County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

SACHI A. HAMAI
Chief Executive Officer

Board of Supervisors
HILDA L. SOLIS
First District

MARK RIDLEY-THOMAS
Second District

SHEILA KUEHL
Third District

JANICE HAHN
Fourth District

KATHRYN BARGER
Fifth District

June 19, 2019

To: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Kathryn Barger

From: Sachi A. Hamai
Chief Executive Officer

SUPPORTING FAMILIES IMPACTED BY THE SHERIFF'S DEPARTMENT (ITEM NO. 9, AGENDA OF OCTOBER 9, 2018)

On October 9, 2018, the Board of Supervisors (Board) directed the Chief Executive Officer (CEO), in consultation with the Sheriff, the Executive Director of the Sheriff Civilian Oversight Commission (COC), the COC Family Assistance and Communication Ad Hoc Committee (Ad Hoc Committee), the Office of Inspector General (OIG), the Executive Officer of the Board, County Counsel, the Medical Examiner-Coroner (ME-Coroner), and any other relevant Los Angeles County (County) departments or stakeholders, to review the "Report of the Sheriff Civilian Oversight Commission Family Assistance and Communication Ad Hoc Committee Recommendations" and report back in writing in 60 days on an implementation plan for consideration by the Board, including establishing any necessary County infrastructure, staffing, trainings, protocols and services, and, if relevant, identifying necessary costs and funding sources. The CEO and impacted County departments were granted an extension from the original due date to allow more time to finalize the program proposal and report.

BACKGROUND

In a November 2016 letter, the OIG requested that the newly formed COC take on the issue of how a jurisdiction communicates with a family following the death of an individual while in custody, or from a fatal use of force by law enforcement, to improve County practices. The COC formed an Ad Hoc Committee which conducted research that included reviewing current Sheriff policies and protocols both in patrol and in custody, meeting and listening to families who lost loved ones, community organizations and County departments who interface with the families, researching effective models for post-incident communication and family assistance, and offered seven recommendations in their September 27, 2018 report (Attachment A).

EXECUTIVE SUMMARY

The CEO convened a workgroup comprised of representatives from COC, OIG, Sheriff, County Counsel, ME-Coroner, Executive Office of the Board, Auditor-Controller, Chief Information Office (CIO), Department of Mental Health (DMH), Department of Health Services (DHS), District Attorney's Office (DA), and Registrar-Recorder/County Clerk. The workgroup engaged in discussions and sharing of ideas, experiences, knowledge and expertise to form program proposals that would improve communication, interactions and support services for families impacted by the loss of a loved one unexpectedly while in custody or from a fatal use of force. In addition to the larger workgroup meetings, several follow-up meetings ensued with various departments and stakeholders to allow more focused development of individual program components. The workgroup also evaluated the ability to leverage existing resources and programs as well as options for new/expanded programs.

The workgroup developed a proposal and framework for a Family Assistance Program (FAP) model that enhances the existing notification process and consists of a multi-disciplinary team that provides support, basic resources, and transparent communication to families of the deceased. As the Family Assistance Advocate, DMH would act as the families' primary County contact tasked with maintaining communication with the family from the moment they are notified of their loved one's death. As the primary contact, DMH would help families navigate the County's process and explain resources that would be available to them. Attachment B illustrates the proposed FAP engagement process. The FAP would also include the development of a pamphlet specifically for family members and a web page that thoroughly explains Sheriff procedures and protocol surrounding in-custody deaths and fatal use of force. The estimated cost of the FAP is $506,000 consisting of $437,000 for ongoing DMH supportive services and $69,000 for web design, portal development and system maintenance ($50,000 one-time and $19,000 ongoing). The estimated annual cost for family burial assistance is $180,000 to $300,000 based on an estimated 24 to 40 incidents per year. In addition, continuous trauma-informed training, communication with media, advocating for State laws regarding access to victim resources were contemplated and addressed through proposals to modify/expand existing programs.

As set forth in more detail, Attachment C provides the workgroup's proposals that address each of the seven COC Ad Hoc Committee Recommendations identifying proposed solutions, resource needs, cost estimates and the framework for next steps required to implement the proposed FAP model.

CONCLUSION

It is recommended that the Board implement the proposed FAP model with enhanced notification processes, program pamphlet, web page and expanded trauma-informed training for all Sheriff personnel as a pilot program. DMH, Sheriff and the ME-Coroner will provide a semi-annual report back to the Board on each of the seven workgroup proposals outlined on

Attachment C, including the status of program implementation, operational objectives, metrics and an assessment of funding requirements based on supported workload.

Should the Board decide to implement the FAP pilot, we will provide budget recommendations during the Supplemental Budget phase to develop an appropriate staffing plan for the program including the creation of a webpage. One-time Assembly Bill (AB) 109 funds may be considered for the one-year pilot project. During the pilot, our office will assess the on-going operational costs and will continue to explore alternative funding sources, such as Mental Health Services Act, Private/Public Partnerships, and AB 109 funding. This will allow for recommendations to be made within the context of the overall budget and numerous competing funding priorities and requests.

The Board may also consider instructing CEO, Legislative Affairs and Intergovernmental Relations along with the Sacramento Advocates to: 1) include a policy in the County's State Legislative agenda to allow the County to support legislation that would expand eligibility of State-funded victim resources to family members/survivors of fatal use of force by law enforcement; and 2) in collaboration with County stakeholders, actively work with statewide stakeholders to identify and advocate for such legislation in the 2019-20 State Legislative Session.

SAH:FAD:MM:SW
RP:JV:cc

Attachments

c: Executive Office, Board of Supervisors
County Counsel
District Attorney
Sheriff
Auditor-Controller
Health Agency
Health Services
Medical Examiner-Coroner
Mental Health
Office of Inspector General
Registrar-Recorder/County Clerk
Sheriff Civilian Oversight Commission

ATTACHMENT A

Report of the
Sheriff Civilian Oversight Commission
Family Assistance and Communication Ad Hoc Committee
Recommendations

Dated: September 27, 2018

Table of Contents

I. INTRODUCTION

In the last five years, 207 people have died while in the custody of the Los Angeles Sheriff's Department (LASD) or in incidents involving lethal use of force by LASD deputies in the field. Families are often left without adequate information regarding the circumstances surrounding the deaths of their loved ones and do not receive sufficient support to address the trauma they experience following the loss of their loved one. We, the members of the Los Angeles County Sheriff's Civilian Oversight Commission (COC), received a substantial number of requests from members of the public that we look into the interaction between LASD and family members of those in custody or who have interactions with LASD, especially those who are involved in fatal use of force cases.

It is clear that how LASD interacts with family members correlates with how the community perceives LASD. Although the events that transpire following an incident are unique to each situation, clear and empathetic communication with family members has the potential to mitigate further trauma. It is at this time that compassion, enhanced communication with the family, and direct family assistance regarding information and answers to questions, are most needed. These families, especially the spouse, partner, parents, children, grandparents and siblings, are oftentimes in a critical and precarious position, precisely at the onset of their grief.

Members of the public reported that the communication that takes place with the family of the deceased immediately following a fatal use of force incident or an in-custody death often contributes to the family's trauma. We have received a substantial number of reflections from family members of those who have had encounters with LASD personnel, are in custody, or are involved in a deadly use of force incident urging the COC to review this issue. The Youth Justice Coalition, a community based organization, presented the COC with the Family Member Bill of Rights (APPENDIX A: YJC's FAMILY MEMBER BILL OF RIGHTS) in the hopes that they would be adopted by the County and/or LASD to address these issues. Additionally, commissioners witnessed interactions between family members and LASD over the course of their work as commissioners and most vividly during a town hall meeting following the fatal deputy

involved shooting of a 16-year-old African American male in the Westmont area of Los Angeles County.

The Family Assistance and Communication Ad Hoc Committee (Committee) set forth in its work with the goal of identifying and addressing systemic issues within LASD that have prevented clear, timely, trauma informed, and precise communication and interactions with families and the community. This was accomplished by:

1. Researching and identifying systemic issues in the interactions between LASD and families.
2. Meeting with and listening to family members who lost loved ones and who were willing to talk about this deeply personal and difficult issue.
3. Meeting with and listening to community organizations and County departments who interface with families.
4. Meeting with and listening to LASD in exploring their current policies and protocols both in patrol and in-custody.
5. Inviting presentations from various entities to educate the COC.
6. Researching effective models for post-incident communication and family assistance.

II. ACTIONS OF THE COMMITTEE

The Committee was established consisting of three commissioners: Commissioner Heather Miller (Chair), Commissioner Patti Giggans, and Commissioner James P. Harris, as well as COC staff member, Analyst Ingrid Williams. Commissioner Miller was replaced by Commissioner Priscilla Ocen upon the expiration of Commissioner Miller's term on the Commission.

The members of the Committee and its staff took the following actions:

1. Submitted a list of questions to LASD regarding communication with families with respect to;
    a. Fatal deputy involved shootings and in-custody deaths,

b. Procedures and policies surrounding everyday supervision of those in custody.

2. Met with LASD to discuss their practices and procedures in regards to communication with families during specific situations.
3. Met with members of the Youth Justice Coalition to discuss their Family Members' Bill of Rights.
4. Met with family members who have had interactions with LASD and other law enforcement agencies to obtain first person accounts regarding their experiences.
5. Spoke to Los Angeles County Department of Health Services to discuss the medical perspective regarding communication with family members.
6. Obtained information regarding the District Attorney's Bureau of Victim Services and the resources available to victims of crime and their family members.
7. Obtained and reviewed a resource binder compiled by the Office of Inspector General, which outlines other departments' policies and procedures, and highlights outside solutions from around the world.
8. Met with the Los Angeles Police Department's Family Liaison Section.
9. Met with the Los Angeles Mayor's Crisis Response Team.
10. Met with Los Angeles County Medical Examiner-Coroner's office to discuss their practices and procedures.
11. Held several meetings with LASD leadership.

III. FAMILY MEMBER EXPERIENCES

Families have come before the Commission, during Town Halls and other meetings with the Ad Hoc Committee, articulating inadequate communication with families by LASD. Families reported that information given to them is often incomplete, confusing, contradictory, and/or not delivered in a sensitive manner. For example, several families reported that they were not informed by LASD that their loved one was deceased, and sometimes, they heard it from the media or another member of the community first. Several instances of confusion and mixed information concerning the location of the

body of their loved one have occurred. Families have requested an explanation as to the protocols regarding whether or not they are allowed to see the body, either at the scene, hospital, or at the morgue, and when that may occur. They would like the communication of this information in a timely and sensitive manner. Some family members expressed that they were treated more like suspects than the family of the deceased. Furthermore, family members reported the trauma of being detained in the rear seat of radio cars awaiting information concerning their loved one.

LASD's communication with the media was identified as especially painful for many of the families with whom we spoke. Several families felt that LASD's reporting of their loved ones as gang-members to the news media appeared preemptive, unnecessary, and often inaccurate or skewed. There is a perception that the incident is prejudged and that the deceased is stereotyped and maligned. Equally important is the consideration that the treatment of these families impacts the community where they reside and erodes trust between LASD and the community.

Community groups echoed the sentiments of the families. They argued that LASD should withhold comments that are not pertinent to the investigation, which they felt served to discredit or vilify the decedent. Comments like, "he was a known gang member in the community" or "it's gang-related" suggest that the use of force might be justified based on that fact alone, and only add to the family's trauma; whether the decedent is a gang member or not, such a fact is not relevant to the use of force. This further diminishes trust between LASD and the community, especially in marginalized communities and communities of color, some of whom have had a negative history with law enforcement.

IV. CURRENT RESPONSE TO LAW ENFORCEMENT-RELATED FATALITIES IN LOS ANGELES COUNTY

Below is a summary of the existing response and protocols followed by LASD and other county departments regarding law-enforcement related fatalities.

LASD FATAL USE OF FORCE INCIDENT RESPONSE

Following a fatal use of force, the Los Angeles Sheriff's Homicide Bureau is the primary investigative agency within LASD that has jurisdiction over conducting an investigation into the use of deadly force. The Los Angeles County Coroner's Office is notified and responds to the scene as they have primary jurisdiction over the remains of the deceased. The Homicide Bureau also notifies the Los Angeles District Attorney's Office and the Office of Inspector General who also respond to the scene. These agencies observe, but do not conduct, their own independent investigations. LASD also responds with a parallel internal investigation team, the Sheriff's Psychological Services team, the Sheriff's Risk Management team, and a Duty Commander responsible for representing the Sheriff and ensuring that all stakeholders involved are following their protocols. Following the incident, the lead investigators on any case assigned to the Homicide Bureau are tasked with making next-of–kin notifications. This is usually done by Homicide Bureau personnel but can be accomplished in coordination with the Coroner's Office as soon as reasonably possible following the incident. Family is identified based on the investigative information available. Investigators attempt to identify the decedent's closest relatives to make the appropriate notification. Typically, LASD does not release the name of the deceased without first notifying the next of kin.

The investigators who provide the notification explain to the next of kin the process of the investigation, including the location of their loved one's body. The investigators also clarify that the Coroner's Office has the ultimate authority regarding how soon the remains will be released to the family. At the time of the death notification, the investigators explain the investigative process and the presence and simultaneous involvement of personnel from the District Attorney's Office and the Office of Inspector General. Investigators also provide the family with information regarding the next steps and a pamphlet (APPENDIX B: LOS ANGELES COUNTY SHERIFF'S DEPARTMENT: DEPUTY-INVOLVED SHOOTING PAMPHLET) explaining the investigative process which includes contact phone numbers for resources outside of the Homicide Bureau. The handling lieutenant is generally the point of contact for the family. Following the incident, the Homicide Bureau sends a letter to further explain the investigative process

to the family. The letter reiterates to the family that the lead investigator and lieutenant are assigned as primary contacts and provides their contact information.

LASD IN-CUSTODY DEATH RESPONSE

The LASD Custody Division also abides by the same notification protocols that take place following a fatal use of force. Following an inmate's death, the Custody Division notifies the Homicide Bureau who is responsible for conducting the death notification for all in-custody deaths. The Custody Division takes an active role in the review process of all deaths that occur within their jurisdiction. The Custody Division conducts a death review for each in-custody death or death of a prisoner in the Community Based Alternatives to Custody program. The death review is conducted in three separate meetings at the following intervals: 24-hours, 7-days and 30-days. The 24-hour review is conducted by Medical Services Bureau to share initial findings and to review the circumstances that surround all in-custody deaths. Both the 7-day and 30-day death reviews are conducted by the Custody Compliance and Sustainability Bureau to share additional findings and discuss the status of any corrective or preventive actions taken since the previous review. If the family members of the deceased have any questions regarding the details surrounding their loved one's death, they are to reach Custody Division services through the Homicide Bureau who is responsible for providing that information in coordination with Custody Division.

LOS ANGELES COUNTY MEDICAL EXAMINER-CORONER RESPONSE

Following a fatal deputy related shooting or an in-custody death, LASD is required to notify the Coroner. LASD staff will call the Coroner's Office to report the death; however, at the time of the initial notification call, the Coroner's Office does not deploy its staff. This allows LASD Homicide investigators to conduct their crime scene investigation. However, this process may take hours to complete and often times the deceased body is on display to the public as well as the grieving family. These delays enhance feelings of neglect and disrespect among the families and the public. Due to their presence, the public often associates the Coroner's Office with the delayed removal of the deceased.

Coroner staff normally awaits approval from the lead homicide investigator before the remains are removed.

It should be noted that at the scene two parallel investigations take place; LASD's investigation as well as the Coroner's investigation. The Office of the Coroner is tasked with identifying how and why the person died, identifying the remains, and notifying the family. Generally, due to the high emotional nature of fatal deputy involved shootings and to preserve the crime scene and state of the remains, Coroner staff does not conduct viewings at the site where the shooting took place. The Coroner's Office does not have viewing facilities for families to view the remains. Viewing of the remains may take place at the mortuary once the Coroner's Office has completed its investigation.

Once the family of the deceased is identified, the Coroner's Office will contact the family to notify them of their loved one's passing. Coroner staff informs the family of the process regarding the autopsy, collection of property, and when they should expect to recover the remains. Although all of the Coroner's records are public records, families may not have access to specific information regarding the case due to a common practice in which law enforcement agencies are able to place a security hold on a specific case. During a security hold, the Coroner's Office does not comment or release any information regarding the specific case until the investigation is completed.

V. EXISTING LOS ANGELES AREA FAMILY OUTREACH AND LIAISON PROGRAMS

The Committee spoke to personnel from the Los Angeles Police Department, the Office of Los Angeles Mayor Eric Garcetti, the Los Angeles County District Attorney's Office, and the Los Angeles County Department of Health Services. Each agency has an existing program that conducts some form of outreach and/or family assistance following death or serious injury and each program has components that informed this report and which may be incorporated into a new County program.

LOS ANGELES POLICE DEPARTMENT'S FAMILY LIAISON SECTION

The Family Liaison Section is responsible for coordinating with the family of those who lost their life in encounters with Los Angeles Police Department (LAPD) personnel or while in the custody of the LAPD, and maintaining contact with the immediate family throughout the entire administrative investigation and adjudication process. The Family Liaison Section provides the family members with a copy of the initial press release regarding the incident and any other releasable information that becomes available. During the various stages of the investigation, the Family Liaison Section maintains contact with the family and assists as a bridge for the family and resources available to them. Once the report is completed the Family Liaison Section will provide the family with a copy of the report.

LOS ANGELES MAYOR'S CRISIS RESPONSE TEAM

The Mayor's Crisis Response Team (CRT) was established in 1998 to assist the LAPD and the Los Angeles Fire Department (LAFD) in crisis situations. The CRT responds to homicides, suicides, death notification assistance, domestic violence support, officer involved shootings, infant deaths, and serious traffic collisions. The CRT operates with the help of over 250 volunteers and works in collaboration with many public agencies and community-based organizations. Volunteers provide immediate on scene, practical, and emotional support to survivors impacted by personal tragedies. CRT members receive extensive, on-going training in crisis care and trauma intervention, they are only involved with survivors in the first hours immediately following an incident. However, they are a crucial component of the LAPD's and LAFD's crisis response and intervention, as they provide immediate support and may function as an advocate of the survivor to obtain necessary information regarding the incident from the LAPD and LAFD. CRT members' affiliation with the Office of the Mayor, rather than the LAPD or LAFD, enables them to establish immediate independent rapport with the survivors. This rapport facilitates the provision of immediate trauma informed care, as well as the dissemination of pertinent information to the survivors.

LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

The Los Angeles County Department of Health Services (DHS) has begun to implement a program that takes a unique approach to working with families following sentinel events and which has been shown in other jurisdictions to decrease trauma, improve patient care and reduce litigation costs. The model described here may have particular applicability to in-custody and shooting deaths. In the medical field, it is generally accepted that lawsuits are driven not only by the damage caused, including loss of life, but also by anger. Medical experts counsel that doctors and hospitals should provide an apology to patients or their families when treatment is substandard. An apology may not require an admission of fault, but is a sign of shared regret at the outcome, and may allow for the early resolution of potential malpractice claims.

Initial findings of agencies that have implemented what may be referred to as "communication and resolution programs" (CRPs) include decreased trauma for patient-victims or their surviving families, increased safety and patient care, and reduced malpractice litigation. Basic CRP components include the following:

- transparent discussion of the events with the patient-victim or family;
- apology for the unfortunate circumstance (NOT yet apologizing for causing harm);
- explanation that there will be prompt investigation to understand what happened;
- identification of any immediate and reasonable needs of the patient or family as a result of the event;
- return to explain the findings of the investigation;
- when the provider or entity is at fault, acknowledgement of that and an apology for causing harm;
- offer of reasonable amends in a way the patient or family feels is warranted (Making amends is often accomplished through monetary compensation, but sometimes may consist just of the apology, assurance that a problem will be fixed, involving the patient/family in fixing the process, or allowing them to tell their story to others); and

- prompt identification and remediation of systemic deficiencies that contributed to or caused the adverse outcome.

The DHS Director of Risk Management, Patient Safety and Risk Management, is beginning to initiate a program here. The Director is a proponent of CRPs and notes that increased transparency improves public trust and acknowledgement of systemic deficiencies protects morale of involved personnel. DHS reports initial success in its program's outreach efforts and confidence in the likelihood of a CRP's success in Los Angeles County and in its potential to change the face of public relations in health care nation-wide.

The DHS program also incorporates principles of Just Culture described below (SEE APPENDIX C: ACHIEVING A JUST CULTURE). Just Culture is a principle and practice toward workplace safety that refers to values-supportive principles of shared accountability and ensures that everyone is treated with kindness and fairness when mistakes are made (SEE APPENDIX D: JUST CULTURE POLICY). When individuals make mistakes that result in adverse outcomes, Just Culture calls for identifying any systemic deficiencies that contributed to the mistake or that prevent mistakes from being made. This shifts focus away from blaming individuals, perhaps for circumstances outside of their control, and toward the correction of systemic issues (APPENDIX E: THE MICHIGAN MODEL).

In June 2017, a group including executives from DHS and LASD attended a workshop hosted by the United States Department of Justice. The workshop focused on working toward a "sentinel event" review process for law enforcement that mirrors what is done in health care described above. The meeting included discussion about the possible role of CRPs in law enforcement. Use of these programs in law enforcement would go hand-in-hand with the principles of restorative justice, trauma informed and community oriented policing, which LASD has committed to and is working to expand. CRP efforts following in-custody deaths that involve insufficient medical or mental health care may be an analogous starting point for LASD but many of the same principles should translate to shooting deaths as well.

LOS ANGELES COUNTY DISTRICT ATTORNEY'S BUREAU OF VICTIM SERVICES

The Los Angeles County District Attorney's Bureau of Victim Services spoke with us regarding an array of services available to crime victims and their families. Unfortunately, these services are not typically extended to family members of fatal use of force incidents because they do not meet the criteria for eligibility. However, the information was useful in that it informed our understanding of what government support could look like.

VI. TOWARD A SOLUTION

In speaking with LASD, we realize the unique pressures and legal requirements they are expected to adhere to, amidst an often highly charged and emotional scene. LASD reported that they communicate with the families and give them as much information as legally allowed. Often, identifying next of kin is not a simple matter and requires time and due diligence. The media may relay information in a more sensationalist and divisive manner distorting the information provided by LASD. This is not conducive to trust building within the community. As it is LASD's responsibility to respond to the press and the community regarding incidents of violence and law enforcement activity, it is essential that it does so in a sensitive manner free of information that may appear as an attempt to prejudge the situation before the facts are fully known. Whether done intentionally or not, this may influence the public's perception. Communicating unnecessary facts to the public, such as race or suspected gang affiliation will only contribute to the biased labeling of specific groups in the community and the additional traumatization of the family and community. However, it will not further the investigation surrounding the incident.

A thorough knowledge of trauma informed care and best practices will greatly enable LASD staff to effectively and empathetically assist and communicate with families who have suffered from the loss of a loved one at the hands of law enforcement. Traumatic grief, or as it is sometimes referred to as complicated grief, occurs when a death is sudden, unexpected and comes out of nowhere. Grief is a natural outcome and a

natural process when there has been a great loss. When a family member tries to grieve this kind of loss, the trauma complicates and severely impacts the grieving process making it even harder to mourn. Grief and trauma go hand in hand and those impacted can become numb, while at the same time cycle with rage and anger, along with depression, fear and confusion. Traumatic grief complicates the non-linear stages of grief: denial, anger, bargaining, depression, and acceptance.

At a time when a family craves information as to the circumstances surrounding the death of their loved one, the manner in which such information is communicated to the family is as significant as the information itself. The trauma that they are experiencing must be taken into consideration throughout all communications. No one reacts or grieves in the same way. It is crucial, therefore, that the spectrum of reactions and emotions be understood as normal due to the traumatic nature of the event. It is essential that anyone who communicates with close family members be trauma sensitive and trauma informed.

LASD should recognize that the families are not responsible for the incident that took place. They are victims in these situations, no matter what the ultimate outcome of subsequent investigations. Although Just Culture is applied primarily in the healthcare industry, there are key components that can be applied in law enforcement, and we are inspired by them. Among them are: transparently discussing the events of the incident with the individual or family, explaining that there will be a prompt investigation regarding the incident, identifying any immediate needs of the family as a result of the incident, and returning to explain the findings of the investigation. For example, using phrases such as "this is behavior we are/not proud of" when discussing the incident are authentic and do not put up a veneer of infallibility.

In addition, we heard feedback from both families and the Coroner's Office that there are often significant delays in removing someone's remains from public view. This enhances feelings of disrespect among the family of the deceased and the community in which the event took place, as they are witness to a horrific scene, which is exacerbated by the untimely removal of the remains. As a result, the community as well as the family perceives that their experience is not valued. We encourage LASD to

identify a mechanism to ensure that this does not occur. We encourage the use of screens, when appropriate, to shield the deceased from public view.

Community, culture, religious and spiritual orientations also come into play immediately following a traumatic incident. There is often a gathering of family, extended family and community members at the scene or at the family home, and grieving can take many forms, from vocal and physically expressive to more stoic. The variations in behavior are normal and should be viewed and treated as such. Cultural humility and trauma sensitivity go hand in hand. Families expressed to the committee that they want to feel respected and treated with compassion for the loss that they are experiencing, regardless of whether their loved one is considered a suspect. Therefore, it is crucial that the individual(s) chosen to communicate directly with the families be the person best equipped to deliver often traumatic, heart-breaking information following a fatal deputy involved shooting.

Following the incident, many family members may associate all LASD personnel as responsible for their loved one's death and may refuse to communicate with LASD officials. Under these circumstances, the family members may prefer to have a liaison or intermediary to communicate what took place and what will come to follow in the investigation. In other instances, family members may view communication with department personnel as official and, therefore, necessary. How families are treated also influences how their community responds.

VII. RECOMMENDATIONS

After much research and consideration of all factors, the Family Assistance and Communication Ad Hoc Committee recommends the following:

1. ***The County should establish an entity consisting of a multi-disciplinary team that is capable of providing ongoing support, resources, and transparent communication to families of the deceased.***

MISSION

To provide ongoing support, trauma informed care, and resources, as well as transparent and timely information to families who have lost a loved one during a fatal use of force or an in-custody death.

VALUES

The core values of the multidisciplinary team should reflect the needs of the families as well as the community and should be thoughtfully designed based upon and clearly articulate plans for adherence to the following principles:

- **Empathy –** All team personnel should operate with the belief that no matter the circumstances, these deaths are tragic for the families of the deceased as well as the community. As such, families and the community deserve to be treated with the utmost compassion.
- **Respect –** Families and the community deserve to be treated with respect, dignity, and the acknowledgement that they are deeply grieving a sudden and unexpected loss and not as if they were the cause of the incident.
- **Continuous Support –** The multidisciplinary team should provide rapid response and ongoing support to families of the deceased throughout the investigation and thereafter.
- **Transparency in Communication –** To ensure that the family's needs are met, team members should maintain transparent communication with the

family of the deceased regarding any information obtained surrounding the investigation.

- **Integrity –** All team members should honor the commitments they make to the family and the community. Ensure that they are readily accessible to answer the family's questions and follow up with the family's requests in a timely manner.
- **Trauma Informed Care –** The team should ensure that families are treated with compassion and an understanding that they are experiencing a great deal of unexpected trauma and grief. As such, the team will advocate for the family with other County departments and agencies as needed.
- **Restorative Justice –** The team should operate with some of the basic principles of restorative justice[1]; to empower the families by giving them an opportunity to voice their grief and ask questions regarding the death of their loved one. It will also give LASD and other County departments the opportunity to respond to and provide resources and information that will facilitate the families' understanding and healing surrounding the unexpected death of their loved one.
- **Just Culture –** One of the objectives of the team should be to identify and correct system flaws rather than blame the family for things outside of their control.

Functions

The functions of the multidisciplinary team should include but are not limited to the following:

- The team will interface with families following in-custody and fatal deputy involved uses of force.

---

1 Restorative Justice is a system of criminal justice that focuses on empowering victims by giving them a voice and offenders the opportunity to make amends. https://restorativejustice.org.uk/sites/default/files/resources/files/1z87_info_packs%20(2)%20police.pdf

- The team will be tasked specifically to assist the families throughout investigations in a sensitive, timely, and thorough fashion.
- The team will be trained on all policies and procedures regarding a fatal deputy related shooting or in-custody death. These policies may apply to but are not limited to policies and procedures of the following departments:
    - Los Angeles County Sheriff's Department
    - Los Angeles County Medical Examiner- Coroner
    - Los Angeles County District Attorney's Bureau of Victim Services
    - Los Angeles County Department of Mental Health
    - Los Angeles County Registrar Recorder County Clerk
- The team will be trauma informed and communicate with the families with compassion, dignity, and respect.
- **The team will obtain resources for the family, establish communication with available resources on their behalf, and provide a warm hand off to the appropriate agency.**
- The Sheriff's Department should play an active and visible role on the multiagency team.

2. ***Continuous trauma informed training for all LASD personnel who come into contact with family members.***

Since the families are grieving and traumatized we want to ensure that LASD is continuously improving the way they communicate with families. These trainings should provide an opportunity for deputies to gain further insight regarding grief, the communication of unforeseen news, and how each individual may react to receiving devastating details involving their loved ones. These trainings should be incorporated into the Department's regular trainings and should cover a variety of topics.

3. ***Department members who speak with the media should be mindful of how they characterize the subject of the investigation. This includes maintaining fairness and withholding judgement.***

Parity should be maintained with regard to the release of information about both the deputy and subject. Maintain parity regarding the parties involved in the incident; the race or gender of the deputy or the subject should not be revealed unless absolutely necessary. Avoid revealing findings that are premature and /or shed negative light on the subject. We recommend a disciplined and thoughtful approach to responding to the sometime unrelenting barrage of questions from the press and media. Nevertheless, the Sheriff's Department should release accurate and pertinent information in a timely manner, especially in high profile incidents

4. ***Los Angeles County should take a lead role that advocates for changes in the current state laws regarding access to victim resources.***

Current state law does not treat the family members/survivors of fatal law enforcement uses of force as victims. This needs to be changed. The Committee recommends that the County push for the state law to be changed to expand eligibility.

5. ***Los Angeles County should establish a program that will assist families who experience a LASD-related death of a loved one with the cost of funeral and other associated expenses including, but not limited to, trauma and grief counseling for family members.***

The expenses surrounding the unforeseen death of a loved one often add additional trauma to the grieving family members whose lives are completely altered by the tragic event. This fund should be available to assist with the funeral and other expenses of the loss of a loved one.

6. ***Develop a pamphlet specifically for the family members of Deputy Involved Shootings and In-Custody Deaths.***

Develop a pamphlet specifically for the family members of Deputy Involved Shootings and In-Custody Deaths. While LASD has a Deputy-Involved Shooting pamphlet which outlines who investigates Deputy Involved Shootings, we recommend that there be a pamphlet, specifically created for the family members of those who were involved in fatal uses of force or in-custody deaths. The pamphlet should outline the

specific protocols that follow each incident. It should be easily understood, trauma informed, in multiple languages, and contain specific phone numbers that will enable family members to directly contact their Family Liaison who can answer their questions in a timely comprehensive manner.

7. ***Create a website/and or social media page that thoroughly explains LASD procedures and protocol surrounding in-custody deaths and fatal deputy related uses of force.***

The website should be a comprehensive collection of available Los Angeles County resources and should thoroughly itemize each department's role during the investigation surrounding the fatal event. Every department should have a link to the site on their website.

VIII. CONCLUSION

Losing a loved one unexpectedly is a traumatic event that requires an extensive amount of time to process. Although the details surrounding each in-custody death or fatal use of force vary, the common denominator is the grieving family and the need for access to information. The Los Angeles County Sheriff's Department has cooperated throughout the Committee's fact finding mission and is receptive to many of the aforementioned recommendations. Effective communication with families following an in-custody death or fatal use of force requires integrity, compassion and transparency. These values require a cultural shift within LASD. The progress that will follow will serve as a unifying bridge between the community and LASD. Los Angeles County, as well as the Sheriff's Department have the opportunity to illustrate to the families and the community that their concerns regarding transparent communication are valid and require immediate attention.

We want to express gratitude for the considerable support the Ad Hoc Committee received from the COC staff especially Ingrid Williams along with the Office of Inspector General, especially Cathleen Beltz. We appreciate the receptiveness from LASD and other County personnel to help us think through complex issues. The catalytic work of

the Youth Justice Coalition under the leadership of Kim McGill provided great impetus in looking at the issue of family assistance and communication and in developing this report. Lastly, we are extremely grateful to all the families who told us their heartbreaking stories. We honor them.

IX. APPENDIX

APPENDIX A: YOUTH JUSTICE COALITION'S FAMILY MEMBERS' BILL OF RIGHTS

ESTABLISH AND UTILIZE THESE ESSENTIAL POWERS FOR OVERSIGHT OF THE LASD:

1. *POWER TO ESTABLISH POLICY FOR THE DEPARTMENT*

2. *POWER TO REVIEW AND FINALIZE THE LASD BUDGET THAT IS PRESENTED TO THE BOARD OF SUPERVISORS. SPENDING DETERMINES PROGRAM AND POLICY PRIORITIES.*

3. *CREATE AND MAINTAIN A NEW, FAIR, TRANSPARENT, ACCESSIBLE AND INDEPENDEDNT COMPLAINT PROCESS FOR THE LASD – BOTH IN COMMUITIES AND IN CUSTODY, INCLUDING HAVING THE OIG AND THE SYSBIL BRAND COMMISSION WORK FOR AND REPORT TO THE OVERSIGHT COMMISSION.*

4. *ADOPT THE FAMILY RIGHTS PLATFORM GOVERNING TREAMENT OF VICTIMS' FAMILIES AFTER USE OF FORCE:*

GUARANTEE LOS ANGELES COUNTY FAMILIES THESE RIGHTS AFTER LAW ENFORCEMENT USE OF FORCE

S.T.O.P. Police Violence and this vision for change was *created and is led by youth who are have been most targeted for police stops, pat downs and surveillance, by people who have been arrested and/or detained in LA, by families who have loved ones who have been killed by law enforcement, and also contributed to by people most impacted by saturation policing such as people without permanent and stable housing, poor and working class communities of color, immigrant communities, people who practice a faith other than Christianity and LGBT2Q communities. S.T.O.P. provides: S = support for families; T = transformative justice to reduce our reliance on law enforcement, courts and incarceration to solve school, family and community problems; O = organizing and public policy development; and P = people power including grassroots leadership development and mobilization.*

Establish these rights for all families – (to address community and family concerns) immediately after law enforcement use of force resulting in homicide or severe injury:

1. Maintain fairness and withhold judgment. After an incident, do not discredit the victim, their family or community. Give the same answer when people ask about the possible misconduct or excessive use of force by members of law enforcement – "We can not comment because the incident is under investigation." (Often, law enforcement claims the person was armed, pointed a gun at officers, was on Parole, was a "gang member," etc. These statements are made immediately after an incident without having any opportunity to investigate. Often, the information is incorrect, and

c/o Youth Justice Coalition / PO Box 73688, LA, CA 90003 / 323-235-4243 / action@youth4justice.org

there is rarely any correction or official apology issued. *The damage to community trust and re-victimization of the family is lasting.*

2. **Reach out immediately to family members after a shooting without delay, and maintain regular and respectful communication with victims' families after each use of force.** Ensure that no family member ever again hears from the media or a neighbor that their loved one was killed.

3. **Ensure that family members have access to see their loved one(s) at the scene, at the hospital and/or at the Coroner's as soon as possible after the incident.**

4. **Demand and support independent investigation into all use of force incidents.** Push the State Attorney general to appoint a Special Prosecutor to investigate incidents statewide. Demand that the District Attorney's Office start an immediate and independent investigation. End law enforcement MOUs with the DA's office establishing that the office won't begin their investigation until the law enforcement agency involved completes tjeir investigation – often as much as one to two years later.

5. **Do not block – "pending an investigation" – family access to victims' compensation funds** to help with funeral and burial costs, as well as to free mental health counseling and other victims' supports. Expedite these resources for all families immediately. Establish a special fund for families to cover additional medical, counseling and other expenses.

6. **After all use of force resulting in serious injury or death, hold a community meeting within 2 weeks** that is open to family members, intervention workers, clergy and/or community- based organizations to air community concerns, and answer questions.

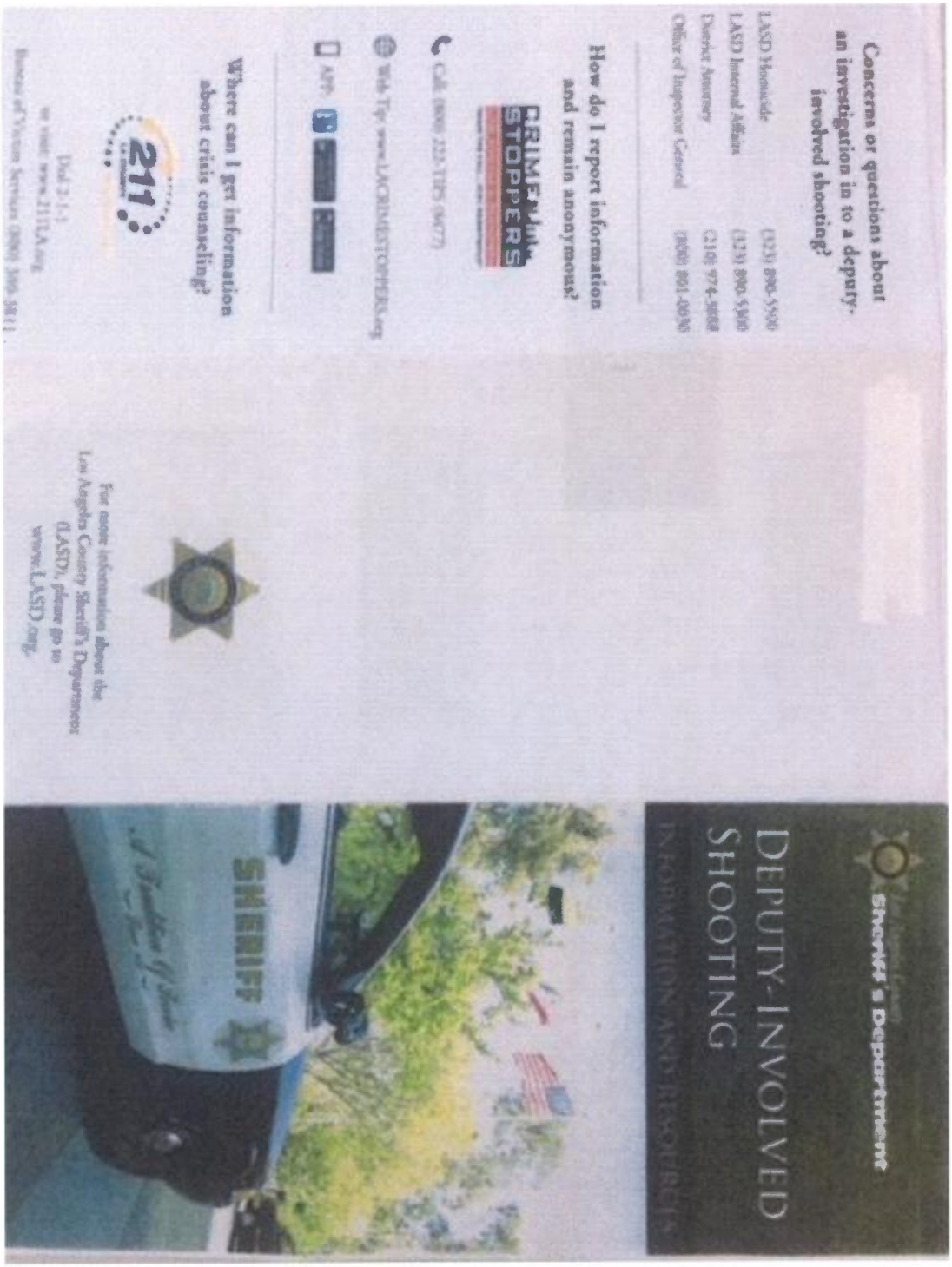
7. **Admit and apologize publicly when law enforcement and/or law enforcement actions are wrong.**

8. Make it clear to the community and enforce within all departments that **officers/deputies involved in any actions alleging misconduct or corruption, and/or resulting in serious injury or death, are immediately removed from the field (community contact)** pending an investigation, and lose all access to their firearm(s). If this is not standard procedure, make it procedure.

9. **Throughout the process, act with humility,** and do not make any comments that deflect responsibility away from the Department, such as "officers risk their lives every day," or "many more people are killed by 'gang'/community violence."

10. Work with use of force victims, their families and community organizations to **hold an investigation and hearings on use of force policies and create new policies** to strengthen protections for LA's communities.

APPENDIX B: LOS ANGELES COUNTY SHERIFF'S DEPARTMENT: DEPUTY-INVOLVED SHOOTING PAMPHLET



MESSAGE FROM THE SHERIFF

Every deputy-involved shooting is a traumatic event for all involved. It is essential that each incident goes through several layers of investigation and analysis. Each deputy-involved shooting is reviewed by several independent investigative agencies to ensure compliance with the law, Sheriff's Department (LASD) policy and the training of our deputies. Even as the LASD conducts its own investigation, investigators with the Los Angeles County District Attorney's Office and the Office of Inspector General conduct their own thorough, objective and independent reviews when someone is struck by gunfire. I am a strong advocate of this process. I believe it is essential to maintaining our high level of public trust and doing all we can to ensure that public safety is at the core of our work with the communities we serve.

I encourage you to share this brochure which illustrates this review process and offers resources, including ways to report information while remaining anonymous. As always, feel free to contact us with your questions, suggestions, or concerns.

Jim McDonnell, Sheriff
Los Angeles County

LASD Homicide Bureau

LASD homicide investigators respond and conduct the field investigation into any crimes committed.

District Attorney

The evidence gathered by the homicide investigators is presented to the Los Angeles County District Attorney's Office, Justice System Integrity Division, which determines whether any criminal charges should be brought against the involved deputy or whether the shooting was legally justified.

Who investigates deputy-involved shootings?

Whenever a deputy-involved shooting occurs, the incident is investigated by several independent entities.

LASD Internal Affairs

The Department's Internal Affairs Bureau responds and conducts an independent investigation into whether the shooting was consistent with Department policies.

Critical Incident Review

Deputy-involved shootings receive a preliminary review within a week by the Critical Incident Review Panel (CIRP). The CIRP determines whether any immediate actions are warranted, such as modifications to Department policy or training, or the reassignment of personnel. The panel is comprised of Department commanders. It includes input from concerned chiefs and captains, LASD's Risk Management and Training Bureaus, Los Angeles County Counsel and the Office of Inspector General.

Executive Force Review

The evidence gathered by LASD's Internal Affairs Bureau is presented to the Department's Executive Force Review Committee (EFRC), which determines whether a shooting was consistent with policy and training. The EFRC also adjudicates discipline in case of any policy violations. The committee is comprised of Department commanders. It includes input from concerned chiefs and captains, LASD's Risk Management and Training Bureaus, Los Angeles County Counsel and the Office of Inspector General.

Office of Inspector General

Civilian attorneys and investigators with a background in criminal law and civil rights issues from the Office of Inspector General (OIG) respond to all deputy-involved shootings and are given unlimited access to all relevant documents, meetings, and personnel within the Los Angeles County Sheriff's Department (LASD). The OIG reports to the County Board of Supervisors and makes recommendations to the LASD regarding the quality of the investigations, policy, training, equipment or tactical issues.

Achieving a Just Culture: Our Shared Vision

"The mission of the Los Angeles County Health Agency (DHS, DMH, DPH) is to improve health and wellness across Los Angeles County through effective, integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy people living in healthy communities."

What is Just Culture?

Just Culture is a principle and practice toward workplace safety: Be kind, be fair. The focus is on identifying and correcting systems flaws rather than blaming individuals for things outside of their control. Just Culture is a framework for shared accountability. It is a guiding principle which recognizes that unintended outcomes, adverse events and errors are an inevitable part of our human and professional experiences. Just Culture helps ensure that everyone is treated kindly and fairly when mistakes occur.

Where did Just Culture come from?

Just Culture has been used for years in high-risk fields like aviation and nuclear engineering. Many health care organizations now see Just Culture as a key component to ensuring excellence in their work.

The concept of Just Culture was embraced at the LA County Health Agency after the Labor Management Just Culture Committee – represented by SEIU, UAPD, AFSCME, Teamsters, CIR, DHS, DMH and DPH – conducted a survey in the Fall of 2016. The survey results revealed the need for a Just Culture policy that would address safety concerns and increase morale in the workplace by improving frontline input on operational issues and by promoting fairness. That's why Just Culture is our number one Labor-Management Partnership priority.

How does Just Culture work?

We recognize that unintended events and outcomes are not solely because of poor individual choices; rather, they are often the result of multiple errors or individual decisions made within intricate, imperfect systems. To ensure fair treatment, Just Culture requires us to achieve a balance – to respond appropriately to individual behavior while simultaneously determining what system changes are necessary so we can prevent similar problems from occurring. To accomplish these objectives, staff must feel empowered and comfortable recommending policy and procedure changes to supervisors.

When mistakes, near misses and adverse outcomes do occur, the review and solution will be collaborative under a policy of Just Culture. Responsibility for outcomes will be shared. Employees will not be subject to retaliation for identifying problems or disclosing errors. Individuals who might need coaching, training or other support will receive it.

Why is Just Culture important to our Health Agency?

Just Culture will help us become a "learning organization" that continuously improves. We will build an organization of trust where we can share our fears, frustrations and foibles with one another. Trust and open dialogue will promote relationships which will help prevent missteps from taking place. When mistakes do occur, under Just Culture, the review and solution will be collaborative and less arduous. We will share the responsibility for the outcomes, treating each other kindly and fairly throughout the process.

When and where will Just Culture be implemented?

Just Culture is our shared responsibility – so the principles of Just Culture will apply to all staff and managers. We will begin a train-the-trainers model of implementation right away. All departments will participate. By creating a Just Culture in which DHS, DMH and DPH act as Employers of Choice, and treat our staff as Employees of Choice, LA County will succeed as the Health Agency of Choice!

OUR HEALTH · OUR COMMUNITY · OUR LOS ANGELES COUNTY
LOS ANGELES COUNTY HEALTH AGENCY

AFSCME

UAPD
UNION OF AMERICAN PHYSICIANS AND DENTISTS

CIR

LOCAL 721 SEIU

APPENDIX D: JUST CULTURE POLICY

Health Agency Just Culture Policy

PURPOSE:

The Los Angeles County Health Agency, Department of Health Services (DHS), Department of Public Health (DPH), Department of Mental Health (DMH) and their Labor Union partners are committed to building, maintaining, and supporting a Just Culture.

A Just Culture is one where accountability is fairly balanced between the organizations and the individual Workforce Members.

It is a culture in which Errors, Near Miss Events, Adverse Events, unsafe conditions, and system problems can be easily reported without retaliation, and are seen as a means to identify system and behavior changes that will improve the safety and quality of care and services we deliver.

A Just Culture environment will encourage and empower each Workforce Member to take part in improving the quality of care and services delivered by the Health Agency and its departments.

DEFINITION(S):

Adverse Event - Any unintended event that interrupts services, causes, or has the potential to cause, an injury or illness and/or damage to persons, property, other assets and/or the natural environment.

Coaching – The process of providing constructive feedback about engaging in safer behavioral choices. Ongoing feedback and coaching is used to communicate about, and reinforce appropriate behavior, teach new skills, motivate high performance, and mentor Workforce Members so they understand their role in the organization.

Consoling – Expressing empathy and providing emotional support to someone in a time of grief or disappointment.

Counseling – Communication with an individual wherein a performance deficiency is identified and expectations for future performance are delineated. Counseling should be memorialized in writing by informal memo or confirmation e-mail, and placed in the department (local) personnel/area file, with a copy provided to the Workforce Member involved. The Workforce Member does not have to sign the document.

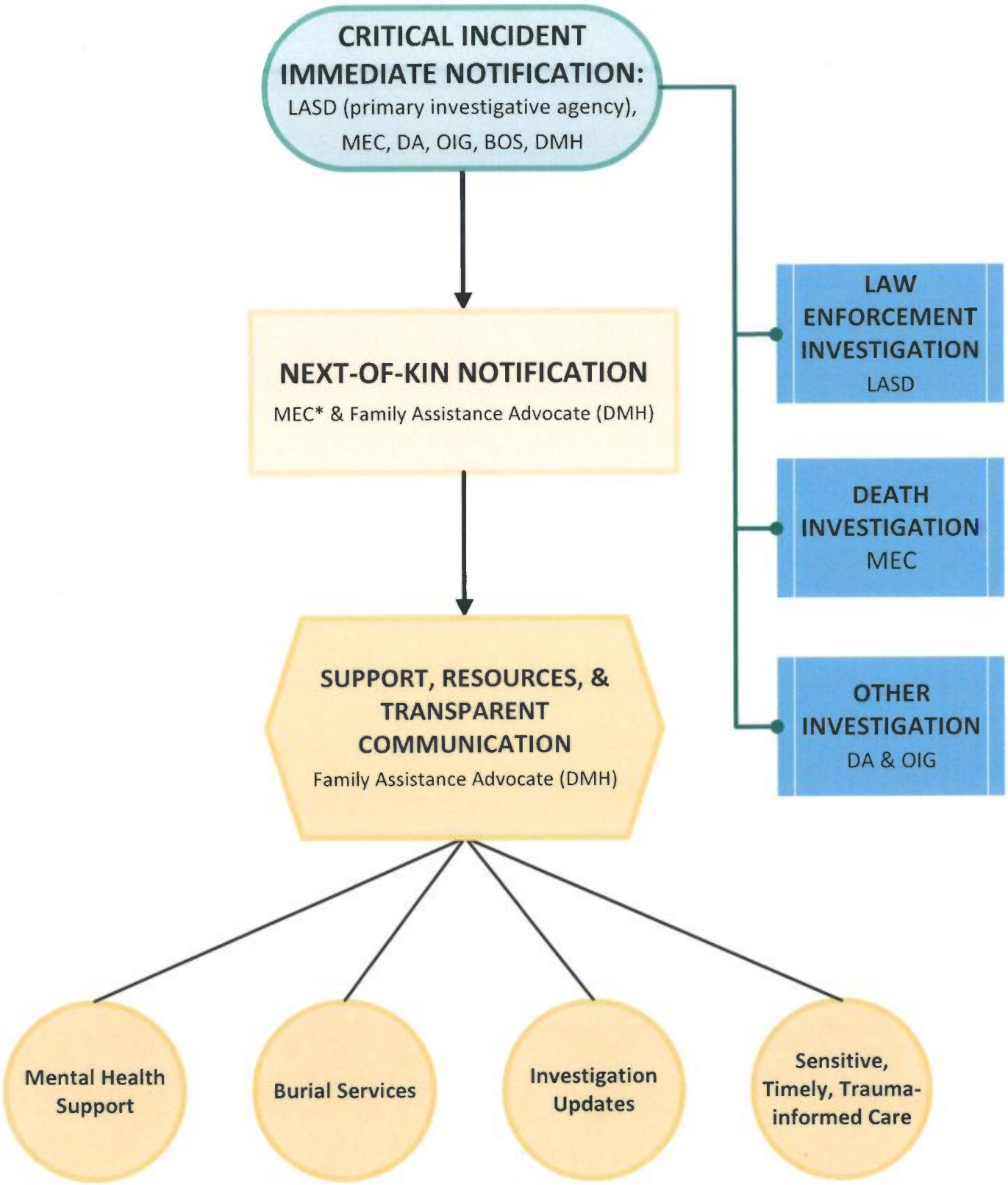
Disciplinary Action – Action taken to ensure adherence to acceptable and reasonable standards of performance and conduct – may include written warning, written reprimand, suspension, reduction/demotion, and discharge, applied in a progressive or non-progressive manner.

Revision/Review Dates: 8/14/17
Department Head/Designee Approval:

APPENDIX E: THE MICHIGAN MODEL

https://www.uofmhealth.org/michigan-model-medical-malpractice-and-patient-safety-umhs#summary

Family Assistance Program (FAP) Proposed Process



*Medical Examiner-Coroner (MEC) may delegate next-of-kin notification to LASD if deemed the most effective and efficient method of notification.

SHERIFF CIVILIAN OVERSIGHT COMMISSION (COC) AD HOC COMMITTEE RECOMMENDATIONS & WORKGROUP PROPOSALS

1. COC RECOMMENDATION

The County should establish a multi-disciplinary entity that can provide ongoing support, resources, and transparent communication to families of the deceased.

WORKGROUP RESPONSE/PROPOSAL

A. CURRENT PROCESS: Following a fatal use of force by a Sheriff's employee, or in-custody death, the Sheriff's Homicide Bureau, as the primary investigative agency, provides notification to the Offices of the Medical Examiner-Coroner (ME-Coroner), District Attorney (DA) and the Inspector General (OIG), and Board of Supervisors. Sheriff's lead investigators provide explanations to the families as to each respective agency's presence and their simultaneous involvement. The Sheriff's lead investigator also explains the investigative process to the families. The lead investigator and handling lieutenant are generally the points of contact for the family as it relates to the investigation and their contact information is provided to the families in a follow-up letter. The timeframe for this communication varies by incident.

The ME-Coroner's Operations Bureau Investigations Division is responsible for providing field investigator response to at-scene death investigations throughout the County. ME-Coroner investigators take the initial and preliminary information regarding these types of death as reportable under State law and are investigated by the ME-Coroner. The medicolegal death investigation is performed by sworn staff who interview witnesses, take photographs, and collect evidence for use in criminal and civil matters, identify deceased persons, and notify the legal next-of-kin.

In fatal use of force or in-custody death incidents, the Sheriff and ME-Coroner confer regarding notification of next-of-kin and ME-Coroner may agree to delegate this responsibility to the Sheriff.

B. PROPOSED PROCESS: Enhance current fatal use of force incident or in-custody death response/process by creating a program to assist impacted families. The proposed program will include a multi-disciplinary team, called the Family Assistance Program (FAP) tasked with providing ongoing support, resources, and transparent communication to families of the deceased. The goal of the FAP would be to foster better communication and provide assistance to families.

Sheriff, ME-Coroner, Register-Recorder, DA and DMH will assign experienced staff as FAP designees. The FAP designees from each department will be well versed in their respective areas of expertise to address the needs of families. The

FAP designees will be the departmental liaisons to a proposed DMH Family Assistance Advocate (FAA). The objectives of the proposed DMH FAA would be as follows:

- To provide Sheriff's and ME-Coroner's lead investigators the ability to quickly access a team of trained professionals from DMH to immediately respond to the scene of a fatal use of force incident.
- To be available during the notification of next-of-kin (similar to the process followed by the Mental Health Evaluation Teams).
- To provide support and make available mental health services and appropriate resources to those families impacted by the traumatic event (fatal use of force or in-custody death) to assist with the families' ability to cope, heal, and recover.
- To be the primary County contact for each impacted family, tasked with maintaining communication with the family from the moment they are notified of their loved one's death.

As the primary contact, DMH's FAA will help the families navigate the County's process and identify resources that may be available to them. The DMH FAA will also provide crisis intervention and stabilization, grief counseling, and general support to families. In addition, the DMH FAA will assist families in communicating and linking with Sheriff, ME-Coroner and Registrar-Recorder regarding matters specific to the departments involvement and expertise. While the DMH FAA will not be able to provide families information regarding the investigation, they may provide details on the status of the investigation and, as necessary, provide direct linkage to the FAP designees in other departments that will be better able to assist the family with specific needs (ex. obtaining a death certificate from Register-Recorder or investigation details/information from the Sheriff).

In addition, DMH, in consultation with the Sheriff and ME-Coroner, propose to enhance the existing notification process by including the DMH FAA in the list of agencies receiving notification of the critical incident. Similar to the Board of Supervisors' notification, the DMH FAA would be contacted regarding the following critical incidents:

- If family members of the decedent are present on a fatal use of force incident;
- Upon notification of the next-of-kin on a fatal use of force incident; and
- Upon notification of the next-of-kin on an in-custody death event.

A flowchart is attached that illustrates the proposed enhanced process (Attachment B).

C. **FISCAL IMPACT:** DMH estimates it would require the following resources for a FAA Unit: 1.0 Clinical Psychologist II, 1.0 Psychiatric Social Worker II, overtime for work of 4.0 Clinicians, and associated services and supplies costs (ongoing and start-up), and one vehicle. The breakdown of the cost estimates are as follows:

Family Assistance Program - DMH Estimated Annual Operating Cost			
	One-time	Ongoing	Total
Salary & EBs (2.0 FTE)	-	$275,000	$275,000
Overtime	-	122,000	122,000
Services & Supplies	5,000	5,000	10,000
Capital Assets	30,000	-	30,000
Total	$35,000	$402,000	$437,000

The DMH FAA will work collaboratively to provide the following:

- 24/7 response to a critical incident;
- 24/7 availability to pair with Sheriff or ME-Coroner investigator(s) during notification of the next-of-kin;
- Compassionate crisis intervention, grief counseling and support services to linkages to appropriate services for families; and
- Traumatic grief informed in-service training to Sheriff and ME-Coroner.

The Sheriff and ME-Coroner indicate no additional funding/resource needs are anticipated at this time.

Next steps would include the following:

- DMH, in consultation with the Sheriff and ME-Coroner, establish policies and procedures to memorialize the proposed FAP model with enhanced notification processes, program pamphlet and web page.
- DMH, in consultation with the Sheriff and ME-Coroner, develop outcome-based objectives that includes: identifying key metrics and describing how each will be used to monitor progress and success; describing quality assurance to ensure program reliability; and describing how workload and costs will be captured. This includes establishing benchmark timeframes for key communication points in notifying, interacting and responding to families.
- Departments to identify a FAP contact person to act as liaison to the DMH FAA.

2. COC RECOMMENDATION

Continuous trauma informed training for all Sheriff personnel who come into contact with family members.

WORKGROUP RESPONSE/PROPOSAL

A. CURRENT PROCESS: The Sheriff provides training on death notifications in both the academy and patrol field training. The academy specifically has a scenario-based death investigation and deputies are graded on the death notification process as it relates to conveying empathy and emotional support to families.

The ME-Coroner provides training on death notifications throughout the Coroner Investigator Trainee (CIT) one-year training program. As part of that program, a CIT spends two weeks in the ME-Coroner Notifications Section. This Section is responsible for conducting due diligent attempts to identify, locate, and notify legal next-of-kin who were unknown at the time of the ME-Coroner's initial investigation into the death. While assigned to the Notifications Section, a CIT learns how to interact with next-of-kin when conducting death notifications and during any subsequent telephonic or in-person interaction with them. For the remainder of the training program, the CIT applies the death notification training "on-the-job", and in real time during actual in-person and telephonic death notifications in the presence of a Field Training Officer.

The California State Coroner's Academy, hosted by the Orange County Sheriff - Coroner's Department, used to present a 24-hour Death Notification training course. It has been several years since that course has been presented and it is not scheduled for the foreseeable future.

B. PROPOSED PROCESS: The Sheriff and ME-Coroner will work with the DMH FAA to develop a curriculum and policy for the design and implementation of traumatic grief informed training.

The Sheriff and ME-Coroner will review current Training Bureau curriculums and, where appropriate, identify opportunities for the insertion of traumatic grief informed principles. In addition, recurrent training every two years will be accomplished with no real associated costs if the principles are integrated into current curriculum. The DMH FAA will provide traumatic grief informed in-service training for personnel going forward.

The Sheriff's and ME-Coroner's Training Bureaus, in collaboration with the DMH FAA team, will identify and implement, a number of traumatic grief informed training options to meet the desired outcome of ensuring their personnel are using effective communication skills, conveying empathy and respect. Once the training parameters are identified, there are several options available to engage personnel:

- **Information** (*Tip of the Week* video);
- **Job Aid** (Newsletter);
- **Training** (Reality based scenarios, Unit level interactive briefings, etc.); and
- **Education** (Learning Management System course, Strategic Communication course, Principled Policing course, etc.)

Next steps would include the following:

- DMH FAA, in collaboration with Sheriff and ME-Coroner, develop curriculum that will provide traumatic grief informed in-service training for Sheriff and ME-Coroner personnel.
- Insert traumatic grief informed principles in Sheriff's and ME-Coroner's current curriculum and provide recurrent training every two years.
- DMH FAA, in collaboration with the Sheriff and ME-Coroner, establish a delivery service order for any requested in-service training for its staff.

C. **FISCAL IMPACT:** There are no additional funding/resource needs anticipated at this time.

3. COC RECOMMENDATION

Department members who speak with the media should be mindful of how they characterize the subject of the investigation. This includes maintaining fairness and withholding judgment.

WORKGROUP RESPONSE/PROPOSAL

The Sheriff indicates homicide lieutenants have been instructed to refrain from commenting on gang affiliation. Additionally, the Sheriff noted that they continuously strive to maintain fairness and impartiality in all investigations with the following practices, which are part of their current process:

- Homicide Bureau is a collector of facts and does not determine guilt or innocence.
- In response to public and media requests, Homicide Bureau attempts to provide a public statement or press release in all cases they investigate.
- The Homicide Bureau attempts to provide as much "fact-based" information as possible, without compromising the investigation.
- In all releases of information, Homicide Bureau provides the most accurate information as possible, without discrediting anyone involved.
- Information should always be based on facts known at the time.

Next steps would include the following:

- Sheriff, in collaboration with DMH, will develop training and regular awareness briefings with the goal of increasing:
  - Mindfulness of the families involved and projecting fairness when responding to the press and media.
  - Releasing accurate and pertinent information when available in a timely manner.
- Sheriff will continue to include the review of policies and protocols related to interactions with media regarding critical incidents as part of their current review practices and make updates accordingly to ensure consistency with the practices highlighted above.

FISCAL IMPACT: There are no additional funding/resource needs anticipated at this time.

4. COC RECOMMENDATION

Los Angeles County should take a lead role that advocates for changes in the current State laws regarding access to victim resources.

WORKGROUP RESPONSE/PROPOSAL

Advocacy options for CEO, Legislative Affairs and the Sacramento Advocates are as follows:

- Include a policy in the County's State Legislative Agenda to allow the County to support legislation that would expand eligibility of State-funded victim resources to family members/survivors of fatal use of force by law enforcement; and

- In collaboration with County stakeholders, actively work with statewide stakeholders to identify and advocate for such legislation in the 2019-20 State Legislative Session.

5. COC RECOMMENDATION

Los Angeles County should establish a program that will assist families who experience a Sheriff-related death of a loved one with the cost of funeral and other associated expenses including, but not limited to, trauma and grief counseling for family members.

WORKGROUP RESPONSE/PROPOSAL

A. PROPOSED PROCESS

Funeral and/or Burial Benefits

The workgroup reviewed the eligibility criteria, process and services provided by the DA's Bureau of Victim Services (BVS) Program to form the framework for a proposal to assist families with burial costs as part of the FAP program. The workgroup recommends that the County begin by establishing a program to assist families with paying burial costs following in-custody deaths as in-custody deaths are typically related to medical or other issues that arise while decedents are in County custody. The Auditor-Controller should establish a spending account that appropriately manages and tracks the expenditures. In addition, it is recommended that assistance with funeral and burial services would be via direct payment to the vendor, up to $7,500 per event, which is consistent with the offering by the DA's BVS Program.

The County should also consider expanding efforts currently underway by the Los Angeles County Department of Health Services (DHS) to implement a "communication-and-resolution program" (CRP) following in-custody deaths. Such programs aim for improved and transparent communication with surviving family members, proactive identification and resolution of problems, and reforms aimed at correcting deficiencies.

Next steps would include the following:

- DMH, in consultation with County Counsel and Auditor-Controller, establish policies and procedures for the burial assistance program to assist families with paying burial costs following in-custody deaths.
- DMH FAA, in collaboration with County Counsel, will consult with the COC and OIG to explore expanding the burial assistance program to include all Sheriff-related deaths, including deaths that occur, as a result of a use of force by Sheriff's deputies; including, the feasibility of establishing a role for the COC to assist in determining eligibility for this program.
- DMH FAA, in consultation with CEO, explore public-private and philanthropic partnerships that may assist families who experience a Sheriff-related death of a loved one with the cost of funeral and other associated expenses that may be above the $7,500 available amount or represent costs the County cannot cover.
- DMH FAA, confer with DHS to explore the creation of a pilot CRP in Correctional Health Services following in-custody deaths. DMH FAA should work with Correctional Health Services and the OIG to coordinate efforts in an efficient and holistic manner.

B. **FISCAL IMPACT:** Funding for funeral and/or burial benefits of in-custody and community deaths on an annual basis is estimated to be from $180,000 to $300,000. The estimated annual cost is based on an average of approximately 24 to 40 incidents per year at a maximum limit of $7,500 for funeral and/or burial financial assistance. The recommended maximum limit of $7,500 is consistent with the amount offered under the DA's BVS Program.

Trauma and Grief Counseling Services
Please refer to COC Recommendation #1 for the workgroup's response/proposal for trauma and grief counseling services for family members.

6. COC RECOMMENDATION

Develop a pamphlet specifically for the family members of deputy involved shootings and in-custody deaths.

WORKGROUP RESPONSE/PROPOSAL

The Sheriff, ME-Coroner and DMH will work together to develop a pamphlet devoted specifically to the services available through FAP. There are no costs anticipated at this time related to this request.

7. COC RECOMMENDATION

Create a website and/or social media page that thoroughly explains Sheriff procedures and protocol surrounding in-custody deaths and fatal deputy related uses of force.

The Committee's recommendation further indicates that the website should be a comprehensive collection of available County resources and should thoroughly itemize each department's role during the investigation surrounding the fatal event. Every department should have a link to the site on their website.

WORKGROUP RESPONSE/PROPOSAL

A. **PROPOSED PROCESS:** Create a website requiring the following activities for web portal development:

- DMH, in collaboration with Chief Information Office (CIO), will engage the Internal Services Department (ISD) for web portal development services.
- ISD may leverage an internal staff or onboard contractor based on the expertise availability at the time of engagement.
- DMH, in collaboration with CIO, work with other departments to gather requirements, policies and procedures. The requirement will also include updating each respective departments' website to include a link to this portal.
- The portal is not expected to have any business logic or workflow mechanism but will consist of static web pages describing policies and procedures.

- The office of the CIO will be available for governance meetings of the project to ensure project progress, quality, and that county standards are met.
- DMH will be responsible for the on-going management of the website.

Because the Ad Hoc Committee's recommendation indicates that the website should be a comprehensive collection of available resources and should itemize each department's role during the investigation surrounding the fatal event, the workgroup recommends that the FAP's website reside in the Los Angeles County's home page, under the Government/County Services link.

B. FISCAL IMPACT: The estimated one-time cost for the development and linkage of the website to every department's website is $50,000. There is also a nominal ongoing cost estimated at $19,000 for ISD to support the website.