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

July 2017

INTRODUCTION

The Office of Inspector General is charged by the Board of Supervisors with four primary functions:

- Monitoring the Department's operations and conditions in the jail facilities, including the Department's response to prisoner and public complaints.
- Periodically reviewing data on the Department's use of force, the Department's investigations of force incidents and allegations of misconduct and the Department's disciplinary decisions.
- Conducting periodic audits and inspections of Department operations and reviewing the quality of the Department's audits and inspections.
- Regularly communicating with the public, the Board of Supervisors and the Sheriff's Department regarding the Department's operations.

This report is a brief summary of some of the Office of Inspector General's activities through the second quarter of 2017 year toward fulfilling these functions.

ACCESS

From January 1, 2017, to March 31, 2017, the Department has placed no conditions or restrictions on access nor has any request for access been denied by the Department.

The Office of Inspector General (OIG), subsequent to the implementation of the Memorandum of Agreement to Share and Protect Confidential LASD Information in December 2015, identified to the Department's Technology and Support Division the data collection systems and databases to which the OIG desired access. The Department has approved OIG access to these databases and data collection systems. The Executive Office's Information Resource Management staff and the Department's Technology and Support Division staff have been coordinating the OIG's secure, read only access to these data systems and full access is anticipated by September 30.

MONITORING

The OIG responds to the investigations of deaths of persons which occur while in the custody of the Sheriff's Department, all deputy-involved shootings in which a human being was shot at or injured, all uses of force which are the proximate cause of a person's death and other significant events.

Deputy Involved Shootings

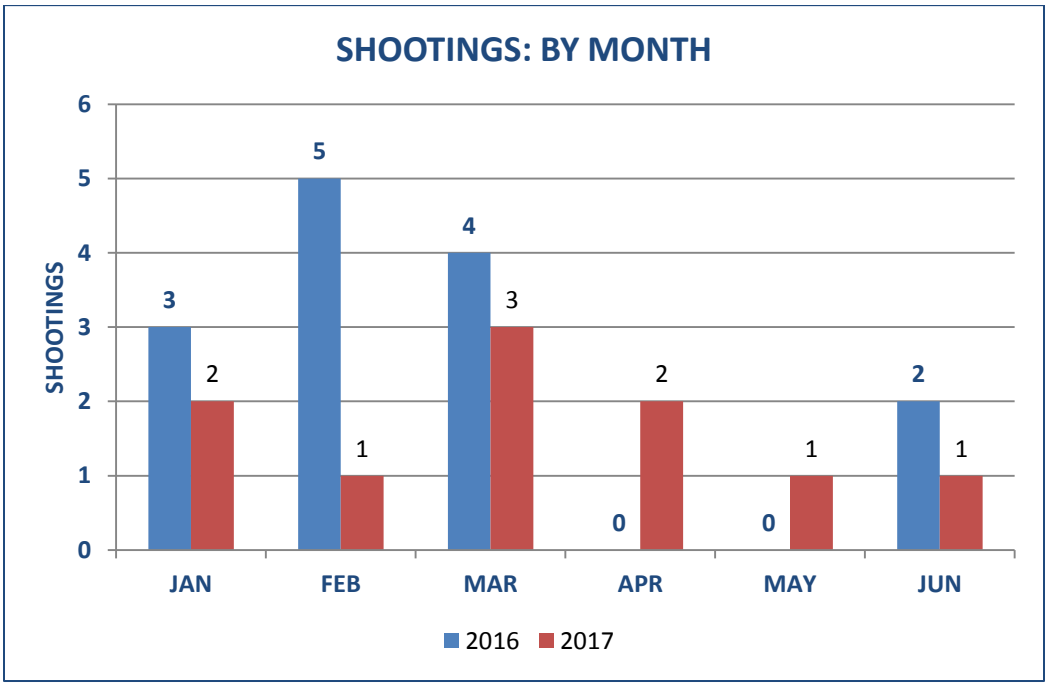
Shootings: April 1 to June 30, 2017

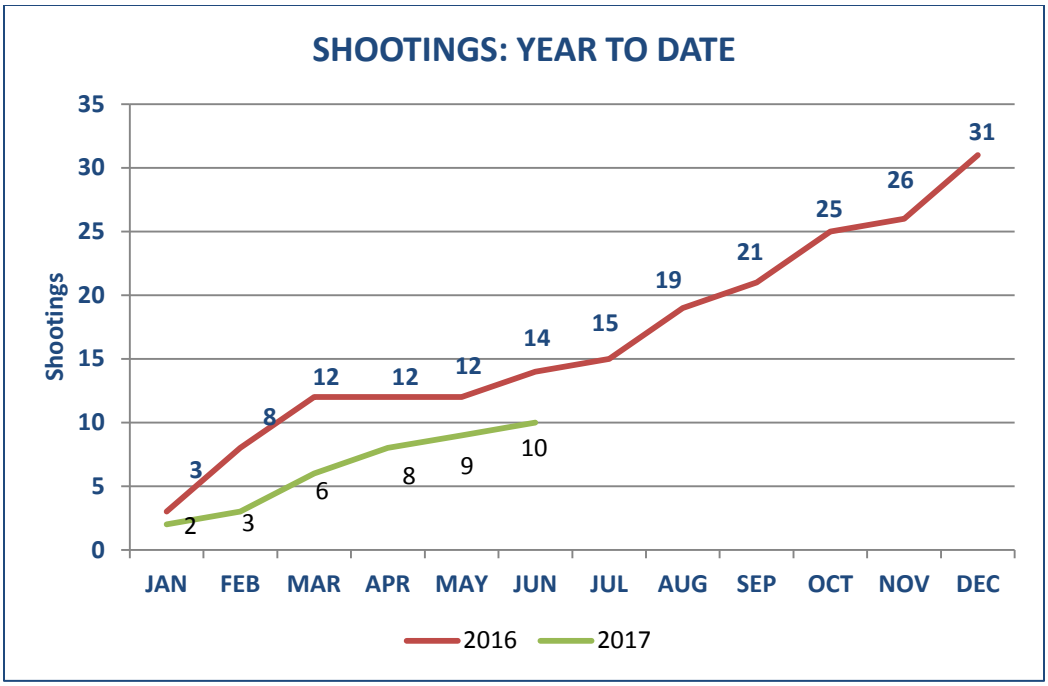
From April 1, 2017, to June 30, 2017, the OIG responded to four investigations of deputy involved shootings. In one of these shootings, no one was struck by gunfire and the suspect at whom the deputy shot became compliant and was arrested.

As a result of the remaining three shootings, three civilians were fatally injured. All of the deceased persons were males – one was Hispanic and two were African American. One of the shootings was accidental: deputies shot at an unleashed dog that had previously bitten a deputy and a person was killed by the gunfire.

All Deputy Involved Shootings which take place in Los Angeles County and which result in injury or death are submitted by the Sheriff's Department to the Los Angeles County District Attorney's Office for review. One of the 2017 shootings, which occurred March 14, 2017, in Compton, has been submitted to the District Attorney's Office.

Comparison: Number of 2017 Shootings to Number of 2016 Shootings





Adherence to Protocols for Granting Office of Inspector General and District Attorney Personnel Access to Scene of Deputy Involved Shooting

The Board of Supervisors directed the OIG to verify the protocols followed by the Department for granting access to both the Inspector General and the District Attorney to crime scenes where there have been deputy involved shootings and determine whether those protocols are followed.

When a deputy involved shooting takes place, the immediate priorities are to care for the injured, apprehend outstanding suspects and secure the scene. The watch commander is immediately notified and assisting units dispatched. Assisting units are to canvas the area to identify witnesses to the shooting. Although shooting deputies may provide assisting units with sufficient information to ensure public safety, they are not to discuss the incident with any one until their immediate supervisor arrives on the scene. Shooting deputies are to be transported immediately to the station and are not to speak to others about the incident until, if a hit shooting, interviewed by homicide detectives, or if no one is hit, they write a detailed report regarding the incident.

If a person is hit by gunfire or a deputy is injured, the watch commander or the supervising lieutenant is to notify homicide of the shooting. The watch commander or the supervising lieutenant is also to notify the Internal Affairs Bureau and the involved deputy's unit commander. Homicide notifies the District Attorney's office.

In all cases of an intentional discharge of a firearm at a person, the Internal Affairs Bureau and either the duty commander or the involved employee's unit commander are to respond to the scene. The Internal Affairs Bureau notifies the OIG.

The watch commander or supervising lieutenant is responsible for securing the scene and sequestering witnesses. The scene of the shooting is to be protected until Homicide detectives complete their investigation or IAB completes its review.

When it can be done without disturbing evidence, the Inspector General and the District Attorney, if present, are given a walk-through of the scene by investigators. If there is a danger of disturbing evidence, OIG and DA personnel are allowed as close to the scene as possible without disturbing that evidence.

Since the implementation of the Memorandum of Agreement to Share and Protect Confidential LASD Information in December of 2015 the OIG has been present at the scene of every investigation of every deputy involved shooting in which a deputy shot at a person, whether that person was injured or not. Although prior to the December MOA the OIG experienced occasional delays in gaining access to the scene, the OIG has not since its inception been denied access to the scene.

In every investigation at which the OIG has observed District Attorney personnel to be present, District Attorney personnel have been granted access to the scene and to the civilian witness. There have been instances in which the District Attorney did not appear prior to the walk through. It is not known in those cases whether the District Attorney later reported and was provided a walk-through of the scene.

When Homicide submits its investigation to the District Attorney, the OIG is provided a copy of that investigation. When the Internal Affairs Bureau investigation is completed, the OIG also receives that investigation. The OIG has experienced no delay by the Department in providing the investigations.

In Custody Deaths

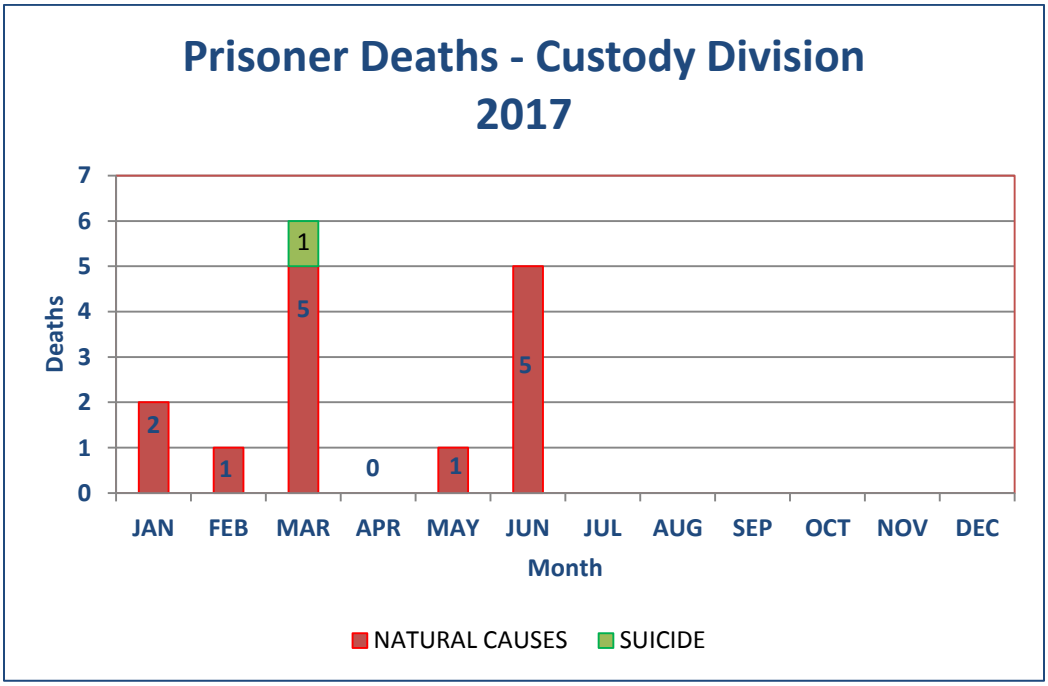
The OIG responds to all in-custody deaths. In most cases, the OIG responds directly to the scene of the death investigation. The exception is when the deceased has been transported before or soon after death occurs. In these cases, the OIG responds to the 24 hour death review.

Between April 1 and June 30, 2017, the OIG responded to six in-custody deaths. One of these deaths was a suicide which took place in the Crescenta Valley Station lockup.

Five prisoners died of natural causes while incarcerated in the Los Angeles County jails.

One of these five deaths occurred in the court lockup at Los Angeles County Criminal Justice Center, to which the prisoner had been transported from Twin Towers Correctional Facility (TTCF) for a scheduled court appearance.

Four of these deaths occurred at Los Angeles County+USC Medical Center, to which the prisoners were transported for medical treatment of a life threatening illness. Two of these prisoners were housed at the TTCF, one at the Century Regional Detention Facility (CRDF) and one at the Men's Central Jail (MCJ).



The OIG attended the death review meetings for each of these deaths,[1] and continues to monitor the Department's evaluative process. The Inspector General has also addressed, and continues to address, specific significant concerns about the standard of medical care provided to Los Angeles County prisoners with the Director, Department of Health Services. The OIG is tracking and monitoring Department and Department of Health Services corrective actions and clinical reviews.

Medical Services in the County Jails

In response to a reported increase in in-custody deaths, on April 11, 2017, the Board of Supervisors directed the OIG to report on the process for prisoners to

[1]Section 4-10/050.00 of the Custody Division Manual (CDM) requires the Department to conduct a death review for each in-custody death or death of a prisoner in the Community Based Alternatives to Custody (CBAC) program. The death review is conducted in three separate meetings: the 24-hour, 7-day and 30-day. According to the CDM, the 24-hour review shall be conducted by Medical Services Bureau (MSB) to share initial findings and to review the circumstances surround all in-custody deaths. The CDM states that both the 7-day and 30-day death reviews shall be conducted by the Custody Compliance and Sustainability Bureau (CCSB) to share additional findings and discuss the status of any corrective or preventive actions taken since the previous review.

request and receive medical care, and to address whether the collaboration between Custody Services Division (Custody) and Department of Health Services—Correctional Health Services (CHS) personnel has improved. This section of the report discusses the current procedures for requesting and providing medical care in the jails and improvements and remaining deficiencies in Department and CHS collaboration that affect patient care.

Medical Request Process

The consolidation of all jail medical and mental health services under CHS was finalized in May 2017. The new CHS leadership inherited underperforming, mismanaged, and insufficient medical and mental health care systems, operated by the Department's Medical Services Bureau and Department of Mental Health respectively. CHS has already made substantial progress in implementing new health care procedures in the jails including the creation of a new medical request process for prisoners. Much work remains to be done.

In September 2016, as a replacement for the previously utilized nurse clinic sign-in sheets,[2] the Health Services Request Form (HSRF) was created. The HSRF allows prisoners to request non-emergent[3] medical services. On HSRF the prisoner is to write a brief synopsis of their medical issue, how long they have experienced the issue, and whether or not the prisoner has received prescribed medication. The HSRF is an improvement on the previous nurse clinic sign-in sheets, which only had space for prisoner names and booking numbers, but no medical information. This did not allow medical staff to prioritize requests. The new process enables the nursing staff to triage and prioritize care based on medical necessity. Once completed, prisoners submit the HSRF in the grievance drop boxes located in each housing location, and envelopes are available to maintain confidentiality.[4] In the first quarter of 2017, the CHS received approximately 37,400 HSRFs from the jail's population of nearly 17,000 prisoners. Medical and custody personnel work together to process these requests.

Collaboration between Department Custody and Custody Health Services Personnel

Collaboration between Custody and CHS personnel begins at the submission of an HSRF. Custody personnel are responsible for collecting the HSRFs and forwarding them to CHS for review. CHS is responsible for documenting the request and scheduling all medical appointments. All requests for medical services are supposed to be reviewed by a registered nurse within 24 hours of submission. Prisoners who

[2] The nurse clinic sign-in sheets was how prisoners reported their medical issues to jail medical staff. The sign in sheets were in every housing location and picked up daily by nursing staff. If the issue was within nursing practice the nurse would evaluate the prisoner. If the issue required a physician the nurse would sign the prisoner up for doctor's line to be seen by a physician.

[3] Emergent medical incidences are handled according to CDM 5-03/060.00 MEDICAL DIAGNOSIS AND TREATMENT which requires custody personnel to immediately summon medical staff and render emergency first aid.

[4] A third party, such as custody personnel, nursing staff, or clergy and family members, can request medical services for prisoners housed in specialty housing such as High Observation Housing (HOH).

require immediate attention are assessed for intervention. After an HSRF is processed, the Department and CHS are jointly responsible for ensuring that prisoners receive timely medical care.

When a prisoner reports on the HSRF a clinical symptom, current protocols provide for a face-to-face assessment by a medical provider to occur within 48 to 72 hours. CHS personnel electronically send medical passes to custody staff, which in many cases, indicates whether a prisoner is physically able to walk to the medical clinic. For the patients who require a security escort to attend medical appointments, medical and custody personnel must coordinate to ensure the availability of escorts. When collaboration fails or is ineffective, prisoners can miss necessary medical appointments.

In cases in which a prisoner dies, collaboration failures are identified by CHS and Custody personnel and are addressed in the detailed "Death Reviews" that are convened following each prisoner death. Death reviews are now co-chaired by a Custody Chief and the CHS Director, who engage in critical post-incident review. The OIG attends all death reviews.

Custody and CHS identified several issues during reviews of the deaths that occurred in the first quarter 2017, including communication failures between custody and medical staff. Also identified was the unproductive practice of shifting blame between personnel of both agencies. This practice has hindered the effective analysis of practices and development of corrective action plans.

In March 2017, a prisoner trustee[5] at the TTCF reported to the nurse clinic that he was in need of medical care for a chronic illness. The nurse referred the trustee to the doctor and instructed the trustee to wait in the clinic to see the physician. The trustee subsequently left the clinic to attend work before the physician had an opportunity to conduct the evaluation. Medical personnel attempted to contact the trustee, however, there was a communication failure between custody and medical staff and the trustee did not return to the clinic that day. Three days later, the trustee experienced a medical emergency related to the same condition. Ultimately, the trustee died from complications related to that condition. Similar communication failures have been revealed during other Death Review meetings.

Collaboration failures were also identified following the deaths of two mentally ill prisoners who refused to eat and lost significant amounts of weight while in custody. Though both prisoners were receiving medical and mental health treatment in the jail, custody personnel and CHS providers failed to identify their substantial food hoarding and drastic weight loss. In one instance, CHS medical personnel were notified by another prisoner rather than by custody of the patient's refusal to eat for approximately eight days. Immediately following these deaths, the Department began revising its policies[6] to address prisoners' refusals to eat and/or

[5] A trustee is a prisoner who has been given the privilege of working in a job on the grounds of the jail.
[6] See Custody Division Manual, Section 5-15/000.00: Inmate's Refusal to eat and/or drink.

drink and to improve communication between the agencies and implement procedures for providing prompt medical care to patients in this type of distress.

Though the death review process is a thorough and effective quality improvement tool, it only occurs after life has been lost and does not, in itself, allow for proactive identification and resolution of patient care and collaboration problems. During the OIG's regular monitoring of the jails, OIG personnel have observed communication and collaboration failures between Custody and DHS personnel, particularly in the Inmate Reception Center (IRC) clinic where wait times are excessive. Some Custody personnel report that excessive wait times are due to a lack of urgency and accountability on the part of CHS medical personnel. However, CHS medical personnel blame the long wait times on medical staffing shortages that exceed 500 budgeted positions. Certainly, Department and CHS staffing deficiencies contribute to excessive wait times, and both agencies are actively recruiting personnel. According to Custody documentation, however, the *average* wait time in the IRC clinic is approximately 10 hours, and prisoners are required to remain seated in waiting area chairs throughout. Prisoners who are at risk of harming themselves are handcuffed to the chairs for the duration of their intake processing, which may take longer than 10 hours. These prisoners are provided regular access to food, water, and toilets, though lapses occur, and the risk for injury under these conditions is substantial.

The long wait times and cramped quarters in the IRC clinic typically produce significant frustration among patients and personnel and, at times, result in prisoner-on-prisoner or prisoner-on-staff violence. The OIG has also received complaints and observed through monitoring that prisoners are not always provided prompt access to toilets and that medical and department personnel can be discourteous in response to complaints or requests for care updates. Personnel from both the Department and CHS have reported that some treatment providers are grossly underperforming. Examples of reported treatment failures include medical doctors who fail to see more than a few patients in an entire eight-hour shift, failure to identify and document treatments or medications prisoners had received in the community, failure to identify and treat chronic or serious conditions, staff indifference to patient medical needs, and or adherence by staff to a lower "jail" standard of care. The OIG is also aware of allegations, and at least one verified incident, of a provider falsifying treatment documentation. The OIG has reported these issues to DHS administration, which should immediately initiate a process to identify and hold accountable all underperforming providers.

When wait times at the IRC clinic exceed 16 hours, prisoners are sent to the IRC clinic overflow, which is located in TTCF. Patients in the IRC clinic overflow can wait days to receive services. Department personnel in this location have minimal communication with CHS medical personnel and, as such, are unable to offer information to frustrated patients. The OIG reviewed video recordings of and records related to one prisoner's three-day intake at the IRC clinic and IRC clinic overflow. The prisoner entered the IRC clinic the night of July 21, 2017, and was transferred to IRC clinic overflow two days later. By the afternoon of July 24, 2017, the prisoner was still waiting to be seen by medical staff and suffering from severe

alcohol withdrawal. After several hours tethered to a bench in module 231, the prisoner became resistant to the fixed restraint and a use of force occurred.

OIG staff members often speak with Custody and CHS personnel during OIG monitoring, and have noted a high degree of frustration between Custody and CHS personnel. Custody personnel have reported to the OIG that some nursing personnel either cannot speak English or "pretend" not to when asked to provide information. OIG personnel have also observed DHS personnel wearing their name tags backwards, which Custody personnel believe is a practice engaged in to intentionally to hide their names and avoid accountability. Whether or not these reports are true, these perceptions are symptomatic of a larger problem which likely impacts patient care.

In one instance, OIG personnel observed a patient who was suffering from diabetic edema and unable to walk scooting unassisted across the dormitory floor to the bathroom after waiting more than 24 hours for a wheelchair evaluation. Custody personnel reported to the OIG that the medical doctor on the floor is slow and rarely treats more than a few patients in one day. When pressed by the OIG, Custody responded quickly, provided the patient with a wheel chair and a system now exists for mobility impaired prisoners to receive interim assistive devices in advance of a complete evaluation. Better communication and collaboration between DHS and Custody line personnel would guard against similar failures specifically, and improve access to care generally.

DHS and Custody executives are aware of these issues and are implementing remedies to them. Ultimately, Custody and CHS executives must create a system in which CHS and the department personnel are collectively invested in and accountable for patient care. As long as personnel are permitted to shift blame between agencies, neither will be motivated toward meaningful solutions. Executives recognize that the failure to collaborate places a great deal of strain on both agencies' operations and ultimately creates long wait periods for prisoners to be processed into the jail.

In addition to the deficiencies addressed above, it is important to note examples of tremendous progress and of exceptional CHS-Department collaboration. CRDF in particular, and new leadership at TTCF, are taking important steps to improve collaboration and patient access to care. The High Observation Housing units (HOH) at CRDF and TTCF have implemented multi-disciplinary meetings between custody, medical and mental health staff. These multi-disciplinary teams are equally invested in patient care and are committed to working together to identify best treatment methods available to them. Together, multidisciplinary teams develop treatment plans which are then implemented and monitored by all team personnel. Because patients in HOH require an intensive level of observation and care,[7] HOH

[7] Prisoners housed on HOH receive welfare checks by custody staff every fifteen minutes. *See* "Custody Operations Directive 15-006," *Inmate Safety Checks* (August 12, 2015). *See also* Policy No. 70.2.1 at 3.3 (3.3.2).

patients have typically spent all of their time outside of their cells (including therapeutic, group, and recreation time) chained with a fixed restraint to tables inside the HOH dayrooms. Also, for safety reasons, Custody has always required HOH prisoners to be housed in single-person cells. Following substantial education of Custody personnel by CHS leadership and by committed Custody executives about the dangers of isolating and tethering mental health patients, TTCF and CRDF are adopting new philosophies and correctional mental health best practices with this population.

TTCF has more than eight HOH housing modules and CRDF has five. Custody and DHS collaborated to improve the care for these prisoners through the creation of "HOH step-down programs" at TTCF and CRDF. As the OIG previously reported,[8] patients in these pods are now housed with cellmates and are allowed, with close support and supervision, to move freely throughout the pod. Among other successes, these patients have a higher rate of medication compliance and are more quickly able to transition to a lower level of care.

Both facilities began the step-down pilot programs in 2016. CRDF has expanded the step-down model to three pods and Custody and DHS personnel work closely to provide services and to improve the quality of the jail environment. Some of the facility's bare, concrete walls now contain scenic murals and positive affirmations, and prisoners sit un-cuffed at tables that now hold art materials and games purchased by particularly dedicated personnel. TTCF is planning to convert a second step-down pod in July and is implementing a two-hour custody collaboration training course designed to train de-escalation techniques and crisis intervention. Both facilities have expressed a commitment to the elimination of the "spider tables" to which patients are tethered and to the expansion of the step-down programs as additional resources become available. The OIG urges the Department to make these resources available as soon as possible.

In addition to step-down and multi-disciplinary models, a tool for improving the provision of medical and mental health services is Custody's proposed "Access to Care Bureau." Access to Care would involve assignment of dedicated Custody personnel solely for transport of patients within facilities to the clinics to receive services. The Department believes that this program is imperative to improve County jail care and will both promote and result from close collaboration between agencies.

The Los Angeles Sheriff's Department is the largest provider of correctional medical services in the United States and provides medical services to over 140,000 prisoners each year. Each time a prisoner needs healthcare services, it is the responsibility of Custody staff to transport the prisoner to treatment. The Memorandum of Understanding between the Department and DHS provides that department personnel are responsible for transporting prisoners in a timely manner

[8] See "The Office of Inspector General Reform and Oversight Efforts: Los Angeles County Sheriff's Department" (April 2017), at 9 for a discussion on the role of Education Based Incarceration in HOH step down modules.

to clinical areas for healthcare services; providing appropriate security presence within the clinical areas, transporting prisoners to off-site medical housing locations, and coordinating court appearances for prisoners with medical needs.[9]

Currently, specific department personnel are not dedicated to the transportation and movement of prisoners with medical needs and must divide their time among other duties, including Title 15 security checks, escorting prisoners to various areas of the facility, security detail, and other collateral and operational duties. Consequently, when department personnel are unavailable to transport, prisoners miss medical appointments or are seen by medical personnel at cell front, which is inadequate and inconsistent with evidence based best practice. In the past, Custody and DHS personnel have blamed one another for patients not being taken from their cells and transported to the clinic for appointments. OIG personnel are aware of instances in which Custody personnel have refused to pull patients for medical appointments or treatment *and* instances in which treatment providers have insisted on treating patients at cell front. The CHS Director has issued strict mandates prohibiting CHS personnel from treating patients at cell front unless medically indicated, but without Custody personnel to transport patients, these efforts will fail.

Similarly, each medical emergency or medical appointment outside of the jail requires off-site transportation of prisoners. TTCF alone reports an average of 173 hospital transports each month. Each time an emergency transport is necessary, two Department employees must leave their duties on the line and transport the prisoner to the hospital in a radio car, which increases personnel shortages at facilities. First responders from the Los Angeles Fire Department must often fill the gaps where CHS medical and Department transport personnel are unavailable or insufficiently coordinated. Recently, a prisoner was experiencing a medical emergency and needed to be transported to the hospital. A Los Angeles County ambulance arrived but could not transport the prisoner because of the unavailability of a Custody support to assist with the transport. The transport of the prisoner was delayed by more than two hours.

The OIG has not completed an independent analysis of the specific personnel and budget resources necessary for an effective Access to Care bureau. However, the Department and DHS should work together to identify specific needs and propose a feasible Access to Care plan that will improve patient care and prevent serious lapses with potentially catastrophic consequences.

Uses of Force

The OIG has identified deficiencies in the Department's methodologies in collecting, recording and reporting data on uses of force and assaults by inmates on staff and other inmates. These deficiencies resulted in the inability to reproduce the

[9] "Memorandum of Understanding between The County of Los Angeles Sheriff's Department and Department of Health Services for Integrated Correctional Health Services," effective December 13, 2016.

methodologies by which data was compiled and to replicate the results. Without identification and analysis of the Department's methodologies for collecting, recording and reporting these statistics, it is not possible for the OIG to perform one of its core functions, ". . . reviewing the Sheriff's Department's use of force patterns, trends and statistics . . ."

As a result of these deficiencies, the OIG initiated a review of the Department's methods for tracking, compiling and reporting jail violence data. This review has been completed and is reported in "A Review of the Jail Violence Tracking and Reporting Procedures of the Los Angeles County Sheriff's Department," a companion report to this report.

The OIG has elected to not include in this report unreliable data or data for which the specific weaknesses cannot be identified. With access to the data systems described in the "Access" section above and the implementation of the OIG's recommendations made in "A Review of the Jail Violence Tracking and Reporting Procedures of the Los Angeles County Sheriff's Department" the OIG will include in the next report the cumulative force data which includes this past quarter and corrected data for the first quarter of this year.

The OIG is also working with Human Resources to create or identify a class specification for a position to replace an existing position within the OIG. The role of this position will be the design of statistical models and methodologies for collecting and measuring data for producing accurate force trends analysis.

Custody Operations

Office of Inspector General Site Assessments

OIG personnel conducted 53 total site visits to the eight Los Angeles County jail facilities the second quarter of 2017. During the OIG's site visits, OIG monitors met with personnel at each rank in the Department's chain of command, from security and custody assistants to facility captains and commanders, and with civilian staff, clergy, and volunteers. OIG personnel met with prisoners in general population, administrative segregation, disciplinary and medical and mental health housing, as well as the Correctional Treatment Center. Monitors met with or received complaints from prisoners at cell front, during recreation and treatment group time, and in private interview rooms as necessary to ensure confidentiality. The following chart represents facilities visited from April 1, 2017, through June 30, 2017.

Facility	**Site Visits**
Century Regional Detention Facility (CRDF)	5
Inmate Reception Center (IRC)	8
Men's Central Jail (MCJ)	13
North County Correctional Facility (NCCF)	6
Pitchess Detention Center (PDC) – North	5
PDC – South (and East)	4
Twin Towers Correctional Facility (TTCF)	12

Citizen's Commission on Jail Violence Updates

CCJV Recommendation 3.8: PPI and FAST should be replaced with a single, reliable, and comprehensive data tracking system

For a discussion of issues relevant to the Department's tracking of force information, see the companion report, ""A Review of the Los Angeles County Sheriff's Jail Violence Tracking and Reporting Procedures."

CCJV Recommendation 3.12: The Department should purchase additional body scanners

This quarter, the Department completed implementation of body scanners at the IRC Booking Front and Old Side. The Department continues to make necessary renovations to the Inmate Processing Areas at North County Correctional Facility (NCCF) and Pitchess Detention Center (PDC) – North Facility to implement the remaining body scanners.

The Department implemented an "overlap team" on April 19, 2017, at IRC Booking Front to help facilitate flow through the body scanners when large groups of prisoners arrive at IRC in the evening. This team is not specifically assigned to Booking Front; instead, deputies follow these large groups of prisoners through IRC processing in order to provide supplemental security. The Department reports that the use of the overlap team minimizes prisoner processing times.

The Department reports that it completed construction, installation and all required inspections of body scanners at IRC Old Side on April 28, 2017. Currently the Department will not allocate additional staffing resources to supervise the flow of prisoners through these scanners but reports that it will continue to monitor the issue to determine if more staffing resources are required.

Funds for the implementation of body scanners at North County Correctional Facility were due to be transferred to the Sheriff's Department in July 2017. In June, the Department reported that if these funds were to be timely allocated, the Department anticipated implementation in December 2017.

The Department is currently awaiting a determination from the Department of Public Works Building and Safety as to whether approval by the Board of State and Community Corrections is required for the construction at NCCF's Inmate Processing Area.

The Department began construction at PDC – North Facility (PDC-North) on June 5, 2017. The OIG conducted a site visit on June 6, 2017, to confirm the initiation of construction in the PDC-North Inmate Processing Area. The Department reported that completion of body scanner installation was anticipated by July 15, 2017. The Department reported that the body scanner vendor is scheduled to deliver the scanners on July 22, 2017. (CCJV Recommendation 3.12)

CCJV Recommendation 7.1: The investigative and disciplinary system should be revamped
CCJV Recommendation 7.6: IAB should be appropriately valued and staffed by personnel that can effectively carry out the sensitive and important work of that bureau

The OIG has observed that the quality of Internal Affairs Bureau investigations is in many cases inadequate to provide Department management with the information required to make fact based evaluations in reviews of force and misconduct. The same deficiencies observed and reported in the Kolts Report in 1992 and observed and reported by the Office of Independent Review have been observed by the OIG in the cases we have reviewed since the Memorandum to Share and Protect Confidential LASD Information was implemented in December of 2015.

The Department has previously reported the implementation status of these recommendations. As to recommendation 7.1, the Department requested funds in three phases to increase the number of investigators in the Internal Affairs Bureau. Phase I and phase II of that increase were funded by the Board of Supervisors. The request for the funding of phase III was withdrawn by the Department in favor of funding the Custody Compliance and Sustainability Bureau.

While the Department reported its progress in implementing staff increases in response to recommendation 7.1, staffing of Internal Affairs Bureau is a critical measure of the value the Department places on the Internal Affairs Bureau, hence the inclusion in this report of recommendation 7.6. The OIG has observed that the number of Internal Affairs Bureau investigators throughout 2016 consistently fell below the targeted number of Internal Affairs investigators.

The OIG commenced and has now completed a review of the Internal Affairs Bureau's reviews of force and investigations of misconduct. An analysis of the review is in progress and our findings and recommendations are forthcoming.

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

The Department reports it is continuing to revamp the prisoner grievance system, focusing on the implementation of iPads as the new method to facilitate grievances and requests.

The Department's Grievance Coordinator plans for the iPads to serve as an information portal for prisoners to gain access to a variety of information, including court information, the penal code and community resources. The iPads will also automate the grievance and request process, while allowing many requests to be answered immediately through the iPad. This will minimize the response times for requests and preserve resources needed to process requests. The Grievance Coordinator reports that the Department is currently working to ensure that iPads can be available to prisoners twenty four hours a day, seven days a week.

In order to troubleshoot and test the functionality of the new iPad grievance system, the Department reports that it will implement iPad functions in phases beginning with 'simple requests' -- court information, release dates and account balances, etc. Once the Department adequately troubleshoots and addresses issues with the iPad program for simple requests, it will implement iPad programs for all requests, followed by grievances. The Department notes that prisoner appeals will still require paper processing, to ensure face-to-face contact between the complainant and department personnel.

The Department reports that one of the greatest challenges related to the grievance system is appropriately categorizing requests and grievances when they are input to the Custody Automated Reporting and Tracking System. Currently, prisoners preliminarily categorize their requests and grievances by checking off check boxes for various categories on standardized request and grievance forms. Before data is entered into the Custody Accountability Reporting Tracking System (CARTS) and subsequently processed, department personnel are responsible for reviewing each request and grievance to ensure that each is properly categorized. However, requests and grievances are often mis-categorized. As a result, the Department must rely on keyword searches to identify complaints within a given category. Keyword searches are an insufficient mechanism for identifying and tracking requests and grievances. The Grievance Coordinator reports that the Department is currently working to address this issue. (CCJV Recommendation 7.14)

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

As previously reported, in response to this recommendation the Department implemented closed-circuit television (CCTV) cameras instead of personal video recording devices (PVRDs). During a PVRD pilot program in MCJ, the Department submitted a request to the CCJV independent monitor and the Board to use CCTV cameras in lieu of the PVRDs. Consultants opined that the expansion of CCTV cameras was needed irrespective of the implementation of PVRDs. In October 2013, the Department directed supervisors to utilize handheld cameras in lieu of PVRDs, for many reasons, including cost.

The Department continues to implement CCTV cameras in all facilities. This quarter, the Department began installation and configuration of cameras at PDC – North Facility. The Department reports that camera installation and configuration will be completed by August 2017. PDC – North Facility currently has a CCTV system, however it does not retain footage for more than a few days and has limited capability compared to the new CCTV system, DVtel. The Department reports that the installation of the DVtel system will not affect the existing camera system at PDC – North, which will continue to operate until the new CCTV system is fully operational.

The DVtel system has not been without its problems. At NCCF, the Department reports that it is still installing cameras in the DVtel system. Recent power outages in the communications room at PDC caused disruptions to the NCCF DVtel system.

On May 5, 2017, the backup generator for the communications rooms failed to properly engage causing the entire network to shut down. Once power was restored, the Department discovered that the outage had corrupted the main directory for the DVtel, which caused the facility-wide crash. The system suffered another power outage on June 20, 2017. The outages resulted in weeks long failures which the Department reports it is currently working to resolve. The Department consulted with and ordered upgrades from the vendor to guard against similar issues in the future. Despite the failures, the Department continues to report an overall completion date for NCCF CCTV installation of December 2017. (CCJV Recommendation 7.15)

A field audit by the OIG of the CCTV systems in the jails is currently in progress.

COMMUNITY CONTACTS

The OIG continues to regularly communicate with the public, the Board of Supervisors, and the Sheriff regarding the work of the OIG and the Department's operations.

OIG staff members regularly attend and participate in meetings with concerned community members, including the meetings of the Public Safety and Justice Committee of the Empowerment Congress. The OIG also attended the monthly meetings of the Los Angeles County Sheriff Civilian Oversight Commission.

The Inspector General or a member of his staff attend all Board proceedings which effect or touch on the Department's operation.

The OIG received eighty seven new complaints in the first quarter of 2017 from members of the public, prisoners, prisoners' family members and friends, community organizations and County agencies. Each complaint was reviewed by OIG staff. Sixty one of these complaints were related to the conditions of confinement within the Department's custody facilities, as shown below.

Complaint/ Incident Classification	Totals
Personnel Issue	
Use of Force	4
Rude/Abusive Behavior	4
Discrimination	7
Failure to take action	1
No discernable subject	2
Medical/Dental Issue	12
Disability Accommodations	8
Mental Health Services	5
Housing	1
Dietary	4
Other Service Issue	13
Total	**61**

Sixteen complaints were related to civilian contacts with department personnel by persons who were not in custody. The classification totals do not equal the number of complaints because some of the complaints address multiple issues.

Complaint/ Incident Classification	Totals
Personnel Issue	
Rude/Abusive Behavior	1
Unlawful Detention	1
Failed to Take Action	1
Discrimination	2
No discernable subject	5
Other Service Issue	6
No Discernable Issue	1
Total	**17**

Eight complaints were not about the Department or department personnel and were referred to the appropriate agency or the complainant was directed to seek counsel. Four of the complaints did not complain about conduct by the Department or department personnel and did not describe the complaint with sufficient detail to refer to another agency or counsel.

The OIG received nine complaints from the Sheriff Civilian Oversight Commission. Eight were related to civilian contacts with department personnel by persons who were not in custody. One was related to contact with department personnel by an individual in custody.

COC Complaint/ Incident Classification	Totals
Personnel Issue	
Discrimination	2
Information Sharing / Previous Complaint	1
No discernable subject	2
Referral	2
No Discernable Issue	2
Total	9

CONCLUSION

The Inspector General and his staff continue to identify issues and to work with the Department to facilitate systemic reform its policies, practices, and operations. The Sheriff and his staff continue to be receptive to OIG recommendations and suggestions.