Stephen J. Connolly
Executive Director

TO: **Board of Supervisors**
FROM: **Stephen J. Connolly**
DATE: **Tuesday, October 30, 2012**
RE: **OIR Activity Report**

I. Discipline Process: Cases and Trends

One of OIR's core functions continues to be the monitoring of all Sheriff's Department's Internal Affairs investigations into allegations of misconduct. Through September 30 of this year, the Department has opened 153 new cases. A further break down of this total includes the following sub-categories:

- 115 of the cases were initiated internally, while 38 stemmed from citizen complaints.
- Patrol Operations and Custody Operations were, predictably, the two largest sources of new cases, with 62 and 57 respectively.
- 13 of the cases had a criminal component and were investigated for potential prosecution.
- 137 related to on-duty misconduct, while only 16 related to off-duty activity.

Meanwhile, the Department continues to refine its Commendation/Complaint process as a means of efficiently adressing feedback from the public. So far this year, the system has logged 69 complaints. While 27 were referred to Internal Affairs for possible policy violations that would merit discipline if sustained, others have been resolved at lower levels of intervention. Not all the cases are complete, but so far 19 of the remaining 42 cases were closed after a determination that the conduct was in policy or that no further action was needed, based on initial interviews and reviews of available evidence (such as PVS recordings). Counseling or training has been recommended in 12 others.

OR has worked with the Department in promoting consistency and documentation in the instances where the conduct at issue does not rise to the level of formal discipline but nonetheless merits attention and correction. Last month, the Department introduced a new "Performance Note" policy that standardizes record-keeping for both positive and negative comments in the employees' personnel file. Among other things, the new "Performance Note" will help ensure that these lower-level issues are getting the attention they deserve – thereby keeping them from becoming patterns of problematic behavior.

Among the individual administrative investigations reviewed by OIR in the last several weeks are the following:

In a case that originated as an inmate's complaint of unnecessary force, the Department conducted a criminal investigation into the actions of one of its deputies. Though the District Attorney's Office declined to prosecute, the subsequent administrative investigation led to the discharge of the deputy who had used force, failed to report it, and ultimately offered a justification for the force that was refuted by other evidence. A key factor in the sustaining of the allegation was the testimony of a witness deputy, who had originally said nothing but later cooperated with the investigation. That deputy received minor discipline for his initial failure to take appropriate action. More substantial was the discipline received by a second deputy who was in the corridor at the time of the incident, who denied having seen any misconduct and said he was looking in the other direction at the time of the force.

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The Department conducted a criminal investigation into allegations of inappropriate contact, including sexual misconduct, by a deputy who regularly encountered prostitutes during his patrol responsibilities. While the criminal investigation did not corroborate the charges to the extent that the District Attorney had a basis to prosecute, the Department's Internal Affairs unit did an extremely thorough review of the deputy's PVS recordings. An investigator watched dozens of hours of video and identified multiple instances in which the deputy appeared to detain prostitutes for questioning, often parking in remote locations in order to have the conversations. This evidence directly contradicted several of the statements made by the deputy during the criminal investigation, and he did not have convincing explanations for the discrepancies when interviewed administratively. Although the most serious sexual allegations were not directly proven, the IA case established a pattern of troubling behavior and a lack of truthfulness by the officer. While the final decision is pending, OIR has recommended termination, and was extremely impressed with the thoroughness of the IA investigation.

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In another jail case involving a minor, but seemingly unnecessary, use of force, OIR recommended a criminal review that did not lead to a prosecution. Nonetheless, the

surveillance video raised questions about the necessity of the force, which was originally unreported. The subsequent administrative investigation led to recommendations of discipline for the involved deputy, as well as a witness deputy who failed to take appropriate action based on what he had seen.

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In a recently opened case that is currently being investigated, an outside law enforcement agency contacted the Department to complain about the way two of its officers had been treated while booking a suspect into the Inmate Reception Center. According to the complaint, the officers were waiting for their turn and overheard a conversation between deputies that featured unprofessional content and graphic language. When one of the officers requested them to stop, multiple deputies responded negatively and inconvenienced the officers as they attempted to complete the booking. This allegation raises several concerns that resonate with other jail cases about the demeanor and professionalism of the deputies, and OIR is monitoring the pending case.

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An off-duty supervisor came across a teenager who was allegedly vandalizing a utility box. The officer, who was in his personal clothes, decided to chase the suspect, and ended up becoming involved in a use of force in the process of apprehending him. He eventually detained the suspect so that responding officers from another agency could place him under arrest. Although the force was determined to be "in policy," the Department's review concluded that the supervisor had violated policy with his level of engagement as an off-duty officer with limited available resources. OIR recommended that the investigation be sustained with low-level discipline, and the Department concurred.

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A supervisor was removed from a field assignment after generating four separate administrative investigations within a year. Weeks into his new position in one of the jails, he allegedly mishandled a deputy's accidental discharge with a Taser by encouraging the deputy to create a memo that falsely accounted for the deployment, and then presenting that memo to the watch commander for the shift. The supervisor was placed on administrative leave, and the resulting investigation substantiated the allegations. OIR has recommended discharge, especially in conjunction with several other recent policy violations; the final decision is pending.

II. Review of Death Investigation

During the public comment period at the end of the September 11 meeting of your Board, a speaker asked for the Board to look into the death of a young adult named

Khalid Flimban, who was found in a Laguna Hills park in the early morning hours of January 6, 2012. The case was initially handled as a Coroner investigation, and classified as a suicide based on the physical evidence, including the autopsy. Mr. Flimban had been found hanging from the bar of some playground equipment, and his cell phone had text messages on it that indicated an intention to take his own life.

The family was troubled by this finding, and prevailed upon the Sheriff's Department to conduct a more comprehensive criminal investigation into the death. The Sheriff's Department's Homicide unit responded to this request, interviewed a number of relevant witnesses as identified by the family, and pursued suggested leads that might have indicated an alternative scenario. In spite of these efforts, the family and supporters continued to be dissatisfied. They have questioned the thoroughness and effectiveness of the Department's findings and investigation in various forums, including a city council meeting and at your Board.

I had the opportunity on September 20 to meet with a group that included family members and friends and to discuss some of the concerns and questions that continued to linger after several months of communications between Mr. Flimban's relatives and the Department. From there, I met with Homicide personnel, and reviewed the Coroner file in the case in an effort to resolve some of the outstanding issues.

While the family's grief and frustration, as articulated at the Board meeting last month, seem very sincere, I do not have reason to believe that the investigation was inadequate or that the findings clash with available evidence. On the contrary, investigation at the scene and the subsequent forensic pathology seem to have established a persuasive weight of evidence. Additionally, the Department appears to have been painstaking in responding to the ideas and theories of the family during several weeks of additional investigation.

I have communicated this information to the family's representative, including answers to fourteen specific questions that emerged from our initial face-to-face meeting. I will also continue to monitor the administrative investigation into the family's formal complaint about the Department's actions in this case, and will provide updates as needed.

III. Deputy-Involved Shootings: 2012 Updates

On Friday, September 28, the District Attorney's Office announced its findings regarding the fatal deputy-involved shooting of Manuel Loggins, which occurred in San Clemente in February of this year. It determined that the deputy's use of deadly force was justified under the applicable legal standards.

As you know, the case raised significant questions and concerns at the time of the incident in February of this year. The sudden death of a well-regarded – and unarmed –

Marine in the presence of his young daughters, and under strange circumstances, was understandably perplexing to the public. This was exacerbated by the halting and initially inconsistent information that the Department shared with the media.

However, from the beginning, the District Attorney's Office, which had the lead role in conducting the shooting investigation, had considerable evidence at its disposal. This included voluntary statements from the involved deputy as well as the additional OCSD personnel on scene. Importantly, the District Attorney was also able to draw on video and audio recordings from the officers' in-car systems. These provided significant and objective information about what exactly had occurred.

Ultimately, the District Attorney concluded that the deputy's articulated fear for the young girls' safety was a reasonable basis for his decision to use deadly force in order to stop Sgt. Loggins from driving away. The plausibility of alternative and less drastic resolutions – including incapacitating the car, removing the daughters from the car during the short interval when Sgt. Loggins had abandoned the vehicle, and stopping him with lesser force such as a Taser – did not negate that reasonableness from the perspective of the deputy's legal justification.

Those latter issues do, however, continue to warrant the Department's attention in terms of possible administrative accountability. The Department's internal review can enter its final phase now that the criminal case is closed, and OIR will monitor that process.

A civil lawsuit against the County continues to be pending in connection with the incident.

The most recent deputy-involved shooting of the year occurred on the evening of September 14 in Dana Point. It was a non-hit shooting involving a drunk-driving suspect who led the involved deputy on a brief vehicle pursuit into an apartment complex. The suspect parked, got out of his car and turned toward the deputy with a dark object in his hand. It turned out to be a carabineer and key chain. After firing one round (and striking the chimney of a nearby apartment building) the deputy saw that the suspect had dropped the object. He was taken into custody and booked after a trip to the hospital for an elevated heart rate.

Consistent with protocol, the District Attorney did not respond to the scene because the suspect was not hit. Nonetheless, the homicide investigation – which included interviews of the suspect, the shooter deputy, and a reserve deputy who witnessed the incident – was packaged for the D.A's consideration regarding the legality of the deadly force. That decision is still pending.

The Dana Point shooting brought the year-to-date total for the Department to four. In all four instances, the suspect was not armed (though, as discussed above, the deputy's rationale for firing in the Loggins case was not the belief that the suspect had a weapon, but instead in order to keep him from leaving the scene in his car). The circumstances

obviously varied in each case, and each has been the subject of its own administrative review. But the Department has also decided to look at three years' worth of shooting incidents in order to look for potential trends and opportunities to improve training, tactics, or equipment.

OIR is participating on the committee that will be evaluating the shootings and ultimately making recommendations to the Executive Command. Interestingly, the process will also include an evaluation of incidents in which deputies who might have been justified in using deadly force refrained from doing so. These will provide additional data points as well as a comparison that may prove useful. The committee has two meetings scheduled in November, and I look forward to sharing the results of its work.

IV. Pro-Active Review Based on Outside Agency Reports

Since the time of my last memo to your Board, two local jurisdictions have published final reports regarding an outside assessment of their own agencies. These were the city of Fullerton (which had hired OIR Group to review its Police Department in the wake of the Kelly Thomas case from last year) and Los Angeles County (which had empowered a special commission to review its jail system in the wake of several disturbing allegations about deputy misconduct and inmate abuse). Each report featured dozens of findings and recommendations, and OIR has worked with OCSD in reviewing the respective reports for ideas that might be relevant to improving the Sheriff's Department here in Orange County.

59 recommendations emerged from the OIR Group Report to the City of Fullerton; of these, 29 had already been implemented by OCSD and reflected in the current structure for internal review. While several were not applicable, due to the structural and size differences between the Sheriff's Department and the Fullerton Police Department, there were several identified as meriting further consideration or review. These include refining the Department's focus on issues posed by the homeless and/or mentally ill, and continuing to address the use of force in a holistic manner.

This month the Department is introducing a new format for supervisors to evaluate force incidents. OIR has worked with the SAFE Division in devising a checklist that will give additional structure and uniformity to the assessment of force incidents. Additionally, OIR is part of a new protocol in which all force cases that feature one of several identified "risk factors" will be subject to automatic additional review and risk management consideration. OIR will meet regularly with SAFE representatives to evaluate these cases and determine what further action might be beneficial.

As for the report by the "Citizens' Commission on Jail Violence" (appointed by the Los Angeles County Board of Supervisors last year), that group produced a lengthy

report that featured myriad findings and recommendations. Categories included force, discipline, agency culture, and even civilian oversight.

Particularly noteworthy was the Commission's sense that the warning signs of dysfunction within the jail were readily available based on existing internal review mechanisms. The Sheriff's Department – either willfully or through inattention – failed to respond appropriately, and the situation appears to have deteriorated over time.

With an approximate capacity of 7,000 inmates, as opposed to L.A. County's 20,000, and with significantly fewer deputies, the Orange County system appears to have a more manageable scale, but several of the lessons remain applicable. One apparent gap in L.A.'s processes was the failure to track inmate allegations of deputy misconduct – though the technological capacity for doing so existed. While individual allegations may well have been addressed, a cumulative record and an attempt to identify *patterns* of behavior did not fulfill the system's potential. Nor were the inquiries into individual complaints very well-documented.

OIR has used the report as an occasion to revisit the issue of inmate grievances within the Orange County jails. An audit of the misconduct allegations under the new tracking system – which went "online" in June of 2011, is underway. While several of the complaints have led to formal Internal Affairs investigations, the majority are resolved internally. The consistency and effectiveness of these reviews is something I will continue to assess in the next few weeks. Meanwhile, the Department is exploring its options for ensuring that personnel who are frequent complaint recipients are receiving appropriate supervision and intervention.

The Sheriff and her Executive Command have made it clear that rigorous internal review continues to be a priority. The Department's response to the opportunities presented by these two high-profile reports is an encouraging example of this trend.

V. Probation Department: Incident Review

The Office of Independent Review continues to monitor the progress of the Probations Department's internal investigation into a February, 2012 incident involving a male and female minor having sex in a Juvenile Hall housing cell. As you may recall, the first phase of the investigation involved the eight employees who were on duty in the relevant unit during the time of the incident, which unfolded over the course of a few hours. The failure to detect the presence of the male juvenile in the cell of the female – or to notice that he was absent from his own assigned cell – indicated that required "safety checks" had not been adequately performed[1], and that activity logs had been filled out inaccurately to cover for this lack of due diligence.

[1] The relevant state and facility regulations call for checks – which are supposed to include visual assessment of the inmates – to occur every 15 minutes.

The second phase of the investigation was an outgrowth of the first: after reviewing hours of tape from surveillance cameras and conducting numerous interviews, the Department realized that the deficient safety checks were perhaps not a singular event but part of a pattern of lax performance within that unit. Eight more employees were placed on administrative leave as subjects of this part of the investigations.

The investigation for the first group of eight was completed by June, and discharge was recommended for each of them. However, the process of finalizing the required notification letters, which set forth the relevant evidence in detail and explain the basis for the Department's decision, proved to be labor intensive. The representatives of the involved personnel have also raised several legal challenges that have protracted the process. At this point, the letters have gone out, and the appellate process – which begins with an internal hearing and an opportunity for the affected employee to respond to the proposed discipline – is underway for these eight individuals.

The investigation for the second group is also complete, and the notification letters are currently being prepared. One of these individuals has already resigned; another has come back to work based on the developing evidence in the case, and the determination that any misconduct on the part of that individual did not rise to the level of discharge as the outcome.

Meanwhile, the Department continues to assess the potential culpability of supervisors who were responsible for the involved unit, either directly or indirectly, during the time period in question.[2] Two of the relevant employees are no longer with the Department; a third has been interviewed and the outcome of the Department's review is pending.

VI. Conclusion

Thank you for your attention to this memorandum. Please feel free to contact me at your convenience regarding these contents or other matters related to my responsibilities.

Best regards,

Stephen J. Connolly
Executive Director, Office of Independent Review

[2] None of the potentially involved supervisors was on duty when the incident between the male and female juveniles occurred in February; their culpability would turn on possible knowledge of deficient performance and/or failure to supervise adequately.