixteenth Semiannual Report** (February 2003) at 43, 48-50.

We were concerned to find that there is no similar fact-checking mechanism in place for FAST. We conducted spot audits that invariably revealed disparities between FAST data and the underlying paperwork. It thus is apparent that the dangers of FAST data corruption are not merely theoretical.

The Department recognized this risk of data corruption when it was designing FAST, and had assured us then that it planned to add a much-needed second layer of data review. As we observed in our **Eighth Semiannual Report** (October 1997):

> "The [CSS] Data Analysis Unit will perform audits of the facilities to ensure the integrity of the data. In the past, because of understaffing, the planning and research unit did not have the resources to perform regular audits of the facilities to verify that data were being collected and inputted accurately. With additional staffing... the Data Analysis Unit intends to audit the reports and logs kept by the facilities to ensure that there is back-up documentation for each of the events reported by the facilities."[14]

Despite those assurances, CSS has never conducted an audit of any facility's FAST data to determine if the data actually matched up with the underlying documentation. Instead, CSS' only auditing mechanism is the Command Inspection, which is limited to determining whether a given facility's FAST data matches up with its CARS data. While this audit is a valuable tool for ensuring that information is transferred to CARS correctly, it does not provide any assurance that the data originally typed into FAST is accurate and complete.

We were told that the Department lacks the resources to expand CSS to the point where it can review each FAST report for accuracy. At the least, the Department should provide CSS with sufficient resources to conduct regular monthly audits to ensure that the information in FAST corresponds to the

14. *Id.* at 49.

paperwork. Furthermore, CSS should keep track of the errors it finds so that it can identify any systemic problems with the data entry process or identify employees who warrant additional training or reassignment. To this end, CSS should confer with the Inmate Reception Center, which recently introduced a similar tracking system to deal with clerical errors in processing inmates' release papers. *See* Chapter Three at 81.

CSS and Custody executives responded positively to this critique and have committed to develop an auditing mechanism that will address these concerns. We will follow the progress of these efforts in a future report.

Inconsistencies in Data Entry. We also found a number of inconsistencies among the various custody facilities regarding how and when they entered data into FAST. For example:

- We found differences among the facilities regarding interpretations of the meaning of a number of fields or values in FAST. For example, the Inmate Injury Module uses the term "Altercation with Deputies" as a possible explanation for an inmate's injuries. The term, however, was interpreted differently. Some facilities thought it applied only to cases where officers admitted using force, whereas others thought it also applied to cases where a use of force was only alleged.

- We also found differences among the facilities regarding the sources from which use of force data was to be drawn. At some facilities, the data are drawn — appropriately, in our view — from the completed force package, thus ensuring that all involved parties, uses of force, and injuries are identified. Data entry employees from other facilities, however, never look at the force package. They simply enter whatever data is contained in the use of force form, which often arrives in their office well before the use of force investigation has been completed. They never check their FAST data entries against the completed force package to ensure they have captured all relevant information.

- We also found differences among the facilities in how the cause of an inmate's injury was coded into FAST's Inmate Injury Module. Some facilities appeared to be following an unwritten (and in our view, inappropriate) rule that if an inmate was fighting with other inmates and subsequently suffered an injury from officers who broke up the fight, the cause of injury was recorded as an inmate assault, rather than the officer's use of force. For example, in one case, officers tried to break up an inmate fight by firing pepperball pellets into the crowd. One of the inmates was struck in the back by several of the half-inch pellets and examined for injury. The only visible injuries to the inmate were the welts from the pepperball pellets. Nonetheless, the FAST Inmate Injury Module stated that the source of injury was an inmate assault.

- We also found differences among the facilities in how they tracked their paperwork due to be entered into FAST. Some facilities, such as IRC, NCCF, and Mira Loma could readily identify which reports had been returned to supervisors and deputies for correction. Others, such as Men's Central Jail, did not know how many reports had been sent back for correction.

We also found internal inconsistencies within individual units regarding the information entered into FAST. For example:

- We found differences in how an inmate's injury was described in the Use of Force Module and how it was described in the Inmate Injury Module. In one case, the Use of Force Module reported that an inmate had suffered a facial injury, whereas the Inmate Injury Module stated that the inmate had injured his fingers. In another case, the Use of Force Module reported that an inmate had suffered a knee injury, while the Inmate Injury Module reported no injury and stated that the inmate had complained of chest pain.

- We also found discrepancies in how officers' use of force was described between FAST Modules. For example, in one case, the Inmate Injury Module reported that an inmate had been injured because a deputy had pushed him. However, the Use of Force Module reported that the inmate had been injured as the result of a "Team Takedown," a term used to describe cases where two or more officers force someone to the ground.

- We also found 359 instances between January 2000 and September 2003 where inmate injuries referenced in the Use of Force Module were not detailed in a corresponding entry in the Inmate Injury Module. Thus, for example, while one force incident logged into the Use of Force Module noted that an inmate had suffered a concussion as the result of an officer's use of force, the injury to the inmate was not logged in the Inmate Injury Module.

Clearly, the facilities need additional guidance and audits from Custody Support Services if these and other discrepancies are to be eliminated. CSS should either create a detailed FAST manual or revise the *Guide to Information Management* to include a comprehensive list of FAST-related definitions and rules for data entry.

2. Existing Quality Control Mechanisms Underutilized

We also found that a number of quality control mechanisms established by CSS have been overlooked or underutilized.

Reports Regarding Delinquent Data Entry. Because FAST is designed to be a "real time" database, each custody facility has an obligation to ensure that all risk-related reports (*e.g.*, Inmate Complaint Forms or Inmate Injury Reports) are promptly logged into the system. FAST contains a useful feature, called Reports Not in FAST (RNF), that compares reports tracked by a separate document control database (known as the Reference Log) to FAST in order to show how many reports on a given subject matter (*e.g.*, inmate

Table 2.7 **Custody Reports Issued But Not in FAST**

Facility	Use of Force	Inmate Complaints	Mental Observations and Suicides	Inmate Injuries	Total
MCJ	58	74	444	197	773
TTCF	22	43	488	127	680
NCCF	15	128	221	141	505
IRC	7	6	N/A*	24	37
CRDF	4	44	724	54	826
Mira Loma	0	21	10	20	51
Pitchess East	6	17	108	29	160
Pitchess North	7	11	20	12	50
Pitchess South	0	2	1	11	14
Total	119	346	2016	615	3096

* As the center for initial processing of inmates, IRC tracks mental observation referrals in a different database.

Source: FAST RNF Reports, October 16, 2003

complaints or injuries) have been issued but are not yet logged into the FAST database. Thus, for example, one can run an RNF query to determine how many Inmate Injury Reports issued at a given jail facility have not yet been logged into FAST. The resulting RNF report identifies each unlogged Inmate Injury Report by reference log number, date, and the person who requested it.

Unfortunately, it appears that this backlog-monitoring system is underutilized. We ran our own RNF reports for all the custody facilities and found substantial numbers of reports that have not, for one reason or another, been logged into FAST. Examples of our findings are set forth in Table 2.7.

According to the RNF reports we generated, most of these underlying reports were issued months ago. For example, 150 of the 197 (76 percent) as-yet unlogged Inmate Injury Reports from the Men's Central Jail were more than three months old.

No one within Custody Support Services or at any of the facilities could account for the apparent backlog. Possible explanations, however, were offered. Some of the reports may have been requested in error. Others may not yet be completed. Others still may have been lost or destroyed.

Nor was there agreement as to who is responsible for dealing with these aging reports not recorded into FAST. Some pointed to the Statistical Coordinators at the facilities. They, we were told, were responsible for tracking their own paperwork. Others pointed to Custody Support Services. CSS, we were told, was responsible for ensuring that FAST is up to date.

We recommend that Custody Support Services generate RNF reports on a monthly basis in order to determine which facilities appear to be falling behind in paperwork processing and FAST data entry. The reports should be circulated not only to those facilities' Statistical Coordinators, but also to the facilities' captains so that they are aware of the problem and can allocate resources accordingly. In addition, a copy of the reports should be circulated to the concerned division chief and commander, so that they too know what problems exist.

Custody Division Chief Scott has expressed great concern over these numbers and has asked CSS to take whatever steps are necessary to eliminate the data entry backlogs and to ensure that RNF reports are run regularly to prevent future backlogs. We will continue to work with CSS on this issue and describe its progress in a future report.

Reports Regarding Overdue Inmate Complaint Investigations. We also found that a similarly useful FAST report designed to track delinquencies was also underutilized. The report, called "Inmate Complaints Over Ten Days," is designed to report all cases where (1) an inmate complaint has been assigned to a supervisor for investigation and (2) the investigation has remained open for more than ten days. (Generally speaking, such investigations take no longer than a week.) The FAST report is particularly useful

in that it sorts the delinquent investigations both by facility and by investigator, so that managers can quickly identify those investigators with a backlog.

Unfortunately, it appears that this report is rarely used by the facilities to keep track of their own complaints, and it has never been used by CSS. When we ran the report in October, we found 105 complaint investigations reported as delinquent, with many investigations reported as weeks or months overdue. We also found several instances in which individual investigators were responsible for a number of substantially overdue investigations. We found, for example:

- Forty-five of the investigations (43 percent) were reported as more than a year old, and 13 (12 percent) were reported as more than two years old. Six investigations (6 percent) were listed as more than one thousand days old, with the oldest listed as having been open for 1,527 days.

- Men's Central Jail accounted for the most overdue investigations, with 51 (49 percent).

- Several investigators had accumulated several significantly overdue investigations. For example:
  - Investigator A was reported as having eight investigations that were 415, 392, 385, 385, 372, 353, 267, and 190 days old.
  - Investigator B was reported as having seven investigations that were 338, 205, 191, 190, 156, 50, and 49 days old.
  - Investigator C was assigned to investigate an inmate complaint on September 30, 2003, even though he was reported to have failed to complete three investigations that were 274, 205, and 170 days old.
  - Investigator D was reported as having two investigations that are 620 and 600 days old.

FAST does not report any explanation for the reported delinquencies. Theories were offered. Some of the investigations may have been completed long ago, but for some reason have not yet been acted upon. Others may have been investigated and acted upon, but for some reason their completion was not logged into FAST. Still other cases may have been transferred to another unit for investigation and disposition. Finally, still other investigations may have been justifiably or unjustifiably closed or abandoned, with the underlying paperwork lost or destroyed. Neither Custody Support Services nor the facilities' Statistical Coordinators knew the reasons for the delinquency in any of the cases we identified.

Statistical Coordinator Meetings. When FAST debuted in 1997, CSS set up monthly meetings with the facilities' Statistical Coordinators to ensure that the data were being collected accurately and to solicit ideas for improving the system. We attended the November 2003 meeting and reviewed the minutes from prior meetings. It is clear that the sessions have improved the operation of the system and are necessary to maintain data integrity.

In this light, we were concerned to note that over the past year, these meetings have become more infrequent. In late 2002 the meetings were held every other month. This year, there have only been three meetings. It appears that the main reason for this reduction in meetings is an increase in the number of special projects assigned to CSS' Data Analysis Unit. However, before CSS can be asked to provide executives with detailed analyses of FAST data, they must first be sure that the data in FAST are correct and complete. Accordingly, we recommend that CSS immediately resume holding Statistical Coordinator meetings on a monthly basis.

C. Additional Areas for Improvement

Over the past several years, we have not only looked at the Department's own risk management-oriented databases such as the PPI, FAST, and CARS, we have also examined similar databases used around the country. As we

examine those other databases, we look, among other things, for features that can be used to improve the LASD's systems. For example, in our **Sixteenth Semiannual Report,** we devoted a chapter to discussing features from other departments' "early warning" systems that may prove useful for the LASD.

We have not, however, come across any other custody-based risk tracking system that is close to FAST in breadth or scope. Nonetheless, we did find a number of technical and administrative areas in which FAST can be improved.

FAST Needs a More Robust Software Platform. FAST is currently written in Paradox, a desktop database program. While there were good reasons to choose Paradox in 1997 (the software was already on LASD machines and FAST was not a large database at that time), the fact that FAST is designed to operate in real time with multiple, concurrent users, renders it vulnerable to data corruption and security breaches by unauthorized users. Thus, unless FAST is transferred to a more stable and secure environment such as Oracle,[15] the Department risks in the near future substantial slowdowns, lockups, data corruption, or even intentional damage or tampering by hackers. As a first step, the Department should provide Oracle programmer training for FAST's creator and administrator, Senior Deputy Arlan Mulford, so that he will be able to assist in the transfer to the new platform.

FAST Modules Should Be Linked. One way to minimize inconsistencies between FAST modules is to link the modules together. Under a linked system, a manager viewing a use of force incident will be able to tell instantly

15. Oracle is a software platform specially designed for providing database access to multiple, concurrent users across a network. In addition, it provides extremely high levels of database stability and security. The LASD uses Oracle for a number of its mission-critical databases, such as the PPI and LARCIS, the Los Angeles Regional Crime Incident System, which tracks criminal histories and cases referred for prosecution.

    An additional benefit of moving FAST to an Oracle platform is that the program will be able to share data with the LASD's other Oracle-based programs, greatly reducing the need for multiple data entry.

whether the incident is reported in other FAST modules, such as Inmate Injuries, Inmate Complaints, or Civil Claims. These features exist not only in PPI, but in an analogous program developed by Industry Station called Admin Tracker. We have already recommended that Senior Deputy Mulford review Admin Tracker to determine whether he can apply its module-linking design to FAST.

FAST Documentation and Training Needed. Currently, there is only one person in the Department who knows the intricate details of FAST: Senior Deputy Mulford. If the system goes down and he is unavailable, there is no one available to help bring the system back up. The Department cannot afford to remain in this vulnerable position. Accordingly, the system needs to be thoroughly documented and at least one other employee trained to become as familiar with the system as Senior Deputy Mulford.

Other Areas. There are many other areas needing improvement, including methods to reduce the amount of repetitive data entry between FAST modules and providing means to link FAST reports to scanned images of underlying documentation. Some of these improvements are costly; many are not. We intend to work with Custody Support Services to see that all practicable improvements to the system are timely put into place.

LOS ANGELES CO. SHERIFF'S DEPARTMENT
INMATE COMPLAINT DISPOSITION DATA FORM

☐ **INMATE COMPLAINT** ☐ **REFERRED THIRD-PARTY COMPLAINT**

Reference # _____ (Any related URN number: _____)

Facility Receiving Complaint:_____ Courtesy Inquiry: **Y N** If Yes, For Which Facility _____

This Complaint is: ☐ Individual Inmate ☐ Recurrent ☐ Group of Inmates (how many?): _____

Inmate's Last Name:_____ First _____ Bkg. #-_____

Sex: **M F** Release Date:_____ Date/Time of Occurrence:_____ Shift: **AM PM EM ALL N/A**

Date Inmate Submitted Complaint: _____

Housing Loc.:_____ Housing Type (Circle Type): 1) General Population 2) Discipline / Admin Seg

3) Pro Per 4) Gang 5) High Power 6) K-11 7) K-12 8) 288 / Sexual Predator

9) Medical 10) Suicide Watch 11) Inmate Worker 12) None 13) Other

ID#	X	COMPLAINT TYPES	DISPOSITION CODE
01		BEDDING	
02		CLOTHING/HYGIENE	
03		COMPLAINT PROCESS	
04		CONTRACT VENDOR	
05		DISCIPLINE / DRB	
06		EXERCISE	
07		FACILITY CONDITION/SANITATION	
08		HOUSING LOCATION / RECLASSIFICATION	
09		INMATE INFORMATION SYSTEMS	
10		INMATE PROGRAMS	
11		INMATE WORK ASSIGNMENT	
12		JUSTICE DELAYS (PRO PER, LAW LIBRARY, ETC)	
13		MAIL	
14		MEALS / FOOD	
15		MEDICAL SERVICES	
16		MENTAL HEALTH SERVICES	
17		MISCELLANEOUS	
18		MONEY / INMATE ACCOUNTS	
19		POLICY / PROCEDURES / ENFORCEMENT OF RULES	
20		RELEASE INFORMATION / SENTENCE	
21		RELIGION / CHURCH	
22		SHOWERS	
23		STORES /VENDING MACHINES	
24		TELEPHONES	
25		TELEVISION	
26		TRANSPORTATION	
27		VISITING	
28		WRISTBAND BAR CODE	
29		REQUEST FOR INFO - NO RESPONSE	
40		PROPERTY - DAMAGED (SEARCH)	
41		PROPERTY - MISSING (SEARCH)	
42		PROPERTY - TAKEN (CONTRABAND)	
43		PROPERTY - OTHER	
44		COMPLAINT AGAINST STAFF	

DISPOSITION CODE NUMBERS

01 UNFOUNDED

02 FOUNDED

03 UNRESOLVED

04 UNIT LEVEL INVESTIGATION

05 I. A. B. INVESTIGATION

06 RELEASED PRIOR TO INQUIRY

07 REFERRED - MEDICAL

08 REFERRED - COURT SERVICES

09 REFERRED - FOOD SERVICES

10 REFERRED - OTHER FACILITY

11 REFERRED - OTHER

12 I.C.I.B. INVESTIGATION

99 NOT APPLICABLE

FOR UNIDENTIFIED COMPLAINANTS, USE A BOOKING #OF 0000000.

(Please complete the reverse side of this load sheet)

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LOS ANGELES CO. SHERIFF'S DEPARTMENT
INMATE COMPLAINT DISPOSITION DATA FORM (CONTINUED)

PAGE TWO

Reference # _____ (Any related URN number: _____)

Date Assigned: _____ Date Completed: _____

Investigator's Name / Title: _____ Emp #- _____

Disposition or Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Watch Commander Approval: _____ Date: _____

Unit Commander Approval: _____ Date: _____

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The Inmate Reception Center 3

Introduction

In previous reports, we have discussed the many challenges facing the Inmate Reception Center (IRC), the primary intake and release facility for the LASD jail system. In particular, we have expressed concerns about three areas: (1) overdetention of inmates who have been ordered released or whose sentences have expired; (2) erroneous releases of inmates; and (3) officers' use of force. Although we have regularly visited IRC, it has not been since our **Eighth Semiannual Report** (October 1997) that we have discussed these areas of concern in any detail.

During this review, we found encouraging indications that IRC continues to improve. First, inmate overdetentions have continued to decline dramatically. While some of the structural changes responsible for the sharp decline in overdetentions came about as the result of costly litigation, others were the result of focused and strong leadership. Second, erroneous releases have also declined, although in a less dramatic fashion. The declines appear directly linked to new quality-control measures introduced in the past several years. Third, much of what we saw regarding use of force was encouraging: use of force trends remain below 1998 and substantially below 2000 levels and management appears to be working actively to reduce force and risk at IRC.

I. Overview of IRC's Operations

IRC is the linchpin of the entire Los Angeles County jail system which, with an inmate population that has ranged from 17,500 to 22,000 over the past decade, is the largest jail system in the country. Part of the LASD's Correctional Services Division,[1] IRC is the largest command in the LASD, with approximately 800 employees, roughly half of whom are sworn officers. It is the unit responsible for processing all new inmates ("new bookings") into the jail system, and maintaining all records regarding inmates' whereabouts in the LASD's seven custody facilities.[2] Each year, IRC books nearly 200,000 individuals into the jail system. On "slow days," IRC processes approximately 500 new inmates; on "fast" days (*i.e.*, days following weekends or holidays), the daily intake approaches 750. Each new inmate must have his identity and aliases confirmed, be classified according to risk, screened by the Medical Services Bureau for medical and mental health problems, and assigned to one of 46 housing categories.

IRC also processes approximately the same number of inmate releases each year. During an average day, IRC processes about 500 inmates for release or for transfer to other institutions, such as prison or the INS.

IRC is also responsible for coordinating inmates' travel to and from 12 Superior Court districts and 49 courthouses in Los Angeles County. On average, nearly 1,300 inmates pass through IRC each weekday on their way to and from court appearances.

Finally, IRC is responsible for overseeing all of the adjustments necessary to reduce jail overcrowding by means of approved early releases, electronic

1. The Correctional Services Division (COSD), of which IRC is a part, provides a variety of inmate-related functions from the inmate intake/release process performed by IRC to the provision of medical and mental health services. In addition, COSD is charged with developing and improving educational, vocational, drug and alcohol, anger management, and religious programs available to the inmate population. COSD is separate and distinct from the Custody Division, which operates the LASD's jails.

2. For a list of the facilities, see page 5, footnote 1.

monitoring, work release, and weekend programs. This year, this task became particularly difficult when decreases in funding have required the Department to reduce the inmate population from roughly 20,000 to 17,500.

II. Overdetentions and Erroneous Releases

In past reports we noted with concern the insufficient resources devoted to ensuring that inmates entitled to be released are not overdetained *(i.e.*, continued to be detained) and that inmates who should remain behind bars are not mistakenly released. In our **Eighth Semiannual Report** we urged the County to provide the necessary resources to automate the communications between IRC and the 49 courthouses it serves:

> "Current manual methods of processing court documents relating to a given inmate's status have overtaxed the staff and resources of the Inmate Reception Center, leading to overdetention of inmates and erroneous releases. Interim fixes at IRC have substantially scaled back on erroneous releases by expanding the staff in the IRC's document section and by setting up additional fail-safes to prevent error. The additional personnel is a very costly way to deal with a set of problems that can easily be cured by better electronic communication between the jail and the courts."[3]

Regrettably, the long-promised integration of the Superior Court's computer system, known as the Trial Court Information System (TCIS), with the LASD's computer systems (*e.g.*, the Automated Jail Information System [AJIS]), has yet to take place. Some of the delay comes from unexpected technical difficulties in making the two systems speak to and understand each other. The rest of the delay is the result of lack of funds.

3. **Eighth Semiannual Report** (October 1997) at 33.

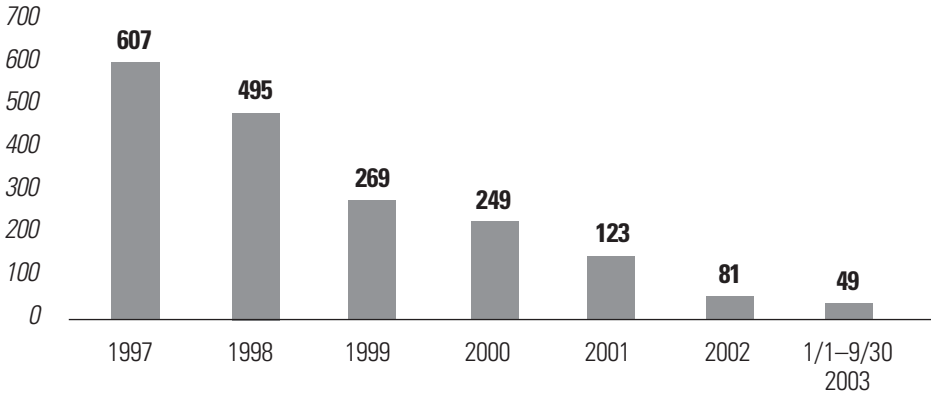
Notwithstanding these setbacks, IRC has continued to make substantial progress in managing the related problems of overdetentions and erroneous releases.

A. Overdetentions

The last time we reported on overdetention statistics was in our **Fourteenth Semiannual Report** (October 2001). At that time, we saw a steep decline in overdetentions, from a high of 712 in fiscal year 1997-98, to 191 in fiscal year 2000-01. *See id.* at 97. Much of this decrease stemmed from a massive commitment of personnel to process release-related paperwork.

IRC's overdetention numbers have continued to drop dramatically. These statistics, computed on a calendar as opposed to fiscal-year basis, show a precipitous decline in overdetentions since we first focused attention on the issue. *See* Table 3.1. As Table 3.1 indicates, in 2000 IRC appeared to reach a plateau in the steady decline of overdetentions, dropping only seven percent from 1999 to 2000. The plateau proved to be temporary, however. The following year, the rapid decline commenced once again, with overdetentions

Table 3.1 **Inmate Overdetentions by Calendar Year**



Source: Inmate Reception Center

dropping by 51 percent. Based on the year-to-date statistics, the number of overdetentions in 2003 will be only one quarter of the number in 2000.

Three factors led to this favorable trend: (1) a substantial overhaul of the Department's handling of court-ordered releases, which was driven largely by litigation; (2) monthly meetings instituted to examine the reasons why inmates were overdetained; and (3) a new tracking system designed to identify employees who need additional training or supervision in processing inmate release papers. We discuss these changes in turn.

1. The In-Court Release and Greenband Program

Most of the decline in inmate overdetentions in the past two years is attributable to a significant change in the LASD's procedures for freeing inmates ordered released by the Superior Court. In May 2001, the LASD instituted the In-Court Release and Greenband Program, in which thousands of inmates each month are released within hours of their court appearances. Because so many prisoners (nearly 3,100 a month) are released in court, the paperwork processing at IRC has been substantially reduced and with it the risk that inmates will be mistakenly overdetained.

To appreciate how revolutionary this new program has been for the LASD, one must understand how the Department previously processed inmates obtaining in-court release orders. Until the spring of 2001, few inmates were released at the courthouse.[4] Instead, inmates appearing in court who were ordered released typically were transported back to IRC that day for further processing. Usually, but not always, the court's order made it back to IRC later that day. Sometimes, however, it did not, resulting in delays in the inmates' release. A significant number of the overdetentions

4. Historically, the LASD did not release inmates at the courthouse unless a court specifically ordered it to do so. Such orders were very rare, in part because it was possible that the inmate might be subject to continued detention in connection with other cases. (*e.g.*, there might be outstanding warrants for the inmate's arrest for other alleged offenses).

prior to 2001 occurred because the paperwork showing that the court had ordered a release was misplaced, or not acted upon for other reasons, after inmates had been returned to IRC for release processing.

In addition, the LASD's previous system for approving inmates for release could cause further delays. Before the LASD releases any inmate from custody, it checks the Automated Justice Information System (AJIS), the Department's computerized law enforcement database, for "wants" and "holds" — *i.e.*, notifications that the prisoner is wanted by another law enforcement agency or subject to a detention order or sentence in another proceeding. For many years, the LASD's practice was to delay running its AJIS check until all of the wants and holds received on that date were typed into AJIS. Because such paperwork was often voluminous, the data entry process could take up to several days. Thus, for example, an inmate ordered released on a Monday might have to wait until Tuesday, or even Wednesday, before Monday's wants-and-holds paperwork had been typed into AJIS and a wants-and-holds query run. Furthermore, the Department typically held off processing other release paperwork until the AJIS query had shown the inmate clear of any wants or holds. Meanwhile, the inmate remained in LASD custody, subject to the same rules — including those regarding strip searches — as other inmates. Because the processing system took several days, there was an increased risk that paperwork would get lost, or computer records would not get updated, and thus the inmate would be detained unnecessarily even after the AJIS query had been completed.

Beginning in 1998, a number of lawsuits challenged the LASD's methods in processing inmates receiving in-court release orders. For example, in *Vanke v. Block*, 1998 U.S. DIST. LEXIS 23488 (C.D. Cal. 1998), a federal judge entered a preliminary injunction barring the LASD from continuing its practice of delaying inmate releases while wants-and-holds paperwork was typed into AJIS:

> "Absent probable cause or reasonable suspicion to believe that unprocessed wants and holds include a want or hold against a particular individual whose release has been ordered, continued detention of that individual longer than required to perform the administrative steps incident to release violates the Fourth Amendment guarantee against unreasonable seizure." *Id.* at 4.

Other state and federal lawsuits challenged not only the Department's release procedures but also challenged the Department's practice of performing strip searches on inmates already ordered released. Many of these cases were class actions, with the potential class size reported to be several hundred thousand former inmates. In May 2001 the County settled 14 of these lawsuits for approximately $27.1 million. Part of the settlement required the LASD to implement certain measures to minimize the delays in processing inmates for release.

One direct result of the class action settlements was the Department's implementation of the In-Court Release and Greenband Program in May 2001. The program requires that each of the 49 courthouses in Los Angeles County be staffed by an In-Court Release Deputy from the LASD's Court Services Division. When a judge orders an inmate released, the bailiff notifies the In-Court Release Deputy, who then promptly checks AJIS for wants and holds. If the AJIS search shows a want or hold, the inmate is returned to IRC for reassignment to his or her regular housing unit. If, however, the AJIS search produces no "hits," the In-Court Release Deputy promptly notifies IRC that the inmate is apparently eligible for immediate release. In addition, the Deputy examines a digitized booking photograph of the inmate covered by the release order to make sure he is dealing with the right person.

An IRC clerk, upon receiving notice from the In-Court Release Deputy that an inmate is apparently eligible for immediate release, pulls the inmate's record jacket and reviews all documentation to ensure that it does not reflect

any outstanding wants or holds. The clerk also checks to see whether the inmate's release is conditioned upon the taking of a DNA sample or a pre-release medical or mental evaluation. In addition, the clerk updates AJIS to reflect that the court has ordered the inmate released.

If the inmate does not have any wants or holds and is not required to provide a DNA sample or to submit to a medical or mental evaluation, the IRC clerk contacts the In-Court Release Deputy and authorizes the release of the inmate at the courthouse. The In-Court Release Deputy then arranges for the inmate to be given a white uniform and released at the courthouse.[5] In those cases where the inmate demands that the LASD transport him back to IRC, the Department will do so, but only if the inmate signs a waiver of liability. The inmate is then segregated from other inmates and returned to IRC as quickly as possible.

In those cases where the inmate's release is conditioned upon providing a DNA sample or submitting to a medical or mental evaluation, the IRC clerk notifies the In-Court Release Deputy that the inmate is to be returned to IRC and processed on an expedited basis. Such inmates, who are identified with a green wristband, are known as "Greenband inmates."[6] They are segregated from other inmates returning from IRC and are not subject to strip search. Upon arriving at IRC, Greenband inmates are sent directly to a designated release area, where technicians and doctors take DNA samples and/or conduct medical or mental evaluations. Upon completion of this procedure, the inmates are ready to be reunited with their property and released. Only those declared medically or mentally unfit for release stay behind. Such inmates are

5. LASD staff notify the inmate he or she can return to IRC any time within the next several months to pick up his or her clothing and other property. If the inmate needs transportation, the LASD will offer to provide a bus token in exchange for the inmate's agreement not to sue the Department for any injuries he or she might sustain on the bus.

6. Inmates entitled to immediate courthouse release but who insist upon being transported back to IRC by the Department are also classified as "Greenband inmates."

Table 3.2
Monthly In-Court and Greenband Releases (2002)

Month	In-Court Releases	Greenband Releases	Returned To IRC In Error	Total	Error Rate*
Jan	2,878	463	0	3,341	0.00%
Feb	2,667	390	0	3,057	0.00%
Mar	3,147	451	0	3,598	0.00%
Apr	3,040	518	15	3,573	0.42%
May	2,872	452	15	3,339	0.45%
June	2,892	419	16	3,327	0.48%
July	3,042	458	9	3,509	0.26%
Aug	2,837	430	12	3,279	0.37%
Sep	2,899	342	9	3,250	0.28%
Oct	3,308	480	5	3,793	0.13%
Nov	2,753	446	10	3,209	0.31%
Dec	3,335	524	1	3,860	0.03%
Total	**35,670**	**5,373**	**92**	**41,135**	**0.22%**

*Error rate: Percentage of inmates erroneously returned to IRC instead of being released in court
Source: Inmate Reception Center and Court Services Bureau

Table 3.3
Monthly In-Court and Greenband Releases (1/1-9/30, 2003)

Month	In-Court Releases	Greenband Releases	Returned To IRC In Error	Total	Error Rate*
Jan	3,421	418	1	3,839	0.03%
Feb	2,162	522	6	2,688	0.22%
Mar	3,097	468	7	3,565	0.20%
Apr	3,497	551	6	4,048	0.15%
May	3,347	516	8	3,863	0.21%
June	3,293	537	3	3,833	0.08%
July	3,532	460	4	3,996	0.10%
Aug	3,316	562	2	3,880	0.05%
Sep	3,365	663	3	4,031	0.07%
Total	**29,030**	**4,701**	**40**	**33,771**	**0.12%**

*Error rate: Percentage of inmates erroneously returned to IRC instead of being released in court
Source: Inmate Reception Center and Court Services Bureau

transported by ambulance to an appropriate medical facility. Tables 3.2 and 3.3 show the monthly breakdown of In-Court and Greenband Releases for the past two years. As both tables indicate, since January 2002, nearly 75,000 inmates have gone through the program, with nearly 65,000 inmates released at the courthouse. Fewer than one quarter of one percent of the inmates processed are mistakenly returned to IRC as Greenband inmates rather than released at the courthouse.

Because many of the Department's overdetentions had formerly occurred as a result of mistakes made in the hours or days following an in-court release order, the In-Court Release and Greenband Program has greatly contributed to the decrease in overdetentions in the past two years.

Nonetheless, the program has not completely eliminated the risk of mistaken overdetentions. While the In-Court and Greenband Program accounts for 3,000-4,000 releases per month, another 9,000-12,000 inmates are subject to release each month for a variety of reasons. Many are misdemeanants whose sentences have expired. Others are pre-trial detainees who have posted bail. Freeing these inmates as soon as they become eligible for release is likewise a departmental obligation. We now discuss how management has met that obligation in the past several years.

2. Monthly Overdetention Meetings

Shortly after now-Commander Richard Barrantes became Captain of IRC in 2000, he and his executive staff began meeting each month to discuss overdetentions (and erroneous releases) that had occurred during the previous month.[7] His aim was to determine the causes of overdetentions. Were they attributable to personnel problems, flaws in the processing system, or both?

At the meetings, each overdetention is presented as a case study. We

7. Captain Barrantes left IRC in April 2002 when he was promoted to Commander in the Correctional Services Division. He was succeeded as Captain of IRC by Tom Laing, who served in that position until November 2003. The current Captain of IRC is Anthony Argott.

reviewed several years' worth of these case studies and attended the overdetention meeting for September 2003. The meetings are conducted as team problem-solving sessions. Staff of all ranks, from custody assistant to commander dissect each overdetention case and look for ways to prevent errors from reoccurring. The meetings have contributed to the great reduction in the number of overdetentions.

3. IRC's New Quality Control Tracking System

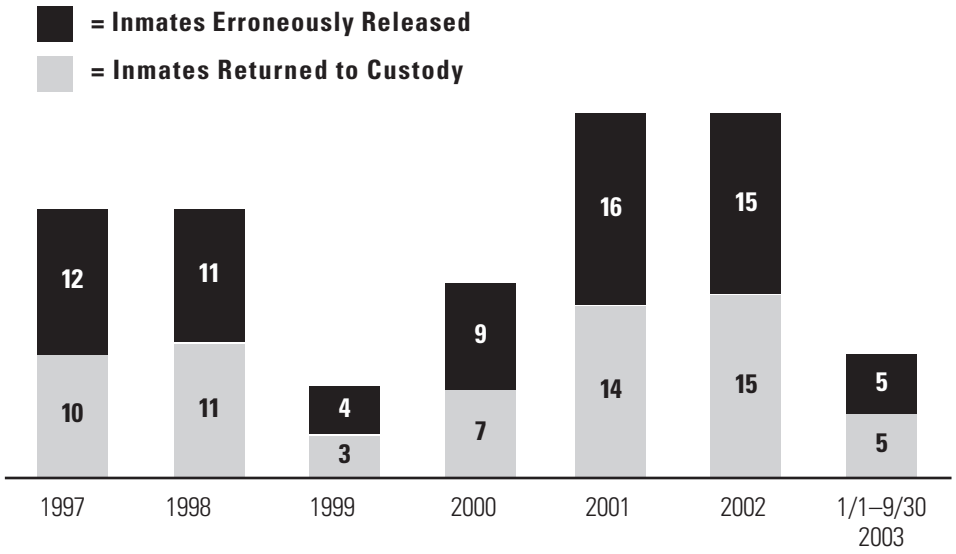
Commander Barrantes' successor at IRC, Captain Tom Laing, took these ideas one step further. In March 2003, Captain Laing implemented the Quality Control Tracking System, in which all papers relating to inmate releases are subject to two separate layers of review. If the employee conducting the second review (known as a Quality Control Clerk) detects an error, he or she is authorized to intervene immediately to prevent a potential overdetention or erroneous release. The clerk logs all errors on a form identifying (1) the person(s) who made the error, (2) the type of error committed, and (3) the means by which the clerk caught the error. Each form is then submitted to a Quality Control Supervisor who reviews the documentation and confirms whether an error has occurred. If it has, the supervisor meets with the employee who made the error to discuss how to avoid similar errors in the future. If this discussion reveals that the employee could use additional training or mentoring, the assistance is provided immediately. Finally, the results of the supervisory reviews are logged into a database for future monitoring of employee performance.

The system was designed to be primarily remedial, rather than punitive. We expect that under the command of IRC's new Captain, Anthony Argott, there will be continuing progress in reducing errors.

B. Erroneous Releases

Few events can shake the public's confidence in law enforcement as much as the erroneous release of a serious offender. Even if the offender is promptly

Table 3.4
Erroneous Releases and Inmates Returned to Custody



Source: Inmate Reception Center

apprehended and returned to custody, the community's confidence has already been damaged. Accordingly, IRC's management of inmate releases affects the Department's relationship with the community.

As Table 3.4 indicates, in the past several years, IRC generally has not been as successful in reducing erroneous releases as it has in reducing overdetentions. On the other hand, this year IRC expects to reduce its erroneous releases by more than 50 percent from the previous year. In addition, in the last two years the Department has been successful in returning erroneously released inmates to custody. Finally, since 1997, only five "major offenders" — *i.e.*, inmates charged with murder, sexual abuse, or serious violent crimes have been erroneously released, with no more than one such offender released in any year.

As with overdetentions, erroneous releases have been subject to monthly review meetings since mid-2000 and tracked by the Quality Control Tracking System since March of this year. Although erroneous releases dipped dramati-

cally in 2000 to only four and then rose once again to nine in 2001 and 16 in 2002, we could find no systemic problems or persistent patterns that could persuasively account for the dip and subsequent rise. We are encouraged, how-ever, that this year is headed for a similarly low number of erroneous releases.

III. Use of Force

In past reports, we expressed concerns about officers' use of force at IRC. During this review, we examined IRC's use of force data for the past several years and audited a sample of use of force cases from January 2002 to the present. On the whole, we were encouraged by what we found: despite substantial increases in IRC's average daily inmate population over the past four years, the force incident rate (as measured on a per-1000-inmate basis) has continued to trend downward. In addition, despite these material reductions, management continues to work actively to achieve further gains in reducing force and risk at the facility. While we did come across some force packages that gave us pause, they constituted a small minority and none involved serious injuries to inmates.

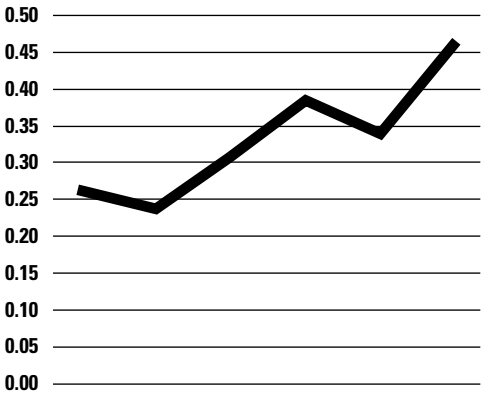
A. Use of Force Data Trends

Table 3.5 shows an array of useful data relating to use of force in IRC since 1998. Because the inmate population processed by IRC has grown dramatically (*e.g.*, the current ratio of inmates per staff is double the ratio in 1999) we can gain a more accurate picture of the facility's force trends by looking at the number of force incidents per 1000 inmates.[8] The number of force events per 1000 inmates rose from 2.184 in 1998 to 3.849 in 2000. The following year saw a substantial drop to 1.54 uses of force per 1000 inmates. After an increase in 2002, the rate for 2003 (year-to-date) was 1.471 per

8. This is a standard method of assessing force trends in custody facilities.

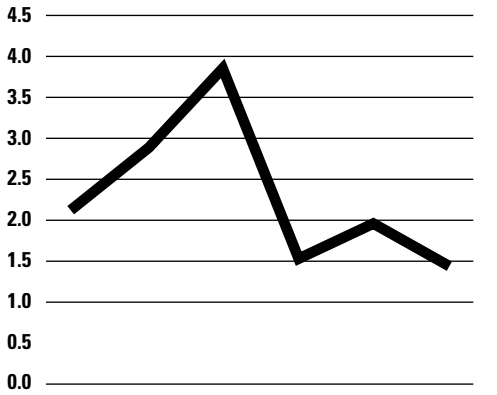
Table 3.5 **IRC Inmate and Use of Force Data 1998-2003**

Inmates per Staff



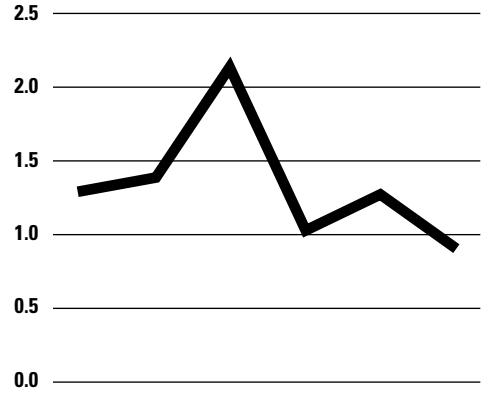
1998	1999	2000	2001	2002	YTD 2003
0.262	0.232	0.253	0.389	0.346	0.468

Total Force Events per 1000 Inmates



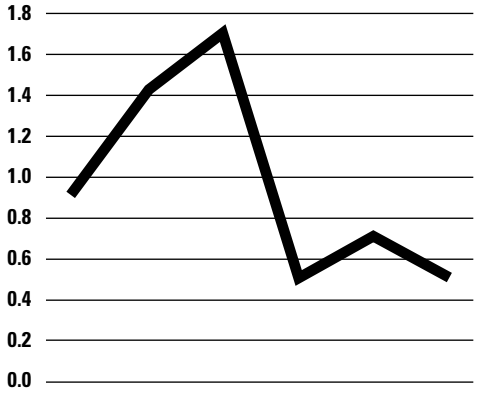
1998	1999	2000	2001	2002	YTD 2003
2.184	2.889	3.849	1.540	1.958	1.471

Significant Force Events per 1000 Inmates



1998	1999	2000	2001	2002	YTD 2003
1.282	1.394	2.142	1.036	1.249	0.897

Less Than Significant Force Events per 1000 Inmates



1998	1999	2000	2001	2002	YTD 2003
0.903	1.495	1.707	0.504	0.699	0.574

YTD 2003: January 1–September 12, 2003
Source: Custody Support Services

1000 inmates. Thus, IRC's current use-of-force rate is one-third lower than the rate five years ago.

The trends were similar for both significant uses of force (*i.e.,* those resulting in injury or complaint of pain other than discomfort from OC spray) and less than significant uses of force. For significant force events, IRC's current rate is 30 percent below 1998 levels; for less significant force events, the rate is 36 percent below 1998 levels.

In addition to looking at statistical trends, it is also worthwhile to assess what factors may contribute to those trends. For example, in the first three months of this year, IRC experienced a brief spike in its use of force incidents. Closer examination revealed that most of the cases involved outbursts by mentally ill prisoners. We and the Department both noted that the temporary increase in the proportion of mentally ill inmates may have stemmed from stepped-up efforts by the LAPD to target certain areas of Los Angeles and Hollywood known for their large transient populations. Other factors may come into play as well. For example, many force incidents occurred in IRC's clinic area, where inmates may end up sitting on metal benches for hours while they await medical or mental evaluation. Although IRC and the Medical Services Bureau, which is responsible for conducting the evaluations, have added resources to speed up the process during peak periods, mentally ill inmates may end up waiting well over eight hours to receive attention. Not surprisingly, frustration builds.

Lack of training and experience — a point we discussed more broadly in Chapter One — can also be a factor. Officers who lack confidence in their own ability to handle an inmate may panic and escalate confrontations unnecessarily. One senior IRC official acknowledged:

> "There's definitely a fear factor with some of them. They see a hundred inmates in a room and look and only see two other officers in the room.

> Some wiseass [inmate] makes a sarcastic remark and the officers are thinking, 'Quick, grab that guy! We're outnumbered! There could be a riot!' The fact is, most of these guys [inmates] don't want trouble. They want to keep their head low and get their [housing] assignment. But that's a training and experience thing. Too many of our guys are too quick to lay hands on. Anyone who's been in custody will tell you that when you lay on the hands, you're gonna' get a fight. So we have to keep working on that."

B. Recent Initiatives To Manage Risk

During this audit we noted that IRC is exploring new means of addressing use of force issues. Perhaps most promising is the institution of monthly force debriefings, in which the Captain reviews the month's use of force cases with the lieutenants and sergeants for each shift. In preparation for each meeting, the supervisors closely review the use of force incidents from the previous month, looking both for potential personnel issues as well as training needs. If a review discussion reveals that an officer needs additional training or is having personal problems that might be affecting his or her performance, the group assigns the officer to a mentor sergeant who becomes responsible for ensuring that the officer's needs — whether they be an extra day of training or a referral to a personal counselor — are addressed, and for reporting back on the officer's progress. Because this program debuted in July 2003, it is too early to gauge its success. However, it is worthwhile to note that other units' experience with similar programs, such as the force review established at Century Station in 2001, has been positive. In our **Fifteenth Semiannual Report** (July 2002) we described the Century system as follows:

> "The [Century Station] Force Review Committee at the station level does not duplicate the work or the mandate of the Department-wide Executive Force Review Committee made up of Commanders and thus

does not pass on whether a given force incident violates law or policy or merits discipline. Rather, the Committee only looks at incidents in which the force appeared to have been justified, with an eye to determining whether the incident offers lessons on tactics or policy. Those lessons are discussed with both the involved deputies as well as their peers at roll-call trainings." *Id.* at 31.

While IRC and Century clearly have different training needs, the concept is the same. IRC can learn much from other units' experience with regular force review.

A second, equally promising development is an effort to provide all line officers with skills-oriented training on handling mentally ill inmates. While IRC has previously offered mental health training without generating significant improvements in inmate handling, Captain Laing believed the trainers, who were civilian health care professionals, may not have connected well with officers who work the line. This past July he introduced training by LASD's Field Operations Mental Health Operations Team, which is staffed by highly-trained and experienced officers. IRC expects to continue this program under the leadership of its new Captain, Anthony Argott.

C. Review of IRC Force Packages

As useful as IRC's use of force data can be, the best way to form a view of a unit's use of force is to review the Department's own files documenting its internal investigation and evaluation of use of force cases. These materials are known as "force packages." During this audit we reviewed a sample of 150 IRC use of force packages from January 2002 to September 2003, representing nearly 40 percent of the total number of packages issued for that period. We made the following observations.

1. Quality of Force Package Investigations

Overall, most of the force packages were well-organized, thorough, and

balanced.[9] In all but a handful of cases, the investigative memos set forth the facts and outlined the policy and tactical issues in a clear and even-handed manner. The few exceptions we did find arose from a similar flaw: the investigator seemed too eager to summarize the case in terms most favorable to the involved officers. For example, while it was appropriate for an investigator in one case to note that the inmate involved was mentally ill and had had a history of violence, the investigator was overzealous in his denigration of the inmate. It should be remembered that force packages are routinely produced to plaintiffs' counsel in litigation, and biased or unprofessional comments by investigators can end up costing the Department credibility in court — even when the officer's use of force was in fact justified.

In a few other force packages, investigators missed obvious issues or failed to pursue leads. In one case, a violent inmate began spitting at officers who were attempting to secure him to a gurney. According to several of the officers present, "someone" put a towel over the inmate's face while another officer went to retrieve a spit mask.[10] Notwithstanding that the inmate later claimed he had difficulty breathing, the use of the towel was never analyzed.

In other cases (roughly 15 percent), investigators failed to document their efforts to obtain statements from inmates who witnessed a force incident. Such cases typically involved a force incident occurring in or near a search, a food line, or a crowded booking area. The investigative file would contain a statement from one or two inmates, but fail to account for the other inmates in the area, if any. Accordingly, we could not tell whether the lack of additional inmate witness statements was attributable to inmates' refusal to talk or inadequate investigative work. Each force package should thoroughly

9. In most cases, our audit was limited to reading the paper file; rarely did we review audiotaped or videotaped interviews. As such, our review was substantially similar to those customarily conducted by LASD captains and commanders.

10. A spit mask is a lightweight mesh mask designed to prevent a patient or inmate from spitting without impairing his ability to breathe.

document all efforts to obtain statements by potential inmate witnesses. If an inmate present at a use of force incident refuses to make a statement, or claims he did not see anything, the investigator should ask the inmate to sign a form containing a statement to that effect. Such documentation not only adds an additional layer of integrity to the investigation, but serves to protect the Department in any subsequent litigation.

2. Management's Evaluation of Force Incidents

Tactical Evaluations. The investigating sergeant or Watch Commander systematically sought to assess each use of force from a tactical, as well as a policy, point of view, seeking to determine not only whether a particular use of force was reasonable, but whether the officer could have taken other steps to minimize the amount of force used or even to avoid the use of force altogether. Where such alternatives appeared feasible, the supervisors typically recommended an informal briefing or counseling session.

We found a decided emphasis on critiquing officers who resorted to throwing punches rather than using more effective and potentially less injurious techniques. In one such case, an IRC Watch Commander aptly observed:

> "I recommend that Sgt. A review with Deputy B his decision to use a personal weapon (a punch) under the circumstances described. While our personnel are taught to use these tools as an option, I believe that more effective control techniques could have been used under the circumstances. It is my experience that punches are normally not effective, and often result in injury either to the deputy or suspect/inmate. In this case, the punch did not appear to be effective and the inmate was placed on the floor by Deputy D, who used a simple take down technique."

In another case, a different Watch Commander offered a similar critique that was communicated to the officers involved:

> "Deputy F used a personal weapon, his fist, to force Inmate G to release the death grip [sic] that he had on the skin around [Deputy F's] mid-section. The force was justifiably utilized, but not necessarily wisely so. As is often the case when deputy personnel choose to employ personal weapons, Deputy F was injured. He inadvertently struck the sharp ratchet of the metal handcuff around the inmate's wrist as he tried to punch the inmate's hand. This was a close quarters operation and there was precious little room for Deputy F to implement [sic] his fist, [which was] thinly gloved in latex. He suffered a predictable injury."

Praise is given to officers who exercised commendable restraint or otherwise prevented volatile situations from escalating. For example, one officer received this notation in his employee performance log:

> "On [date], you were involved in an incident in the clinic, in which you confronted an inmate that appeared to be prepared to throw a box containing a computer printer at you. You ordered the inmate to drop the box, but he failed to comply. Instead of physically engaging the inmate, you chose to deploy our O.C. spray. This resulted in the inmate's complete cooperation. The end result was a less than significant use of force, with no injuries to yourself or the inmate.
>
> This is a fine example of weighing out tactical options before engaging a potentially dangerous inmate/suspect. You are to be commended for your quick assessment of the situation, your excellent split-second decision making, and for properly deploying your O.C. spray."

Thus management reinforces effective and restrained responses to situations where force is justified, and adequately analyzes deficiencies.

Troubling Cases. Some of the IRC force packages we reviewed, however, seemed out of step with the positive trends we observed. In a small number of cases, fewer than 10 percent, it appeared that management lacked

the resolve to declare inappropriate uses of force or the disrespectful treatment of inmates as being out of policy.[11]

In one case, a deputy sought to prevent an inmate from spitting on another officer by grabbing the inmate by the throat and choking him. According to the deputy, he maintained the chokehold for several seconds until he was sure the inmate had swallowed the spit in his mouth. The inmate suffered no serious injuries, although a nurse did observe two bright red welts on his neck. No one involved in the review of the incident disagreed with the Watch Commander's assessment of the incident: "[A] spitting assault [would not] justify a choke hold that temporarily stopped [the inmate] from breathing... The situation could have been handled with a lesser degree of force than applying a choke hold." Nonetheless, neither the Watch Commander nor the Captain was willing to reach the conclusion that the Deputy's use of force was unreasonable. Indeed, the Watch Commander concluded his otherwise-critical write-up with a finding "that the force used was *necessary and within Department policy*." (Emphasis added). This finding was accepted, and no disciplinary action was taken.

In a second case, an inmate standing in a food line began yelling that he wanted to see a supervisor. A deputy responded by taking the inmate out of line and using a rear wrist lock to place the inmate against a wall. The deputy then began lecturing the inmate on how to behave in line. Noticing that the inmate's head was bowed, the officer pulled on one of the inmate's braids in order to force the inmate to look at him. The deputy admitted to the hair pulling and conceded that the inmate was not assaultive and did not otherwise pose a threat. Again, all who reviewed the incident agreed that the force was

11. The LASD's policies state that discipline is mandatory for all instances of unreasonable force or mistreatment of inmates. *See, e.g.*, LASD Policy and Procedure Manual § 3-01/025.10 (Nov. 2003) ("Unreasonable force is prohibited. The use of unreasonable force *will* subject Department members to discipline and/or prosecution.") (emphasis added); LASD Custody Procedures Manual § 3-04.000.00 (Nov. 2003) ("Inmates are entitled to fair and impartial treatment... Members shall treat those persons in custody with respect and dignity... Any Department member who violates this policy *shall* be subject to discipline.") (emphasis added).

The Jimenez/Burkhalter Case

On September 24, 2003, a federal grand jury indicted two IRC officers, Deputy Abel Jimenez and Senior Deputy Phalance Burkhalter, for their alleged roles in the beatings of two IRC inmates in 2001 and subsequent efforts to cover them up. Specifically, the indictment alleges that on November 28, 2001, Deputy Jimenez assaulted an inmate by throwing him to the ground and punching him. The indictment then alleges that his immediate supervisor, Senior Deputy Burkhalter, sought to cover the incident up by trying to persuade the inmate not to report the assault and to falsely attribute his injuries to falling out of his bunk. The indictment also alleges that on December 31, 2001, Deputy Jimenez assaulted a second inmate in a similar manner, forcing the inmate to the ground and punching him, and that the two officers conspired to cover up this assault.

The case was evidently under criminal investigation by the LASD and the FBI since January 2002. Because the case is currently pending, it would be inappropriate for us to try to assess the strength of the case against the two men.

We are encouraged by signs that the Department is using the jarring effect of the indictments as an opportunity to reinforce its core values with its officers and staff.

unnecessary and the deputy's treatment of the inmate disrespectful.[12] Nonetheless, the deputy's actions were found to be in compliance with the Department's policies regarding use of force and treatment of inmates.

While we saw relatively few of these cases and none involved serious injury, nonetheless we remained concerned. Such concerns linger particularly given that, as described in the accompanying text box, two IRC officers are currently facing federal charges for their alleged role in two inmate beatings. Violations of policies should be labeled as such, and appropriate discipline must be meted out for such violations.

12. For example, the investigating sergeant stated in his report: "It was unnecessary and inappropriate for Deputy G to pull the inmate's braid, even to get the inmate to raise his head. . . . [T]he inmate had only been verbally uncooperative up until this point in time." In a similar vein, the Watch Commander stated in his report that the Deputy "should not have pulled [the inmate's] braid." He observed that such conduct was "both unprofessional and inappropriate."

Table1 **LASD Litigation Activity, Fiscal Years 1992-2003**

	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	FY 01-02	FY 02-03
New Force Related Suits Served	88	55	79	83	61	54	41	54	67	78	68
Total Docket of Excessive Force Suits	381	222	190	132	108	84	70	93	102	71	118
Lawsuits Terminated											
Lawsuits Dismissed	79	90	60	42	39	27	20	24	34	21	37
Verdicts Won	22	9	10	6	3	6	1	1	4	3	5
Verdicts Against LASD	3	7	3	5	2	1	2	2	0	1	0
Settlements	70	81	103	82	41	45	32	12	21	23	41

Lawsuits Terminated Fiscal Year 2002-2003

	Dismissed	Settled	Verdicts Won	Verdicts Against	Totals
Police Malpractice	116	89	28	6	239
Medical Malpractice	12	10	0	0	22
Traffic	14	33	2	0	49
General Negligence	5	6	0	0	11
Personnel	1	4	0	1	6
Writ	3	0	2	2	7
Total	**151**	**142**	**32**	**9**	**334**

Active Lawsuits by Category 1998-03

	7/1/98	7/1/99	7/1/00	7/1/01	7/1/02	7/1/03
Police Malpractice	224	247	341	299	322	313
Traffic	47	43	37	50	57	59
General Negligence	7	8	3	12	9	10
Personnel	19	22	16	16	13	23
Medical Malpractice	22	28	25	30	31	33
Writ	8	6	13	15	8	10
Total	**327**	**354**	**435**	**422**	**440**	**448**

Source: Risk Management Bureau

Table 2 **Litigation, FY 2002-2003 Department Financial Summary**

	Dept. Funded	Contract City Funded	MTA Liability Funded	Totals
Lawsuits				
Police Liability	$3,097,539.46	$1,785,461.44	$0.00	$4,883,000.90
(Portion of Total for Alleged Excessive Force)	*$2,130,500.00*	*$616,412.34*	*$0.00*	*$2,746,912.34*
Personnel Issues	$338,000.00	$0.00	$0.00	$338,000.00
Auto Liability	$1,898,614.40	$1,759,759.25	$107,000.00	$3,765,373.65
Medical Liability	$1,258,500.00	$0.00	$0.00	$1,258,500.00
General Liability	$131,519.80	$0.00	$0.00	$132,519.80
Writs	$0.00	$0.00	$0.00	$0.00
Lawsuit Total	**$6,724,173.66**	**$3,545,220.90**	**$107,000.00**	**$10,376,394.35**
Claims				
Police Liability	$95,266.11	$5,691.09	$0.00	$100,957.20
(Portion of Total for Overdetentions)	*$23,300.00*	*$0.00*	*$0.00*	*$23,300.00*
Personnel Issues	$0.00	$0.00	$0.00	$0.00
Auto Liability	$84,173.41	$113,934.33	$27,575.28	$225,683.02
Medical Liability	$0.00	$0.00	$0.00	$0.00
General Liability	$259.85	$0.00	$0.00	$259.85
Claim Total	**$179,699.37**	**$119,625.42**	**$27,575.28**	**$326,900.07**
Incurred Claims/ Lawsuits Liability Total	**$6,903,873.30**	**$3,664,846.32**	**$134,575.28**	**$10,703,294.42**
Fiscal Year 2001/02 Total	$8,737,757.74	$1,822,667.01	$26,523.97	$10,586,948.72
Fiscal Year 2000/01 Total	$18,718,421.00	$492,489.00	$10,525.00	$19,221,435.00
Fiscal Year 1999/00 Total	$7,002,511.00	$479,227.00	$387.00	$7,482,125.00
Fiscal Year 1998/99 Total	$5,298,092.00	$27,926,889.00	N/A	$33,224,981.00
Fiscal Year 1997/98 Total	$6,006,592.00	$2,856,734.00	N/A	$8,863,326.00

Source: Risk Management Bureau

Table 3 **Litigation, Force Related Judgments and Settlements**

FY 95-96	**FY 96-97**	**FY 97-98**	**FY 98-99**
$17 million*	$3.72 million	$1.62 million	$27 million**
FY 99-00	**FY 00-01**	**FY 01-02**	**FY 02-03**
$4.6 million***	$2.9 million	$6.4 million	$2.7 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.

Source: Risk Management Bureau

Table 4 **LASD Force**

Department Wide*	**2000**	**2001**	**2002**	1/1–6/30 **2003**
Force Incidents (Total)	2233	2190	2399	1328
Total Force/100 Arrests	2.31	2.31	2.60	2.77
Significant Force: Hospitalization/Death/100 Arrests	0.02	0.01	0.02	0.01
Significant Force: Visible Injury/100 Arrests	0.52	0.52	0.63	0.65
Significant Force: Complaint of Pain/100 Arrests	0.30	0.37	0.37	0.37
Significant Force: No Complaint of Pain/Injury/100 Arrests	0.31	0.35	0.42	0.45
Less Significant Force Incidents/100 Arrests	0.45	0.43	0.75	0.39
OC Spray/100 Arrests	0.71	0.63	0.41	0.90

Field Operation Regions (FOR)	**2001**	**2002**	1/1–6/30 **2003**
Region I Force Incidents	349	401	181
Per 100 Arrests	1.19	1.40	1.29
Region II Force Incidents	584	568	278
Per 100 Arrests	1.85	1.96	1.83
Region III Force Incidents	353	271	176
Per 100 Arrests	0.21	0.96	1.16
FOR Total Force Incidents	1286	1240	635
Per 100 Arrests	1.43	1.45	1.43

Field Operation Regions (FOR)	**2001**	**2002**	1/1–6/30 **2003**
Regions I, II & III Significant Force	739	700	354
Per 100 Arrests	0.82	0.82	0.80

*Includes all patrol stations and specialized units, including custody and court services.

Source: Management Information Services

Table 5
LASD Force/100 Arrests All Patrol Stations

Station	2000	2001	2002	1/1–6/30 2003
Altadena	NA	NA	1.87	2.52
Crescenta Valley	0.9	1.2	0.53	1.29
East LA	1.32	1.04	1.38	1.59
Lancaster	1.09	0.92	1.39	1.06
Lost Hills/Malibu	0.52	0.86	0.67	0.89
Palmdale	2.05	1.79	1.81	1.82
Santa Clarita	1	1.15	1.42	1.11
Temple	1.36	1.52	1.28	0.77
Region I Totals	**1.22**	**1.21**	**1.40**	**1.29**
Carson	1.61	1.33	1.44	1.66
Century	1.71	2.42	2.29	2.10
Compton	2.44	1.71	2.59	2.20
Community College	NA	NA	NA	5.00
Lomita	2.06	1.5	2.32	1.05
Lennox	1.29	1.31	1.41	1.52
Marina del Rey	0.81	1.42	2.17	2.66
Metrolink	NA	NA	0.87	NA
Transit Services Bureau	NA	NA	1.71	1.85
West Hollywood	2.36	2.19	2.29	1.53
Region II Totals	**1.59**	**1.87**	**1.96**	**1.83**
Avalon	0.96	2	1.43	1.39
Cerritos	0.73	1.2	1.65	1.03
Industry	1.34	1.16	0.71	1.07
Lakewood	1.55	1.35	1.39	1.68
Norwalk	0.85	1.16	0.90	0.97
Pico Rivera	0.96	0.97	0.67	0.97
San Dimas	0.77	1.17	0.83	1.22
Walnut	0.78	0.78	1.03	0.75
Region III Totals	**1.17**	**1.21**	**0.96**	**1.16**

Source: LASD/MIS/CARS - 10/28/03

Table 6 **Los Angeles Police Department (LAPD) Shootings**

Year	Total # of OISs	# of Hits	# of Suspects Injured	# of Suspects Killed
1996	122	54	27	27
1997	114	41	17	24
1998	98	23	10	13
1999	97	23	9	14
2000	79	33	22	14
2001	66	22	15	7
2002	77	35	20	15
1/1–6/30 2003	32	12	6	6

Year	Total # of Non Hits	# of Accidental Discharges	# of Animal Discharges	Other
1996	29	11	29	1
1997	23	11	35	4
1998	12	13	45	5
1999	16	16	42	1
2000	11	6	29	NA
2001	13	11	20	NA
2002	21	10	11	NA
1/1–6/30 2003	11	3	6	NA

Source: LAPD, Office of Inspector General, 10/21/03

Table 7 **LASD Hit Shootings by Unit**

	1997	1998	1999	2000	2001	2002	2003
Number Of Incidents	**35**	**20**	**22** *	**18**	**19**	**22**	**11**
Altadena Station	NA	NA	0	1	0	0	0
Carson Station	1	0	2	1	1	2	0
Carson/Safe Streets Bureau	NA	NA	NA	NA	NA	1	NA
Century Station	7	7	1	2	5	5	1 ***
Century/Norwalk/SEB	NA	NA	NA	0	1 **	1	NA
Compton Station	NA	NA	NA	NA	NA	0	3
Court Services Bureau	1	1	0	NA	NA	0	0
East Los Angeles Station	2	0	2	2	0	0	0
Industry Station	NA	NA	NA	0	1	1	1
Lakewood Station	2	2	2	0	2	1	0
Lancaster Station	7	2	0	1	0	1	0
Lennox Station	1	2	4	0	4	2	0
Mira Loma Facility	0	1	0	NA	NA	0	0
Miscellaneous Units	0	2	0	NA	NA	0	0
Narcotics Bureau	0	0	1	1	0	0	0
Norwalk Station	3	1	0	1	0	1	1 ****
Palmdale Station	0	1	1	1	0	3	0
Pico Rivera	0	0	1	0	0	1	0
Safe Streets Bureau	1	1	0	NA	NA	1	1
San Dimas	0	0	0	0	0	1	0
Santa Clarita Valley Station	NA	NA	1	1	0	0	0
Special Enforcement Bureau	2	0	2	2	2	0	2
Temple Station	6	0	2 *(1 off duty)*	3	1	1	1
Walnut Station	1	0	0	0	1	0	0
West Hollywood Station	1	0	2	NA	NA	0	0
Number of Suspects Wounded	17	18	12	6	8 **	11	5
Number of Suspects Killed	20	11	10	12	12	11	8

* In the Temple Station shooting (11-21-99), two suspects were wounded, in the SCV Station shooting (6-13-99), no suspects were killed or wounded but one deputy was hit by friendly fire.

** In the Century Station shooting (2-18-01), two suspects were wounded

*** In the Century Station shooting (5-1-03), one suspect was killed and one suspect was wounded.

****In the Safe Streets Bureau shooting (1/28/03), two suspects were killed.

Source: Internal Affairs Bureau

Table 8 **LASD Non-Hit Shootings by Unit**

	1997	1998	1999	2000	2001	1/1–6/30 2002	1/1–6/30 2003
Number Of Incidents	**20**	**15**	**8**	**15**	**14**	**16**	**15**
Asian Crime Task Force	NA	NA	NA	NA	NA	1	0
Carson Station	1	0	1	2	0	1	0
Century Station	7	4	0	2	6 *(1 off duty)*	3	4
Century/Compton Transit Services	NA	NA	NA	2	1	0	0
Cerritos	NA	NA	NA	NA	NA	1	0
Compton	NA	NA	NA	NA	NA	2	3
East Los Angeles Station	0	3	3	1	1	1	1
Industry Station	1	2	NA	2	6	2	1
Lakewood Station	1	1	NA	2	0	0	1
Lancaster Station	1	0	NA	NA	NA	1	0
Lennox Station	4	2	1	0	1	1	2
Marina del Rey	NA	NA	NA	0	1	0	0
Men's Central Jail	1	0	NA	0	1	0	0
Narcotics Bureau	NA	NA	1	0	0	0	0
Norwalk Station	0	1	1	0	0	2	1
Palmdale Station	1	0	NA	0	1	0	0
Pico Rivera	0	0	0	2	0	0	0
Safe Streets Bureau	0	0	1	0	1	0	1
Santa Clarita Valley Station	NA	NA	NA	2	0	0	0
Special Enforcement Bureau	1	0	0	1	1	0	0
Temple Station	1	0	0	1	0	1	0
TRAP	NA	NA	NA	0	1 *(1 off duty)*	0	0
Twin Towers	NA	NA	NA	NA	NA	0	0
Walnut Station	0	1	NA	NA	NA	0	1

Incidents Resulting in Force/Shooting Roll-Out	1997	1998	1999	2000	2001	1/1–6/30 2002	1/1–6/30 2003
	126	**112**	**86**	**91**	**87**	**92**	**45**

Source: Internal Affairs Bureau

Table 9 **Total LASD Shootings**

	1996			1997			1998		
	On Duty	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*
Hit[1]	22	3	25	33	2	35	15	5	20
Non-Hit[2]	15	4	19	17	3	20	15	0	15
Accidental Discharge[3]	24	2	26	7	1	8	11	2	13
Animal[4]	38	0	38	31	5	36	37	1	38
Warning Shots[5]	0	0	0	0	0	0	0	0	0
Tactical Shooting[6]	3	0	3	1	0	1	0	0	0
Total	**102**	**9**	**111**	**89**	**11**	**100**	**78**	**8**	**86**

	1999			2000			2001		
	On Duty	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*
Hit	21	1	22	18	0	18	19	0	19
Non-Hit	8	0	8	15	0	15	11	3	14
Accidental Discharge	4	0	4	11	1	12	9	4	13
Animal	33	1	34	35	2	37	33	1	34
Warning Shots	1	0	1	2	0	2	0	0	0
Tactical Shooting	1	1	2	0	0	0	0	0	0
Total	**68**	**3**	**71**	**81**	**3**	**84**	**72**	**8**	**80**

	2002			1/1–6/30 2003		
	On Duty	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*
Hit	22	0	22	10	1	11
Non-Hit	16	0	16	15	0	15
Accidental Discharge	12	1	13	4	1	5
Animal	35	5	40	23	3	26
Warning Shots	0	0	0	0	0	0
Tactical Shooting	1	0	1	0	0	0
Total	**86**	**6**	**92**	**52**	**5**	**57**

1 **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).

2 **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.

3 **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.

4 **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.

5 **Warning Shot Incident:** An event consisting of an instance of a deputy(s) intentionally firing a warning shoot(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.

6 **Tactical Shooting:** 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 non hit shooting incident.

Source: Internal Affairs Bureau