COUNTY OF LOS ANGELES
OFFICE OF THE COUNTY COUNSEL

648 KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET
LOS ANGELES, CALIFORNIA 90012-2713

MARY C. WICKHAM
County Counsel

TELEPHONE
(213) 974-1609
FACSIMILE
(213) 626-2105
TDD
(213) 633-0901
E-MAIL
rgranbo@counsel.lacounty.gov

June 27, 2018

TO: CELIA ZAVALA
Acting Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: ROGER H. GRANBO
Senior Assistant County Counsel
Executive Office

RE: **Item for the Board of Supervisors' Agenda**
County Claims Board Recommendation
The Estate of Johnny Martinez, et al. v. County of Los Angeles, et al.
Los Angeles Superior Court Case No. BC 579 140

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary and Summary Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary, and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda.

RHG:scr

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled The Estate of Johnny Martinez, et al. v. County of Los Angeles, et al., Los Angeles Superior Court Case No. BC 579 140 in the amount of $2,500,000 and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Sheriff's Department's budget.

This lawsuit concerns allegations of State-law civil rights violations, battery, and negligence after Plaintiff's son was fatally shot by Sheriff's Deputies.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME		Estate of Johnny Martinez, et al. v. County of Los Angeles, et al.
CASE NUMBER		BC 579140
COURT		Los Angeles Superior Court
DATE FILED		October 5, 2014
COUNTY DEPARTMENT		Sheriff's Department
PROPOSED SETTLEMENT AMOUNT	$	2,500,000
ATTORNEY FOR PLAINTIFF		Panish Shea & Boyle, LLP Maas & Marinovich, PLC
COUNTY COUNSEL ATTORNEY		Millicent Rolon Principal Deputy County Counsel
NATURE OF CASE		This is a recommendation to settle for $2.5 million, inclusive of attorneys' fees and costs, a State-law civil rights and wrongful death lawsuit filed by the minor child and parents of Johnny Martinez alleging that Sheriff's Deputies used excessive force against Mr. Martinez and caused his death. The Deputies deny the allegations and contend their actions were reasonable. Given the high risks and uncertainties of litigation, a reasonable settlement at this time will avoid further litigation costs. Therefore, a full and final settlement of the case in the amount of $2.5 million is recommended.
PAID ATTORNEY FEES, TO DATE	$	169,625
PAID COSTS, TO DATE	$	14,409

Case Name: H.M., a minor, et al. v. County of Los Angeles, et al.

Summary Corrective Action Plan

The intent of this form is to assist departments in writing a corrective action plan summary for attachment to the settlement documents developed for the Board of Supervisors and/or the County of Los Angeles Claims Board. The summary should be a specific overview of the claims/lawsuits' identified root causes and corrective actions (status, time frame, and responsible party). This summary does not replace the Corrective Action Plan form. If there is a question related to confidentiality, please consult County Counsel.

Date of incident/event:	October 4, 2014
Briefly provide a description of the incident/event:	**H.M., a minor, et al. v. County of Los Angeles, et al.** Summary Corrective Action Plan 2018-004 On October 4, 2014, at approximately 6:45 p.m., four uniformed Los Angeles County deputy sheriffs, assigned to Century Station, responded to an assault with a deadly weapon call at the location. Upon arrival, the deputy sheriffs contacted the victim who had been stabbed in the head by the decedent (his neighbor). The victim claimed the decedent had stabbed him with a knife in an unprovoked attack. The decedent had last been seen near the back of the duplex at the location. The decedent's father contacted the deputy sheriffs and advised them the decedent no longer had a knife. The deputy sheriffs formulated a plan of contact with the decedent including "hands-on," Taser/less-lethal, lethal, and radio designated assignments. The deputy sheriffs instructed the victim to wait for the responding emergency medical services personnel at the curb in front of the location, which he did. With their plan in place, the four deputy sheriffs walked towards the rear of the location and encountered the decedent as he sat on the steps of a residence at the duplex. The decedent's mother was standing next to him and was cooperative when she was asked to stand aside. The deputy sheriffs approached the decedent and gave him orders to place his hands behind his back. The decedent refused the deputy sheriffs' orders by yelling, "No, no, no!" The first deputy sheriff grabbed the decedent's left arm in order to handcuff and detain him pending an assault with a deadly weapon investigation. The decedent protested to the contact by yelling at the deputy sheriffs, as he continued to sit on the steps. The decedent used his right hand to grab a seven-inch knife he had concealed under his right leg. The decedent then held the knife out in front of him. Identifying the knife threat, the first deputy sheriff released his hold of the decedent and moved away. Simultaneously, from a seated position on the steps, the decedent slashed his knife at the first deputy sheriff, narrowly missing his face. The decedent's mother attempted to intervene, but complied when she was ordered to move away. The second deputy sheriff activated his Taser, striking the decedent in the upper torso with both darts. Although the Taser appeared to deploy

	properly, it did not appear to have any effect on the decedent. The decedent stood up and pulled the Taser darts out, while still holding the knife in his hand. The deputy sheriffs gave the decedent several orders to drop the knife, but he refused. The first deputy sheriff sprayed the decedent in the face with a four-second burst of oleoresin capsicum spray[1], which also appeared to have no effect. Based on the decedent's aggressive demeanor and actions, the deputy sheriffs feared they were about to be attacked with a deadly weapon. All four deputy sheriffs pulled out their duty weapons and pointed them at the decedent. The third deputy sheriff gave the decedent several more orders to drop the knife, but he continued to refuse. The deputy sheriffs maintained a distance of about eight feet away from the decedent in a semi-circle type position. Without warning, the decedent held out his knife and charged directly at the second and fourth deputy sheriffs. Fearing for their safety and the safety of each other, all four deputy sheriffs fired at the decedent. A total of 36 rounds were fired and the decedent was struck 36 times. The first deputy sheriff fired eight rounds, the second deputy sheriff fired seven rounds, the third deputy sheriff fired six rounds, and the fourth deputy sheriff fired fifteen rounds. Emergency medical services were summoned to the location to provide the decedent with medical care. The decedent succumbed to his injuries and was pronounced dead at the scene. While the Los Angeles County Fire Department was at the scene treating the victim for his injuries caused by the decedent, they observed the victim had an apparent gunshot wound to his upper left leg. The victim was transported to the hospital where he was treated for his injuries. During the crime scene investigation, it was determined one of the bullets, fired by one of the deputy sheriffs, struck a metal guide rail for a sliding vehicle gate on the ground near the victim. A fragment of the bullet ricocheted off of the guide rail, was re-directed upward, and struck the victim in the leg.

[1] Commonly known as OC spray or pepper spray.

1. Briefly describe the **root cause(s)** of the claim/lawsuit:

A **Department** root cause in this incident was the lack of investigation regarding the decedent's alleged mental illness prior to making contact with him.

Another **Department** root cause in this incident was the unintentional injury to the victim caused by a bullet fragment that ricocheted off a metal guide rail near the victim, as four members of the Los Angeles County Sheriff's Department employed deadly force against the decedent, who had actively attacked them with a knife.

A **non-Department** root cause in this incident was the decedent's failure to comply with the lawful orders of Los Angeles County deputy sheriffs. Instead of obeying orders, the decedent armed himself with a weapon and charged at the deputy sheriffs. The decedent's actions caused the deputy sheriffs to fear for their lives, resulting in a deputy involved shooting.

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

Criminal Investigation
The incident was investigated by the Sheriff's Department's Homicide Bureau to determine if any criminal misconduct occurred. On July 18, 2016, the Los Angeles County District Attorney's Office concluded the deputy sheriffs acted lawfully in self-defense and the defense of others when they used deadly force against the decedent. They closed the file and will take no further action in this matter.

Administrative Investigation
This incident was investigated by representatives of the Sheriff's Department's Internal Affairs Bureau to determine if any administrative misconduct occurred before, during, or after this incident. The results of the investigation were presented to the Executive Force Review Committee (EFRC) for adjudication. On February 9, 2017, the EFRC determined the tactics and use of deadly force were within Department policy. No further action was taken.

Mental Illness - Station Desk Training
It was discovered when the victim advised the station desk personnel the decedent was "acting crazy," the desk personnel could have better clarified what that meant. If the decedent's mental illness had been identified earlier in this incident, the involved deputy sheriffs could have made informed decisions based on that information.

Since this incident, Century Station training staff have conducted several in-service training sessions with Century Station desk and field personnel during shift briefings to discuss the specific issues identified in this case. Desk personnel were trained on how to identify key words and behaviors that could assist responding personnel regarding possible mental illness issues. Desk and field personnel were trained on interacting with mentally ill persons and taking necessary steps to safeguard victims and/or witnesses during tactical responses or operations.

Mental Illness Training
The "Investment in Mental Health" Task Force has collaborated with the DMH to improve patrol response to mental illness related contacts and incidents. As a result, the Department has implemented several programs to educate personnel. Several layers of training have been implemented with further expansion expected in the future.

A mandated Peace Officer Standards and Training Mental Illness update training video has been produced and distributed. As of this report, the Department has had 3,582 sworn patrol personnel (94.4%) complete the training. Century Station has trained 174 of their 224 sworn personnel and is currently 77.68% compliant with the training. Century Station expects that by the end of May 2018, 100% of their current personnel will be trained on this training video.

A non-mandated eight-hour "Law Enforcement and Effective Interaction with Mentally Ill" training course is available. As of this report, 856 Department personnel have attended this training for a total of 22.57% of patrol personnel. Century Station has sent 24 of their personnel to this training course.

The Mental Health Evaluation Team (MET) has developed a non-mandated eight-hour "Mental Health Update & Interactions with the Developmentally Disabled" training course. The course combines classroom lecture, training videos, and a responsive role playing critical incident MILO simulator (currently fixed at Industry Sheriff Station). MET is in the process of constructing a portable MILO simulator trailer which could be moved anywhere. The goal is to provide in-service mental health training to all sheriff station personnel.

The autism portion of the training course teaches the identification and challenges of interacting with people that have Aspergers or Autism. This portion of the course ends with interaction between the class and families with autistic children. This course helps employees recognize subject behavior and emphasizes de-escalation techniques. As of this report, 342 Department personnel have attended this course.

A non-mandated 32-hour mental illness "Crisis Intervention Training" (CIT) course was started in December of 2016. As of this report, 189 sworn deputy sheriffs (in addition to DMH clinicians) have completed this course, 20 of which are personnel from Century Station.

A 40-hour "Mental Health Crisis Intervention for Patrol" training class was launched in 2016. At the time of this report, 50 Department personnel have attended the 40-hour training class.

Several additional mental illness training classes are scheduled to be completed through 2018.

MET Deployment at the Time of this Incident

During October 2014, the Department had five countywide Mental Health Evaluation Teams (MET) scheduled to cover seven days a week:

- 10:00 a.m. to 6:00 p.m. - Two teams
- 3:00 p.m. to 11:00 p.m. - Three teams

On the night of the incident, two MET teams were deployed. A MET team was not requested to respond to the location before, during, or after the incident.

Current and Future MET Deployment

The current MET team deployment has increased to 23 teams deployed between 6:00 a.m. and 2:00 a.m., seven days a week (with three additional teams currently training for deployment).

The MET team triage desk is now staffed 24 hours a day, seven days a week. The triage desk can assist patrol stations with after-hours mental health issues. If an immediate response is needed, the triage desk can call a team to come in early.

The current growth model is to deploy 45 MET teams, with adequate supervision and support staff with Department of Mental Health (DMH) to match. This deployment will provide 24/7 coverage.

Utilizing a Risk Assessment Management Program (RAMP) MET monitors their recurrent and high need service users. This process allows MET to better identify and address critical cases which need immediate attention. RAMP cases are monitored closely by a panel of mental health experts. Each case is reviewed and a plan of action is created based on the service users threat to the public, danger to self or others, health (both mental and physical), and other risks imposed by the patients continued environmental conditions.

3. Are the corrective actions addressing Department-wide system issues?

☐ Yes – The corrective actions address Department-wide system issues.

☒ No – The corrective actions are only applicable to the affected parties.

Los Angeles County Sheriff's Department

Name: (Risk Management Coordinator)

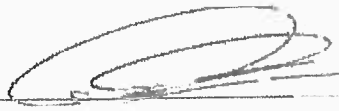
Scott E. Johnson, Captain
Risk Management Bureau

Signature: 

Date: 5-10-18

Name: (Department Head)

Alicia E. Ault, Chief
Professional Standards and Training Division

Signature: 

Date: 5/14/18

Chief Executive Office Risk Management Inspector General USE ONLY

Are the corrective actions applicable to other departments within the County?

☐ Yes, the corrective actions potentially have County-wide applicability.

☒ No, the corrective actions are applicable only to this Department.

Name: (Risk Management Inspector General)

Destiny Castro

Signature: Destiny Castro

Date: 5/14/2018