CITIZENS' COMMISSION ON JAIL VIOLENCE

EXHIBITS
August 3, 2012 MEETING

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Custody Division Working Group Report

July 2012

Prepared by the
Association for Los Angeles Deputy Sheriffs,
MEBA, AFL-CIO

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Introduction

Background

The Los Angeles County Sheriff's Department (LASD) operates the most vast and complex county jail system in the nation, comprised of eight separate facilities, and housing over 18,000 inmates on any given day. Deputy Sheriff personnel are tasked with the security and safety for those incarcerated, along with protecting themselves and the many civilian staff assigned to those facilities.

Recently, the media and outside interest groups have brought to light some perceived problems within the Custody Division of the LASD. In an effort to address the criticism of custody operations, the Sheriff's Department has begun to implement structural changes to the policy, tactics, and equipment used within the custody environment.

The Association for Los Angeles Deputy Sheriffs (ALADS) believes that to create meaningful change to the working environment within the Custody Division, input from the personnel working in those facilities is necessary. Many of the changes recommended to custody have been presented by persons who have not worked in custody for many years or who have never worked in a correctional environment. Omitting the valuable insight and expertise of custody personal hampers organizational success. To implement change without having looked at the situation in its entirety would be a counterproductive exercise.

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Custody Division Working Group

In December 2011, ALADS made a request to LASD Sheriff Leroy Baca to form a Working Group of deputy personnel assigned to the Custody Division. The purpose of this Working Group is to develop deputy-driven solutions to the perceived problems within custody. It is ALADS' belief that the persons who work in the facilities are the best source to recommend potential changes in policy and procedures. This request was approved by Sheriff Baca.

ALADS selected 19 personnel to participate in the Custody Division Working Group (Working Group). The Working Group included a diverse cross-section of deputy sheriffs. Men and women ranging from novice deputies within their first three years of service to deputies on the eve of retirement were united as members of the Working Group. They represented the perspective of sworn line personnel at the following facilities:

- Men's Central Jail
- Inmate Reception Center
- Twin Tower Correctional Facility
- Century Regional Detention Facility
- North County Correctional Facility
- Pitchess Detention Center South
- Pitchess Detention Center East

From January through April 2012, personnel assigned to the Working Group convened to review and find solutions for:

- Staffing
- Supervision
- Equipment
- Operating Procedures
- Facility Functionality
- Deputy Training
- Length of Assignment in Custody
- Inmate Accountability and Behavior

A representative of the Working Group also met with health and mental health workers represented by the American Federation of State, County and Municipal Employees (AFSCME) and Service Employees International Union (SEIU) to hear their perspective on the custody working environment.

When reading this report, it is important to note that the opinions represented are those of the experience of the individual deputy sheriffs who participated in the Custody Division Working Group and backed up by the survey of line personnel working in custody.

ALADS believes that this Working Group, comprised of sworn line staff required to handle the day-to-day challenges within the nation's largest county jail system, can deliver real solutions to the issues within the LASD Custody Division.

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Sincerely,

[insert signature]

Floyd Hayhurst
ALADS President

Custody Division Working Group Findings and Recommendations

1. Staffing

The Los Angeles County Sheriff's Department, like countless other agencies across the United States and around the world, has suffered dramatic budget cuts over the last several years**. Filled positions within the LASD Custody Division are down by 29%, or 533 filled positions** (Fiscal Year 2011-12 vs. 2007-08; Source: LASD, June 2011). Further, the overtime that has historically been cost-effectively used to fill existing vacancies has been drastically reduced, workload has increased, and the inmate population has changed dramatically.

Filled positions within the LASD Custody Division are down by 29%, or 533 filled positions. A study of staffing levels in Custody Division was completed by the firm of Crout & Sida Criminal Justice Consultants. While this report has never been made public, ALADS was led to believe that the findings indicated that severe understaffing was present throughout custody.

- Procedural changes and increased scrutiny of force incidents has led to a dramatic increase in the amount of time required to interview witnesses and related paperwork. By way of example, when a force incident occurs in a housing location where 100 inmates are possible witnesses to an incident, deputy and supervisory personnel are required to interview every inmate.
- The demand for programs designed to reduce recidivism, Title 15 mandates, and Town Hall meetings have added additional responsibilities to custody deputies' workday.

Agency	Custody Staffing Ratio
LASD	1:6.5
Cook County	1:2.5
New York	1:5

Note: These ratios reflect the total staffing level for LASD Custody Division. Facility staffing numbers per shift reflect a significantly lower number of sworn staff on duty at any given time.

Source: LASD, June 2012

- The majority of inmates in the jails are incarcerated for more violent crimes. This is due to the early release of misdemeanor and non-violent felons, leaving the jails filled with more potentially violent and higher risk inmates serving longer sentences.

This chronic understaffing relative to workload has a dramatic affect on operations and morale. Most notable, when confronted with a recalcitrant inmate, deputies working alone may be required to use a higher level of force. Simply

put, deputies working alone may be in situations where inmates are likely to be more aggressive, potentially necessitating an increase in force by sworn personnel.

Despite the comparatively low staffing in LASD facilities, the number of force incidents per inmates in LA County is significantly lower on a per inmate basis than at comparable urban custody facilities:

Agency	Avg. # of Inmates	# of Force Incidents	Ratio
LASD	15,013	585	1:26
Cook County	8,779	800	1:11
New York	12,421	1,973	1:6

Source: LASD, June 2012

In a survey conducted in March 2012 of deputy sheriffs assigned to custody, the following concerns were noted:

How often do you find yourself in an unsafe working condition because of short staffing?	**Response**
Daily	67.8%
Weekly	19.3%
Monthly	6.7%
Never	6.7%

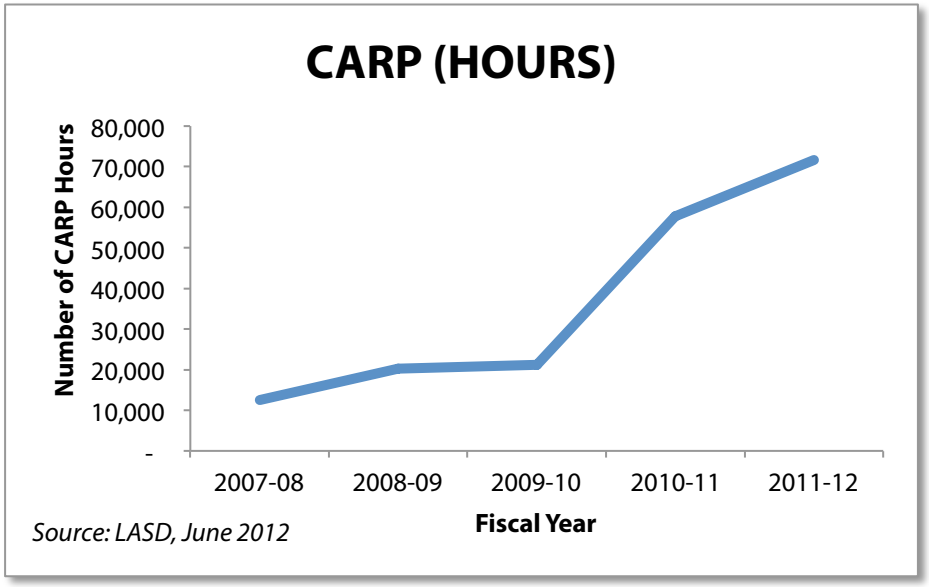
Recently, new inmate programs and meetings have been scheduled. How do these impact your ability to do your job?	**Response**
The requirement to move inmates to these programs reduces the number of deputies available for supervision.	59.7%
With all of the programs, I am not able to get the required work done during my shift.	32.8%
It does not impact my work.	27.4%

When deputies are required to take inmates on radio car runs,* how does that impact your unit?	**Response**
It does not affect my unit.	16.5%
We don't have enough deputies to supervise inmates while the deputy is gone	56.7%
There aren't enough deputies to fulfill the required responsibilities.	58.5%

** Note: The term "radio car runs" refers to transporting of inmates to other facilities.*

Have you been ordered to "volunteer" to teach or monitor an inmate program (e.g., Town Hall meetings, EBI, etc.)?	Response
Yes	15.4%
No	76.3%
Not applicable	8.9%

With budget cuts that have nearly eliminated overtime coupled with chronic understaffing, staff has been assigned as "Cadre of Administrative Reserve Personnel" (CARP) to work in the jails. These CARPs backfill for duties that otherwise would have been performed by additional deputies or with overtime.



An overwhelming majority of custody deputies report that the CARP drastically limits facility operations and limits productivity. The result is that though the CARP is a "body" to backfill the lack of personnel, deputies feel strongly that the CARP serves a limited function as a practical matter. This has left the deputies feeling as if they are constantly "working short" in an unsafe situation.

When your unit is staffed with a CARP'ed employee, how does that impact your work?	Response
It does not affect my unit	18.0%
The CARP is helpful	10.9%
The CARP is not beneficial to unit productivity	58.9%
I have to train the CARP	55.7%

The additional workload, the understaffing, the backfilling with CARPs, and other related issues have had a tremendous impact on morale in the Custody Division.

Has low morale in your unit affected?	Response
Officer safety	70.1%
Reduced productivity	87.4%
Use of force	39.0%
Increased absenteeism due to stress	57.5%

Although the ALADS Board of Directors and the Custody Division Working Group certainly understand and are empathetic to the fiscal constraints faced by the County of Los Angeles, clearly the use of CARPs continues to have a negative impact on custody operations.

Recommended Solutions

1. Increase sworn staff in the LASD Custody Division to industry-standard levels and maintain minimum staffing levels at all times.
    - Institute minimum staffing ratios in all facilities that are appropriate for the inmate classification in a particular unit.
    - Conduct a forensic audit of the LASD budget to determine if any additional funds can be used to increase staffing to industry-standard levels.
    - Conduct an exhaustive analysis to assure full cost recovery from contracts and AB 109 inmates.
    - Develop two 5-year plans to increase staffing to industry standard levels:
        (a) Based on available economic forecast data; and
        (b) Based on available economic forecast data and potential new revenues.
    - Explore the potential of a new revenue source dedicated to fund countywide public safety services provided by the LASD.

2. If the CARP program is going to continue, a CARP should be on a loaned program for three (3) months so that he or she can be a productive staff member in custody.
3. Increase the number of "prowlers" (line deputies who are assigned to rove a custody facility) to help during inmate disturbances, with movement and radio car runs, and with paperwork.
4. Create set times for programs and assign additional deputies to monitor the inmates during program, visiting, and yard time.
5. In overcrowded housing units, increase the number of deputies to assure deputy and inmate safety.
6. Explore the use of video conference technology to minimize the dangerous and time-consuming movement of inmates.
7. In order to reduce the movement of inmates, behavioral observation reclassifications should be implemented at the inmate facility where an inmate is housed, rather than sending the inmate back to Inmate Reception Center (IRC). This will allow direct admits and reduce staff time for transportation and processing.
8. Reform the Education Based Incarceration (EBI) program as follows:
    - Fully staff Education Based Incarceration (EBI) programming and coordinate with daily job tasks.
    - Create a tracking program to determine the cost effectiveness of EBI programs on reducing recidivism and provide quarterly reports to the ALADS Custody Division Working Group.
    - No EBI programs should be created without additional funded sworn staff to handle all aspects of program implementation (movement, training, etc.).
    - When custody deputy resources are needed to implement EBI programs, coordinate the schedule to assure that programs do not conflict with daily job tasks (e.g., yard duty, pill call, etc.).
9. Universally apply the LASD policy on fraternization and physical contact with inmates, assuring that it is being consistently applied throughout all ranks. Any exceptions to the policy must be approved in advance.
10. See additional staffing recommendations in the Health and Mental Health section.

2. Sworn Personnel Morale

Assignment to the Custody Division of the LASD has historically been a "less than desirable assignment." Many deputies and supervisors view the time that they spend in Custody as nonproductive and a negative for promotional purposes.

LASD management and several outside influences have suggested the creation of a Custodial Deputy position with promotional opportunities within the custody division. There has also been a proposal to civilianize the jails. Many issues are associated with these proposals and this report is not the proper means to address those issues.

Many deputies and supervisors view the time that they spend in Custody as nonproductive and a negative for promotional purposes.

The LASD should, however, look at much simpler means to create a desirable work environment for personnel assigned to the custody division.

Recommended Solutions

1. Create a promotional opportunity that still requires the current mandates but affords personnel that want to remain in Custody the ability to promote and remain.
2. Explore more condensed work schedules for deputies and supervisors.
3. Create a compensated Custody Training Officer program.
4. Implement a training program that meets the needs of personnel assigned to custody.
5. Explore transportation options for personnel that work the Custody Division.
6. Implement educational incentives for personnel assigned to custody.

3. Inmate Accountability and Behavior

Deputy Sheriffs assigned to custody with varying lengths of service – from those recently out of Academy to those nearing retirement – report a significant change in inmate behavior in recent years. It is deputies' general belief that some of this change in behavior, including but by no means limited to increasingly aggressive behavior toward deputies, is based on cultural changes outside the control of the LASD (e.g., the transfer of state prisoners to county jails pursuant to AB 109). However, deputies believe that new policies and procedures implemented in response to allegations of abuse have had unintentional consequences on inmate behavior and deputies' ability to control inmates without incident.

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As noted by one deputy sheriff in the Custody Division Survey:

> "There are no true repercussions for insubordinate inmate behavior. Inmates are not disciplined because there is insufficient discipline housing for inmates that are insubordinate and disrespectful to staff. This empowers inmates to feel they do not have to obey rules or orders from staff."

This lack of respect has led inmates to be significantly more hostile toward deputies and resistant toward their directives. Simply put, deputies feel that they have largely "lost control" of the jails, with a sense that "the inmates are running the jails." This problem has been exacerbated by the lack of sanctions available to deputy sheriffs to control the inmate population. "**Just send me to the hole**," is a common response from a recalcitrant inmate, an action with little consequence for many inmates who prefer time spent in the hole as a "break" from General Population.

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Under public safety realignment (AB 109), "non-non-non" state prisoners are now being housed in LA County jails. Have you noticed any change in inmate behavior since the implementation of AB 109?	**Response**
I have not noticed any change	39.2%
I have noticed more aggressive inmate behavior	50.0%
Inmates have been more hostile toward deputies	33.8%

Recently, Command staff has been holding town hall meetings with inmates. Have you noticed a change in inmate behavior toward deputies since these town hall meetings began?	Response
I have not noticed any change	20.8%
I have noticed more aggressive inmate behavior	51.2%
Inmates' respect for deputies has declined because they feel "empowered"	70.9%
Inmates have been more hostile toward deputies	49.0%

In your facility, are inmates permitted to bypass a deputy sheriff and take their complaints to a supervisor?	Response
Maybe	11.8%
Yes	81.7%
No	6.5%

How often do you see inmates picking fights, creating a disturbance, or other behavior to control their housing location?	Response
Daily	50%
Weekly	28%
Monthly	11%
Never	11%

Recommended Solutions

1. All reasonable orders given by deputy sheriffs working in LASD custody to inmates must be supported so that inmates show respect for and comply with the directives of deputies.

    - If an inmate takes a concern to a Sergeant or higher, he or she should be instructed to follow the appropriate chain of command by taking that concern first to a deputy sheriff.
    - When a deputy sheriff makes a decision regarding an inmate, the LASD should have a policy that encourages the supervisor to support the deputy decision, especially in the presence of inmates. Wherever possible – as in patrol operations – that decision should be final.

2. For inmates that are remanded to the custody of the LASD, the LASD should create consequences for hostile and recalcitrant inmate behavior, including but not limited to the filing of false reports against deputies. Specifically, recalcitrant inmates should lose good time/work time credits for time served, and a dedicated hearing system should be created to swiftly take away credits from an inmate for negative behavior.
3. The LASD should work with the courts to assure that inmates are sentenced for the time prescribed by the Penal Code, without regard to good time/work time credits. A sentenced inmate should not be given good time/work time credit by the courts.
4. The LASD should increase available discipline housing if necessary.

Recalcitrant inmates should lose good time/work time credits for time served, and a dedicated hearing system should be created to swiftly take away credits from an inmate for negative behavior.

4. Health and Mental Health

The Los Angeles County Sheriff's Department inmate population has a high level of mentally ill inmates, both in the mental health units as well as in general population. Deputy sheriffs are not mental health professionals trained to manage mentally ill inmates. Further, deputies' working relationship with mental health staff is weak in some facilities and deputies have limited to no information on the mental health status of mentally ill inmates declassified to general population.

Deputy sheriffs are not mental health professionals trained to manage mentally ill inmates.

Deputy Sheriffs participating in the Custody Division Working Group as well as those surveyed feel strongly that changes need to be made to ensure they are better able to manage an incident, avoid use of force, and remain safe in the workplace.

How frequently do you see inmates with serious mental issues declassified and put into general population?	**Response**
Daily	29.1%
Weekly	25.7%
Monthly	23.9%
Never	21.3%

How frequently do you experience inmates with serious mental health issues moving unsupervised through a custody facility?	**Response**
Daily	26.9%
Weekly	21.4%
Monthly	18.3%
Never	33.4%

In your experience, do you feel that having inmates with serious mental health issues in general population is a personal safety concern for you or inmates?	**Response**
Maybe	5.3%
Yes	93.8%
No	0.9%

In light of the large number of mentally ill inmates in general population, mandatory job rotations are of particular concern to deputy sheriffs and to mental health workers represented by both AFSCME and SEIU. Civilian workers represented by both AFSCME and SEIU stated strongly that **day-to-day consistency of sworn staffing is very important.**

Do mandatory job rotations interfere with your inmate-deputy working relationships?	**Response**
Don't affect my inmate-deputy working relationships	16.6%
I won't be able to develop the rapport with inmates that allow me to keep incidents down, be aware of contraband coming into the facility/develop intel, etc.	60.9%
Does not apply	22.9%

Recommended Solutions

Overhaul the policies and procedures related to medical and mental health care:

1. To provide a better quality of medical and mental health care and improve operational efficiencies within the LASD, create a fully function medical services division that includes mental health and transportation within the LASD (similar to the concept used in patrol of the Mental Evaluation Team (MET)).
2. The LASD should implement the recommendations of the Corrections Standards Authority (CSA) (as of July 1, 2012, the CSA is known as the Board of State and Community Corrections (BSCC), specifically by exploring the creation of a Memorandum of Understanding (MOU) with the Department of Mental Health and the Department of Health Services. This will ensure that when DMH and DHS staff work inside the jails, they are united under the command structure of the LASD.
3. The County of Los Angeles should designate the LCMC jail ward as its own entity managed by the LASD. This will assure that medical staff and LASD staff work in concert to minimize impact on custody operations.
4. The LASD should increase sworn staffing at LCMC to allow custody deputies to drop off the inmate, rather than wait an average of 2-6 hours to return the deputy to their facility. This could free up 10-15 deputies per shift, per day.
5. The LASD should create a medical services facility at North County Correctional Facility (NCCF) to minimize costly and operationally disruptive medical runs to downtown Los Angeles. This will improve operational efficiency.

6. Create a unit within transportation to move inmates with medical or mental health issues.
7. Staff Pitches Detention facilities with psychological technicians and other staff to facilitate direct admissions.
8. Custody facilities should have more of a "team" environment between sworn and civilian mental health workers. Mental health staff should work in cooperation with sworn staff to manage the mentally ill inmate population throughout the facilities.
9. The curriculum for Jail Operations, Custody Operations, and Custody Command Schools should reflect the change in the inmate population. The curricula should include training from County mental health workers on how to manage mentally ill inmates and how to identify when an inmate is slipping into psychosis.
10. Add in-service trainings for deputies and supervisors centered on officer safety, management of mentally ill inmates, and other issues that relate to force.
11. Additional beds should be added to avoid declassifying mentally ill inmates into general population, and to segregate younger and older inmates to avoid inmate-on-inmate violence, bullying, and "shot calling." *(Note: A "shot caller" is "an individual who runs the prison, even respected by the guards...someone who calls the shots." Source: www.urbandictionary.com)*
12. Increase the number of mental health professionals at all facilities and assure that they are available 24x7 to do immediate evaluations, necessary paperwork, and direct admissions for inmates with mental health needs. This will help ensure proper use of the deputies' time.
13. Limit or eliminate mandatory job rotations.
14. Increase the number of "overlap deputies" and carefully select them so that they are properly suited for the position. Overlap Deputies should routinely attend morning meetings with mental health staff. (Note: Overlap Deputies are deputy sheriffs who work in tandem with, and the same hours as, mental health professionals (i.e., their hours overlap).)
15. Assign Overlap Deputies and deputies assigned to JMET teams to participate as instructors on how to deal with mentally ill inmates.

16. When an inmate is declassified into general population, he or she should continue to wear a blue wristband – or have some other identifying sign – so that deputies are aware of the inmate's mental health needs. (Once an inmate is declassified to general population, deputies have no way of knowing prior history of that inmate.)
17. Pill call (the distribution of medicine) can be a dangerous time for deputies. Cell doors should be modified where necessary so that all pill calls can be done through the doors.

> Deputies report that, all too often, mentally ill inmates are transferred into general population to make room for newly arrived ones.

18. For clinic visits, inmates should go to the clinic on a staggered basis, floor by floor. This will reduce the number of inmates being moved concurrently. Current policy requires that movement occur when notice is sent to housing location. All notices are sent at the same time.

5. Policies and Procedures

Deputy Sheriffs report significant inconsistencies in the application of policies and procedures, not only from one facility to another, but also from one shift to the next. Not only does there appear to be a lack of clarity and consistency from the top down; but application of policies at the line level appears to be highly dependent upon a supervisor's interpretation of a policy, procedure, or unit order.

Additionally, deputies report that many of these policies and procedures that come down from command staff are often vague, open to interpretation, and are counterproductive to the day-to-day operational mandates of the Custody Division. One deputy summarized the sentiment of survey respondents:

Many of these policies and procedures that come down from command staff are often vague, open to interpretation, and are counterproductive to the day-to-day operational mandates of the Custody Division.

> "[Sheriff management] is so removed from the custody environment that they make changes to the way we run things that don't make sense. Sometimes I feel as if we are moving backwards, and some changes are so extreme that it is nearly impossible to run our program efficiently."

Another wrote:

> "With the implementation of new policies, it has been extremely difficult to accomplish all tasks and requirements demanded of us during our shift. Morale is at an all-time low."

Before a new policy or new program is implemented in your unit, does your supervisor discuss how it will impact your work?	Response
Yes, my supervisor checks with deputies to see how the new policy or program affects:	
(a) My ability to get my job done each day	38.6%
(b) The safety of staff	27.4%
(c) The safety of inmates	21.6%
No, my supervisors does not discuss with me	47.9%

Furthermore, custody deputies do not have a clear understanding of new policies, procedures, or unit orders. There is inconsistent positive mentoring and constructive debriefing from supervisors. Briefings are rare. When they do occur, supervisors rarely use briefings as an opportunity to critique the use of force incidents that have occurred, or to learn from, and prevent future incidents.

How often do you have briefings in your unit?	**Response**
Daily	7.6%
Weekly	51.3%
Monthly	35.8%
Never	5.6%

Custody deputies report that the quantity and quality of training on custody operations and how best to handle recalcitrant inmates is weak. Further, there is little incentive for a deputy to train and/or mentor new deputies.

In your briefings, are you trained on current policy changes and/or unit orders?	**Response**
Never	5.8%
Sometimes	53.1%
All the time	41.3%

In your briefings, how often are you trained and/or mentored on proper force procedures?	**Response**
Never	10.9%
Sometimes	70.2%
All the time	18.9%

Would debriefing and critiquing incidents with your unit help reduce future uses of force?	**Response**
Never	8.0%
Sometimes	71.6%
All the time	20.4%

Recommended Solutions

1. Within their probationary period, all supervisors and managers assigned to custody should attend a Custody Operations School (for Sergeants) or a Custody Command School (for Lieutenants and Captains) with an emphasis on the policies, procedures, and culture of custody, as well as significant training on how to manage mentally ill inmates.
2. Policies should be short and easy to understand.
3. New policies, procedures, and unit orders should be written in tandem with the ALADS Custody Division Working Group to assure that there is no negative impact on deputies' ability to get their job done, on the safety of staff, and/or on the safety of inmates.
4. Briefings should be consistent and focused on directly educating deputies on policies and procedures, and on mentoring young deputies on how to appropriately deal with recalcitrant inmates.
5. Always debrief on serious and significant uses of force.
6. Create a Custody Training Officer (CTO) program that provides incentives for deputies to serve as trainers and mentors.
7. Once final, sergeants working in the Custody Division should be fully trained on new policies and procedures.
8. Recognizing that inconsistencies between supervisors on the interpretation and enforcement of policies creates confusion at the deputy rank, management must be trained on all policies (current and future) so that they can be consistently applied from shift to shift, unit to unit, and facility to facility.

6. Operational Efficiency

With the LASD Custody Division, there is an inordinate amount of paperwork, much of which is redundant. This paperwork takes away from deputies' time supervising inmates. The paperwork required on force incidents is particularly cumbersome.

Personnel are often required to complete reports and paper work prior to the end of their shift. To accomplish this and avoid paying overtime, this will often mean taking the deputy out of service for part of their shift, leaving that position short staffed.

There is a lot of paperwork required when there is an incident, even if it is a non-significant use of force. How often does excessive paperwork leave your unit understaffed and unsafe?	**Response**
Daily	41.7%
Weekly	37.2%
Monthly	14.1%
Never	7.0%

Recommended Solutions

1. The LASD should do an audit of all forms/reports to identify redundancy and research new opportunities to utilize technologies that efficiently capture information.
2. In order to reduce paperwork and allow deputies more time to directly supervise inmates, implement a check off list for non-significant uses of force.
3. Expand the use of kiosks in inmate housing to include the daily agenda, account balance, release status, etc.
4. Explore the use of handheld technologies to expedite reporting and to allow deputies to have immediate access to important information regarding inmates' arrest record, criminal history, and mental health status.

Conclusion

The following is a summary of recommendations from the ALADS Custody Division Working Group:

1. Staffing: Recommended Solutions

1. Increase sworn staff in the LASD Custody Division to industry-standard levels and maintain minimum staffing levels at all times.
    - Institute minimum staffing ratios in all facilities that are appropriate for the inmate classification in a particular unit.
    - Conduct a forensic audit of the LASD budget to determine if any additional funds can be used to increase staffing to industry-standard levels.
    - Conduct an exhaustive analysis to assure full cost recovery from contracts and AB 109 inmates.
    - Develop two 5-year plans to increase staffing to industry standard levels:
        (a) Based on available economic forecast data; and
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    - Explore the potential of a new revenue source dedicated to fund countywide public safety services provided by the LASD.

2. If the CARP program is going to continue, a CARP should be on a loaned program for three (3) months so that he or she can be a productive staff member in custody.
3. Increase the number of "prowlers" (line deputies who are assigned to rove a custody facility) to help during inmate disturbances, with movement and radio car runs, and with paperwork.
4. Create set times for programs and assign additional deputies to monitor the inmates during program, visiting, and yard time.
5. In overcrowded housing units, increase the number of deputies to assure deputy and inmate safety.
6. Explore the use of video conference technology to minimize the dangerous and time-consuming movement of inmates.

7. In order to reduce the movement of inmates, behavioral observation reclassifications should be implemented at the inmate facility where an inmate is housed, rather than sending the inmate back to Inmate Reception Center (IRC). This will allow direct admits and reduce staff time for transportation and processing.
8. Reform the Education Based Incarceration (EBI) program as follows:
    - Fully staff Education Based Incarceration (EBI) programming and coordinate with daily job tasks.
    - Create a tracking program to determine the cost effectiveness of EBI programs on reducing recidivism and provide quarterly reports to the ALADS Custody Division Working Group.
    - No EBI programs should be created without additional funded sworn staff to handle all aspects of program implementation (movement, training, etc.).
    - When custody deputy resources are needed to implement EBI programs, coordinate the schedule to assure that programs do not conflict with daily job tasks (e.g., yard duty, pill call, etc.).
9. Universally apply the LASD policy on fraternization and physical contact with inmates, assuring that it is being consistently applied throughout all ranks. Any exceptions to the policy must be approved in advance.

2. Sworn Personnel Morale: Recommended Solutions

1. Create a promotional opportunity that still requires the current mandates but affords personnel that want to remain in Custody the ability to promote and remain.
2. Explore more condensed work schedules for deputies and supervisors.
3. Create a compensated Custody Training Officer program.
4. Implement a training program that meets the needs of personnel assigned to custody.
5. Explore transportation options for personnel that work the Custody Division.
6. Implement educational incentives for personnel assigned to custody.

3. Inmate Accountability and Behavior: Recommended Solutions

1. All reasonable orders given by deputy sheriffs working in LASD custody to inmates must be supported so that inmates show respect for and comply with the directives of deputies.

    - If an inmate takes a concern to a Sergeant or higher, he or she should be instructed to follow the appropriate chain of command by taking that concern first to a deputy sheriff.
    - When a deputy sheriff makes a decision regarding an inmate, the LASD should have a policy that encourages the supervisor to support the deputy decision, especially in the presence of inmates. Wherever possible – as in patrol operations – that decision should be final.

2. For inmates that are remanded to the custody of the LASD, the LASD should create consequences for hostile and recalcitrant inmate behavior, including but not limited to the filing of false reports against deputies. Specifically, recalcitrant inmates should lose good time/work time credits for time served, and a dedicated hearing system should be created to swiftly take away credits from an inmate for negative behavior.
3. The LASD should work with the courts to assure that inmates are sentenced for the time prescribed by the Penal Code, without regard to good time/work time credits. A sentenced inmate should not be given good time/work time credit by the courts.
4. The LASD should increase available discipline housing if necessary.

4. Health and Mental Health: Recommended Solutions

Overhaul the policies and procedures related to medical and mental health care:

1. To provide a better quality of medical and mental health care and improve operational efficiencies within the LASD, create a fully function medical services division that includes mental health and transportation within the LASD (similar to the concept used in patrol of the Mental Evaluation Team (MET)).
2. The LASD should implement the recommendations of the Corrections Standards Authority (CSA) (as of July 1, 2012, the CSA is known as the Board of State and Community Corrections (BSCC), specifically by exploring the creation of a Memorandum of Understanding (MOU) with the Department of Mental Health and the Department of

Health Services. This will ensure that when DMH and DHS staff work inside the jails, they are united under the command structure of the LASD.

3. The County of Los Angeles should designate the LCMC jail ward as its own entity managed by the LASD. This will assure that medical staff and LASD staff work in concert to minimize impact on custody operations.
4. The LASD should increase sworn staffing at LCMC to allow custody deputies to drop off the inmate, rather than wait an average of 2-6 hours to return the deputy to their facility. This could free up 10-15 deputies per shift, per day.
5. The LASD should create a medical services facility at North County Correctional Facility (NCCF) to minimize costly and operationally disruptive medical runs to downtown Los Angeles. This will improve operational efficiency.
6. Create a unit within transportation to move inmates with medical or mental health issues.
7. Staff Pitches Detention facilities with psychological technicians and other staff to facilitate direct admissions.
8. Custody facilities should have more of a "team" environment between sworn and civilian mental health workers. Mental health staff should work in cooperation with sworn staff to manage the mentally ill inmate population throughout the facilities.
9. The curriculum for Jail Operations, Custody Operations, and Custody Command Schools should reflect the change in the inmate population. The curricula should include training from County mental health workers on how to manage mentally ill inmates and how to identify when an inmate is slipping into psychosis.
10. Add in-service trainings for deputies and supervisors centered on officer safety, management of mentally ill inmates, and other issues that relate to force.
11. Additional beds should be added to avoid declassifying mentally ill inmates into general population, and to segregate younger and older inmates to avoid inmate-on-inmate violence, bullying, and "shot calling." *(Note: A "shot caller" is "an individual who runs the prison, even respected by the guards...someone who calls the shots." Source: www.urbandictionary.com)*
12. Increase the number of mental health professionals at all facilities and assure that they are available 24x7 to do immediate evaluations, necessary paperwork, and direct admissions for inmates with mental health needs. This will help ensure proper use of the deputies' time.
13. Limit or eliminate mandatory job rotations.

14. Increase the number of "overlap deputies" and carefully select them so that they are properly suited for the position. Overlap Deputies should routinely attend morning meetings with mental health staff. (Note: Overlap Deputies are deputy sheriffs who work in tandem with, and the same hours as, mental health professionals (i.e., their hours overlap).)
15. Assign Overlap Deputies and deputies assigned to JMET teams to participate as instructors on how to deal with mentally ill inmates.

5. Policies and Procedures: Recommended Solutions

1. Within their probationary period, all supervisors and managers assigned to custody should attend a Custody Operations School (for Sergeants) or a Custody Command School (for Lieutenants and Captains) with an emphasis on the policies, procedures, and culture of custody, as well as significant training on how to manage mentally ill inmates.
2. Policies should be short and easy to understand.
3. New policies, procedures, and unit orders should be written in tandem with the ALADS Custody Division Working Group to assure that there is no negative impact on deputies' ability to get their job done, on the safety of staff, and/or on the safety of inmates.
4. Briefings should be consistent and focused on directly educating deputies on policies and procedures, and on mentoring young deputies on how to appropriately deal with recalcitrant inmates.
5. Always debrief on serious and significant uses of force.
6. Create a Custody Training Officer (CTO) program that provides incentives for deputies to serve as trainers and mentors.
7. Once final, sergeants working in the Custody Division should be fully trained on new policies and procedures.
8. Recognizing that inconsistencies between supervisors on the interpretation and enforcement of policies creates confusion at the deputy rank, management must be trained on all policies (current and future) so that they can be consistently applied from shift to shift, unit to unit, and facility to facility.

6. Operational Efficiency: Recommended Solutions

1. The LASD should do an audit of all forms/reports to identify redundancy and research new opportunities to utilize technologies that efficiently capture information.
2. In order to reduce paperwork and allow deputies more time to directly supervise inmates, implement a check off list for non-significant uses of force.
3. Expand the use of kiosks in inmate housing to include the daily agenda, account balance, release status, etc.
4. Explore the use of handheld technologies to expedite reporting and to allow deputies to have immediate access to important information regarding inmates' arrest record, criminal history, and mental health status.

While these recommendations are not all encompassing, they are a starting point. It is our opinion that the time one spends in the custody environment can and should be productive and career enhancing.

Acknowledgements

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ALADS Custody Survey

March 2012

1) How often do you have briefings in your unit (check only one)?		
Answer Options	**Response Percent**	**Response Count**
Daily	7.6%	34
Weekly	51.3%	231
Monthly	35.8%	161
Never	5.6%	25
answered question		450
skipped question		3

2) In your briefings, are you trained on current policy changes and/or unit orders (check only one)?		
Answer Options	**Response Percent**	**Response Count**
Never	5.8%	26
Sometimes	53.1%	239
All the time	41.3%	186
answered question		450
skipped question		3

3) Would debriefing and critiquing incidents with your unit help reduce future uses of force?		
Answer Options	**Response Percent**	**Response Count**
Never	8.0%	36
Sometimes	71.6%	323
All the time	20.4%	92
answered question		451
skipped question		2

4) In your briefings, how often are you trained and/or mentored on proper force procedures (check only one)?		
Answer Options	**Response Percent**	**Response Count**
Never	10.9%	49
Sometimes	70.2%	315
All the time	18.9%	85
answered question		449
skipped question		4

ALADS Custody Survey

March 2012

5)Has low morale in your unit affected (check all that apply):

Answer Options	Response Percent	Response Count
Officer safety	70.1%	300
Reduced productivity	87.4%	374
Use of force	39.0%	167
Increased absenteeism due to stress	57.5%	246
answered question		428
skipped question		25

6) Do sergeants and command staff provide positive leadership for deputies working in custody (check only one)?

Answer Options	Response Percent	Response Count
Never	9.8%	44
Sometimes	70.4%	316
All the time	19.8%	89
answered question		449
skipped question		4

7) How often do you see inmates picking fights, creating a disturbance, or other behavior to control their housing location (check only one)?

Answer Options	Response Percent	Response Count
Daily	50.0%	223
Weekly	28.0%	125
Monthly	11.0%	49
Never	11.0%	49
answered question		446
skipped question		7

8) Recently, Command staff has been holding town hall meetings with inmates. Have you noticed a change in inmate behavior toward deputies since these town hall meetings began (check all that apply)?

Answer Options	Response Percent	Response Count
I have not noticed any change	20.8%	93
I have noticed more aggressive inmate behavior	51.2%	229
Inmates' respect for deputies has declined because they feel "empowered"	70.0%	313
Inmates would rather have their regular programming than go to town hall meetings	17.4%	78
Inmates have been more hostile toward deputies	49.0%	219
Other	10.1%	45
Other (please specify)		42
answered question		447
skipped question		6

ALADS Custody Survey

March 2012

9) Under public safety realignment (AB 109), "non-non-non" state prisoners are now being housed in LA County jails. Have you noticed any change in inmate behavior since the implementation of AB 109 (check all that apply)?

Answer Options	Response Percent	Response Count
I have not noticed any change	39.2%	174
I have noticed more aggressive inmate behavior	50.0%	222
Inmates have been more hostile toward deputies	33.8%	150
Other	8.1%	36
Other (please specify)		34
answered question		444
skipped question		9

10) Does the security level system used for county inmates appropriately classify the state inmates in a way that creates a safe working environment for deputy personnel?

Answer Options	Response Percent	Response Count
Yes	22.8%	103
No	45.9%	207
I don't know	31.3%	141
answered question		451
skipped question		2

11) Do you feel that the security level system for county inmates should be the same standards set for state inmates?

Answer Options	Response Percent	Response Count
Yes	59.6%	263
No	40.4%	178
answered question		441
skipped question		12

12) In your facility, are inmates permitted to bypass a deputy sheriff and take their complaints to a supervisor (check only one)?

Answer Options	Response Percent	Response Count
Maybe	11.8%	53
Yes	81.7%	367
No	6.5%	29
answered question		449
skipped question		4

ALADS Custody Survey

March 2012

13) Has a nurse, doctor, or mental health worker ever attempted to intervene in your attempt to control a recalcitrant inmate (check only one)?

Answer Options	Response Percent	Response Count
Yes	31.4%	141
No	68.6%	308
answered question		449
skipped question		4

14) How frequently do you see inmates with serious mental health issues declassified and put into General Population (check only one)?

Answer Options	Response Percent	Response Count
Daily	29.1%	130
Weekly	25.7%	115
Monthly	23.9%	107
Never	21.3%	95
answered question		447
skipped question		6

15) In your experience, do you feel that having inmates with serious mental health issues in General Population is a personal safety concern for you or inmates (check only one)?

Answer Options	Response Percent	Response Count
Maybe	5.3%	24
Yes	93.8%	422
No	0.9%	4
answered question		450
skipped question		3

16) How frequently do you experience inmates with serious mental health issues moving unsupervised through a custody facility (check only one)?

Answer Options	Response Percent	Response Count
Daily	26.9%	121
Weekly	21.4%	96
Monthly	18.3%	82
Never	33.4%	150
answered question		449
skipped question		4

ALADS Custody Survey

March 2012

17) How do you rate your working relationship with Mental Health/medical staff in custody (check only one)?

Answer Options	Response Percent	Response Count
Excellent	6.4%	29
Good	33.7%	152
Fair	40.8%	184
Poor	16.2%	73
Does not apply	2.9%	13
answered question		451
skipped question		2

18) Before a new policy or new program is implemented in your unit, does your supervisor discuss how it will impact your work (check Yes or No and if Yes, please check all that apply):

Answer Options	Response Percent	Response Count
Yes, my supervisor checks with deputies to see how the new policy or program affects my ability to get my job done each day.	38.6%	166
Yes, my supervisor checks with deputies to see how the new policy or program affects the safety of staff.	27.4%	118
Yes, my supervisor checks with deputies to see how the new policy or program affects the safety of inmates.	21.6%	93
Not applicable/never discussed with me	11.2%	48
No	47.9%	206
answered question		430
skipped question		23

19) Recently, new inmate programs and meetings have been scheduled. How do these impact your ability to do your job? (check all that apply)

Answer Options	Response Percent	Response Count
The requirement to move inmates to these programs reduces the number of deputies available for supervision.	59.7%	264
With all of the programs, I am not able to get the required work done during my shift.	32.8%	145
It does not impact my work	27.4%	121
Other	8.6%	38
Other (please specify)		36
answered question		442
skipped question		11

ALADS Custody Survey

March 2012

20) When deputies are required to take inmates on radio car runs, how does that impact your unit?

Answer Options	Response Percent	Response Count
It does not affect my unit.	16.5%	74
We don't have enough deputies to supervise inmates while the deputy is gone.	56.7%	254
There aren't enough deputies to fulfill the required responsibilities.	58.5%	262
Other	7.4%	33
Other (please specify)		31
answered question		448
skipped question		5

21) In your unit, how many inmates are on yard/recreation time at the same time?

Answer Options	Response Percent	Response Count
Does not apply	36.4%	165
Number of inmates	63.6%	288
Insert number		287
answered question		453
skipped question		0

22) And how many deputies are supervising the inmates on yard duty?

Answer Options	Response Percent	Response Count
Does not apply	36.5%	162
Number of deputies	63.5%	282
Insert number		282
answered question		444
skipped question		9

23) When inmates receive clinic passes in your facility, how many inmates are typically sent at the same time?

Answer Options	Response Percent	Response Count
Does not apply	23.0%	101
Inmates are sent sporadically	30.8%	135
Number of inmates	47.2%	207
Insert number		211
answered question		439
skipped question		14

ALADS Custody Survey

March 2012

24) And how many deputies are supervising the inmates at the clinic?		
Answer Options	**Response Percent**	**Response Count**
Does not apply	15.5%	68
Number of deputies	84.5%	372
Insert number		373
answered question		440
skipped question		13

25) In your unit, are deputies required to have direct contact with inmates during pill call (check only one)?		
Answer Options	**Response Percent**	**Response Count**
Yes	83.9%	371
No	16.3%	72
answered question		442
skipped question		11

26) Do mandatory job rotations interfere with your inmate-deputy working relationships?		
Answer Options	**Response Percent**	**Response Count**
Won't affect my inmate-deputy working relationships.	16.6%	74
I won't be able to develop the rapport with inmates that allows me to keep incidents down, be aware of contraband coming into the facility/develop intel, etc.	60.9%	271
Does not apply.	22.9%	102
answered question		445
skipped question		8

27) When your unit is staffed with a CARP'ed employee, how does that impact your work (check any/all that apply)?		
Answer Options	**Response Percent**	**Response Count**
Does not impact my work	18.0%	79
The CARP is very helpful	10.9%	48
The CARP is not beneficial to unit productivity	58.9%	259
I have to train the CARP	55.7%	245
answered question		440
skipped question		13

ALADS Custody Survey

March 2012

28) Have you been ordered to "volunteer" to teach or monitor an inmate program (e.g., Town Hall meetings, EBI, etc)?

Answer Options	Response Percent	Response Count
Not applicable	8.9%	40
No	76.3%	341
Yes	15.4%	69
How recently:	2.2%	10
Insert answer		12
answered question		447
skipped question		6

29) With budget cuts, LASD Custody Division does not have as many deputies. How often do you find yourself in an unsafe working condition because of short staffing (check only one)?

Answer Options	Response Percent	Response Count
Daily	67.8%	305
Weekly	19.3%	87
Monthly	6.7%	30
Never	6.7%	30
answered question		450
skipped question		3

30) There is a lot of paperwork required when there is an incident, even if it is a non-significant use of force. How often does excessive paperwork leave your unit understaffed and unsafe (check only one)?

Answer Options	Response Percent	Response Count
Daily	41.7%	184
Weekly	37.2%	164
Monthly	14.1%	62
Never	7.0%	31
answered question		441
skipped question		12

31) Do you feel that safety is jeopardized because of scrutiny behind the possible use of force?

Answer Options	Response Percent	Response Count
My personal safety is jeopardized	89.4%	398
Inmate safety is jeopardized	18.2%	81
Not applicable	9.2%	41
answered question		445
skipped question		8

CARP (CADRE OF ADMINSTRATIVE RESERVE PERSONNEL) CALCULATIONS

Total CARP Hours 2011	71,656 Hours
CARP FTE Equivalent	36 FTE[1]
Total Number of Deputy Sheriffs, Custody Division	1873
Total Number of Custody Assistants	1093
Total Custody Personnel	3,002
CARP Percentage of Custody Personnel[2]	**1%**

[1] Calculation based on 50 weeks/year and 40 hours/week, resulting in 2,000 hours/year for one FTE (full time equivalent).

[2] This calculation does not include the 207 Bonus Deputies. If we included the Bonus Deputies in the calculation the difference in percentage is not significant.

INFORMATION PROVIDED BY ALADS

	Average Filled Positions by Fiscal Year				
Facility	2007-08	2008-09	2009-10	2010-11	2011-12
Men's Central Jail					
SWORN (ITEMS)	619	626	615	552	556
C/A (ITEMS)	140	150	149	161	157
CARP (HOURS)	1,832	2,192	2,496	8,148	12,704
Inmate Reception Center					
SWORN (ITEMS)	312	315	316	297	279
C/A (ITEMS)	157	170	169	183	179
CARP (HOURS)	5,981	10,336	4,656	10,576	26,592
Twin Tower Correctional Facility					
SWORN (ITEMS)	479	510	501	455	440
C/A (ITEMS)	197	254	261	266	259
CARP (HOURS)	1,000	2,088	2,992	2,488	6,392
Century Regional Detention Facility					
SWORN (ITEMS)	271	275	278	271	259
C/A (ITEMS)	141	155	152	149	146
CARP (HOURS)	200	1,392	3,650	18,552	13,680
North County Correctional Facility					
SWORN (ITEMS)	338	334	334	322	
C/A (ITEMS)	52	72	75	80	73
CARP (HOURS)	2,203	1,912	2,120	7,736	6,968
Pitchess Detention Center South					
SWORN (ITEMS)	196	198	200	185	172
C/A (ITEMS)	49	70	75	77	72
CARP (HOURS)	1,144	2,079	4,389	9,226	3,104
Pitchess Detention Center East					
SWORN (ITEMS)	161	154	152	146	137
C/A (ITEMS)	33	49	53	58	53
CARP (HOURS)	120	240	852	1,040	2,216
Total					
SWORN (ITEMS)	2,376	2,412	2,396	2,228	1,843
C/A (ITEMS)	769	920	934	974	939
CARP (HOURS)	12,480	20,239	21,155	57,766	71,656

CITIZENS' COMMISSION ON JAIL VIOLENCE
AUGUST 3, 2012 HEARING
WITNESS BIOGRAPHY OVERVIEWS

MICHAEL P. JACOBSON
President and Director, VERA Institute
Former Commissioner, NYC Department of Corrections and NYC Department of Probations

Michael P. Jacobson joined the Vera Institute of Justice as its fourth director in January 2005. He is the author of Downsizing Prisons: How to Reduce Crime and End Mass Incarceration (New York University Press, 2005). A Ph.D. in sociology, he has an ongoing academic career as well as over twenty years of government service.

He was the New York City Correction Commissioner from 1995 to 1998. In that capacity, he was responsible for all aspects of the NYC jail system including Rikers Island.

During his tenure he was responsible for overseeing the largest decline in violence (63 percent) in the system's history, cut overtime by 50 percent and reduced the sick rate by 38 percent. From 1992 to 1996, he was New York City's Probation Commissioner and he worked in the New York City Office of Management and Budget from 1984 to 1992 where he was the Deputy Budget Director.

Immediately before joining Vera, he was a professor at the of New York Graduate Center and the John Jay College of Criminal Justice and Graduate Center of the City University of New York (from 1998 to 2005) where he taught courses in urban sociology, criminology, public policy and finance, corrections and criminal justice policies and public administration. He also established and coordinated an associate degree program on Rikers Island for correction officers and staff and received funding from New York State Legislature to design, implement and evaluate a credit-bearing college course on police leadership and human dignity for first line police supervisors.

In October 2010, Jacobson was appointed to the New York State Permanent Sentencing Commission by Chief Judge of New York State, Jonathan Lippmann.

MARTIN J. HORN
Distinguished Lecturer in Corrections, John Jay College, City University of New York; Executive Director, New York State Sentencing Commission
Former Commissioner, NYC Department of Corrections

Martin F. Horn is Distinguished Lecturer in Corrections at the John Jay College, City University of New York and serves as Executive Director of the New York State Sentencing Commission by appointment of the Chief Judge of the State of New York. Horn is also a Managing Director of KeyPoint Government Solutions, Inc. He was appointed by Mayor Michael Bloomberg to serve as Commissioner of the New York City Department of Probation, effective Jan. 1, 2002. A year later Mayor Bloomberg appointed him to simultaneously serve as Commissioner of the New York City Department of Correction, the City's jail system, and he held both positions simultaneously until July 31, 2009. As Correction Commissioner, Horn rebuilt morale, accountability and integrity following a series of highly publicized scandals. He reduced suicides and cut jail violence in half. Under his

leadership several conditions of confinement lawsuits were satisfactorily resolved. Horn reduced the introduction of drugs into jail by initiating New York's first drug interdiction program including the first wide scale drug testing in the City's jails and he reduced suicides among inmates. Horn created the largest and most ambitious jail reentry program in the nation. He reengineered the intake process to insure all inmates were properly screened for vulnerability, possess the documents needed to work upon release, created transitional job opportunities for persons released from jail, and created systems to identify high frequency jail and shelter users. He worked with the City's housing and homeless services community to address the needs for housing of discharged persons.

As Probation Commissioner Horn focused on high-risk offenders, improving the delivery of treatment for addiction to alcohol and other drugs, employment of offenders, the Department's IT capacity, and streamlining the probation violation process. As a result of his efforts recidivism among adult probationers dropped faster than in any other jurisdiction in New York State. His "Project Zero" effort led to major changes in the City's approach to juvenile delinquents, paving the way for a 70% reduction in the City's placement of juvenile delinquents and a tripling of the number of alleged delinquents diverted following arrest.

Horn served, from March 1995 until January 2000, as Pennsylvania's Secretary of Corrections. During his tenure staff and inmate safety and health care improved, suicides were reduced, three long standing consent decrees were dissolved, and classification and information systems were modernized. He created an innovative addiction treatment program that for the first time provided funding for post release treatment of released offenders. Under his leadership, improvements to the provision of mental health services were made including an enlargement of facility based acute care and step-down programs, "rule out" protocols to keep mentally ill inmates out of punitive segregation, and innovative release programs for inmates with mental illness were initiated.

Prior to his return to his home state of New York he served as a member of Governor Tom Ridge's Senior Staff as Secretary of Administration for the state of Pennsylvania. He also chaired the state's Tobacco Settlement Investment Board, the Pennsylvania Employees' Benefit Trust Fund, the ImaginePA Executive Committee (Enterprise Resource Management), and the JNET Council (Justice Network), and was a board member of the Public School Employees' Retirement System. Horn earlier served as executive director and chief operating officer for the New York State Division of Parole, and held a variety of positions within the Department of Correctional Services including Superintendent of Hudson Correctional Facility. He was an assistant professor of criminal justice at the State University College in Utica, New York from 1975 to 1977. He began his career as a New York State Parole Officer in 1969. He has served as co-chair of the American Bar Association Corrections Committee and has chaired the policy and resolutions committees of both the American Correctional Association and the Association of State Corrections Administrators. He is a Commissioner of the Commission on Accreditation for Corrections and a member of the Advisory Board of the New York State Commission on Quality of Care for Persons with Disabilities established by the State's SHU Exclusion Law.

MATTHEW CATE
Secretary, California Dept. of Corrections and Rehabilitations ("CDCR")

Matthew Cate has served as Secretary of the California Department of Corrections and Rehabilitation since May 16, 2008. He also serves as Chairman of both the Corrections Standards Authority and the

Prison Industry Authority. In addition, in 2010, Mr. Cate was elected Regional President of the Association of State Correctional Administrators.

Prior to his appointment as Secretary, Mr. Cate served for four years as the California Inspector General. As Inspector General, Mr. Cate was responsible for public oversight of the California Department of Corrections and Rehabilitation. Since 2007, he has also served on the California Rehabilitation Oversight Board and, in that capacity, is responsible for reporting to the state legislature on the progress made by the Department in fulfilling its obligation to provide effective rehabilitative programs to California's inmates and parolees.

Prior to becoming California's Inspector General, Mr. Cate served as a state and local prosecutor. From 1996 to 2004, he held the position of Deputy Attorney General at the California Department of Justice. In that capacity, he supervised a team of trial and appellate prosecutors, managed a criminal trial caseload of political corruption matters, and provided counsel to county grand juries. In 2003, while working on federal fraud and corruption matters, Mr. Cate was cross-designated as a Special Assistant United States Attorney. From 1994 to 1996, Mr. Cate was a Deputy District Attorney for Sacramento County, last serving in a special assignment prosecuting juvenile rape and murder cases. Prior to joining the public sector, Mr. Cate worked as a business litigation attorney with the law firm Downey, Brand, Seymour & Rohwer. He has also held several positions as an instructor of legal and law enforcement-related topics, including standards training for peace officers.

Mr. Cate earned his Doctor of Jurisprudence from the University of Oregon School of Law and a Bachelor of Science degree in business administration from Linfield College, where he was a National Scholar Athlete. He is a member of the California State Bar.

JEFFREY T. SCHWARTZ, PhD

Jeffrey Schwartz is the founder and President of LETRA, Inc., a criminal justice training, research and consulting organization in Campbell, CA. He has 30 years experience in criminal justice management coupled with a psychology Ph.D. in research methodology. Over those years, he has worked with prisons, jails, community corrections and others on new approaches to training and has led efforts in "turn-around management" and culture change in a number of troubled institutions and agencies. He has done more critical incident reviews after high profile prison and jail emergencies, crises and natural disasters then anyone in the country and has worked with hundreds of jails and prisons across the US and Canada. In the use of force area, Dr. Schwartz worked with the top managers in corrections departments in numerous states to reduce improper use of force.

Dr. Schwartz has many years experience working with the National Institutes of Corrections, including conducting two large national management training programs using original curriculum and innovative training methodology to train five hundred managers from all areas of corrections and from all 50 states in a management skills training program. He has been the project director for more than ten major NIC grants/cooperative agreements and the technical expert on more than twenty-five NIC technical assistance projects and has authored three book length NIC publications.

In Shelby County, TN (Memphis) Dr. Schwartz completed a comprehensive operational review of a then deeply troubled large jail system after the Federal Court had found the county in contempt of all five major elements of a long-standing consent decree (2000). He developed the plan to cure the contempt findings, worked on transformation of the jail and on use of force concerns, and helped

institute changes in their inmate grievance system and management training and practices. Dr. Schwartz was deeply involved in similar "turn-around management" work with Milwaukee Sheriff's Office and the Milwaukee House of Corrections.

Dr. Schwartz has been an instructor at a number of colleges and universities including the University of California at Santa Cruz, Denver University and San Francisco State University; he has also been a guest lecturer at Stanford Law School. He does expert witness work, with both Plaintiff and Defense-sides, on issues including use of force, inmate-on-inmate violence, and management of mentally ill and suicidal offenders. He served as a special consultant to the California Assembly and has authored or co-authored more than fifteen training texts and presented invited addresses at ACA, APPA, AJA, CPPCA and IACP meetings as well as state correctional associations.

MICHELE DEITCH
Professor of Law, University of Texas

Michele Deitch is an attorney with over 26 years of experience working on criminal justice policy issues with state and local government officials, corrections officials, judges, and advocates. Her areas of specialty include independent oversight of correctional institutions, institutional reform litigation, prison conditions and management, prison and jail overcrowding, prison privatization, juvenile justice reform, and juveniles in the adult criminal justice system.

Most of Professor Deitch's current research focuses on two issues: independent prison oversight, and the management of juvenile offenders. Her work on both subjects has been recognized nationally. The author of numerous articles about correctional oversight—including a 50-state inventory of prison oversight models—she helped coordinate and edit a landmark publication of the Pace Law Review in 2010 called a "Sourcebook on Prison Oversight." She was invited to provide lead testimony on the prison oversight issue before the National Prison Rape Elimination Commission and the Commission on Safety and Abuse in America's Prisons, and she organized a major international conference entitled "Opening Up a Closed World: What Constitutes Effective Prison Oversight?," (PDF) held at the LBJ School in April 2006. The Texas Legislature also honored her with a resolution for her research and work on this topic. She currently co-chairs (with Prof. Michael Mushlin from Pace Law School) the American Bar Association's committee on independent correctional oversight. Previously, she served as Reporter (draftsperson) to the American Bar Association Task Force that wrote recently adopted national standards on the treatment of prisoners.

Prior to entering academia, Deitch held some key positions with the Texas Legislature, including serving as General Counsel to the Texas Senate Criminal Justice Committee and as the Policy Director of the Texas Punishment Standards Commission. Working in those posts, she was involved with virtually every major criminal justice policy initiative considered by state officials in Texas in the early 1990s. She also served as a full-time monitor of conditions in the Texas prison system, appointed by Federal District Judge William Wayne Justice as part of the well-known Ruiz prison reform lawsuit. For more than 18 years, Deitch has also served as an independent consultant to state and local policy-makers and agency officials around the country on a wide range of corrections and sentencing issues.

GARY RANEY
Sheriff, Boise, Idaho

Sheriff Gary Raney has served as the Sheriff in Boise, Idaho, in the Ada County Sheriff's Office (the largest law enforcement agency in the State of Idaho) since 2005; he joined that office in 1983 and advanced through the ranks. During his time in office, Sheriff Raney has been recognized locally a d nationally for bringing good business practices and data-driven decisions to the leadership of the agency. By using a blend of innovative thought and performance measures, the Sheriff's Office has become a model organization and is nationally recognized.

Sheriff Raney earned a Bachelor's Degree and later a Master's Degree from Boise State University and also graduated from Northwestern University's School of Police Staff & Command, the FBI National Academy and the National Executive Institute – a prestigious international law enforcement leadership consortium. Sheriff Raney is currently an adjunct professor for Boise State University and Northwestern University's Center for Public Safety. He is often sought as a guest speaker and trainer on criminal justice issues and organizational leadership. In 2010, Sheriff Raney was asked to speak to Congress on prevention programs for at-risk children; in 2011 he spoke at the leadership retreat for NASA's Kennedy Space Center in Florida, discussing organizational development and innovating thinking.

In 2010, the United States Attorney General appointed Sheriff Raney to the Advisory Board of the National Institute of Corrections, where he helps provide a nationwide vision for jails and prisons. He is one of only two sheriffs in the nation to sit on the board. Sheriff Raney is also very active in the community and nationally and has been invited to advise other Sheriff and law enforcement departments on organizational change and leadership issues. He was also appointed by the Governor to both the Idaho Peace Officers Standards & Training Council and the Idaho Criminal Justice Commission to help set state policy on the top criminal justice issues in the State.

MARTIN F. HORN

EMPLOYMENT

EXECUTIVE DIRECTOR **SYSTEM** **October 2010-Present**	**NEW YORK STATE UNIFIED COURT** **SENTENCING COMMISSION**
DISTINGUISHED LECTURER **JUSTICE** **September 2009-Present**	**JOHN JAY COLLEGE OF CRIMINAL** **CITY UNIVERSITY OF NEW YORK**
COMMISSIONER OF CORRECTION **January 2003-August 2009**	**CITY OF NEW YORK**
COMMISSIONER OF PROBATION **January 2002-August 2009**	**CITY OF NEW YORK**
SECRETARY OF ADMINISTRATION **January 2001 – December 2001**	**COMMONWEALTH OF PENNSYLVANIA**
SECRETARY OF CORRECTIONS **March 1995 – December 2000**	**COMMONWEALTH OF PENNSYLVANIA**
EXECUTIVE DIRECTOR **August 1991 – February 1995**	**NEW YORK STATE DIVISION OF PAROLE**
DIRECTOR OF PAROLE OPERATIONS **April 1985 – August 1991**	**NEW YORK STATE DIVISION OF PAROLE**
SUPERINTENDENT **April 1984 – April 1985**	**HUDSON CORRECTIONAL FACILITY**
ASSISTANT COMMISSIONER **SERVICES** **December 1980 – April 1984**	**DEPARTMENT OF CORRECTIONAL** **STATE OF NEW YORK**
CONFIDENTIAL ASSISTANT **SERVICES** TO THE COMMISSIONER **December 1978 – December 1980**	**DEPARTMENT OF CORRECTIONAL** **STATE OF NEW YORK**
DIRECTOR **SERVICES**	**DEPARTMENT OF CORRECTIONAL**

TEMPORARY RELEASE PROGRAMS
June 1977 – December 1978

STATE OF NEW YORK

ASSISTANT PROFESSOR
CRIMINAL JUSTICE
January 1975 – June 1977

STATE UNIVERSITY COLLEGE, SUNY
UTICA, NEW YORK

SENIOR PAROLE OFFICER
PAROLE OFFICER
June 1969 – January 1975

NEW YORK STATE DIVISION OF PAROLE

EDUCATION

M.A., CRIMINAL JUSTICE
1974

JOHN JAY COLLEGE
CITY UNIVERSITY OF NEW YORK

B.A., GOVERNMENT
1969

FRANKLIN & MARSHALL COLLEGE
LANCASTER, PA

PUBLICATIONS

Bonacum, William T., Farmer, Michael T., Fein, Scott N., and Horn, Martin F. **Crime and Justice in New York: Proceedings of the Governor's Conference on Crime**. Albany: Office of the Governor, 1982.

Dvoskin, J. and Horn, M. (July August 1994). ***Parole Mental Health Evaluations***, Community Corrections Report, **1(6),5-6.**

Greifinger, R.B., Horn, M. ***Quality Improvement Through Care Management,*** **chapter in Puisis, M. (ed),**
Clinical Practice in Correctional Medicine, St. Louis: Mosby, 1998.

Horn, M. (1999, Feb.-March). ***Avoiding 20-20 Hindsight by Getting Back to Basics: Lessons Learned From a Major Escape.*** Correctional Security Report, **1(1), 1-2, 13.**

Horn, M. (1999, Winter). ***Change and Challenge: Pennsylvania's Prison System.*** Corrections: The Newsletter of the Pennsylvania Bar Association Committee on the Corrections System, **1(3), 1-4.**

Horn, M. (2001, Summer). ***Rethinking Sentencing.*** Corrections Management Quarterly, **5(3), 34-40.**

Horn, M. and Smith, D. "Public Safety" chapter in Benjamin, G. ed. *Handbook of New York State Politics*, New York: Oxford University Press, forthcoming.

Papers

Horn, M. "Project Zero: Pathway to Reform," a paper presented at the Disproportionate Minority Confinement Conference of the **Franklin H. Williams Judicial Commission on Minorities, New York State Judicial Institute**, White Plains NY(September 18, 2006);"Overall Systems Management in Corrections," A paper presented at the **US Dept of State Latin America Regional Workshop**, Bridgetown, Barbados October 23, 2009; "Creating Safe Correctional Environments," A paper presented at the **AGM of the International Corrections and Prisons Association,** Bridgetown Barbados, October 27,2009;"Practitioner Reflections on the Use of Evidence in Management of Correctional Facilities," **Fall Research Conference of the Association for Policy Analysis and Management** Washington, DC November 6, 2009;
"Using Performance Measurement to Improve Human Rights in Prisons and Jails," A Paper presented at the **9th Biennial International Conference, John Jay College of Criminal Justice**, Marrakech, Morocco

June 4.2010;"Acts of Violence, Death and Suicide in the Context of Prisons" A paper presented at the **IId Latin American Regional Corrections Seminar**, Buenos Aires, Argentina, June 9, 2010.

EXPERT WITNESS

Jeanette Perez v State of New York, et. al.
New York State Court of Claims, Claim No. 108710 (2010)

Alan Newton v. City of New York et. Al
SDNY 07-CV6211SAS (2010)

Jeffrey A. Schwartz, Ph.D.

SUMMARY

Thirty years experience in criminal justice management coupled with a psychology Ph.D. in research methodology. Detailed, hands-on experience with police, prisons, jails, community corrections; adult and juvenile; local, state, federal and foreign correction agencies. Development of innovative training programs and new approaches to training methodology. Planning for "turnaround management" and culture change in troubled institutions and agencies.

PROFESSIONAL EXPERIENCE

LETRA, Inc., Campbell, CA (1972 - present), A non-profit training and research organization, serving criminal justice and other governmental agencies, business and industry.

Founder and Chief Executive Officer:
All phases of corporate and fiscal management, supervision of professional staff, consultants. Policy development and procedures for emergency preparedness, use of force and conflict resolution. Design of new training programs and training of trainers.

RICHMOND POLICE DEPARTMENT, Richmond, CA (1968-1976)

Administrative Consultant to the Chief of Police:
Organizational development, research, program evaluation, new training programs and grants. Developed first generalist police crisis intervention training program in the U.S.. Planned and organized innovative department-wide juvenile diversion project, used as state model. National research on female and minority employment in policing.

PALO ALTO VETERAN'S HOSPITAL, Palo Alto, CA (1969-1971)

Chief of Program Evaluation Unit:
Founded, organized and managed new applied research unit in large medical/psychiatric teaching hospital. Developed research and statistical strategies for evaluating effectiveness of clinical programs. Served on Hospital Director's Executive staff.

EDUCATION

1960-1964	Western Reserve University	B.A. Chemistry major.
1964-1965	Toledo University	Graduate work: Psychology
1965-1968	Denver University	M.A. & Ph.D. Experimental Psychology (Research Methods, Learning, Statistics)
1968-1969	Palo Alto Veteran's Hospital	Internship: Clinical and Community Psychology

CORRECTIONS EXPERIENCE (representative sample)

National Institute of Corrections: Thirty years experience working with NIC. Conducted two large national management training programs over three years. Developed original curriculum, innovative training methodology, trained 500 managers from all areas of corrections from all 50 states in a residential 7-day, intense corrections-specific management skills training program. Administrated all aspects of these projects. Project Director for more than 10 major NIC grants / cooperative agreements; technical expert on more than 25 NIC technical assistance projects from all four NIC operating Divisions; authored 3 book length NIC publications. Helped plan new NIC courses and evaluated NIC operating procedures.

Shelby County, TN (Memphis) Jail: Comprehensive operational review of deeply troubled large jail system after Federal Court found the county in contempt of all five major elements of consent decree (2000). Developed plan to cure contempt findings, drafted response to Civil Rights Division of US DOJ to avoid second 1983 suit, worked on transformation of jail to direct supervision and on population management, use of force, inmate grievance system, management training and practices. Achieved discharge from Federal Court supervision in 2005 and from DOJ supervision in 2009.

California Youth Authority (CYA): The development of Conflict Management and Crisis Intervention procedures in all Youth Authority institutions; training and procedures for the management of hostage situations; training of trainers. LETRA's Crisis Intervention training program has been required by policy of all CYA institutional staff and in use for over 15 years, and LETRA's Emergency Preparedness course was in use state-wide for over ten years.

Montana Department of Corrections (DOC): After the maximum security unit riot and hostage situation at the Montana State Prison in Deer Lodge, in 1991, selected by NIC to head the seven person Administrative Inquiry Team commissioned to investigate the events leading to and surrounding the riot. Coordinated the writing of the Inquiry Team Final Report ("Riot at Max") and managed extensive media contacts for the Inquiry Team.

Michigan DOC, Hawaii DOC, Alaska DOC: Initiated state-wide training programs in each state on institutional crisis intervention. All three State DOC's continued to provide this training to all or almost all institution staff for many years.

Pennsylvania DOC: After Camp Hill riots, conducted assessment of Department's emergency response capacity, developed plan to increase preparedness including recommendations for specialized equipment, staff, etc. Conducted administrative policy seminar, tailored emergency training curriculum to department's needs, trained cadre of mid-managers to deliver emergency preparedness training at all 16 institutions to both management and line/supervisory staff and developed format for new institutional emergency plans.

Nebraska, Iowa, Wyoming, Oregon, Kentucky, North Carolina, Missouri, Kansas, Florida, Delaware, North Dakota, Hawaii, Nevada, Arkansas, Vermont and New Hampshire DOC's, the Omaha, Jacksonville, Greenville and Boise jail systems: Emergency Preparedness. Typically began with security analysis and evaluation of existing emergency plans and procedures, review of emergency policies, leading to adaptation of LETRA's detailed, comprehensive and generic ("all risk") emergency system. Provided Emergency Preparedness training for all staff at all institutions on new emergency system by training and certifying department instructors.

Hawaii DOC: Worked with Department's top managers to create new Use of Force policy, then developed and tested curriculum to train all staff to new policy. Prepared Department staff as instructors so that Department would be self-sufficient. Achieved substantial reduction in frequency of allegations of improper use of force. Similarly adapted LETRA's model use of force policy and training for state DOC's in Oregon, New Mexico, Shelby Co. jail.

Correctional Service of Canada: Crisis Intervention and Conflict Resolution work at Stony Mountain Penitentiary following riot and murder of two staff members. Development of Conflict Resolution program (in English and French) for all Regions of the penitentiary service. Administrative seminars with top management leading to revised and expanded emergency policies governing crisis management situations at all Federal institutions in Canada.

POLICE CONSULTATION EXPERIENCE (representative sample)

FBI National Academy, Quantico, Virginia: Presented two seminars on Domestic Crisis Intervention to police executives from largest 50 police departments in U.S. LETRA was the first outside group (non-FBI) to be invited to present an entire course at the FBI Academy.

Richmond, California, Police Department: Developed new 40-hour training program for generalist patrol officers on child and juvenile issues. Course ranged from gangs to drug abuse to battered and neglected children. All uniformed officers and detective trained within one calendar year.

Sacramento, California, Police Department and Sheriff's Office: Long-term project to train trainers in Crisis Intervention. Over 1500 patrol officers trained in LETRA's Domestic Crisis Intervention during an 18 month period. Evaluation showed 40% reduction of officer injuries, reduction in time spent on disputes. Similar projects in Rochester, NY; San Jose, CA; and other police agencies.

COLLEGE/UNIVERSITY TEACHING EXPERIENCE

Denver University, San Francisco State University, San Jose City College, University of California at Santa Cruz, Guest Lecturer at Stanford Law School. Psychology courses taught: Learning, Theory of Measurement, Educational Psychology, Introductory Statistics. Criminal justice courses: Correctional Management, Police Supervisory Training, Training for Trainers, etc.

EXPERT WITNESS
(Plaintiff and defense-side experience)

Use of Force (Police and Corrections)
Failure to Protect (Staff Sexual Misconduct with Offenders; Suicide; etc.)
Operation of Correctional Facilities
Emergency Preparedness and Emergency Response (Prisons and Jails)
Crisis Intervention (Police, Probation, Parole, Jails and Prisons)

CRITICAL INCIDENT REVIEWS ("after-action reports")

Camp Hill (PA) riots; Hurricanes Katrina and Rita and the LA DOC; Hostage taking at Delaware Correctional Center; "Riot at Max" at Montana State Prism; Wyoming Penitentiary carbon monoxide poisonings; Southern Ohio Correctional Facility (Lucasville) riot.

AWARDS, PUBLICATIONS AND INVITED ADDRESSES

National Merit Scholar; NDEA Fellow in Graduate Psychology. Presented invited addresses at ACA, APPA, AJA, CPPCA, IACP meetings, State Correctional Associations. Published numerous articles and chapters on corrections, on research methodology, in police science and in psychology. Authored or co-authored more than 15 training texts, three book length NIC publications.

PROFESSIONAL ORGANIZATIONS
(current and former)

American Correctional Association; American Probation and Parole Association; American Jail Association; California Probation, Parole and Corrections Association; American Psychological Association; International Association of Chiefs of Police

COMMUNITY INVOLVEMENT

Elected Trustee, West Valley-Mission Community College District, for three terms. Served as President of Governing Board 1984-85 and 2005-2006. The District serves over 25,000 students, with more than 1000 employees and a budget of over $100 million dollars per year.

Member, Bd. of Directors, former President of large homeowners' association in Saratoga, CA.

Vice Chair, Board of Directors (1988 - 1995), Women's Housing Connection, which was the only homeless shelter in Santa Clara County exclusively for women and women with young children.

Co-founder and Director (1986-2009), Visa Technologies (now Momar Industries), a computer supply and flexible packaging company with over $10M in sales, annually.

Volunteer Mediator, Child Find, Inc., A national organization that attempts to locate missing children, reconcile run-away children and juveniles with their families, and prevent child abduction.

ADDITIONAL SKILLS AND EXPERIENCE

Budget and Personnel Management: As President of a College Board of Trustees, oversaw a budget in excess of $100M/year with approximately 1000 professional and support staff. Oversaw private corporate budget (Visa Technologies) in excess of $10M/year with 65 employees. Extensive experience teaching leadership development, personnel administration, budget and fiscal control and other management topics to criminal justice managers.

Media Relations and Public Speaking: Extensive media experience in community activities as well as with criminal justice work. Frequent public speaking in a wide variety of contexts.

Legislative Liaison and Policy Analysis: Substantial experience working with local legislative delegations, testifying before legislation bodies, analyzing and drafting policy and regulations.

Special Consultant to the California Assembly: (1) Investigation and hearings leading to resignation of Insurance Commissioner Charles Quackenbush. (2) Investigation and hearings on the state of California contract for Oracle software.

DISCIPLINE FOR DISHONESTY
LASD/CDCR COMPARISON

A. LOS ANGELES SHERIFF'S DEPARTMENT GUIDELINES

VIOLATION	DISCIPLINARY RANGE[1]
False statements/lying to a supervisor	10 days to discharge
Knowingly giving untruthful or misleading statements during internal investigations	15 days to discharge
Failure to report UOF	5-25 days
Failure to report witnessed force	5-10 days

B. CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION GUIDELINES

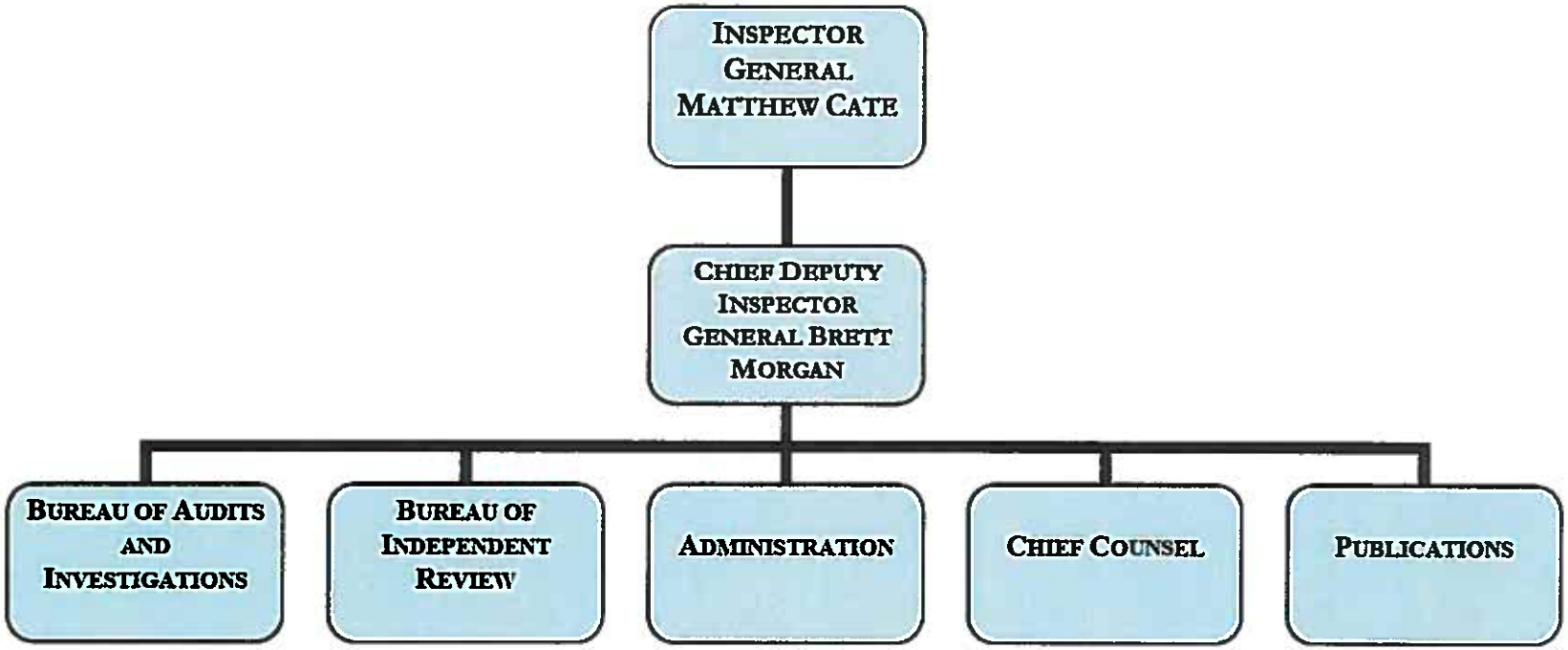
VIOLATION	DISCIPLINARY RANGE[2]
Making false or intentionally misleading statements to a supervisor	Base penalty: Termination
Falsification or making intentionally misleading statements in official reports or records	Base penalty: Termination
Failure to report *own* use of force	Base penalty: Salary reduction of 10% for 3-12 months or suspension w/out pay for 6-24 days
Failure to report use of force witnessed	Base penalty: Salary reduction of 10% for 3-12 months or suspension w/out pay for 6-24 days
Failure to report *own* unreasonable UOF	Base penalty: Termination
Failure to report unreasonable UOF witnessed	Base penalty: Termination

[1] Based on Sections 3-01/030.10, 3-01/040.70 and 3-01/040.75 of the LASD Guidelines for Discipline and Education-Based Alternatives (dated 3/20/11).

[2] Based on CDCR Operations Manual, Article 22, Section 33030.17 and 33030.19 (disciplinary matrix). The matrix provides a base penalty within the penalty range that represents the starting point for any disciplinary action; that base penalty shall be imposed absent any aggravating or mitigating factors.

Important Elements for Independent Oversight Organizations

- Independent from the correctional agency
- Authority to investigate and conduct regular inspections
- Unfettered access
- Financial independence, adequate resources and job security
- Public reporting of findings


Inspector General Matthew Cate
Chief Deputy Inspector General Brett Morgan
Bureau of Audits and Investigations
Bureau of Independent Review
Administration
Chief Counsel
Publications

EXAMPLES OF DISCIPLINE IMPOSED FOR INCIDENTS INVOLVING DISHONESTY

A. BJ Brewery Case

Recommendation by IAB for a 15 day suspension based on findings that deputy:

- Displayed his badge to patrons and became involved in a bar fight
- Hit a woman with a closed fist in the head
- Grabbed anther patron from behind and tried to throw him down
- Lied about these events (made "false and/or misleading statements during an investigation")

FINAL DISCIPLINE IMPOSED: 10 DAYS, 5 DAYS HELD IN ABEYANCE

Note:

- Letter of intent to impose penalties referenced violation of Manual of Policy and Procedure (MPP) Section for "failure to make statements and/or making a false statement during department internal investigations" noting that deputy made multiple "false and/or misleading statements in to investigators."

- Final letter of discipline from MCJ Captain: Department imposed discipline exclusively under MPP Sections for "professional conduct and disorderly conduct."

- The time for resolution of this case -- from the time of the incident to the time of the final letter of imposition -- was just under 2 years (721 days). In that intervening period of time, this same deputy was involved in the mini module inmate beating that Captain Mark Bornman recounted and was eventually discharged for his involvement in that subsequent event.

B. 2007 Jail Beating Incident

Al Gonzales Testimony (CCJV May 14, 2012 hearing):

- Supervisor observed deputy beating inmate who was not resisting and saw another deputy standing nearby observing
- Deputies later gave a version of the events that was "totally opposite" to what the Sergeant had observed

OIR October 2011 Report
(Case #1, p. 13)

> "... *deputy began punching the inmate in the head and neck. A sergeant saw the unprovoked attack from a distance and yelled at the deputy to stop, an order the deputy ignored until the sergeant got much closer. After an investigation and based*

largely on the statements provided by the sergeant, the Department fired the deputy and suspended his partner for failing to tell the truth about the incident."

FINAL DISCIPLINE IMPOSED by Department: 5 DAYS SUSPENSION on partner deputy who failed to tell the truth about the incident; deputy who assaulted the inmate was discharged (employee didn't file any response to letter of intent).

Note:

- Final imposition letter has no reference to false statements; discipline imposed is under MPP provision for "obedience to laws, regulations and orders."
- Final letter by Department referenced conduct as including "stating that you did not know what actions [other deputy] took against inmate *** when you were within inches of deputy ***'s unnecessary and unreasonable use of force on inmate."

C. LASD response to CCJV request for "all records of cases involving discipline for failure to report"

CCJV requested "all PPI records showing discipline imposed on custody personnel in the past 5 years for dishonesty, false statements and/or filing false reports in regard to use of force."

Information produced by LASD contains *only 2 cases* during this 5 year period with a finding of false statements

Jeffrey A. Schwartz, Ph.D.

1610 La Pradera Drive
Campbell, California 95008

(408) 379-9400 ♦ FAX (408) 379-9410
jasletra@aol.com

Ramirez v. Baca, et. al

February 8, 2011

I. Introduction and Background

My name is Jeffrey A. Schwartz and my office is at 1610 La Pradera Drive in Campbell, California. I am the president of LETRA, Inc., a small criminal justice training and consulting organization that has had offices in the San Francisco Bay area since its incorporation in June, 1972. I have worked full time with law enforcement and correctional agencies across the United States and Canada for approximately 35 years, both as LETRA's president and as a private consultant. The largest proportion of my work for the last 20 years has been with prisons and jails. I have worked with more than 40 of the 50 state departments of corrections and with small, medium and large jails and local departments of corrections. During my career I have worked with and toured literally hundreds of prisons and jails. A copy of my resume is attached to this report as Appendix A. Within the last few years I have authored four published articles on use of force in correctional facilities.

I have served as an expert on law enforcement and corrections issues for more than 15 years. In the last several years, expert work has constituted perhaps 10% to 20% of my total professional time. I charge $250 per hour for consultation, document review and other preparation activities and $350 per hour for actual testimony at trial or in deposition. A copy of cases I have worked on as an expert is attached to this report as Appendix B.

In early January, 2011, I was retained as an expert in this action by Adam Rottenberg, esq., of the law firm of Proskauer Rose LLP, of Los Angeles, CA. Mr. Rottenberg represents the Plaintiff in this case, Mr. David Ramirez. Mr. Rottenberg subsequently requested a written report of my professional opinions about this case. Prior to preparing this report, I have reviewed the following documents:

1. Letter from Adam J. Rottenberg to Jeffrey A. Schwartz, received January 25, 2011, dated January 25, 2001, 2 pgs.
2. Expert Witness Service Fees for Jeffrey A. Schwarz, 1 pg.
3. Stipulation Regarding Production of Confidential Documents and Information, Case No. CV08-02813-DSF (JC), dated January 26, 2011, received January 26, 2011, 11 pgs.
4. Defendant LeRoy D. Baca's Responses to Plaintiff's Special Interrogatories, Set Two, Case No. CV08-2813-DSF, received January 27, 2011, 22 pgs.
5. Defendant LeRoy D. Baca's Dep.Marquez's, and Deputy Rashford's Lof of Privileged Documents in Regards to Responses to Plaintiff David Ramirez's Request for Production of Documents, Set Two, received January 27, 2011, Case No. CV08-2813-DSF (JCx), 4 pgs.

6. Defendant Deputy Sheriff Marquez's Responses to Plaintiff's Special Interrogatories, Set Two, Case No. CV08-2813-DSF, 16 pgs.
7. Letter from Seki, Nishimura & Watase, LLP to Adam J. Rottenberg, dated October 26, 2010, 1 pg.
8. Defendant LeRoy D. Baca's Response to Plaintiff's Request for Production of Documents, Set Two, Case No. CV08-2813-DSF, 26 pgs.
9. Defendant Sheriff Deputy Rashford's Responses to Plaintiff's Request for Production of Documents, Set Two, Case No. CV08-2813-DSF, 26 pgs.
10. Defendant Sheriff Deputy Marquez's Responses to Plaintiff's Request for Production of Documents, Set Two, Case No. CV08-2813-DSF, 26 pgs.
11. Defendant Deputy Sheriff Rashford's Responses to Plaintiff's Special Interrogatories, Set Two, Case No. CV08-2813-DSF, 16 pgs.
12. County of Los Angeles Sheriff's Department Custody Division, Use of Force Extraction, dated May 2, 2005, 2 pgs.
13. County of Los Angeles Sheriff's Department Supplemental Report Narrative, dated May 2, 2006, 2 pgs.
14. Civil Rights Complaint Pursuant to 42 U.S.C. 1983, Case No. CV08-02813 DSF (JWJ), dated May 1, 2008, 16 pgs.
15. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Purpose of Order, Reference: MPP 4-08/000.00, dated March 28, 2006, 6 pgs.
16. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Reference: Custody Division Manual, MCJ Unit Orders. Title 15 Requirements, dated November 30, 2006, 2 pgs.
17. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Reference: CDM 2-01/090.00; CDM 2-01/100.00; Title 15, Article 3 Section 1027, 1029, dated August 24, 2010, 2 pgs.
18. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Reference: Custody Division Manual, MCJ Unit Order, Title 15 Requirements, dated October 24, 2006, 2 pgs.
19. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Reference: CDM 1-09/000.00; Title 15, Article 3, Section 1029, dated November 2, 2006, 2 pgs.
20. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Reference Title 15, Section 1073; CDM 5-12/010.00, dated June 15, 2005, 3 pgs.
21. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Reference: Title 15, Section 1073' CDM 5-12/010.00, dated June 15, 2005, 3 pgs.
22. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Reference: Title 15, Sections 1200 (a) and 1208; CDM 5-03/000.00 thru 5-03/060.00, dated December 27, 2006, 2 pgs.
23. Los Angeles County Sheriff's Department Custody Division Men's Central Jail, Reference: Title 15, Article 10, Section 1220; CDM 3-14/090.00, dated January 8, 2009, 2 pgs.
24. 5-05/080.00 Cell Extractions, 11 pgs.
25. 4-10/010.00 Accountability/Risk Management Program, 4 pgs.
26. Email from Edwin Rathbun to Adam Rottenberg, dated December 8, 2010, 1 pg.
27. Statement of Uncontroverted Facts and Conclusions of Law in Support of Defendants' Motion for Summary Judgment or, In the Alternative, Summary Adjudication, Case No. CV08-2813-DSF (JWJ), Filed December 23, 2008, 8 pgs.
28. Fax from Andrew M. Datzenstein to Richard M. Norman, Esq, Mark S. Gregory, Steven A. Jung, Esq, Ellen Hageman, dated October 25, 2010 1pg.
29. County of Los Angeles Sheriff's Department Custody Division, Unit: Men's Central Jail; Use of Force Extraction Incident Anylysis I Review Package, Incident Report # 006-00633-5100-057, dated May 2, 2006, 37 pgs.

30. County of Los Angeles Sheriff's Department Supplemental Report, URN # 006-00633-5100-057, dated, May 2, 2006, 133 pgs.
31. Email to Adam Rottenberg from Edwin Rathbun, dated November 17, 2010, 2 pgs.
32. United States District Court, Central District of California (Western Division – Los Angeles) Civil Docket For Case #: 2:08-cv-02813-DSF – JC, Date Filed: April 30, 2008, 14 pgs.
33. County of Los Angeles Sheriff's Department Incident Report, dated May 2, 2006, 4 pgs.
34. Los Angeles County Sheriff's Department Crime Analysis Supplemental Form—Suspect/Subject Information, URN # 006-00633-5100-057, By Deputy Juarez, J., 2 pgs.
35. County of Los Angeles Sheriff's Department Supplemental Report, File No. 006-00633-5100-057, dated May 2, 2006, By Ramirez, David, 9 pgs.
36. Plaintiff's Responses to Defendant Leroy D. Baca's First Set of Special Interrogatories, Case No. CV08-2813-DSF (JWJ), 12 pgs.
37. Los Angeles County Consolidated Criminal History Reporting System, for David Ramirez, dated March 24, 2010, 18 pgs.
38. Inmate Information From of David Ramirez, 5 pgs.
39. Los Angeles County Sheriff's Department Inmate Discipline Report, dated March 23, 2005, 3 pgs.
40. Los Angeles County Sheriff's Department Inmate Discipline Report, dated July 30, 2006, 3 pgs.
41. Los Angeles County Sheriff's Department Inmate Discipline Report, dated September 11, 2006, 3 pgs.
42. Los Angeles County Sheriff's Department Inmate Discipline Report, dated October 15, 2006, 3 pgs.
43. Housing Location Inquiry (The information was current as of: 10/04/2010 05:58), 2 pgs.
44. Deposition of David Garcia Ramirez, Friday February 6, 2009 Delano, California, Case No. CV08-02813 DSF (JWJ), 72 pgs.
45. United States District Court Central District of California, Case No. CV08-02813 DSF (JWJ), Filed April 16, 2008, 12 pgs.
46. Exhibit A, 26 pgs.
47. Los Angeles County Sheriff's Department Medical Services, Declaration of Custodian of Medical Records, dated January 13, 2009, 70 pgs.
48. Miscellaneous Including Information from LA County Medical Center, Medical and Dental Records of David Ramirez, 248 pgs.
49. Email from Edwin Rathbun to Adam Rottenberg, Re: Ramirez v. Baca, et al. dated December 6, 2010, 3 pgs.
50. Defendants LeRoy D. Baca's, Sheriff Deputy Marquez's, and Sheriff Deputy Rashford's Notice of Motion and Motion for Summary Judgment or, In The Alternative, Summary Adjudication, Case No. CV08-2813-DSF (JWJ), 13 pgs.
51. Statement of Uncontroverted Facts and Conclusions of Law In Support of Defendants' Motion For Summary Judgment or, In The Alternative, Summary Adjudication, Case No. CV08-2813-DSF (JWJ), 8 pgs.
52. Exhibit "A" Case No. 2:08-cv-02813-DSF-JC, Filed December 23, 2008, 6 pgs.
53. Exhibit "B" Case No. 2:08-cv-02813-DSF-JC, Filed December 23, 2008, 1 pg.
54. Exhibit "C" Case No. 2:08-cv-02813-DSF-JC, Filed December 23, 2008, 2 pgs.
55. Memorandum of Response to Defendants Summary Judgment Motion, Case No. CV08-2813-DSF (JWJ), Filed January 8, 2009, 4 pgs.
56. Report and Recommendation of United States Magistrate Judge [Docket No. 28], Filed November 6, 2009, 24 pgs.
57. Exhibit "1" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 7 pgs.
58. Exhibit "10" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 2 pgs.
59. Exhibit "11" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 2 pgs.

60. Exhibit "12" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 2 pgs.
61. Exhibit "13" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 2 pgs.
62. Exhibit "14" Case No. 2:08-cv-02813-DSF-JC, To Be Submitted, Filed February 23, 2010, 1 pg.
63. Exhibit "2" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 3 pgs.
64. Exhibit "3" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 6 pgs.
65. Exhibit "4" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 1 pg.
66. Exhibit "5" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 1 pg.
67. Exhibit "6" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 13 pgs.
68. Exhibit "7" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 2 pgs.
69. Exhibit "8" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 8 pgs.
70. Exhibit "9" Case No. 2:08-cv-02813-DSF-JC, Filed February 23, 2010, 3 pgs.
71. Defendants' Exhibit List and Exhibits, Case No. CV08-2813-DSF (JCx), Filed February 23, 2010, 4 pgs.
72. List of All Eyewitnesses and Witnesses, Case No. CV08-2813-DSF (JCx), Filed March 1, 2010, 4 pgs.
73. United States District Court, Central District of California (Western Division – Los Angeles) Civil Docket For Case #: 2:08-cv-02813-DSF – JC, Filed April 30, 2008, 14 pgs.
74. Letter to Dr. Schwartz from Adam J. Rottenberg, dated January 25, 2011, 2 pgs.
75. "Come and Get Me!": The Best and Worst in Cell Extractions; in "American Jails", Jul-Aug, 2009.

In addition to the documents listed above, I also reviewed the California jail standards in force during 2006 (Title 15), and the American Correctional Association Jail Standards, "Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, June, 2004.

I have requested that a tour of the L.A. County Jail, Men's Central Facility be arranged for me, but that has not yet been scheduled. I have also requested a phone interview with the Plaintiff, Mr. Ramirez, but that has not yet been scheduled either.

I am not a medical expert and I have not been asked nor have I attempted to form opinions about medical treatment issues in this case.

Substantial discovery remains to be completed in this case and I reserve the right to add to or change the opinions in this report if and when additional relevant information becomes available to me after the date of this report.

II. Fact Situation

David Ramirez is a 31-year-old Hispanic male. On May 2, 2006, Mr. Ramirez was being held as a pre-trial detainee in the Men's Central Jail (MCJ) of the L.A. County Sheriff's Office. Mr. Ramirez was housed in the "3500 block" of the jail on May 2, 2006. That cell block (or "module") is an administrative segregation unit consisting of two tiers, or "rows" (referred to as "alpha row" and "Charlie row", or "A row" and "C row", respectively). At that time, the 3500 block was comprised of 52 single man cells, with 26 cells on each row. It housed high security Hispanic inmates alleged to be "Southside" gang members who were also alleged to be "shot callers" or otherwise influential within that gang. The Sheriff's Office believed these inmates to be potentially dangerous to other inmates and to the staff, and to be potentially disruptive to the general population. As is true with many administrative segregation housing units in both jails and prisons, the inmates on the 3500 block were locked in their cells 23 hours a day with one hour of out-of-cell time for showers and/or exercise. When these inmates did come out of the their cells, they were moved in restraints.

At approximately 7:30 p.m. on May 2, 2006, the facility was locked down because of a disturbance that started on A row. According to Mr. Ramirez, the A row inmates became upset because they did not get their commissary orders that day although C row had received their commissary. Also according to Mr. Ramirez, the A row inmates had either had difficulty getting commissary or had not received commissary for several weeks. In any event, the inmates on A row began to yell at the staff and throw things out of their cells. All of the inmates on A row and C row were locked in their cells. According to staff, the A row inmates were verbally threatening individual staff members and throwing liquids at staff (variously reported as full milk and juice cartons or, in one case, as an unknown milky white liquid with a foul urine smell.

The staff decided to do cell extractions on all of the inmates on both tiers. It had been reported that inmates were "kiting" (using strings to transport notes or contraband from one cell to another) between A row and C row. Mr. Ramirez, the Plaintiff, was in cell #9 on C row. According to him, the C row inmates had not been upset and were not involved in the A row reaction to the commissary issue. However, when the C row inmates learned that they were to be extracted from their cells, they became angry and also began to shout, swear, threaten and throw things from their cells into the cell corridor.

A Sergeant directed that both of the institution's emergency response teams (ERT's) and both cell extraction teams be mobilized. The afternoon Shift Commander, Lieutenant Sutton, briefed the teams and directed that C row be extracted prior to A row. Both extraction teams worked on C row.

From that point forward, there is some quite limited videotape that was shot by staff and which shows some small portions of the events that transpired, although the videotape is of very poor quality.

Prior to beginning extractions, a Sergeant yelled down C row, twice ordering inmates to surrender and make themselves available for "cuffing". Very quickly after that, two staff armed with pepperball guns shot pepperballs down the corridor and then another staff member used a Mk-46 projector (a "magnum" canister of OC chemical agent designed to shoot high volumes of aerosol OC distances of up to 30-feet. The Mk-46 projector is manufactured and sold by the firm Defense Technology). The corridor outside the C row cells was filled with sufficient OC from the Mk-46 and OC in powdered form from the pepperball guns that visibility down the corridor was difficult. The extraction teams entered the corridor and began performing "serial extractions", which is the term used when cell extractions are begun at one end of a housing unit and proceed from one cell to the adjacent cell until all of the inmates in all of the cells have been extracted.

The cell extractions on C row were accomplished by first shooting five to ten pepperballs into the walls and ceiling towards the rear of each cell to fill that area with OC powder. If portions of the inmate were visible, the pepperball gun was used to shoot directly at the inmate, below the waist. In some cases, "stinger" rounds (projectiles loaded with small, hard rubber pellets that disburse upon impact and hit multiple targets) were also used. The round is typically fired from a 37 millimeter or 40 millimeter gas launcher although stinger rounds are also manufactured for 12 gage shot guns). In addition to the stinger rounds, tasers were also used on some of the inmates and at least one "stinger grenade" was used.

After the pepperballs were shot into a cell, a high volume of OC was sent into some cells and the stinger rounds were used on the a number of the inmates. Although the order of various weaponry varied, two or more Deputy's were sent in to the cell to put handcuffs on the inmate and that was done after the use of pepperballs, or the OC from the Mk-46. In some cases a taser was used after Deputies first went into the cell; the taser was discharged into the inmate from one to four times. Once the inmate was in handcuffs,

he was dragged out of the cell and taken to a school area of the facility, where medical triage had been established. At least some inmates were dragged face down on the floor with two Deputy's lifting and dragging them by the back of their shirts.

Many of the inmates were punched in the face and some were kicked. At least one inmate was kicked in the head by one Deputy and kicked in the face by another Deputy. A number of inmates had injuries severe enough that they required hospital treatment.

The Plaintiff, Mr. Ramirez, had pepperball rounds shot into his cell, then had two Deputies enter his cell and hit him in the face, head and shoulders. He was also tasered. Mr. Ramirez did later receive medical treatment.

When Mr. Ramirez was interviewed (and videotaped) during the time he received medical treatment, he said that he did not want to talk about what had happened to him and at one point said something to the effect that he had fallen down stairs. Mr. Ramirez has since said that Deputy's told him not to say anything about what went on during the cell extractions or he would "leave the jail in a body bag". Staff have said that threats of that sort did not happen.

Mr. Ramirez is suing the L.A. County Sheriff, Leroy Baca, in his official capacity, and suing individual members of the Sheriff's staff that participated in the uses of force against Mr. Ramirez. In addition to Mr. Ramirez claims that his civil rights were violated by unconstitutional and excessive force used against him, he also has cited a cause of action for failure to provide him with access to the jail's grievance procedure.

III. Method

The central element in this case is the staff duty to protect inmates in the L.A. County Jails from unreasonable or excessive force by staff. Staff do contest that duty and maintain that the force used in the May 2, 2006 incident in the Men's Central Jail was necessary and reasonable in general, and specifically so in the case of Mr. Ramirez. It is Mr. Ramirez's contention that the cell extracting was a pretext for corporal punishment and that the force used against him was excessive, malicious and retaliatory and used in utter disregard for his safety and well being.

Within contemporary American corrections there is well-established methodology for dealing with the kinds of questions raised in this case. The first step is to determine the applicable duties, looking to relevant law and regulations, to departmental policies and procedures, to professional standards and to widely accepted correctional practices. The second step is to determine whether the various duties identified have been complied with or have been breached by examining the documents and other information available in the case as well as facts from other sources that might illuminate the defendants' compliance or lack of compliance with the various duties identified. An additional step in this analysis is to examine the existing policies, procedures and practices to determine whether they are wrongly formulated or insufficient. That is most often accomplished by comparing them to legal and regulatory requirements and/or to comparable policies, procedures and practices in use in other correctional agencies. An additional important step in this method is, where possible, to review the results of the policies, procedures and practices in question to determine whether they have been effective at accomplishing their objectives.

The method summarized above is not exclusive to expert analysis of prisoner tort cases alleging failure to protect. It is also the general method used for auditing correctional institutions for accreditation, whether

by the American Correctional Association (ACA) or by the National Commission on Correctional Health Care (NCCHC). It is also used as a major component in critical incident reviews (also called "after-action reports") following major crises or emergencies in jails or prisons. This consultant has used this method for critical incident reviews following a number of very high profile crises in correctional institutions and I have also used this methodology as the central approach on many occasions when I have been commissioned to evaluate the emergency readiness of a particular correctional agency or correctional facility.

In addition to the method discussed above, the analysis of the record in this case must also reach the questions of whether it was reasonably predictable that harm would befall inmates if the various identified duties of the defendants regarding reasonable use of force were not fulfilled, and whether the harm that occurred to Mr. Ramirez in this case was a direct result of the breach of those duties by the defendants.

IV. The Duty to Protect Inmates from Staff Use of Excessive Force or, Conversely, to Use Only the Minimum Amount of Force That is Reasonable and Necessary to Stop or Control a Person or Situation, when Force is Required.

There is no question about the Defendants' duty in this regard. The obligation to use of force only when there is no reasonable alternative and to use the minimum amount of force necessary to control the situation is common to all law enforcement and correctional agencies nationally and it applies specifically to jail staff. That duty is reflected in state and federal law and it is a central element in jail standards, such as those promulgated by the American Correctional Association. In the L.A. County Sheriff's Office, that duty is reflected in the departmental use of force policy and it is also a part of the Jail's policy on cell extraction.

There is similarly no doubt that Defendants', both individually and as a group, were familiar with this duty. It is taught in detail at the recruit academy and is then reviewed in a variety of in-service training programs ranging from defensive tactics to training on specific tactical equipment. It also arises in both formal and informal discussions among staff in any jail.

Finally, Defendants were aware that if they breached their duty to prevent excessive or unnecessary staff uses of force, it was predictable and foreseeable that unnecessary inmate injuries might be the direct result, because that is little more than common sense.

V. Analysis and Opinions

A. Foundational Questions in this Case

There are three fundamental questions in this case. The third and last of these, in logical order, has to do with the extent of damages and I cannot speak to that question because it is medical in nature. I do not have medical expertise.

The first basic question has to do with the cause of the disturbance on C row on the evening of May 2, 2006. Did the disturbance begin on A row, as Mr. Ramirez contends, and was it started because the A row inmates were angry about not getting commissary, as Mr. Ramirez also contends? Were the inmates on C row initially uninvolved in the disturbance, as the Plaintiff has testified, and were they goaded by staff into participating in the disturbance when staff informed them that they were going to be extracted from their cells? Or, was this, as staff contend, a disturbance started by inmates for no good reason on both rows? Also, was there no reasonable

opportunity for staff to talk with the inmates on A row and C row about any issues the inmates may have been responding to, in an effort by staff to avoid physical confrontations?

The next, or second, of the three questions has to do with what happened inside cell C-9 when Mr. Ramirez was subject to a cell extraction. Was he given an opportunity to surrender without the use of force? Did staff beat and taser him without good reason to punish him for the earlier disturbance and did jail staff continue to beat him and choke him as they dragged him toward the school area of the jail for medical triage? Did Mr. Ramirez fight, kicking and punching, when Deputies entered his cell to apply handcuffs after the cell had been saturated with pepperballs and OC spray?

Both of the major questions discussed directly above are vexing. The answers to each should be easy, but they are not. The first question should be answerable through some combination of reports, ongoing documentation and investigations after the incident. None of those are available. On the second question, there should be videotape showing the extraction of Mr. Ramirez from cell C-9 but that is similarly unavailable. The four video segments that are available are so ludicrously poor that they do not answer the key question about any of the extractions including that of Mr. Ramirez. As a result, both questions resolve down to rather classic "he says, they say" situations. On the one hand, for both questions there is the testimony of the Plaintiff, David Martinez. On the other hand, with regard to the cell extraction of Mr. Martinez, there are the written reports of a jail Sergeant and five Deputies. There is, however, a substantial amount of circumstantial evidence on each of the two central questions.

The two alternative explanations stand in stark contrast to each other, particularly with regard to the question of whether David Ramirez was intentionally and unnecessarily beaten during the May 2, 2006, cell extractions. The overall record in this case makes it clear that there is little room for middle ground. Either the staff reports are accurate and Mr. Ramirez is lying about those events or Mr. Ramirez is telling the truth, in which case the staff reports are false and constitute a concerted cover up of what transpired on that day.

B. The Culture of MCJ with Regard to Excessive Force and Retaliation Against Inmates who Complain

In order to assess the potential for a number of staff to participate in a cover up of this magnitude, the culture of the organization is an appropriate beginning consideration. The American Civil Liberties Union (ACLU) has been closely involved with the MCJ for more than thirty years. As a result of a conditions of confinement lawsuit filed by the ACLU more than thirty years ago, and still active today, ACLU staff continue to tour MCJ on a weekly basis in their role as the court appointed monitor. The ACLU has access to all areas of the jail and its monitors speak with inmates throughout the jail. They also receive complaints directly from inmates.

In May, 2010, the ACLU published its annual report on conditions inside MCJ for the years 2008 and 2009. That report, a joint project of the ACLU of Southern California and the ACLU's National Prison Project, begins with a discussion of the history of the organizational culture at MCJ and the serious and longstanding problems that continue to exist at MCJ in spite of improvements over time in some areas.

When the report considers specific problems areas at MCJ, it begins with "Deputy abuse". The second problem area discussed is "Retaliation". The section of the report on "Deputy abuse"

begins, "Many of the most troubling complaints the jails project receive involve allegations of serious physical abuse of prisoners at the hands of deputies". After detailing several specific complaints by inmates of serious injuries resulting form excessive force by Deputies, the report states (at page 12): "In each of these incidents, there was no apparent justification for the use of force, and if the circumstances did justifying using force, the degree of force used appears to be clearly disproportionate to the degree of danger justifying it."

The section of the report on "Retaliation" begins (at page 13): "At least since the inception of the ACLU's monitoring efforts, there has been a persistent pattern of prisoners claiming they have been retaliated against and harassed by jail staff for communicating with the ACLU or otherwise challenging conditions of the confinement. In many instances, prisoners have told us that Deputies have made it clear that prisoners who file grievances or communicate in any way with the ACLU will be punished."

This report is not conjecture by a community group unfamiliar with the realities of the L.A. County Jail system. It is the product of court ordered monitors of MCJ who have a long-term and close familiarity with operational issues within the Jail. The report does not speak to the specifics of the incident of May 2, 2006 or Mr. Ramirez, but it does describe the dysfunctional staff culture that has existed at MCJ for many years.

Any law enforcement or correctional agency may find itself the victim of outrageous or unconscionable acts by one or even a few of its staff members. That is, in spite of careful hiring, rigorous background investigations and extensive training, a rogue officer or a few rogue officers may commit acts that are repugnant to the community and to almost all other members of the organization, and which criminally violate the law and the values of the organization. That is a very different situation from an organization in which the culture condones and/or supports unprofessional, unethical or illegal behavior. In that latter situation, a pattern and practice of inappropriate behavior on the part of staff is likely to develop and persist.

C. The Overall Situation on May 2, 2006

Approximately 18 inmates were on C row of the thirty-five hundred block on May 2, 2006 when the cell extractions occurred. In addition to exposure to chemical agents, many of these inmates had signs of being beaten, with head and face injuries particularly frequent. At least five of these inmates were injured so seriously that they had to be transported for hospital treatment, as their injuries could not be adequately treated by the extensive medical staff in facilities at the jail. Mr. Ramirez believes that one inmate had his front teeth knocked out, another inmate had fractures of the bones in his face and that a third inmate had to be flown out in a wheelchair. Mr. Ramirez also heard from other inmates that one inmate "flat lined" as a result of his cell extraction injuries, but ultimately survived.

On one the four videotape segments furnished by the jail, two of the seriously injured inmates are seen during triage. Both inmates appear to be unconscious during some or most of their time on tape. The first inmate shown is dragged into the triage area by two Deputies pulling him by the back of his shirt. He is essentially being dragged face down on what appears to be a concrete or similar hard surface floor.

(That, in and of itself, would be grounds for investigation and probable disciplinary action against involved staff in many jails and prisons. Moving an inmate after restraints have been applied

during a cell extraction is almost always considered part of the cell extraction procedure itself. Appropriate training and procedure requires staff to carry or support an inmate in a manner that protects him from falling downstairs, hitting his head or face on the floor or other preventable injuries.)

When the first inmate regains consciousness on the video, it appears that he has been badly beaten about the face and head. The second inmate shown also appears to be unconscious when first filmed. He is on a gurney or bed and it appears that he has a horribly bruised and swollen right eye. When he regains consciousness, one of the Deputies using or working with the camcorder keeps asking him what happened to his eye while the inmate holds his chest with one hand and murmurs "My heart, my heart". One of the two inmates appears to be having seizures and medical staff can be heard asking if that inmate has a history of seizures.

With a wide variety of less than lethal chemical agents and other tactical equipment available, ranging from the taser to stinger rounds and sting ball grenades, and with a large number of Deputies dressed out in riot gear and available, why was it necessary to kick and punch these inmates in the face and head and generally beat them so severely? The staff answer in their reports is that the situation was an emergency and that the disturbance had to be "put down" immediately and quickly. At least two staff reported seeing inmates displaying shanks on A row or C row and one of those two staff reported seeing multiple shanks. Staff further reported that when they began cell extractions on C row, every inmate, with one exception, chose to physically fight with them, throwing punches and kicking, even after the saturation of each cell with pepperballs and in many cases the additional application of high volume OC from the Mk-46 projector, stinger rounds from a 37 millimeter launcher and/or a sting ball grenade.

If the situation were as staff described it in their reports, it would be expected that there would have some staff injuries do the hand-to-hand fighting. That is not what the record in this case reveals. There is no indication in the record of any staff injuries, even minor. If there were, those records would have been produced by LASO in response to Mr. Ramirez's request for documents relevant to this incident, and they were not. It is a good outcome if no staff were injured in this incident and despite whatever else may have gone on, no reasonable person can wish that staff had been injured. However, in 15 or more individual situations, in the close quarters of individual cells, with mostly young and quite physically capable inmates kicking and throwing punches at staff, it would be extraordinary if no staff member received any injuries.

The question of shanks also leads to extraordinary results. It was the presence of shanks and shanks being displayed to threaten staff, as reported by two different staff members, in addition to another staff report that shanks and other contraband were being "kited" from cell-to-cell and row-to-row, that led to the decision to do emergency cell extractions. Otherwise, the key question would be "Where's the fire?" That is, while the inmates were involved in a disturbance, and were yelling and throwing things into the corridor from their cells, all of the inmates were locked in their individual cells on the two rows and as long as staff stayed at a distance there was no imminent danger of serious injury or loss of life. It was evidently the threat that inmates were moving shanks around to better attempt to assault or kill staff that lead to the staff decision to take immediate action. Otherwise, one of the available alternatives would have been to use time and wait until the inmates lost some of their enthusiasm for yelling and challenging and trashing the unit. After all, the corridor was already littered with trash and whatever shanks or other inmate-forged weapons were in the unit, were already there. Given more time, the inmates might forge more weapons, but they might do that where ever they were housed after the cell extraction. The Jail policy on cell

extractions contains a number of provisions that specify that extractions will be a last resort, that multiple attempts will be made to talk and negotiate with inmates and that is particularly true with situations in which multiple cell extractions are the last resort. On May 2, it appears to be the sightings of weapons that led staff to decide that they could not wait and that no other options were feasible. Those staff decisions should have been borne out by the contraband found after the extractions were completed. That is, the whole purpose for the serial cell extractions was ostensibly so that the two rows of inmates could be emptied, the individuals personally searched for weapons and the two rows and individual cells individually searched and cleared of contraband. However, the record in this case reflects no such expected result. Evidently, no shanks or other weapons were recovered from individual inmates or from a search of the two rows. Any contraband weapons found would have been documented and those documents would have become part of the record in this case, in response to Mr. Ramirez's request for production of documents relevant to the May 2 situation.

D. Serial Cell Extractions

What was done on C row was a classic example of "serial extractions". It is a practice that is well known in prisons and jails but strongly discouraged if not outright prohibited in all but the most extreme situations in most correctional agencies. The LASO Custody Division policy manual makes clear and useful distinctions between "directed" extractions, "calculated" extractions and "emergency" extractions. A directed extraction is a situation in which an inmate initially refuses to comply with orders to come out of his cell and then chemical agents are introduced into the cell and have the effect of gaining the inmate's compliance. The inmate is restrained without the need for physical force and remains complaint. A "calculated" extraction is a situation in which time and circumstances permit repeated attempts to talk the inmate into compliance, the use of different staff members to try to convince the inmate to comply, often including mental health personnel, and where there is time for staff to do as much planning as necessary to effect the safest possible extraction procedure. An "emergency" extraction is the opposite of a calculated extraction and occurs when there is imminent danger of loss of life, serious injury or massive destruction of state property. These distinctions and three types of cell extractions are not inconsistent with a situation in which an entire housing unit must be emptied. There are a wide variety of situations in which a high security housing unit might need to be moved or evacuated, including situations like smoke from a fire accumulating in the unit, a power outage or other mechanical failure, etc. In these situations, staff could move from cell to cell trying to get as many inmates as possible to comply with verbal directions to be restrained and to leave their cells. For those inmates who refuse to comply, more time and more attempts at non-force resolution might be used or chemical agents might be used, depending on the nature of the situation. If chemical agents failed to produce a "directed cell removal" then either a cell extraction team or other less than lethal tactical weapons might be used. However, that is not a "serial extraction" in the common sense of the word. "Serial extractions" are pretexts for administering corporal punishment to inmates. It has been a common practice in some jails or prisons that if inmates get loud, throw trash, talk disrespectfully or otherwise anger staff, the staff then reacts by deciding to do a serial extraction. In a serial extraction, an extraction team is sent into every cell, whether the inmate in that cell was part of the problem or not and whether the inmate in that cell was willing to comply with orders to have restraints applied or not. In a serial extraction, the extraction team roughs up, "tunes up" or simply beats the inmates as or after the inmates are restrained. Again, this happens without regard to whether individual inmates are resisting or not. Serial extractions are often accompanied by the use of large amounts of chemical agents on all inmates in the unit, again without regard to whether the chemical agents were needed in general or in individual

situations. It is Mr. Ramirez' contention in this case that what the Deputies did on C row was, in fact, a serial extraction and a pretext for using corporal punishment on the C row inmates. If staff actions in this incident did constitute a serial extraction and were a pretext for beating or otherwise applying corporal punishment to the inmates on C row, then Mr. Ramirez's version of what happened inside his cell and what happened to him while he was being moved for medical triage, are highly likely to be truthful. In addition to the evident failure to discover weapons in the aftermath of the extractions, and the evident lack of even minor injury to any staff member during individual assaults by 16 or 18 individual inmates, there is a host of other evidence in the case record that is consistent with Mr. Ramirez's version of events.

E. The Cell Extraction Policy

There are a number of important provisions in the Jail's cell extraction policy that were violated by staff during this incident. The policy notes that chemical agents "must be given appropriate time to take effect". I have emphasized that same point in an article that I recently published on cell extractions. In this case, although both pepperballs and aerosol OC were shot down the corridor of C row well prior to the extraction teams going onto the row, when the extraction teams moved to a particular cell for an extraction of that inmate, they would begin by firing five to ten pepperballs (or more, "saturating" the cell with pepperball dust). Rather than waiting for the pepperball dust to have an effect on the inmate, videotape E-4 clearly shows the extraction teams entering the cells immediately after or within a matter of seconds after the pepperball gun has been used.

The Watch Commander classified this incident as an emergency extraction. The policy states that an emergency extraction is authorized when "the behavior of the inmate (s) constitutes an immediate and serious threat to the safety of that inmate, staff, visitors, other inmates (i.e., assaults and suicide attempts), or the institution (i.e., controlling disturbances, including the massive destruction of property). Of these various conditions, only "controlling disturbances" might fit the situation on May 2, but the disturbance was already "controlled" to the extent that inmates were all individually locked in cells and there was no indication that the situation was spreading or getting worse.

Importantly, the cell extraction policy states, "In situations involving anticipated extractions of inmates in multiple cells or of an entire row, the Watch Commander and Unit Commander shall carefully evaluate all circumstances prior to authorizing the extractions team's deployment. In these cases, extraction teams should be used a last resort and based on the belief that no less intrusive methods or tactics are appropriate. "That policy statement applies directly to this situation and it appears that it was entirely ignored or violated by the Watch Commander. There is nothing in the record indicating that the Watch Commander even notified the Unit Commander prior to the extractions on C row, let alone any consultation between the Watch Commander and the Unit Commander in which they "carefully evaluated all circumstances prior to authorizing the extraction team's deployment". In fact, there is no indication in the case record that any "less intrusive methods or tactics" were considered.

The policy requires that the Unit Commander shall be notified of any directed removal by written memorandum. There is no such written memorandum or other notification of the Unit Commander in the record.

The extraction policy also requires that the Unit Commander be notified prior to commencing a calculated extraction. For the purposes of the requirement to notify the Unit Commander, this situation was clearly akin a calculated rather than emergency extraction. There was no inmate being attacked by a cellmate, no inmate was attempting suicide and there was no spreading disturbance. The Watch Commander had time to attempt a phone call to the Unit Commander. There are a variety of other requirements for the Watch Commander in this situation that were also ignored or violated. The policy requires the Watch Commander to watch the videotape of the extractions with the extraction Team Leader and to personally debrief the extraction team as soon as possible after the event has concluded. There is no indication in the case record that these things happened immediately after the extractions were completed, or that they ever happened.

The Watch Commander is responsible for ensuring that all cell extractions are videotaped. Here, the videotape segments produced by Defendants indicate that perhaps one third of the C row extractions were videotaped. The Watch Commander is also responsible by policy to make sure that there are videotaped interviews of all inmates involved in the incident and that there is visual documentation of all injuries. (This latter requirement can be accomplished with videotape, 35-millimeter film or a combination of both.) If videotape interviews were done with all individuals extracted from their cells and if all injuries were photographed, they were not included in the documentation provided by Defendants and this consultant has no way to know that they do or did exist.

F. The Videotape Segments

As I have discussed in articles on use of force that I have published, the use of battery operated hand held camcorders to record cell extractions has been a dramatic positive change for jails and prisons. Videotaping a cell extraction allows staff, including supervisory, management and training staff, to review the videotape in detail to identify problems ranging from equipment to policy, procedure or training. The review of the videotape can be an invaluable tool in improving performance in subsequent cell extractions. Second, videotape can offer the best possible documentation of what actually happened. It is not unheard of for an attorney representing an inmate or considering whether to represent an inmate, to view the videotape of the staff use of force on the inmate and then drop the matter because the video made it obvious that the inmate's allegations were untruthful and that staff had handled the situation reasonably and professionally. Third, the more subtle but perhaps most important advantage of videotaping cell extractions is that it has a prophylactic effect on staff behavior. The presence of the camcorder changes the chemistry of the situation and a staff member who may have been inclined to take short cuts, even those increasing his or her own safety in the situation, doesn't do so because of the knowledge that a camcorder is creating a permanent record. A staff member who may have been inclined to be unnecessarily rough or to taunt an inmate with insults during the heat of the moment, feels constrained to act within policy, knowing that to do otherwise might lead to disciplinary consequences, career problems or even personal litigation.

In order for videotaping of cell extractions (or of other "planned" uses of force) the videotaping must be done properly and reasonably. Many correctional agencies have detailed video protocols specifying that the extraction team will introduce itself individual by individual at the beginning of the event, providing assignments, that the tactical plan for the extraction will be reviewed on camera, that the attempts at non-force resolution will be videotaped, etc. The most important requirement is that the videotape run continuously from the beginning of the situation until the end (or until change of videotape is required) and that the camera be positioned as well as possible

to show the physical actions of staff as they enter the cell and of the inmate in the cell. Some correctional agencies require training or orientation in the use of the video camcorder for all supervisors, for all members of extraction teams or other tactical teams, etc. Other departments may require that the camcorder will only be assigned to a staff member who has completed some training or orientation on its use.

In this case and in the situation on May 2, 2006 at MCJ, almost every objective and advantage of the use of a camcorder in cell extraction situations has been defeated either intentionally or by an exceptional amount of incompetence. In my opinion, the misuse of the camcorder was intentional. During almost all of the time the camcorder is recording actual extractions, the camcorder is pointed down the corridor and is not in a position to see anything inside the cells. The point of using the camcorder, of course, is exactly to record what does happen in the cells. The camcorder operator further obscures the view of the camera by keeping it placed directly behind one or more staff members for much of the time the filming is going on, so that the videotape shows the backs of staff lined up in the corridor. Even when the camcorder operator moves closer by a few steps to the cell where an extraction is occurring, the camera focuses on the face helmet and face shield of a female deputy rather than on the cell where the incident is occurring. It is standard practice to begin and end recordings with the camcorder operator or an assistant narrating the name of the camcorder operator, the time, date and location, the situation encountered, etc. In addition, the camcorder operator should provide additional narration for clarity and for the viewer's later information as the situation progresses. None of that happened.

As long as the correct date and time are initially set on a camcorder, subsequent recordings will contain a "time stamp" that provides the time and date of each recording and which can be replayed on screen if desired. The camcorder or camcorders used to record the four video segments included in this case record did not have the correct time or date set.

In spite of a policy that requires camcorder or 35-millimeter camera photography of inmate injuries, the camcorder operator is careful to keep the camcorder view raised so high that when inmates are extracted from their cells and then carried or dragged down the corridor past the video operator, the video operator either entirely avoids any videotaping that includes visuals of the inmate or moves past the inmate quickly so that he is on camera for less than a few seconds. On a few occasions the camera is pointed at the floor or at the ceiling for substantial periods of time, recording but showing nothing. There are other occasions when the camera is either set at so much wide angle or so much telephoto that the usefulness of the videotape is compromised. All handheld camcorders are designed so that the operator controls what is being recorded by looking either through a viewfinder or at an LCD screen. In either case, the camera operator is looking at the same view that the camera lens is recording and the operator can reposition the camera, point the camera in the necessary direction and zoom in or zoom out to get the most useful picture. For the cell extractions, that was simply not done.

The misuse of the camcorder has direct implications for the questions about the extraction of Mr. Ramirez. One of the four video segments includes material that appears to show the staff outside cell C-9 during that extraction. Pepperballs are fired into the cell but the extraction team is sent in almost immediately, rather than allowing time for the pepperball powder to have effect. Inmates are heard yelling and chanting on the tape but there is little from staff that is loud enough to hear. Staff may have yelled something at Mr. Ramirez but it does not sound like there were attempts at discussions about compliance both before and after the pepperballs. What can be heard loud and clear in the video recording is Mr. Ramirez (if it is C-9) screaming repeatedly just after the two

Deputies enter, the cell. It is possible that Mr. Ramirez is screaming as he attacks the two Deputies but it sounds like instead, it is Mr. Ramirez repeatedly crying out in pain.

G. Reports

The staff version of the May 2 incident are contained in the internal reports prepared by various staff members. These reports are crucial. Every correctional agency and law enforcement agency recognizes that incident reports must be detailed and accurate because staff may have to testify about an incident, whether for an internal investigation or litigation, months or even years later. In some cases, staff members simply do not remember the specifics of an incident and must rely on the report that they wrote contemporaneous with that incident. In fact, in law enforcement and corrections, one of the "rules" that staff have heard so often that they joke about it is "If it isn't documented, it didn't happen".

In this case, some crucial reports are missing, others are substantially incomplete and still other reports are inaccurate or false. The overall picture is consistent with the Plaintiff's, Mr. Ramirez's, version of events and inconsistent with the staff version.

The Watch Commander is required by policy to include in his/her Report of Force memo the identities of any inmates injured including the nature and extent of their injuries. The Watch Commander, Lieutenant Sutton, did not do that. The cell extraction policy for the Custody Division of LASO places the primary responsibility for reporting and documentation of any cell extraction incident squarely upon the Watch Commander. In addition to the requirements in the paragraph above, the policy specifies, "The Watch Commander shall ensure that proper reporting procedures are followed in documenting all uses of force during the cell extraction/removal." Also, "The Watch Commander shall completely document the incident using the 'use of force-extraction, incident analysis/review package'...". In this case, the Shift Commander, Lieutenant Sutton (who is also referred to as the "incident Lieutenant") did none of that.

The heart of the documentation on a cell extraction at MCJ is the use of force extraction package prepared by the Shift Commander. That package is the foundation of the review of the incident by the Unit Commander and perhaps by other managers and administrators in the Department; it also is required to be forwarded to the training unit of the Department for their review with regard to potential training modification and performance improvement. Lieutenant Sutton's use of force extraction package for the May 2 cell extractions is closer to a bad joke than a serious report. The first page is a checklist and is titled "Incident analysis/overview". Some answers are incorrect. For example, for the question, "Was medical staff present, and did they conduct an on-scene triage?", Lieutenant Sutton answered "Yes". Actually, the medical staff were present at the school area and not on-scene. On another question, "Once it was determined that force would be used, was OC spray used before other methods were applied?", Lieutenant Sutton answered "Yes". Actually, both with regard to chemical agents in the corridor of C row and chemical agents in individual cells, the pepperball gun (which is an impact weapon as well as a chemical delivery system) was used prior to aerosol OC. The next age of the package is another check sheet for the Watch Commander, titled "Incident Analysis/Review". Lieutenant Sutton did not answer any of the questions in that checklist. The third page is a narrative section asking crucially important questions, such as "Why did this extraction have to take place?", and, "Why was the degree of forced used appropriate?", that page is supposed to be completed by reviewers as are the following two pages of the package. There are no reviewers listed and these pages are blank in the package on this incident.

The following page is intended to be completed by the Unit Commander and the page after that by the Area Commander. Those two pages are blank. Following that there is a page, which contains another checklist for the Shift Commander. One of the questions on that checklist is "Were all reports complete, with an accurate description of the need for application of force, the force used, and the resistant encountered?", Lieutenant Sutton answered "Yes" to that question although some reports are missing, some are incomplete and others are inaccurate. It is also required that incident and supplemental reports be reviewed and signed off on by a supervisor as "approved". Most reports of this incident are not signed off on, and approved. The next five pages of the package are forms, which constitute the "Supervisor's report on use of force". They are blank.

The next page in the package has a table that has been filled out. The table is intended to identify which staff used force against which inmates, including what type of force was used and what part of the inmate was injured by the force. That table is filled out inaccurately. For example, is does not list David Ramirez, the Plaintiff in this case, among the injured inmates. The section of the package that is intended to provide initial documentation of inmate injuries has been filled out only for two inmates (Jamie Avala and Melvin Guevara). Only one other page of the package is filled out and that simply provides cross-referencing of inmate names against cell numbers and "suspect numbers" in supplemental reports.

In summary, only a handful of pages in this 31-page package have been completed and some of the information that has been provided is inaccurate or incomplete. There is nothing from the Unit Commander or Area Commander, nor is there a team of reviewers although there are policy provisions that requiring most of that.

One of the positions that may be assigned on an extraction team is referred to in the LASO cell extraction policy as a "Scribe". That person maintains a record, either verbal or by means of a cassette tape recorder, written, of cell numbers, weapons utilized, numbers of rounds fired and which extraction team members dealt with the inmate. He/she also "Writes a chronological log of events for reference during subsequent reporting phase." Finally, "Upon completion of extraction/removal incident, provides all logged and recorded information to the Watch Commander, Team Leader and additional extraction personnel..." During the cell extractions, Officer Martinez was assigned as a "Scribe". However, there is no written or verbal record from Officer Martinez nor is there a chronological log of events that he was required to prepare. Either of those documents would have been very useful in establishing what happened when because of the large number of sequential extraction in a high adrenaline situation and the difficulty for staff in remembering exactly what happened in what order at each cell with each inmate, after the whole incident was concluded. What happened to the assigned Scribe and his/her work products continues to be a mystery.

There are other key documents that should be in the case record but are not. In addition to the Watch Commander, the Sergeants also have responsibilities to complete debriefing reports after debriefing their teams. There are no debriefing reports and it appears that one of the two teams was not debriefed as required by policy. Each housing unit in the L.A. County Jail system is required to maintain and complete daily activity logs (formally called "unit daily activity log", or "UDAL") which must be signed by the Senior Deputy, Sergeant and Watch Commander. Additionally, for segregation housing units and other high security units, there is a required safety check sheet which must be attached to the UDAL. The UDAL's are required to be retained for five years, by policy. No UDAL's have been furnished by the Defendants in response to Plaintiff's

request for production of relevant documents. This consultant does not know whether MCJ maintains UDAL's or not. If they are completed as specified in policy, they would almost certainly shed light on Mr. Ramirez's contention that the situation on May 2 was an out-growth of a continuing conflict between the A row inmates and the jail staff over access to commissary goods by those inmates. The most disturbing aspect of the staff reports on this incident are the many indications that the reports are not what they purport to be. Each incident report or supplemental report is supposed to be an independent statement by the staff member submitting the report with regard to that staff member's personal knowledge and memory of the events being reported. If a staff member reports what someone else told them, they should report the source of the information rather than reporting it as their own knowledge or observation. Similarly, if staff consult with each other about the events they are reporting they should reflect that in their individual reports (although that practice generally compromises the integrity of individual reports).

In a situation as lengthy and complicated as the May 2 cell extractions, some differences with regard to reporting of the factual situation are to be expected. Different individuals will be physically positioned differently, hear and see slightly different things and, most importantly, memories about details will differ somewhat when reporting on lengthy or complicated events. Total agreement on details is simply unrealistic.

In jails and prisons, where it is common for use of force incidents to involve several or more staff, the almost complete agreement on details by several different staff, frequently indicates that staff have collaborated in order to make their reports consistent or that they have used each other's reports or some other single source rather than relying on their individual knowledge and memory. That kind of collusion is often accompanied by an individual actual copying portions of one person's report, and then presenting it as his own. This incident is rife with examples of those kinds of corrupt reporting practices. For example, on Sergeant Jurnigan's red extraction team, there were typically five to seven individual staff reports, including Sergeant Jurnigan's, on any particular cell extraction. Those reports reflect a degree of agreement that would be unrealistic if the reports were prepared independently by each staff member. The reports differ to a minor degree in wording but in most cases agree exactly on the sequence of events at each cell extraction, the number of times the taser was used, the number of stinger rounds fired, the inmate's responses, etc. Another inescapable example is provided by Deputy Ochoa. It is understandable that if an individual is writing reports which contains background information or information describing the development of the situation, the individual reporting may well choose to write those sections of the report once and then copy them for other required reports. Thus, there is nothing wrong with a situation in which a Deputy has submitted five separate reports on five separate cell extractions but each report begins with the same two paragraphs, verbatim, describing the housing unit and the assembly and briefing of the extraction team. However, when that Deputy goes on to describe what he/she observed at each of the five cell extractions, the Deputy is obligated to report his/her memory and knowledge of those five situations in detail and independently. Deputy Ochoa's report on the cell extraction of inmate Perez from cell #6 states in relevant part, "He was hiding in the alcove at the rear of the cell, under a mattress. Sergeant Jurnigan ordered him several times to surrender by coming out from behind the mattress with his hands up. He refused to do so. I was directed by Sergeant Jurnigan to fire approximately five to ten pepperballs into the cell, above the mattress area. The cell treatment of the pepperballs had little to no effect as inmate Perez refused to come out from behind the mattress."

When Deputy Ochoa prepared his report about removing inmate Hernandez from cell #3, he wrote, in part, "He was hiding in the alcove at the rear of the cell, under a mattress. Sergeant

Jurnigan ordered him several times to surrender by coming out from behind the mattress with his hands up. He refused to do so. I was directed by Sergeant Jurnigan to fire approximately five to ten pepperballs into the cell, above the mattress area. The cell treatment of the pepperballs had little to no effect as inmate Hernandez refused to come out from behind the mattress."

On the cell extraction from cell #26, Deputy Ochoa wrote the same five sentences verbatim. He wrote the same thing, word for word, for the cell extraction from cell #6. He used the same five sentences for the extraction from cell #7 and used the same material, verbatim, to describe the cell extraction in cell #4.

Obviously, the cell extraction situation at MCJ on May 2, 2006 was not "Groundhog Day". The exact same situation did not happen five times with five different inmates. Perhaps one inmate said something unusual or another moved unexpectedly to a different part of the cell or perhaps the staff reactions were somewhat different in some of those five situations. It is not reasonable to suggest that Deputy Ochoa's independent memory of each of those situations was best expressed with exactly the same words in exactly the same order, phrasing and sentence structure.

There are other examples of this same sort of problem in the staff reports on this incident, including a great deal of "boilerplate" substituting for real details in Sergeant Jurnigan's several page master report.

A different kind of problem is apparent with the reports on the cell extraction of the Plaintiff, David Ramirez. Two Deputies actually entered Mr. Ramirez's cell to effect the cell extraction, Deputy Picarella and Deputy Serna. Their reports are plagiarized, either one copying from the other or both copying from some third source. The first seven paragraphs of each of their reports are essentially identical but with minor wording changes to make it look as if they are different reports. For example, the first paragraph of Deputy Picarella's report reads, "The purpose of this supplemental report is to provide additional information regarding my actions and observation during the above incident." The first paragraph of Deputy Serna's report reads, "The purpose of this supplemental report is to provide active additional information of my actions and observations during the extraction of module 3500 on 05/02/06." The next paragraph in both reports is a single sentence describing the assignment of the Deputy followed by "The Men's Central Jail response teams, 1 & 2, along with the green and red extraction teams...". The third paragraph of both reports begins "I was assigned as a capture Deputy on the green extraction team under the direction of Sergeant Bottomley, ...".

It would be burdensome to continue with this example but the situation is much the same through seven paragraphs in a row in each of the reports. The odds that each of the two Deputies chose the same number of paragraphs and the same sentence structure and the same word choice for most of those paragraphs would be astronomical.

Another large and obvious flaw in the staff reporting on this situation has to do with inmate injuries. If one simply reads the large number of staff reports on this incident from Deputies involved on the extraction teams, the conclusion would be that there were no inmate injuries, or at least none that were visible at the time the inmates were actually removed from their cells. One report describes one staff member kicking an inmate in the head and another staff member kicking the same inmate in the face but there is no mention in the report of visible cuts, bruises or bleeding. Another report describes an inmate as falling forward and hitting the sink in the cell and a number of reports describe various staff members punching inmates. Many inmates were

injured, some quite seriously and their injuries had to be obvious to the staff who caused those injuries and those witnessing the uses of force. The existence of injuries is a major issue in any incident and it is well accepted that injuries should be documented as quickly as possible, particularly since disputes are common about when or where an injury occurred or when it first became apparent. There is no plausible explanation for a large number of staff all deciding not to report obvious inmate injuries unless there was either formal or informal direction from managers in the department or staff had informally agreed among themselves that injuries would not be reported. There is a major issue about staff retaliation which is discussed later in this report but the apparently universal practice of not reporting staff injuries must be considered as part and parcel of that discussion of staff retaliation.

In addition to not reporting inmate injuries, the reports that describe tasering an inmate or those describing the order to use the taser in a particular inmate, make no mention of where the taser darts or "dry tase" hit the inmate. That is important because taser training includes areas of the body that are not to be tased, such as the face. With no references to where tasers were used on inmates, it is difficult to know whether the taser use was consistent with training on manufacturer's instructions for use.

There are still other serious reporting problems in this incident. For example, Deputy Picarella reports that he punched Mr. Ramirez twice in the rib area and then once on the left side of Mr. Ramirez's face. However, Deputy Serna, who is the other Deputy in the cell with Deputy Picarella, reports that he struck Mr. Ramirez several times on his thighs using his right fist and then a few moments later struck Mr. Ramirez several more times in the right thigh with his right fist when Mr. Ramirez "began to kick at Deputy Picarella with his right leg". Deputy Serna concludes his report with the statement, "I did not use or witness any other force." Deputy Serna was right next to Deputy Picarella. How could Deputy Serna have not noticed that Deputy Picarella punched Mr. Ramirez twice in the ribs and once in the face? This is not isolated example with Mr. Ramirez. There were a number of other individual extractions during this incident in which (for example, in the reports on the cell extraction from cell #25, Deputy Adragna reports that inmate Altamirano began punching at him and that he hit Mr. Altamirano in the face three to five times in response. Deputy Douesnard was assigned to the taser and observed the physical force, reporting on Mr. Altamirano's assaultive behavior towards Deputies in the cell. However, Deputy Douesnard does not report any use of force by Deputy Adragna. Deputy Lawler was the shield Deputy and also describes punching Mr. Altamirano several times in the upper torso but he does not report witnessing any use of force by Deputy Adragna nor does Deputy Adragna report any use of force by Deputy Lawler. It is my opinion that there is a substantial "code of silence" operating at MCJ with regard both to reporting inmate injuries and reporting witnessing the use of force by other staff.

It must be emphasized that these are most serious issues. They reflect directly on the credibility of the staff and of the staff reports involved in this incident. If Deputies copied each other's reports or collaborated on the details and sequence of events, then what purports to be a series of independents reports by separate individuals, each corroborating the same basic fact pattern, is not that at all. It is instead a false representation of one or more unidentified and unknown sources, as if they were independent and individual records of the events. The obvious question is if the integrity of the staff reports on this situation are compromised by collaboration or plagiarism or similar inaccurate or untruthful representations of the situation, why would staff reports be credible with regard to the specific actions of David Ramirez or the two Deputies when he was extracted from his cell on May 2, 2006?

It is also my opinion that these kinds of improper and misleading reporting practices cannot go on in a frequent or wide spread manner, without being condoned by mid managers, managers and administrators. These kinds of problems are not hard to spot. They will become apparent to anyone who reviews sets of reports on major incidents thoroughly and in detail. Even where the staff are too smart to copy paragraphs or documents verbatim and have tried to disguise their actions with a small amount of rewording and adding or deleting a particular reference here or there, a pattern quickly emerges and can be verified with reference to additional reports by the same individual or reports from other individuals on the same situation.

H. Review, Investigation and Accountability

One of the most disturbing aspects of this incident is that there was apparently not so much as a cursory review of the situation, let alone a serious investigation. To be clear, the policies within the LASO Custody Division have appropriate checks and balances regarding reviews and investigations of use of force situations. However, written policy may not be real policy. When written policy is ignored or when clear violations of policy are condoned, then the real policy of the agency is based on the practices that are accepted rather than the rules which are written but not followed.

Almost all jails and prisons have review and investigation policies and procedures for use of force situations. Some are better designed than others and some are adhered to more closely than others. However, it is more than unusual to find a large correctional agency that simply ignores all of its policy requirements regarding reviews and investigations of major incidents, let alone individual uses of force. The cell extraction on May 2, 2006, was a major incident, if for no other reason than the number and severity of inmate injuries. Typically, any use of force situation that produces a major injury is subjected to a rather high level of review and/or investigation by the responsible department. That did not happen at MCJ. As far as Mr. Ramirez is aware and as far as the documents in this case record reflect, no one ever looked into this incident in any manner. It follows that with no review and no investigatory procedure in actual practice, there is no accountability. The signal from top management to staff at every level is clear: "Do what you want, nothing will happen." This issue, like the issue of staff choosing to not report inmate injuries in use of force situations and choosing not to report uses of force by other staff, are part of a larger picture with regard to staff retaliation.

There is no point in dwelling on the specifics of use of force reviews or use of force investigations. It does not really matter what policies or procedures have been formally adopted if they are not followed. Sufficeit to say that in most jails and prisons a well-defined, rigorous and unbiased review and investigation protocol is one of the most important elements in managing use of force situations as professionally as possible.

From a different perspective, was there no one in the MCJ mid-management or management ranks, or among the L.A.S.O. Custody Division administrators who was curious about how and why a serious disturbance started on an administrative segregation unit? If for no other purpose, that information is potentially important in preventing a repeat of the same situation, perhaps with worse consequences.

I. Retaliation

The question of exhaustion of grievance and complaint procedures or other due process remedies available to inmates at MCJ, has been raised and contested earlier in this litigation. Defendants have stated that MCJ has a grievance procedure and that Mr. Ramirez could have availed himself of that avenue. They have further argued that when Mr. Ramirez did write a complaint about the May 2 cell extraction, it was almost a year later and the complaint was not accepted because it was not on the appropriate MCJ complaint form (it was instead written on a form 602, apparently from the California State Department of Corrections and Rehabilitation.) Mr. Ramirez acknowledges that he did not complain or grieve about the situation in its immediate aftermath. He alleges that he was told not to mention his injuries or how they happened, by Deputies, and that they further told him that if he did complain, he would leave MCJ "in a body bag". Mr. Ramirez acknowledges being intimidated by these threats and, in fact, when he was interviewed on videotape about his injuries he refused to talk about them and at one point told staff he had fallen down stairs. Defendants deny his allegations of threats and intimidation to silence him.

There are a number of facets to the question of staff retaliation. The threats that Mr. Ramirez reports are exactly the same kinds of threats that the ACLU talks about in its current report on MCJ as constituting a long running pattern and practice of intimidation and retaliation by staff against inmates. Also, the retaliation issue makes sense of some other practices at MCJ that are otherwise difficult to explain. For example, the staff practice of not reporting inmate injuries makes sense if taken in conjunction with the practice of intimidation and retaliation. If staff do not report inmate injuries, and if inmates then do not grieve or complain or otherwise bring attention to the situations that created their injuries, then an inmate injury at the hands of staff may be a tree falling in a forest: if no one sees it or later hears of it, did it happen? That same explanation holds for the staff practice of not reporting uses of force by other staff. Again, if inmates can be kept quiet, then for all intents and purposes, nothing happened. The final arrow in this quiver is the agency stance about reviews and investigations of staff uses of force. If reviews and investigations are not taken seriously, or if, as in this case, they simply do not occur, then there is little reason for staff heartburn over almost anything that may occur in the jail. Make no mistake about it, this is an odious picture of a situation in which jail staff are a law unto themselves and inmates are at their mercy and without recourse. There are other possible explanations but they seem highly unlikely. It is possible that the jail did conduct appropriate reviews and investigations of this incident and that they were lost. That seems improbable. It is also possible that the jail has those documents and for some reason did not produce them in response to Plaintiff's various requests for documents. That also seems unlikely and in any event this consultant cannot analyze the situation or reach conclusions based on documents or other records to which he has no access. A third possible explanation is that this incident was an anomaly. That is, something idiosyncratic about this incident resulted in staff failures to report things and departmental and institutional failures to review and investigate; that this incident, although it involved a large number of deputies and several supervisors, did not represent the practices and procedures in use in the jail. However, that too seems unlikely. There is some other dramatic evidence that bears on this question and is quite independent of Mr. Ramirez. That is the behavior of the other inmates involved. It is acknowledged that the 5300 block (or module) held primarily or exclusively "heavy" inmates with strong gang affiliations and serious criminal records. Yet these sophisticated and hardened inmates, to a person, "clammed up" when asked about the incident or asked how they had received their injuries. This is not a case of some "inmate code". Inmates may not inform on each other but there is nothing in any real or perceived inmate code that prohibits inmates from

reporting staff malfeasance or misfeasance. There is no good reason that inmates with very serious injuries caused by staff use of force would refuse to even answer a factual question about how the injury occurred, unless they were simply intimidated by staff threats of retaliation.

In this regard, it is worth noting that the Defendants have raised the issue of Mr. Ramirez's complaint in 2007 (about the May, 2006 incident not being on the proper form). The Jail policy regarding grievances and complaints states emphatically that no complaint shall be rejected because it was not on the proper form and also states that all complaints will be investigated.

The final piece in this puzzle has to do with inmate prosecutions and inmate punishment. On initial review, it was puzzling that there were no records of either criminal prosecution or administrative discipline for any of the inmates involved in the May 2 incident. Some of the inmates were specifically cited in staff reports for serious crimes, including assault with a deadly weapon and assaulting a Peace Officer. Potentially, all or almost all of the inmates involved in the cell extractions could at least have been charged with interfering with or resisting a Peace Officer in the performance of his/her duties. If the staff version of events is to be believed, then charges of in citing to riot or participating in a riot or disturbance might have also obtained. It may be that pursuing criminal charges would be impractical for staff. There are many locations in the United States where local or state prosecutors do not pursue new criminal charges against inmates for anything much less serious than murder. In some cases that is due to workload considerations and in other cases it may be a result of existing overcrowding in the jails or prisons, or perhaps it is for some other reason. However, serious offenses such as assault with a deadly weapon or possession of a shank or assault on a Peace Officer are, at a minimum, pursued through administrative discipline channels at a minimum, almost everywhere. Certainly MCJ pursues much less serious offenses through the established administrative discipline procedure for inmates. That is clear from the disciplinary records of inmate David Ramirez before the May 2 incident. Once again, the answer may be tied to practices of staff retaliation and intimidation. If administrative discipline hearings are scheduled, then there would likely be discussion of what happened during the cell extractions and perhaps discussion of the inmate injuries. That is the most plausible reason that there are no records of any disciplinary hearings following the serial extraction incident.

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Jeffrey A. Schwartz, Ph.D. Date

At: Campbell, CA

CITIZENS' COMMISSION ON JAIL VIOLENCE
FINDINGS IN REGARD TO USE OF FORCE STATISTICS[1]

1. **Three facilities accounted for the bulk of force incidents from 2007 through 2011: Men's Central Jail ("MCJ"), Twin Towers Correctional Facility ("TTCF"), and Inmate Reception Center ("IRC").**

   - 4,460 total force incidents occurred in all LASD jails from 2007 through 2011.
   - 1,311 force incidents occurred at MCJ from 2007 through 2011. This was 29% of the total force incidents.
   - 1,058 force incidents occurred at TTCF from 2007 through 2011. This was 24% of the total force incidents.
   - 976 force incidents occurred at IRC from 2007 through 2011. This was 22% of the total force incidents.
   - Combined, 75% of the total force incidents occurred in these three facilities.

2. **A clear majority of force incidents involved significant force rather than less significant force.**

   - From 2007 through 2011, 65% of the use of force incidents involved significant force and 35% involved less significant force.
   - While total force incidents have declined over the past few years, the percent of incidents involving significant force has been on the rise. In 2007, 55% of use of force incidents involved significant force. The figure has risen since then: 62% in 2008, 72% in 2009, 67% in 2010, and 72% in 2011.

3. **Inmate assaultive activity played a role in less than half of the use of force incidents in 2011.**

   - In 2011, there were 581 total use of force incidents at all LASD jails. Of these, 250 involved either (1) an inmate vs. inmate assault or (2) an inmate vs. staff assault. Thus, 331 incidents, or 57%, did not involve an inmate assaulting another person and resulted from other circumstances.

[1] All information is based on Use of Force data provided to CCJV by the LASD.

4. **Non-directed force was far more common than directed force at LASD jails from 2007 through 2011.**

   - 86% of force incidents at MCJ were non-directed.
   - 90% of force incidents at TTCF were non-directed.
   - 84% of force incidents at IRC were non-directed.

5. **The vast majority of force from 2007 through 2011 occurred without a supervisor present.**

   - 73% of force incidents at LASD jails occurred without a supervisor present.
   - 69% of force incidents at MCJ occurred without a supervisor present.
   - 87% of force incidents at TTCF occurred without a supervisor present.
   - 78% of force incidents at IRC occurred without a supervisor present.

6. **LASD determined that less than 1% of use of force incidents involved founded allegations of unreasonable force from 2007 through 2011.**

   - LASD reported that there were 23 incidents in which allegations of unreasonable force were deemed founded for incidents occurring from 2007 through 2011.
   - During this same time period, there were 4,460 use of force incidents in LASD jail facilities. Thus, 0.5% of these incidents were determined to involve founded allegations of unreasonable force.

2006 FORCE

Annual Bookings 178,103

	FORCE	LESS SIGNIFICANT FORCE	SIGNIFICANT FORCE
MCJ	440	271	169
TTCF	176	46	130
CRDF	106	49	57
NCCF	117	58	59
EAST	42	18	24
SOUTH	0	0	0
NORTH	53	25	28
MLDC	13	6	7
IRC	223	109	114
TOTAL	1170	582	588

2007 FORCE

Annual Bookings 170,734

	FORCE	LESS SIGNIFICANT FORCE	SIGNIFICANT FORCE
MCJ	367	207	160
TTCF	225	68	157
CRDF	80	33	47
NCCF	83	42	41
EAST	27	16	11
SOUTH	5	4	1
NORTH	40	21	19
MLDC	13	8	3
IRC	268	104	164
TOTAL	1106	503	603

2008 FORCE

Annual Bookings 168,612

	FORCE	LESS SIGNIFICANT FORCE	SIGNIFICANT FORCE
MCJ	273	102	171
TTCF	243	93	150
CRDF	70	34	36
NCCF	73	24	49
EAST	27	13	4
SOUTH	17	5	12
NORTH	33	14	19
MLDC	8	5	3
IRC	244	77	167
TOTAL	978	367	611

2009 FORCE

Annual Bookings 152,767

	FORCE	LESS SIGNIFICANT FORCE	SIGNIFICANT FORCE
MCJ	330	72	258
TTCF	296	88	208
CRDF	65	28	37
NCCF	71	26	45
EAST	42	25	16
SOUTH	26	2	24
NORTH	8	2	6
MLDC	5	2	3
IRC	214	50	164
TOTAL	1056	295	761

2010 FORCE

Annual Bookings 145,821

	FORCE	LESS SIGNIFICANT FORCE	SIGNIFICANT FORCE
MCJ	168	52	116
TTCF	201	52	149
CRDF	83	32	51
NCCF	102	45	57
EAST	19	13	6
SOUTH	19	8	11
NORTH*	0	0	0
MLDC	5	1	4
IRC	142	42	100
TOTAL	739	245	494

2011 FORCE

Annual Bookings 142,862

	FORCE	LESS SIGNIFICANT FORCE	SIGNIFICANT FORCE
MCJ	172	33	139
TTCF	94	25	69
CRDF	93	30	63
NCCF	77	34	43
EAST	22	11	11
SOUTH	13	2	11
NORTH*	0	0	0
MLDC	3	2	1
IRC	107	26	81
TOTAL	581	163	418

2012 FORCE

(Annual Bookings not available for 2012)

	FORCE	LESS SIGNIFICANT FORCE	SIGNIFICANT FORCE
MCJ	69	23	46
TTCF	46	21	25
CRDF	27	18	9
NCCF	34	15	19
EAST	13	6	7
SOUTH	7	3	4
NORTH*	0	0	0
MLDC	1	0	1
IRC	32	22	10
TOTAL	229	108	121

Source of force incidents: FAST and W/C Logs as of 07/17/2012.
Source of Average Daily Inmate Population & Annual Bookings:
Inmate Reception Center Daily Inmate Statistics.
*North Facility was closed in March 2010 and re-opened in July 2012.

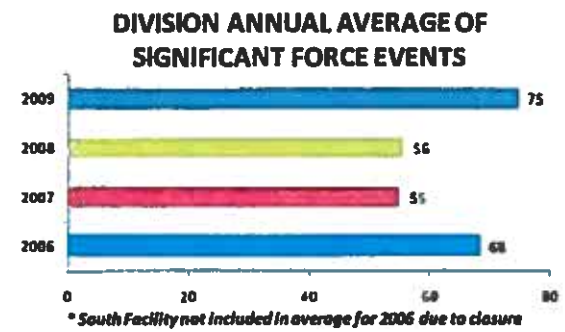
CUSTODY OPERATIONS DIVISION

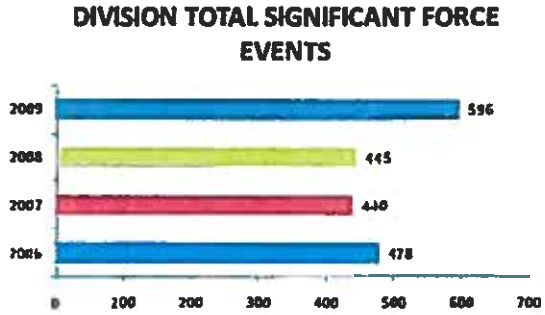
2006 – 2009

May 27th, 2010

CHIEF DENNIS H. BURNS

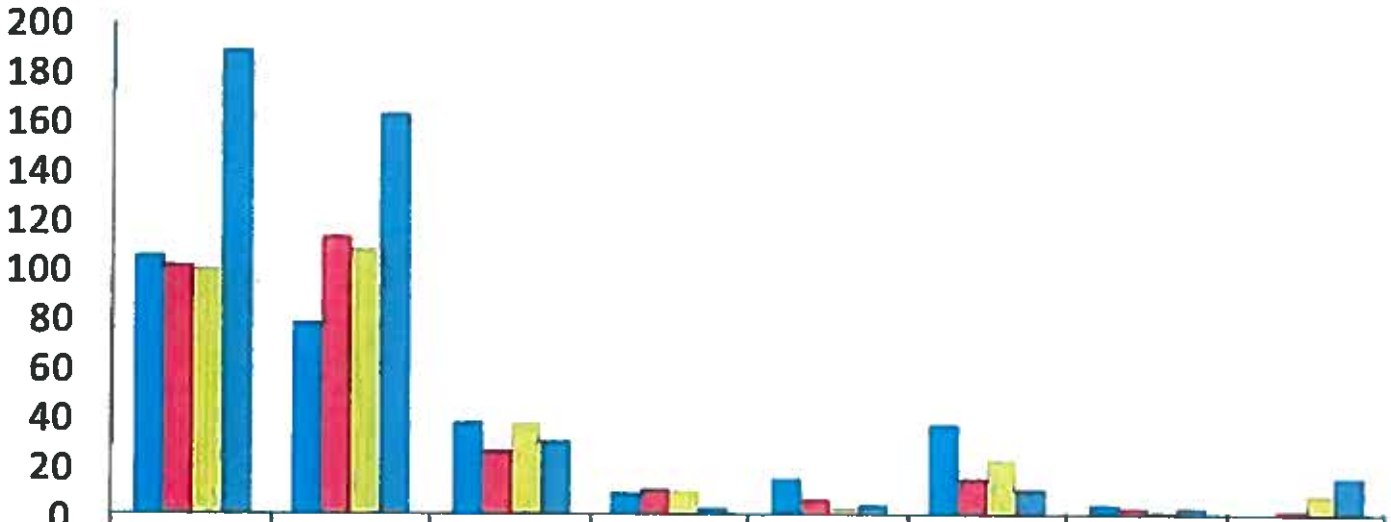
Significant Force Events





	MCJ	TTCF	NCCF	NORTH	EAST	CRDF	MLDC	SOUTH
2006	166	131	59	26	25	64	7	0
2007	161	156	41	18	14	46	3	1
2008	170	151	49	19	4	37	3	12
2009	259	212	45	6	11	36	3	24

Significant Force – Inmate Has Visible Injury



	MCJ	TTCF	NCCF	NORTH	EAST	CRDF	MLF	SOUTH
2006	106	78	38	9	15	37	4	0
2007	102	114	26	10	6	14	3	1
2008	100	109	38	10	3	22	1	8
2009	190	164	30	3	4	10	2	15

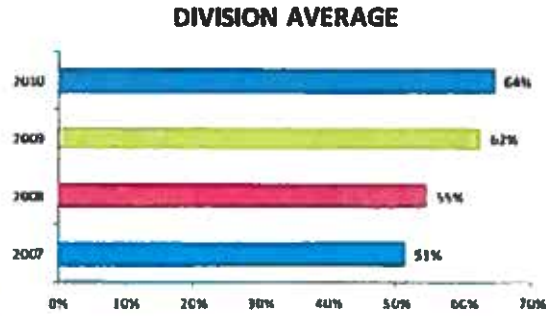
CUSTODY OPERATIONS DIVISION

2007 – 2010

2011

CHIEF DENNIS H. BURNS

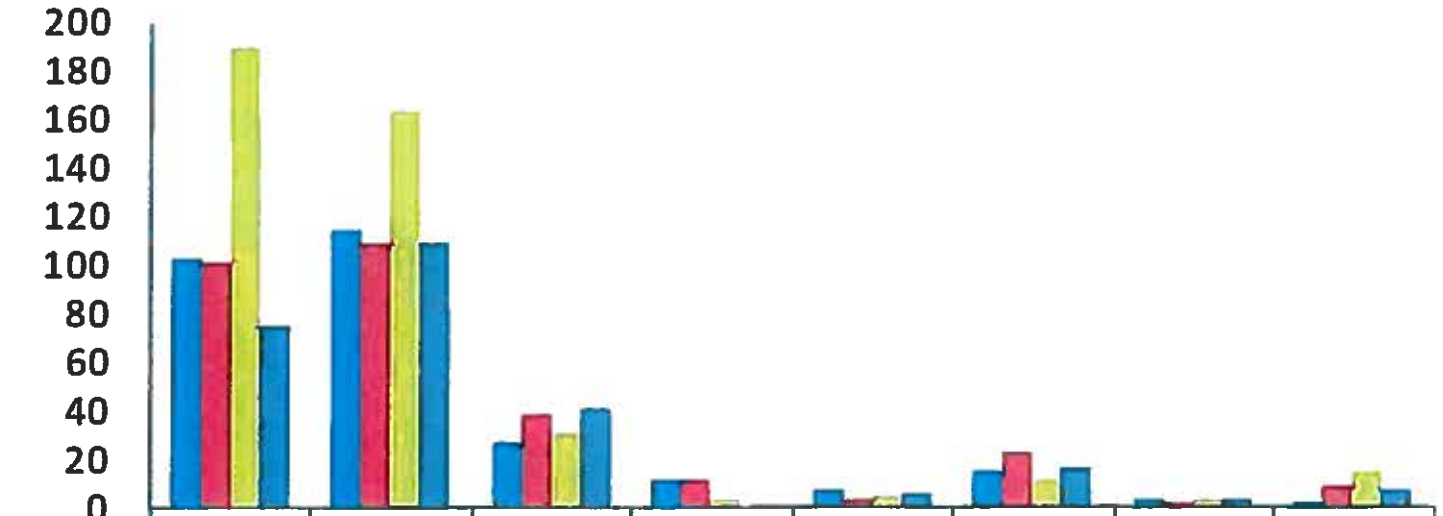
Significant Force As a Percentage of Total Force



	MCJ	TTCF	NCCF	NORTH	EAST	CRDF	MLDC	SOUTH
2007	44%	69%	49%	45%	52%	58%	25%	14%
2008	62%	62%	67%	58%	24%	53%	30%	75%
2009	79%	72%	63%	75%	27%	58%	60%	92%
2010	69%	74%	56%	0%	45%	62%	57%	63%

- South Facility Closed in 2001, reopening in mid 2007.
- North Facility closed in March 2010.

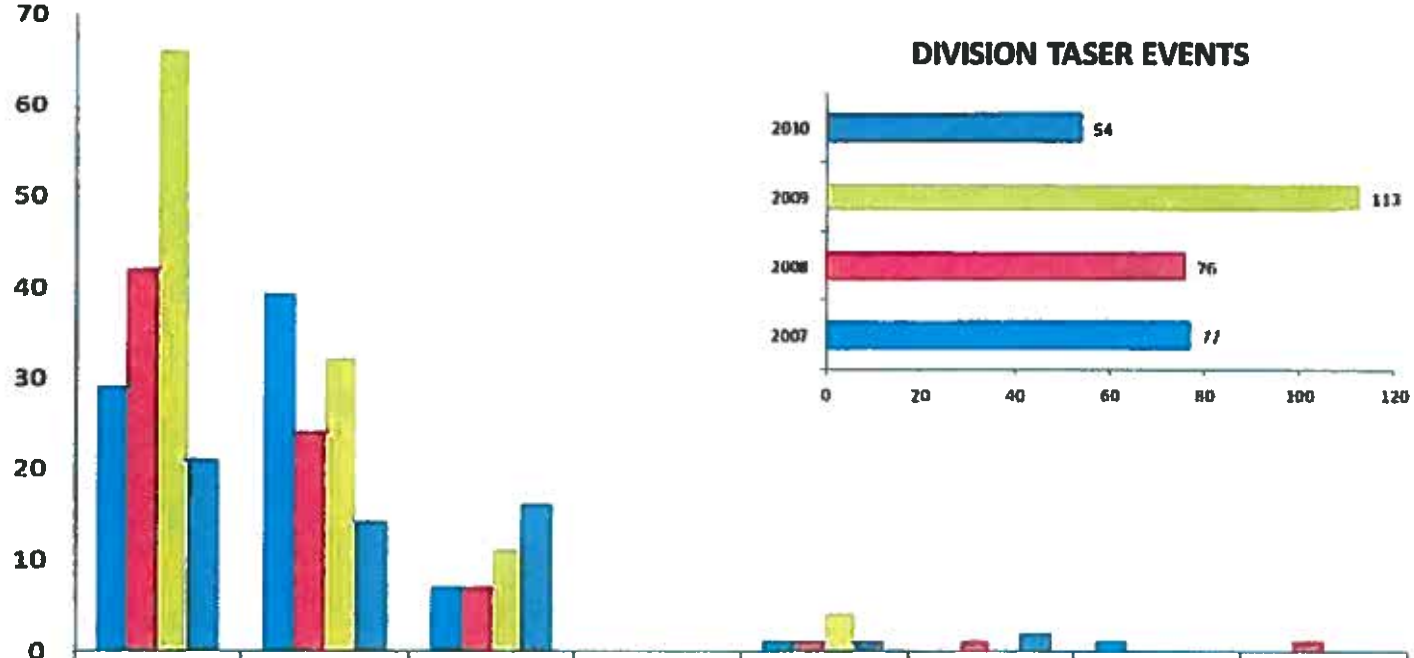
Significant Force – Inmate Has Visible Injury



	MCJ	TTCF	NCCF	NORTH	EAST	CRDF	MLF	SOUTH
2007	102	114	26	10	6	14	3	1
2008	100	109	38	10	3	22	1	8
2009	190	164	30	3	4	10	2	15
2010	74	109	40	0	5	16	2	6

- South Facility Closed in 2001, reopening in mid 2007.
- North Facility closed in March 2010.

Taser Events



	MCJ	TTCF	NCCF	NORTH	EAST	CRDF	MLDC	SOUTH
2007	29	39	7	0	1	0	1	0
2008	42	24	7	0	1	1	0	1
2009	66	32	11	0	4	0	0	0
2010	21	14	16	0	1	2	0	0

- South Facility Closed in 2001, reopening in mid 2007.
- North Facility closed in March 2010.

Los Angeles Inmate on Staff Assault Data

	2011[1]	2012 (Annualized)[2]
Inmate vs. Staff Assaults	157	94
Force Incidents Involving Inmate vs. Staff Assaults	135	70

[1] Figures are from Los Angeles Incidents of Force and Inmate Assaults Data for 2011 from FAST (as of 3/7/12).

[2] Figures are an annualized calculation based on the Los Angeles Incidents of Force and Inmate Assaults Data for January through June 2012 from FAST (as of 7/7/12).

3-02/035.00 FORCE PREVENTION POLICY

It is the Sheriff's Department's responsibility to provide a safe custody environment for the inmates and a safe working environment for Sheriff's personnel. All employees shall view their professional duties in the context of safety for themselves, other employees, and inmates.

All jail personnel should maintain a professional demeanor, according to each situation, keeping in mind the Department's Core Values.

Department members shall only use that level of force which is objectively reasonable to uphold safety in the jails and should be used as a last resort. Reasonable efforts, depending on each situation, should be made by jail personnel to de-escalate incidents by first using sound verbal communications when possible. If verbal communications fail, reasonable efforts should be made to call a supervisor to assist in seeking compliance from disruptive inmates (Refer to CDM 5-05/090.05, Handling Insubordinate, Recalcitrant, Hostile or Aggressive Inmates).

In cases where Sheriff's Department personnel must take action to conduct lawful duties where there is not necessarily an immediate physical threat, such as prolonged passive resistance or cell extractions, there shall be a tactical plan predicated on preventing the use of force whenever possible. Supervisors shall be present during planned tactical operations.

All inmates are issued a copy of jail rules and regulations and subject to discipline for violating those rules. All Department members shall focus on upholding safety, respect and professionalism, even in situations where force is required.

When force must be used, deputies and staff shall endeavor to use restraint techniques when possible, and use only that level of force required for the situation, consistent with Department's Situational Use of Force Options Chart (as defined in Manual of Policy and Procedures, Use of Force Categories, section 3-01/025.20).

Our collective and individual goal is to prevent force through effective communication emphasizing safety, respect, and professionalism as emphasized in the Department's Core Values.

Revised 03/19/12
11/08/11 CDM

Creating and Improving Organizational Culture in Jails

An informal opinion paper presented to the Los Angeles County Citizen's Commission on Jail Violence

Sheriff Gary Raney
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July 17, 2012

Who's this Sheriff from Boise?

I am Sheriff Gary Raney, sheriff of Ada County (Boise) Idaho. I have been with the Ada County Sheriff's Office for 28 years, coming up through the ranks from my beginning as a jail deputy and ultimately being elected sheriff in 2004. The ACSO is a full service sheriff's office with all of the operational duties of any similar office, but also including a consolidated communications center and soon to be services for misdemeanor probation. By national standards, we have a large agency with well over 600 employees and over 1,200 beds in the jail. By Los Angeles standards, we are small. Ada County does not face many of the problems that large metropolitan counties do, but good leadership is applicable among all organizations.

A few short months after I was sworn in as sheriff, the opportunity to make change in the Ada County Jail came along and we did. The chance sprang from the escape of the most dangerous inmate in the Ada County Jail. It was an event that was almost unfathomable as to how his luck aligned and he took advantage of it, but he did. After ten days he was captured and returned. The escape was a symptom of a much bigger organizational illness that had grown over several previous years of seemingly smooth sailing. When I took office I was aware that we had lost our organizational direction and become stagnant in our leadership, but I did not have the leadership skill at that time to create the change I wanted. After the escape, I knew that the change had to be big and it had to be meaningful. In the 18 months that followed, we reinvented our organizational culture in the jail and eventually became nationally recognized for the way the Ada County Jail operates today. I am excited to share some of what I learned in that process and the changes that followed and that's why I am writing this briefing.

As for me personally, I have a Masters Degree in Criminal Justice and am an adjunct professor for Northwestern University's Center for Public Safety and Boise State University. I am a graduate of all four of the FBI's leadership programs, including the National Academy and the National Executive Institute, as well as several other executive development programs. In the past few years I've focused my personal attention on understanding organizational development in public safety agencies. I own Leadership Consulting Group, LLC wherein we individually or collectively help public safety agencies, mostly police and sheriff's agencies, define their outcomes and begin making decisions based on those definitions. The largest

agency I have consulted for was the Pierce County, WA Sheriff's Office where I spent sixteen months helping them improve communication, outcomes, accountability, organizational priorities and cultural development. The largest agency I presented to was NASA's Launch Services Program Management Retreat in Florida. I have been a keynote speaker or presenter at several state jail association meetings from Wisconsin to Texas to Oregon. Beyond that, I have been fortunate enough to be invited across the U.S. over the past few years to consult, train or present to thousands of law enforcement personnel in dozens of venues, mostly focusing on organizational leadership, strategic planning and aligning culture with desired organizational outcomes. In 2009 I was appointed by the US Attorney General to the Advisory Board of the National Institute of Corrections - one of two sheriffs in the nation to sit on that board.

Overall my experience, my education, my reading and work with agencies has given me strong beliefs about organizational development in law enforcement and jail operations. I am honored to be asked to share those with you.

Introduction

Director Marilyn Chandler Ford of the Volusia County Florida Detention Center said it well when she spoke about the status of jail leadership in the United States. She said, "Corrections is a craft-based discipline, meaning we learn how to do things from the people before us, not from science like a profession does."[1] The experiential nature of corrections learning leads to many leadership challenges, not the least of which can be a cancerous organizational culture when the learning process includes an acceptance of poor performance, misconduct, apathy and sometimes violence.

Leadership is complicated and difficult. I do not claim to know all of the answers about how to create positive organizational cultures, but I do believe I have found commonalities in research and learned how to apply them to other organizations. My goal in offering this paper is to provide information to the Commission that might ultimately support the good men and women working in the Los Angeles County jail who work every day to make it the best it can be for both staff and inmates.

Jails operate well when there is predictable routine and discipline. Checks are made on time, inmates are fed when they expect it, people move in harmony, schedules keep the workload manageable and so on. Unfortunately, this routine makes it difficult to continue to keep employees challenged and engaged after a few years. Routine breeds monotony and monotony breeds complacency. Complacency is the cancer of any organization and can be especially dangerous in jails where that complacency may lead to escapes, failures to intervene in potential violence and an unwillingness in leaders to proactively modify employee behaviors.

Complacency is further entrenched when personal relationships between people cause a reluctance to take corrective action, even in a supervisor/subordinate relationship. In a setting like a jail this issue can be particularly prevalent because employees are sometimes dependent upon each other for their personal safety. Some of the greatest contributors to a "code of silence" are fears that future aid may be delayed in retaliation for reporting a coworker's

[1] Dr Marilyn Chandler Ford testifying to the Advisory Board of the National Institute of Corrections, November 2011.

misconduct or omission. In a dysfunctional organization where informal power groups provide the true day-to-day leadership, it is common for jail employees to develop an "us-them" mentality both about organizational leaders and inmates. This may cause staff to form stronger horizontal alliances with each other in a way that overshadows good decision making about what is right and wrong.

Another major contributor to the "code" is a lack of effective supervision and apathetic attitudes of leadership. Employees who witness misconduct often rationalize their failure to report by relating current events to prior ones where supervision or leadership failed to respond appropriately to policy violations. It is easy for an employee to say to themselves, "Well, if they don't care, why should I?" Anywhere there is a "code of silence" within an organizational culture, ethics will begin to become subordinate to personal loyalties and danger is on the horizon.

When employees, particularly supervisors, do not have a clear understanding of a jail's core mission and priorities, or do not support them if they exist, their attention often diverts to personal interests more than what really matters. Whenever I work with an agency facing supervision issues, we work on an assessment of the amount of time a supervisor spends on specific activities. In simple terms, a supervisor should:

1. Keep every employee engaged in carrying out the mission of the organization and hold substandard employees accountable to the minimum standards of behavior and performance
2. Manage crisis when it occurs
3. Facilitate communication up, down and across the organization, particular to solve operational issues and share leadership messages

Most people would agree that at least 50% a supervisor's time should be spent interacting with and developing employees. Complacent jails often report less than 10% of a supervisor's time actually spent on such duties. In the absence of effective supervision, informal power groups form and unintended acts or omissions often begin to occur. There is no greater influence on employee behavior and the effective operation of a jail than the performance of the first line

supervisor. However, ineffective first line supervision always follows ineffective organizational leadership. Also, good supervisors have to be good people and good employees first, so the long term success of an organization must begin with the selection and promotional processes.

Recruiting, Selection and Promotion

Poor performing jails often run on the philosophy that it is better to have a mediocre employee for many years than a good employee for a few. I disagree. I would prefer someone who is less experienced but engaged in solving problems than someone who knows what to do but may be reticent about taking action. Leadership is difficult and leadership in an occupation that, by the nature of the work breeds complacency, is even harder. From the executive leadership level on down, the organization has to be committed to high standards and the leadership and supervision personnel have to be actively engaged in supporting and developing employees. This means the organization must be diligent in hiring, promoting and developing its leaders at all levels.

In many sheriff's agencies, jail staff are clearly the bottom of the pecking order. They may be paid less than their policing counterparts. They may wear different uniforms. They may have titles that relegate them to feeling like they are "just a jailer." They do not see executive staff as frequently as their policing counterparts and they are often hoping to "promote" out of the jail. There are reasons for some of the disparity, but many times the problem is more about a lack of appreciation for jail employees in the organizational culture. Ultimately, the message is often clear that jail employees are less valued than the police employee. Those stigmas make it difficult to recruit, develop and maintain effective leaders within the jail.

Most law enforcement agencies still rely heavily upon a written test and oral board as the core of their selection process. Unfortunately most written tests measure current knowledge or aptitude for academic learning and oral boards are notoriously poor selection tools. Progressive law enforcement agencies rely much more on tools that help identify behaviors and traits rather than knowledge. How strong is a person's ethical character? What is their emotional intelligence quotient? How prone are they to making rash judgments or physical reactions? Are they prejudiced or inappropriately biased? Have they engaged in unethical or immoral

conduct that is of concern? All of these characteristics are difficult to identify with written tests, oral boards and the more traditional selection processes. Wise agencies make an investment in the hiring process to use polygraph examinations and psychological testing to better determine an applicant's true character. Many agencies decide not to use these tools because of cost, but the long-term cost of dealing with poor attitudes and unethical behaviors can prove far most costly.

Whatever the selection process, once a recruit is chosen he may consider himself a part of a process that inevitably starts in the jail and hopefully ends somewhere else. The still frequent agency practice of requiring everyone to start their career in the jail and then return there for most promotions is long since antiquated and should be abandoned. It often attracts employees who are just biding their time until they can get to patrol and who are not invested in the mission of the jail. I firmly believe that all sworn employees should be treated as equals and the message between the police function and the jail function should be, "One job is not better or worse than the other. They're just different." Agencies who adopt this philosophy can eventually create a culture where people can find the best fit for their own skills and ask to be assigned to the jail. In the Ada County Sheriff's Office, police deputies are more and more often requesting transfers to the jail for a variety of reasons. Going to the jail used to be punishment, but after years of working to develop a positive perception and culture, the stigma is gone. Again, I believe that only happened because the practice and culture of the organization values jail employees as much as it values police employees.

Beyond selecting the right person for the job there remains the challenge of effective training. In policing, there are only one or two standard post-academy training programs commonly accepted across the United States. In jailing, there is no standard program. As the introductory quote said, learning the business of working in a jail is a craft, not a science. Therefore the various ideas about how to pass on information from a veteran jail employee to a new one is as individualized as the people are. Still, most training programs rely upon the traditional academy classroom training followed by on-the-job training with a certain training officer or a set of training officers. In the Ada County Sheriff's Office, we rethought this process several

years ago and applied adult learning principles when recreating our training program. We relied heavily upon the idea that adults learn better through experience and reflection, so we created the Learn-Do-Review, or LDR, or LeaDeR Academy. The program relies upon a continuous cycle of learning the policies and philosophies of a task, experiencing the task immediately, then reflecting on the process through journaling and group reflection. One or two veteran deputies lead the academy as coordinators, but many other employees are engaged in training and working with the recruits throughout. Upon completion, the recruit is assigned a "coach" who helps them individually apply the learned skills until they reach the point of being able to work independently. The change to the adult learning model in the LDR program has not only heightened the level of retained information in recruits, but it has also had the intentional result of creating higher standards of teamwork and inter-reliance among coworkers.

The development and selection of first line supervisors is just as important as recruit selection. They form the daily work ethic and are the front line of creating culture. In sheriff's offices, jail supervisors and leaders are often drawn from the police side of the agency. While there may be times when this practice is the best course, it can reinforce the perception that jail employees are less capable than police employees and not worthy of promotion. In private business, managers may have many different levels of responsibility and varying degrees of technical ability. In law enforcement, the quasi-military culture suggests that all sergeants or all lieutenants should be compared to each other rather than compared to how well their skills fit their assignment. A progressive organization should strive to create clear paths to professional development and promotion for jail employees and train them purposefully to be great supervisors in their facility.

Roles and Responsibilities

Whenever an organization is contemplating whether or not to create new supervisory positions the fundamental question should be, "Does this position make all of those people reporting to it more accurate and effective than they would be without it?" The answer is often "No." In addition to being wasteful of money, too many levels of supervision and too many people at

each level often lead to confusion over authority and responsibility. Inefficient rank positions almost always create overlaps of responsibility, leading to confusion among staff as to who is in charge and accountable for decisions.

Further problems can arise when an organization lacks unity and accountability for command. This is most common when an organization uses a cascading work schedule as opposed to a team schedule. Cascading schedules place employees, including supervisors, off duty on varying days of the week. This means employees may have multiple supervisors. On a four day work schedule, an employee's three days off may fall on the supervisor's four days on, making it impractical to have an effective supervisor/subordinate relationship because someone else is in charge for three quarters of the employee's work time. While this example is uncommon, it is common on a cascading schedule to have half of an employee's time supervised by one person and half by another. Shared supervision almost always leads to a lack of accountability and confusion over responsibilities.

Another major area that causes leadership confusion is when one person in middle to senior management bypasses a level below them to take corrective personnel action. This often occurs when the senior official is a "take charge" person and wants to make sure the message or action gets done in just the right way. This undermines the authority of the lower ranking leader, devalues their authority and often allows them to abdicate their responsibility in the future. Each level of rank that has accountability should also have authority and vise versa. Bypassing people, excluding them from communication or unduly reversing their decisions gives them a tacit pass to be apathetic from that point forward and sidestep their leadership responsibilities.

Effective organizations understand the role for each level of supervision and respect those roles in their daily operations. This does not mean that modern organizations should have a rigid chain of command. It means everyone who needs information should get that information when they need it. A sheriff should feel comfortable walking and talking to line level employees, but decisions from the information the sheriff receives should be inclusive of all levels in between. Today's generation of socially networked employees do not respond well to

strict communication boundaries. Communication should occur at all levels both vertically and horizontally, but responsibility for the final actions should be predicable and enforceable. For example, a first-line supervisor should be responsible to immediately correct detrimental behavior by an employee. Effective communication and policy decisions should be in place to ensure everyone knows what is acceptable and what is not. That supervisor should be supported, and held accountable, to take corrective action on employees who do not meet the policies and norms of the agency. Any unnecessary circumvention of this process of communication and accountability will erode the unity of leadership and often lead to supervision failures.

Understanding Jail Outcomes

Many government organizations have lost their core sense of direction. Public safety in particular is a service industry and as such relies upon the *process* of delivering service. Over time many agencies, and I would argue most agencies, devolve to focusing on the process of what they do rather than the outcome of what they create. For example, fire and emergency medical service departments disrupt hundreds of people when responding with lights and sirens to a call for medical service regardless of the fact that only a handful of those calls will have a more successful outcome because of their reduced response time using lights and sirens. They're focusing on the process of getting there more than the outcome for community safety.

In jails, the routine is the process and tends to become the focus of attention. In other words, the agency begins to focus on the minutia of daily activity and loses sight of whether all that activity really makes a difference. If most jail administrators were asked to identify their indicators of success, few would truly have that answer at hand.

I believe there are three fundamental outcomes for the internal operation of a jail:

1. Staff Safety: Just as we know a community will only thrive if people feel safe leaving their homes and interacting, jail staff must feel safe leaving their places of comfort and interacting with inmates. Maslow's hierarchy of need places safety as the first step

above basic physiological needs for humans.[2] If jail staff live with an underlying level of fear each day, they are likely to decrease their contact with inmates, allowing the dominant inmate(s) to control the cell blocks. In order for a jail to run effectively, staff must have a reasonable sense of safety - enough to feel comfortable interacting with inmates and addressing disruptive behaviors at onset.

2. Security of the Facility: One of the primary functions of a jail in our society is to isolate dangerous people from the rest of the community. Escapes from jails will occur, but a cultural focus on preventing escapes has several benefits beyond the obvious. Preventing escapes requires staff to pay attention to detail and to think. They must be tuned in to notice the small things that are out of order and to use "possibility thinking." When staff actively work to challenge their paradigms and think about possibilities, they not only recognize and intercept potential problems, but they also stay more mentally engaged in their work.
3. Inmate Wellbeing: Jail staff should be personally concerned about the wellbeing of each inmate in the jail. This statement would bring ire from an us/them group, but this idea is the core outcome of the detention process. If inmates feel reasonably safe and secure and they have their basic needs met, the entire jail will run better for staff and for the efficiency of the operation. Violence will decrease, suicides will be less frequent and there will be less tension between staff and inmates. How does this occur? Staff must communicate effectively. Everyone wants to be heard, whether it is the jail staff being heard by the administration or the inmates being heard by jail staff. When staff clearly understand the policies and procedures of the jail, and still empathetically listen to inmates when they have problems and concerns, both will be better off. There will be better communication and a more reasonable dialogue between the two.

Baseline Metrics

It is easy to talk about how a jail should operate, but the only way to know if our actions have the response we intend is to use reliable and objective measures. If metrics are used at all,

[2] http://www.netmba.com/mgmt/ob/motivation/maslow/

most agencies overcomplicate them with too many details. If there is one metric that people see every day, they know that is the most important thing. If there are fifty metrics then people will have difficulty distinguishing which are the most important. For that reason, any use of performance measures or metrics must start with a focus on the core mission and priorities of the organization and remain limited to the outcomes that really matter.

I have discussed what I believe to be the most important outcomes for the internal operation of a jail. Therefore, any measures should align with each of those outcomes and have meaning. A good ongoing assessment must look at the data as a whole and seek to find strengths and weaknesses. For example, an executive cannot look at only the measure for inmate wellbeing without taking into account the rate of inmate-on-inmate violence. I believe every jail should measure, review, contemplate and understand the following data trends:

- Staff Safety
    - The rate of inmate on staff violence
    - The rate of inmate on inmate violence
    - The rate of serious injuries to both groups
- Security of the Facility
    - The number of escapes from secure facilities
    - Number of items of contraband or weapons located
- Inmate Wellbeing
    - The rate of inmate suicides and active suicide attempts
    - The rate of general grievances
    - The rate of medical grievances
    - The rate of appeals to disciplinary actions or some other measure of inmate confidence in the disciplinary system

Those items are all that is necessary. It is tempting to develop elaborate reports, but additional datasets should only come when the organization has identified and embraced its core outcomes and the additional details become support for leadership, not a distraction.

Such metrics are rarely seen, and I believe that's because it's in our government's nature to focus on process counts rather than outcomes. Just as many police executives do not know their crime solution rate, many jail executives do not know their rate of violence. For an organization to be properly focused on delivering the best community results for the resources given, upper management thinking must shift from watching process to watching outcomes. Watching process builds process. Watching outcomes creates change. An executive has to lead the organization toward embracing the right priorities first, and only then begin to measure them because the measurements mean accountability. It is generally human nature to avoid accountability, so resistance is imminent if the groundwork is not reasonably in place before the measures begin.

People fear numbers that suggest success or failure in numerical form like we had in school. I submit to you that the initial numbers should be ignored. Organizational development occurs in trends, not individual numbers. Over months, quarters or years, executives should focus on whether there is improvement or decline toward their goals. If there is improvement, understand why and celebrate success. If there is decline, it is even more important to understand why and develop strategies for change. Some will succeed and some will fail, but if each review process includes open and honest discussions to talk more about *why* than *what,* the organization has the potential to become a learning organization. A learning organization is, "an organization made up of employees skilled at creating, acquiring, and transferring knowledge."[3] Jails need systems where employees depend less on the concept of a craft occupation and more on one where the learning becomes institutionalized and standardized. Developing a learning organizational environment is critical to the consistency we want in our jail operations and leadership.

As I studied private sector practices and thought of how to apply them to government agencies, I realized we needed clear goals, a balanced scorecard and consistent messaging. In the Ada County Sheriff's Office we use two different reports agency wide to reinforce the goals and

[3] Harvard Business Review. March 2008. Available at http://hbr.org/2008/03/is-yours-a-learning-organization/ar/1

provide the consistency in our messaging.. The most important is probably the Employee Satisfaction Survey that will be explained later. Another important report is simply called the *Quarterly Report*. It reviews the metrics of the entire organization and is a blend of internal measures, outcome measures, customer service measures, etc. For each quarterly report the entire command staff of the Sheriff's Office assembles in a room to review the report. and people, particularly me as sheriff, ask about changes, seek explanations and document plans for change that will be reviewed at the next quarterly meeting. I use this meeting as a significant leadership messaging tool to both praise good effort and positive results and to sometimes hold senior leaders accountable to do something about a problem. The concept came from studying the COMPSTAT model of police accountability that was first conceived in New York City and has been adopted and modified in hundreds of organizations across the United States.

(See attached Quarterly Report for further information)

I cannot close this section without discussing the need for leadership alignment in an organization that uses metrics and measures. An inclination by some who may be held accountable for the measures may be to alter the data to show better outcomes than what really exist. It is essential to the long-term success of an agency that the right measures be selected early on in the process and then fervently guarded. If the definition of an outcome measure changes or the methodology changes, all previous data becomes relatively worthless. I have long believed, and continue to believe, that the misrepresentation of data by supervisors or mid-managers will eventually reveal itself if the data collection process is valid. For example, if a supervisor is underreporting violence, it will eventually show up in discrepancies between their shift and the reports from other shifts or when another supervisor or group takes over that position and suddenly the numbers change.

Organizational development, leadership alignment and the successful use of outcome measures is a long-term process. It requires a clear vision by leadership, alignment throughout the workgroup and the dedication to eventually make a positive difference. Realistically, the private sector can make personnel changes much more rapidly than government, however,

positive change should become obvious within eighteen months following a clear commitment by leadership.

Employee Satisfaction

Happy employees tend to be more productive employees. If you agree, then employee satisfaction has to be high on the list of priorities for a jail. Just before I took office, I had my planning and research unit conduct an employee satisfaction survey. Most of it came from the ideas in the book, "First, Break All the Rules: What the World's Greatest Managers Do Differently."[4] We evaluate employees, so I wanted the employees to be able to evaluate us. I wanted to have a report card on management.

There were a couple of key philosophies that I have always stuck to during this process. First, i has to be anonymous. For that to happen, we cannot, for any reason, try to examine any results at the individual level and usually not at the team level. This is not a tool to identify who thinks what. It is a tool for the working groups of the agency to provide honest feedback about their satisfaction and perceptions. Overall, it has probably been the most useful feedback tool that I have had in my eight years as sheriff.

Every fall we survey all employees with three core questions:

1. Are you satisfied working at the ACSO?
2. Do you understand the direction in which the ACSO is headed?
3. Do you feel communication within the ACSO is adequate?

There are additional questions that are used year-to-year to measure our effectiveness. They are:

4. Do you understand your job responsibilities?
5. Are you involved in decision making about your job?
6. Do you feel evaluations fairly reflect your job performance?

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[4] Buckingham and Coffman. *First, Break All the Rules: What the World's Greatest Managers Do Differently*. Simon & Schuster. 1999

7. Does your supervisor effectively solve problems for you and your coworkers when needed?
8. Does your supervisor provide you with honest feedback?
9. Do you feel that your opinions count at the division level?
10. Do you feel that your job is important to the ACSO?
11. Are your coworkers committed to doing quality work?
12. Do you receive recognition or praise for doing good work?
13. Does someone in the ACSO encourage your professional development?

Lastly, there are often a few current topic questions that are added to the survey and change from year to year. These are more of a direct feedback mechanism and not something that we use to establish trend lines for change.

As expected, in the first one or two years the survey response was tentative and to this day the survey remains voluntary. Each time the survey process ends, I write to all employees and share my thoughts and understanding of what the survey meant and what I intend to do about the response. As employees began to trust the survey and see that it had meaning, the response rate increased to the point that in 2011 we had had an 85% response rate!

In the first few years it was easy to show great improvement. The tool gave us focus and there was a lot of low hanging fruit. Eight years later, we are left with the tough issues and so change is less dramatic, and sometimes the responses are difficult to interpret. While I never use the tool as the justification for discipline, it has led to conversations that ultimately led to the dismissal or agreeable resignation of three management staff in the last few years. More importantly, it continues to provide all of the leadership team with areas to focus on and goals to achieve. In the last three years we have received poor scores about the questions on employees being included in decision making. That is one of the most important areas of effort for us this year and I hope to see the trend reverse.

(See attached Employee Satisfaction Survey for further information.)

Inmate Survey

Survey inmates? Who cares what they think? We do. The inmate survey is a good early warning system and as with the other efforts, helps us focus on our internal outcomes. On an ongoing basis my Planning & Research Unit oversees the surveying of inmates. This information, like the Employee Satisfaction Survey, is used to establish and monitor trend lines in order to demonstrate positive change or potentially predict problem areas. There are two key components to the inmate survey. First is the survey about their observations. This is weighed heavily as the early warning indicator for problems in the jail. Inmates are asked as to whether they've observed behaviors like gang and sexual activity and items like weapons and drugs. Again, the point is not really the score itself. Rather, it is the trend of an increase or decrease and the resulting discussion as to why the change is occurring.

The second part of the survey is about perceptions. As previously described, the most important outcome in the Ada County Jail is the safety of our staff. Inmates are asked to respond to the measure, "I feel safe in the Ada County Jail." Just like Maslow's hierarchy for staff, the same thing applies for inmates. The less safe an inmate feels, the more likely they are to create a weapon or act out. The more likely they are to possess a weapon or act out, the more likely our staff is to be injured. Therefore, perceptions of inmate safety have a direct correlation to the safety of our staff.

Inmates are also asked about jail cleanliness, food, health care and other things. Along with the information we receive, I believe it has value that we are asking the inmates what they think. Everyone likes to be heard and asked their opinion. Inmates are no different.

Closing

Many books and movies show examples of great leadership: the military platoon leader charging up the hill with his troops or the ethical protagonist standing his ground in the face of adversity and challenging the evil antagonist. These examples and others lead some to believe that leadership can be a single act of outstanding personal courage. In reality, leadership happens in many small ways every day. It begins with communicating a vision and continues on through individual actions that consistently support that vision over the days, months and years

that follow. Jails need strong leaders who fight off complacency and effectively make the facility a better place than it was before.

I struggle to imagine what it would be like to face the challenges of running the jail in Los Angeles County. As I said in the introduction, I am sure there are challenges most of us probably never realize. I have never been inside the LA Jail or claim to know the strengths and weaknesses of leadership there. I offer you my preceding thoughts and opinions believing that they are true of any organization and hoping they help guide you in making your jail a better place for employees and inmates alike.

Reflections on the ALADS Custody Division Work Group Report dated July, 2012

The following is a supplementary statement provided to the Los Angeles County Citizen's Commission on Jail Violence.

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August 1, 2012

Public safety agencies have a patterned response to misconduct issues. The executive leadership of an agency will identify the misconduct, create a policy to prohibit it and possibly provide training on the policy and related issues. Far too often, leaders then consider the matter closed and move forward, or take a passive position to wait and see if any more issues arise. The problem with this approach is that it often only addresses the surface issues and not the underlying organizational culture. Leaders have to look beneath the surface to create long-term change. Part of reducing fear in most jails comes from changing the culture through communication, alignment, supervision and accountability.

It is a fact that violence occurs in jails. Thirty years ago jails across our nation were built and ran with a perspective that inmates deserve what they get and that the unsavory conditions of incarceration would deter them from reoffending. That atmosphere often bred violence because it made jails a place where people, both inmates and staff, were demeaning and feared. Inmates would control their environment and conditions with a fight-or-flight response – however they were unable to flee, therefore they fought. Today, we know that way of thinking was not only archaic for our jails, but detrimental to our communities because of the costs of civil litigation and the fact that many of those practices actually increased the likelihood that the offender would recidivate.

Jails must be a place where inmates have a chance to succeed. One major role for a jail is to isolate an offender and keep the community safe by eliminating any opportunity for them to commit another crime. However, the other major role has become being a place where offenders learn how to change their thoughts and behaviors so as to decrease the likelihood of recidivism. It is with that result in mind – less victimization – that we are thinking differently about how to approach violence in jails. When I began my career as a jail deputy, I was taught to react to violence with violence. It was a competition of force where the good guys are assured of eventually winning. This "I'll show you" attitude was easy. It took no more skill than physical strength and force weapons. Jail staff today have to think very differently than they did thirty years ago. Communication skills are the greatest tool a jail deputy can possess. By understanding the root causes of violence, like fear and mental illness, jail staff will better know how to react to it and gain voluntary compliance from inmates. Jail staff must learn to control the jail through skill, not violence. For example, when an inmate refuses to obey a simple order, the old way of doing business was to escalate the demand, call for backup and use force. Modern jail professionals will avoid reactivity and respond to the misconduct in a logical, professional manner. In short, the inmate isn't going anywhere, so why do we let them control the timing of our response?

The ALADS report suggests a significant philosophical and probable operational gap between LASD leadership and line staff. When use-of-force policy and training are changed without a viable plan to change organizational culture, confusion and resentment by line staff often causes an apathetic approach to any real change. "They just don't understand what we do." and "This is going to get someone hurt." are the common responses to any attempt to decrease the use of force. Supervisors may actually support the traditional responses they are comfortable with. Additionally, new workloads may be put upon line staff which only further broadens the disconnect between leadership and staff. It appears many of the changes that have been implemented are logical and appropriate as an operational response, but none of the reading addresses how the culture is being changed. Without a unified effort to change culture, an organization is only addressing the symptoms of the problems and not the root cause.

Changing culture is difficult. In smaller to mid-sized organizations research has shown that it takes about eighteen months from the time a change is agreed upon until the actual cultural adoption of it. I can only imagine the difficultly of creating cultural change in an organization the size of the Los Angeles County Jail. I suspect it would take a generation of employees to have any lasting cultural change.

ALADS Report

As noted in my first paper, everyone wants to be heard and there is certainly a tone in the ALADS report that suggests the line staff of the jail do not feel they are being heard. I applaud the ALADS constructive attempt to offer recommendations and solutions that would improve the jail, however the report lacks an objectivity that would give it more weight. Stronger lines of communication between leadership and line staff might help create the alignment needed for lasting change and help both sides understand the concerns of the other. If the line staff was excluded from input on the changes that have occurred, it is predictable that the culture still rules the decision making process and change will be slow at best.

The following are some further thoughts on specific topics discussed in the ALADS report:

Staffing:

- I find no value in making comparisons of staffing ratios to other jails. There is no such thing as an industry standard for jail staffing. Every jail is unique and the appropriate staffing levels for each may vary greatly. A staffing analysis for a jail is actually a rather simple process as compared to many occupations and the LASD should have its own independent staffing analysis to determine the minimum base number of workers.

Morale:

- While many of the recommendations made in the report are worthy of consideration, I do not believe they would make a significant impact in the overall morale of jail employees. Promotion and compensation incentives only help those who are eventually promoted or who receive the extra responsibility tied with incentives. Morale comes from daily work satisfaction.
- I do support the development of training opportunities and professional development, both because it demonstrates that an organization values its employees *and* because it helps the organization deliver its services more effectively and efficiently.

Inmate Accountability and Behavior:

- I fully agree that the rules of inmate conduct need to be clearly understood by both staff and inmates. If there are violations of those rules, commensurate reactions should occur. That doesn't always mean utilizing traditional jail discipline procedures, but should include intelligent and innovative actions that change behavior, not just punish it. Inmates have often experienced violence and trauma in their lives (well over 90% have). In the reading, someone commented that inmates sometimes act out in order to be placed in solitary confinement. Such inmate behavior is a symptom. The disease is likely the fear that exists in the larger housing units. So long as that fear exists, violence, weapons and other misconduct will continue to occur. Jail staff should endeavor to establish a culture of mutual respect. That concept will be met with resistance by many staff members – until they see the long term result of operating a facility where mutual respect and good communication is the norm. This is the essence of cultural change.
- The ALADS work group reports an undermining of deputy authority by supervisors who alter their disciplinary decisions. That concerns me as much because it breeds apathy and complacency as it does about the confusion it causes in daily operations. Both staff and inmates should be held

to reasonable standards of behavior. If such a system is in place, supervisors should support staff when they are right and correct them, but empower them to remedy the action, when they are wrong. Including the involved employee in the solution patterns the behavior of the employee and allows them input into the ultimate resolution of the problem. At the same time, supervisors exist to uphold the policies and standards of an organization and they must do so effectively. To do that, they have to pay attention to what is happening in the jail and consistently hold employees accountable for the policies and standards of behavior.

- Communication should also be improved to educate staff as to the inconsistencies that probably exist in their reactions to inmate misconduct. It is common - almost a given - that deputies want autonomy over the initial discipline process. However, few are in a position to see the inconsistent application of discipline that can occur when autonomy exists. Simple reports that begin to establish norms and share non-traditional ideas for discipline can easily be created and shared with staff.

Health and Mental Health:

- Many of the ALADS recommendations seem to be very worthy of consideration. Two fundamental things should be kept in mind when considering the problem. First, mental health disorders are almost always coupled with other life issues, most commonly substance abuse. Treating an inmate with psychotropic medication to gain complaint behavior while doing nothing else is like charming a cobra - it's great until we stop.
- Most of all, the recommendations to increase staff training and use multi-disciplinary approaches to problem solving are very wise. The jail should not create a team of deputies for mental health responses when mental health professionals are available. There should be a balance of security staff, mental health professionals, physical health staff and classification staff in regular case management meetings.

Policies and Procedures:

- Most of these recommendations seem based in logical thought, especially, "Policies should be short and easy to understand." The fact that this statement is included is bothersome as the foremost purpose of policy should be to help staff (as opposed to covering a base for liability).

EFFECTIVE JAIL OVERSIGHT

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Los Angeles County Citizens' Commission on Jail Violence
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Introduction

It is an honor to be asked to provide written testimony to this Commission on the subject of jail oversight.

By way of background, I am a Senior Lecturer at the Lyndon B. Johnson School of Public Affairs at the University of Texas. Much of my research and writing over the last five years has been on the issue of correctional oversight. I helped edit OPENING UP A CLOSED WORLD: A SOURCEBOOK ON PRISON OVERSIGHT, a special volume of the Pace Law Review (30 Pace L. Rev. (Fall 2010)). Among my publications on this subject are: *Independent Correctional Oversight Mechanisms Across the United States: A 50-State Inventory*, 30 Pace L. Rev. 1754 (2010), *Distinguishing the Various Functions of Effective Prison Oversight*, 30 Pace L. Rev. 1438 (2010), and *The Need for Independent Prison Oversight in a Post-PLRA World*, 24 Federal Sentencing Reporter 236 (April 2012). I also co-chair the American Bar Association's Subcommittee on Correctional Oversight, and helped draft the ABA's policies on this oversight issue. I also served as the original drafter of the ABA's new Standards on the Treatment of Prisoners.

Beyond that, I also have a long history of working directly on correctional reform issues. I served for several years as a full-time federal court-appointed monitor of conditions in the Texas prison system as part of the landmark *Ruiz v. Estelle* class action litigation. And I have been a consultant to numerous jail systems around the country in an effort to help them address issues related to crowding, sexual assault, violence, conditions, and Internal Affairs operations.

This wide range of experience has persuaded me that effective independent oversight is absolutely essential to the safe operation of prisons and jails. As this Commission seeks solutions to the violence that has plagued the Los Angeles County Jail, it must look to the establishment and strengthening of effective oversight mechanisms as one of the most important strategies in that campaign.

Systems of Accountability: An Overview

In this testimony, I will touch briefly on just a few critical aspects of effective oversight. Any discussion of oversight in the correctional context must begin with the recognition that oversight is not a goal in and of itself. Rather, oversight is a means of achieving the twin objectives of transparency of public institutions and accountability for the operation of safe and humane prisons and jails. "Oversight" does not come in only one flavor, and it is neither desirable nor effective to adopt a "one size fits all" strategy. There can be—and should be—many different effective ways to identify and correct safety problems in correctional institutions, and to increase public awareness. In combination, these mechanisms can work to provide the levels of transparency and accountability that public institutions demand.

Internal accountability measures and external oversight

Effective prison management demands both internal accountability measures and external scrutiny. The two go hand-in-hand, and neither is a replacement for the other. A robust system of correctional oversight involves sound internal auditing and accountability measures, complemented by credible and effective forms of external scrutiny. These two systems of accountability are not in competition with each other. They serve different needs and different constituencies.

Systems of internal review offer a valuable management information tool for administrators, allowing them to identify and correct operational problems at an early stage. Whether the administrator reviews data about the number and types of incidents happening at a particular facility, reads prisoner grievances in order to know the inmates' complaints, watches videos of use of force incidents, has auditors assess staff compliance with policies, or disciplines staff for wrongdoing, the goal is to improve management capability and therefore improve agency operations.

External scrutiny may sometimes look similar, but the goal is to shine a light on what happens in correctional institutions. External scrutiny is essential any time that a closed institution is responsible for the control of individuals; it is a linchpin in any effort to ensure the safety of prisoners. It serves the goal of transparency as well as the goal of accountability. Such transparency provides both a form of protection from harm and an assurance that rights will be vindicated. External oversight responds to the public's need for information and provides a credible, objective assessment of conditions in correctional facilities. There will always be public skepticism about an agency's ability to assess itself, and so the external review complements whatever internal assessments are conducted. Moreover, external involvement is necessary whenever staff or inmate behavior crosses the line from administrative wrongdoing to criminal actions. The power of the state must be called upon to investigate and prosecute such criminal behavior, as in the case of a sexual assault or an act of brutality by a staff member or by an inmate.

At the same time that external oversight serves this transparency function, it also benefits administrators by providing them with the objective feedback they need about their performance. It adds to the toolkit of management information systems.

The Various Functions of Correctional Oversight

The term "oversight" is often used, but it is not a term of art. It might be helpful if we begin to frame the concept of jail oversight as a catch-all, umbrella term that refers to at least seven distinct functions:

- Regulation
- Audit
- Accreditation
- Investigation
- Legal
- Reporting
- Inspection/Monitoring

Each of these functions is an essential—but separate—part of effective jail oversight. Each contributes to the overall goals of transparency and accountability. But there should be a variety of separate mechanisms in place to serve each of these functions. While there are certainly some examples of hybrid oversight models combining two or three of these functions, it would be a mistake to seek to combine all these functions within one entity. No one entity can meaningfully serve every function, if for no reason other than the fact that there are different constituencies involved with regard to each function.

The problem is that when we speak of "oversight," we tend to merge these concepts and assume that they are in competition with each other when it comes to which is "most effective." Moreover, we each have in mind a different one of these functions when we talk about oversight, which makes communication about these issues very difficult: we are often talking at cross-purposes. I think we need to begin to talk about these as separate functions, and consider how to make each of these specific functions as strong and effective as possible.

How the Regulation, Audit, Accreditation, Investigation, Legal, Reporting, and Inspection/Monitoring Functions Differ

Let me be more precise about the key differences I see among each of these oversight functions, with particular emphasis on the least known of these—the inspection/monitoring function.

The **regulation** function is served by those governmental entities that have some ability to wield a hammer over the correctional agency. Those entities may set mandatory standards or policies, and they have the power to enforce these standards and policies through, for example, the imposition of fines, the ability to close an institution,

the ability to hire or fire directors, or the ability to control the purse strings of the agency. The key concept here is "enforcement authority."

The **audit** function is concerned with whether the agency is meeting established performance indicators, standards, or policies. These could be performance indicators mandated by the legislature; they could be standards required by an accreditation body such as the ACA; they could even be requirements set by the agency itself. The auditing tasks could be fulfilled either by an internal auditing mechanism or by an outside entity. It could be as simple as a paper review involving a checklist; it could be a more complex audit to see if an agency is worthy of accreditation. But as a general matter, the auditing function is designed to give either prison/jail administrators or those who regulate them some objective measures of how the agency is doing and/or whether tax monies are being well-spent. The emphasis is on the audit as a management tool: are agency staff following established policy or standards? Is there any gap between policy and practice? Are statistics changing over time and, if so, why? Answers to those questions are very valuable to correctional administrators and they aid in effective and proactive prison management. Most internal auditing processes are designed to remain confidential. They support the needs of management for information and accountability without being designed to further the additional goal of public transparency.

The **accreditation** function is a form of oversight insofar as it requires an agency to meet certain standards in order to be eligible to receive what amounts to a stamp of approval by a professional organization in the field. It is designed to measure an agency's specific operations against best practices in the field, rather than to assess whether any wrongdoings or human rights violations have occurred. Accreditation is typically a voluntary process in the correctional context, which means that it is initiated from within the agency.

Investigations are a critical aspect of oversight because they offer a means to ensure accountability for wrongdoing, presuming the investigations and resulting discipline are conducted in a timely manner. This function can encompass everything from a grievance coordinator's investigation of a prisoner's complaint, to an internal affairs investigator's review of an excessive use of force claim, to a prison ombudsman's handling of a family's concerns, to an independent entity's review of agency operations in the wake of a series of complaints, to criminal prosecution and civil lawsuits. What distinguishes the investigation function from some of the other oversight functions is that it is essentially reactive. The function is only triggered once a complaint is received or a scandal breaks.

The **legal** function involves the use of the courts and the legal process to achieve redress for wrongdoing as well as corrective action. In conjunction with a lawsuit over jail conditions or mistreatment of prisoners, a court may order either damages or injunctive relief, and it can back up its orders with legal sanctions such as contempt or fines. In rare cases, of course, the courts have exercised long-term supervision over correctional agencies to ensure compliance with orders. Federal law also allows for the involvement of and oversight by the United States Department of Justice at a stage prior

to the filing of a lawsuit, under the Civil Rights of Institutionalized Persons Act (CRIPA). A CRIPA investigation of poor correctional conditions may lead to an agreed-upon set of standards that the agency must meet and to long-term monitoring by the Justice Department to assess compliance with these standards. The legal function, like the investigation function, is reactive in nature, though the ongoing supervision by the legal system is designed to fix an unacceptable set of conditions and not just punish wrongdoing. Transparency may be a by-product of court oversight, but it is not the primary goal.

The **reporting** function refers to the role of the media, human rights groups, and temporary commissions (such as your own) in exposing jail conditions or investigating a particular incident. This function goes to the heart of the goal of transparency, of course, because it increases public awareness of jail-related issues. In some cases, this can lead to public pressure on elected or appointed officials to change policies or practices, so it potentially serves the goal of accountability as well. Typically, those who perform this oversight function do not have the ability to demand access to correctional facilities, so information has to be gathered through other means. The distinguishing feature of the reporting function is that it primarily serves the needs of the public for information and analysis of prison or jail conditions.

Finally, there is the **inspection and monitoring** function. Monitoring involves an entity outside of the corrections agency with the power and the mandate to routinely inspect correctional institutions and to report on how people within that prison or jail are treated. There are four distinguishing features of this function. First, it involves routine and regular review of every institution as a preventative measure; it is oversight to help in improvement, not to point out what went wrong. Second, it involves an outside entity, a body not answerable to the management of the agency and a body without a potential conflict of interest. It necessarily involves external scrutiny. Third, the focus of the inspection function is on how prisoners are treated and how prison life affects them. The monitor looks holistically at interactions and institutional cultures that are not always captured by standards and policies, or even by performance measures. What's more, an inspector does not aggregate the data he or she finds, recognizing that in some instances, aggregation could mask the fact that appropriate treatment or services may have been denied to certain prisoners. Fourth, there is no enforcement mechanism; the recommendations of an inspector are advisory in nature. The monitor's strength comes from the power of persuasion, not control.

Of those oversight functions designed to enhance transparency through external scrutiny, the inspection/monitoring function is the only one that is intended to be preventative in nature. (Investigations, for example, are focused on past behavior.) Problems are identified through inspection and monitoring (and hopefully corrected) before there are lawsuits about conditions or incidents that make the front page of the newspaper. Monitoring is not about blame for past mistakes, it is about preventing occurrences in the future. It is about finding ways to meet agreed-upon goals. Moreover,

the routine and regular inspection process ensures that this form of oversight applies equally to all correctional facilities within the jurisdiction of the monitor, not just those with publicized problems. Regular monitoring helps keep the quality of correctional services high, because the staff's knowledge that an inspector could arrive at any time acts as a means of informal control over staff behavior. In other words, it "keeps staff on their toes" and helps them avoid complacency, even when everything is going well. External scrutiny of this type helps reassure citizens that prison and jail conditions are appropriate and consistent with constitutional requirements.

As this Commission considers ways in which oversight structures may help address the problem of violence in the jail, I hope it will identify ways to implement and strengthen a variety of oversight mechanisms. To ensure the greatest possible amount of transparency and accountability in corrections, we need to ensure that each of these critical functions is being served effectively.

For purposes of this hearing, however, my comments will focus on two of these functions—investigation and monitoring—because these two functions are most immediately relevant when it comes to addressing the problem of violence. Investigation is essentially a **reactive** form of oversight, providing accountability for past wrongdoing. Monitoring is a **preventative** form of oversight, seeking to prevent such occurrences in the future.

The Need for an Independent Jail Monitoring and Investigation Mechanism

The American Bar Association's Policy on Correctional Oversight

In 2008, the American Bar Association adopted a policy that called on all units of government to establish independent entities to regularly monitor and report publicly on the conditions in all prisons, jails, and other adult and juvenile correctional and detention facilities operating within their jurisdiction. The policy also set forth a detailed list of key requirements for the effective monitoring of correctional and detention facilities.[1] The importance of the ABA's position on the need for such oversight structures is also reflected by the fact that the ABA's Treatment of Prisoners Standards (2010) also included standards requiring independent monitoring of prisons and jails, as well as effective internal accountability mechanisms.[2]

Thereafter, the ABA established a subcommittee charged with being a resource to jurisdictions seeking to implement the oversight policy. I have the honor of co-chairing that subcommittee, along with my colleague Professor Michael Mushlin at Pace Law School, one of the country's leading authorities on prisoners' rights. We have been in

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[1] A.B.A., RES. 104B KEY REQUIREMENTS FOR THE EFFECTIVE MONITORING OF CORRECTIONAL AND DETENTION FACILITIES (2008), *available at* http://www.abanet.org/crimjust/policy/104b.doc.

[2] *See* A.B.A., CRIMINAL JUSTICE STANDARDS ON THE TREATMENT OF PRISONERS (2010), Standards 23-11.1-11.4.

touch with policymakers, practitioners, and other stakeholders in a number of counties and states interested in pursuing the development of correctional oversight entities, and we have provided testimony in several instances as well. We are very encouraged by the work of this Commission and its recognition of the importance of effective jail oversight structures.

The Essential Elements of Effective Jail Oversight

When I first started researching correctional oversight, I assumed I would be able to identify the best way to structure a correctional oversight mechanism. But the more I examined this issue, the more I realized that it is less critical that all oversight mechanisms look alike or have the same label than it is that they have in place the essential elements for effectiveness as an oversight body.

The ABA's policy spells out 20 key elements for effectiveness, and I encourage Commission members to review that list as it provides an excellent resource. However, I think the most critical of those features are as follows:

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(1) They must **be independent of the correctional agency**, and able to do their work without interference or pressure from the agency or any other body. "Independence" is a complicated concept, but it includes:

--***structural independence***—The entity does not report to the agency head; it is situated outside of that reporting structure. Moreover, the agency has no control over the release of reports or the monitoring entity's resources.

--***fiscal and physical independence***—The monitoring body should not be co-located in the Sheriff's Department and should not include Sheriff's personnel. Nor should the monitoring body be reliant on the Sheriff's office for budget support, infrastructure support, Internet services, or email.

--***true independence***—There needs to be strong leadership with the backbone and resolve to stand up to the head of the correctional agency and any political pressure that may exist, and to report candidly on problems and concerns. A term-limited tenure for the head of the monitoring body can be helpful in this regard.

--***perceived independence***—The public—and prisoners, especially--must perceive the monitoring body as independent of the correctional agency under review, and not susceptible to pressure.

(2) The oversight body must have a **mandate to conduct regular, routine inspections** of the facilities under their jurisdiction, and the authority to investigate, and issue reports on, a particular problem at one or more facilities.

(3) Monitors must have a "golden key," giving them **unfettered and confidential access** to facilities, prisoners, staff, documents, and materials, and they should have the ability to visit any part of a facility at any time of day without prior notice.

(4) The oversight body must be **adequately resourced**, with sufficient staffing (e.g., attorneys, investigators, and support staff), office space, and funding to carry out their monitoring responsibilities, and the budget must be controlled by the monitoring entity.

(5) The oversight body must have the power and the **duty to report** its findings and recommendations in a timely manner, in order to fulfill the objective of transparency, and it should control the release of its reports.

(6) Monitors must take a **holistic approach to evaluating the treatment of prisoners**, relying on observations, interviews, surveys, and other methods of gathering information from prisoners as well as on statistics and performance-based outcome measures.

(7) There must be **a means of fulfilling both the investigative function and the monitoring function**, in order to provide accountability for past wrongdoing in individual cases and to prevent future problems. These functions need not be performed by the same oversight body, though it is possible to combine these functions, as is the case with the California Office of the Inspector General, which provides oversight of California's state prisons. (The California OIG was nationally recognized as an oversight model at an international conference on effective prison oversight in Texas in 2006, when Matt Cate led the office.)

(8) The **correctional agency must be required to cooperate fully** with the oversight body and to **respond promptly and publicly** to its findings.

These factors are far more critical than whether a monitoring entity is set up as an independent governmental body, a legislative committee, an Ombudsman, an Inspector General, a non-profit organization, a lay citizens' oversight group, or a court-created monitoring structure. What structure is chosen for any given jurisdiction must necessarily take into account the culture and norms of that jurisdiction and the oversight mechanisms that are already in place. Each way of structuring a monitoring entity presents its own challenges, often involving trade-offs between the extent of independence and the ability to be effective.

There is some disagreement among experts in this field as to whether an oversight body should have enforcement authority when it comes to the power to implement their recommendations. My own view is that such enforcement authority is neither essential nor desirable, if we are talking about a monitoring entity. The investigation and monitoring functions should not be confused with a regulatory function. Jail inspectors are not managers, and they are not policy-setters; they should not exercise control over an agency or its staff, for in doing so they become yet another layer of management. Enforcement should come from a regulatory body, a budget-setting body, or the courts. In contrast, the monitor's strength comes from the power of persuasion, not control.

Conclusion

As the ABA has urged, systems of accountability must be developed to ensure that prisoners are safe and are being treated appropriately. There must be effective internal accountability measures so that correctional administrators can better manage their facilities. And there must be meaningful forms of external scrutiny, including routine monitoring of correctional facilities and investigation of prisoner complaints. The importance of creating an independent oversight body in Los Angeles County to help prevent and respond to future incidents of violence in the jail cannot be overstated. That body should, at a minimum, include both routine monitoring and investigatory responsibilities.

There are numerous examples of oversight bodies to which this Commission can turn for ideas on how a new oversight body can be structured, and with which responsibilities it should be imbued. Examples of such models are discussed in various articles in the volume OPENING UP A CLOSED WORLD: A SOURCEBOOK ON PRISON OVERSIGHT, 30 Pace L. Rev. (April 2010).

It is critical, though, that whatever oversight model(s) this Commission chooses to develop and adopt (and whatever it is called) contains the essential elements of effective oversight. Moreover, it makes sense to have multiple forms of oversight in a jurisdiction, because one entity cannot serve all the purposes for which oversight is necessary. Meaningful correctional oversight calls for a layered approach, involving complementary models.

I want to end on a note of caution, however. Even the most effective correctional oversight mechanism will not solve the problem of violence in jails. External oversight is a piece of the puzzle, a way to ensure that the public knows what is happening in the jail, and a way to ensure that wrongdoers will be punished for criminal behavior. It allows both the public and correctional administrators to know whether the goal of having the jail be a safe and humane place is being met. Transparency provides both a form of protection from harm and an assurance that rights will be vindicated. But effective and safe administration of correctional facilities is, ultimately, a task that falls squarely at the feet of corrections officials. Even the most effective oversight system will not prevent violence in a correctional facility where leadership is lacking and the culture, policies, and practice do not support safe operations.

External oversight, to quote former New York City Corrections Commissioner Martin Horn, a nationally regarded corrections leader who spoke at a Texas conference on prison oversight in 2006, "makes us better; ...it forces us to question what, why, and how things are done."[3] Similarly, a top British prison administrator commented to me

[3] These comments are summarized in: Michele Deitch, ed., *Opening Up a Closed World: What Constitutes Effective Prison Oversight?: Conference Proceedings*, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, 2007, p.37. Available:

that when outsiders routinely come into an institution, it acts as a means of informal control over staff and inmate behavior. If external oversight can help administrators improve the level of safety in their correctional facilities in these ways, then it must be looked to as part of the solution to eliminate violence in prisons and jails. As this Commission continues to work on this jail crisis, I encourage Commission members to see oversight as the linchpin in any effort to ensure the safety of prisoners.

One final issue worthy of your consideration in this process is the value of a custody division in the Sheriff's Department that is separate and apart from the law enforcement function. Problems often arise in jails where the patrol and corrections functions are not bifurcated and given equal status. Sometimes the corrections staff can be made to feel like second-class citizens compared to sworn peace officers, if there are differences in pay or prestige. This perceived lack of respect reduces the jail staff's professionalism and morale, which in turn can lead to problems in staff behavior. Some of the most professional jail operations I have seen in this country are ones in which there is a jail director who is appointed by the county commissioners; the jail is not a function of the Sheriff's office at all. That structure is certainly not essential for effective and professional jail operations, but it offers a possibility worthy of further review by this Commission.

Thank you again for the opportunity to present you with this information today.

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http://www.utexas.edu/lbj/archive/prisonconference/prison_conference_proceedings_final.pdf. Martin Horn also serves on the ABA Subcommittee on Oversight and helped develop the ABA's policy statement on correctional oversight.

Comparison of Custody Training[1]

Department	Length of Custody Specific Initial Training
Los Angeles	2-4 weeks[2]
Cook County	16 weeks
Miami Dade County	22 weeks
New York City	16 weeks
San Diego County	16 weeks

[1] Unless otherwise noted, all information in this chart came from interviews with jail leaders in California and around the nation.

[2] Commander Management Task Force members testified on July 6th that LASD recently added one week of custody specific training to the academy to supplement preexisting 8 hour training; Sheriff Baca testified on July 27th that the custody specific training is a "two weeks extension in the academy" and another two weeks before deputies go into the jail. CCJV has reviewed the current curriculum for training; that curriculum reflects 2 hours of custody specific training during the academy, slightly over one week of supplemental training post-academy on subjects that are not solely related to custody, and two weeks of basic training when deputies report to their custody assignment.