The Los Angeles County

Sheriff's Department

25th Semiannual Report

by Special Counsel Merrick J. Bobb and Staff

and Police Assessment Resource Center (PARC)

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Introduction

This is the **25th Semiannual Report** by Special Counsel and staff on the Los Angeles County Sheriff's Department (LASD or Department). Our ongoing role has been to examine for the Board of Supervisors whether the LASD is doing all it could and should to prevent avoidable and unnecessary injury or death in the jails and on the streets. We assess whether the Department is minimizing liability to County taxpayers for the acts and omissions of LASD personnel. We assess policies, practices, training, and performance to test whether legitimate law enforcement ends can be accomplished with less risk to all concerned—the deputy, the suspect, third parties, and bystanders. Our examination considers the systems the LASD has in place to identify and correct the persons and situations that have already lead to injury and subsequent liability or which may lead to liability in the future.

We look for patterns. We look at practices and systems. We focus on the areas that were the subject of the **Kolts Report**—LASD practices on the streets and in the jails that may give rise to complaints or allegations of misconduct about LASD personnel from the persons who come in contact with the LASD. Use of force by the LASD has been a constant subject of our inquiry, as has medical care in the jails, the quality of supervision of deputies, deputy-involved shootings and their investigation and review, the fairness and objectivity of internal investigations of alleged misconduct, and the proper use of systems such as the LASD's early intervention software, the Personnel Performance Index or PPI.

The LASD is one of a small group of law enforcement agencies that have a nationwide influence and is looked to for leadership and innovation. It is a large urban agency serving millions of people in a richly diverse environment. The challenges facing the LASD in Southern California are often presented before the balance of the nation will experience them. In policing, as in other fields of endeavor, it happens first in California, and what California does will have a disproportionate impact everywhere else.

California was certainly the first place in recent times where use of force by law enforcement came under intense scrutiny. For the LAPD, it began with Rodney King and the subsequent **Christopher Commission Report** in 1991. For the LASD, it was a series of officer-involved shootings and the alleged predations of a tattooed gang of LASD officers in Lynwood that led to the subsequent **Kolts Report** in 1992. Out of each report came recommendations for ongoing independent outside monitoring and review of law enforcement. In the case of the LAPD, the Police Commission was given wider powers and the office of Inspector General within the Police Commission was created. In the case of the LASD, the Office of Special Counsel and later an Ombudsman and the Office of Independent Review (OIR) came into being.

Los Angeles County's tripartite structure—Special Counsel, OIR, and the Ombudsman—has become the gold standard by which monitoring and civilian oversight have come to be measured. There is an Ombudsman to focus on the satisfaction of complainants with the investigation and resolution of their public complaints against LASD personnel. There is the OIR to monitor individual internal investigations and help make sure the disciplinary outcomes in individual cases fairly reflect the Department's policies and aspirations. There is Special Counsel to examine whether the LASD is doing its best to avoid unnecessary injury or death. The methods and approaches of Special Counsel and OIR have been emulated throughout the country and have been encapsulated in proposed national guidelines for police monitors commissioned

by the US Department of Justice.

This Semiannual Report examines two broad areas of the Sheriff's operations—the provision of care to women who are inmates in the LA County Jail and the lessons learned from litigation.

Women in the Jail

Three chapters in this Report are devoted to the provision of care to women who are inmates in the LA County Jail, where they are currently housed at the Century Regional Detention Center (CRDF). Our research on the status of women in the jails, of which these three chapters are a first installment, is being supported in part by a grant from the John Randolph and Dora Haynes Foundation, to whom we express our gratitude.

In the first of these chapters, we look at medical care of female inmates, focusing specifically on the issue of timeliness of evaluation and treatment. For the reasons discussed in this chapter, we acknowledge progress in the housing for women who report a medical condition. We saw firsthand the dedication of many nurses. Nonetheless, there were areas for improvement, principally because of the dearth of written policies in many important areas, including delivery and birth, and the lack of accountability to ensure treatment within 24 hours (72 hours on weekends) as prescribed by authoritative medical standards in a correction setting. Delays in the provision of medical services are not even tracked, contrary to good practice as defined by the medical profession. Our key recommendation is that every woman who asks for medical attention or to see a nurse gets to do so within 24 hours of the request being made, except, of course, for medical emergencies demanding immediate attention. The 24 hour requirement may be as simple as a nurse seeing the woman briefly to assess whether the asserted need for medical attention is legitimate or not or to ascertain the immediacy of the need for examination and treatment.

We were particularly concerned with the imbalance between demand and supply for medical services. Sick call, synonymous with nurse clinics, serves far fewer women on a daily basis than sign up to see the nurse. Yet seeing the nurse is a necessary first step to seeing a doctor or specialist. The constant backlog to see the nurse therefore reverberates and causes delay throughout the system.

Our next chapter considers pregnancy and child care in the jail setting. In a year's time, more than 1400 pregnant women enter the Los Angeles County Jail system. As many as 60 pregnant women will be in the jail at any given time. All of them will require prenatal care. The LASD, surprisingly, does not keep track of how many women deliver children while in custody, although the Department guesses that there are no more than 30 births in a year. Some women deliver at the jail itself. Others deliver at the jail treatment center or at County USC Hospital.

Few of the policies and programs relating to pregnancy are reduced to writing. As a result of this failure to have written policies, we encountered understandable but ultimately unacceptable confusion about actual policies, particularly those relating to the transportation and restraint of women in labor and shackling during delivery. We also found inconsistencies in or confusion about the provision of pregnancy tests and the timing of commencement of prenatal care and postpartum care. All of these should be formalized in written policies. One key recommendation is that the LASD in written policy and practice conform to California state law prohibiting the shackling of women before, during, and after labor and delivery absent extraordinary security requirements.

Although many aspects of its approach to pregnancy and its aftermath are praiseworthy, Los Angeles County lags behind San Francisco and San Diego Counties in key areas. In San Francisco, women are allowed contact with their babies after they return to the jail post-delivery. In Los Angeles County, there is no such program. In San Francisco, children wanting to visit their mother

are given specific appointment times. The LASD, in contrast, is more like a lottery. Visitors are taken on a first-come, first-served basis. Children may sit all day and never get to see their mother. If they come back the next day, it starts all over: There is no preference given for children who were unable to see their mother the previous day. A small child could sit in a jail all day for two days straight and not get to see his or her mom. Our key recommendation here is that the LASD institute specific appointment times for visits by children with their mothers. We further recommend that the LASD permit mothers to hold and touch their infants after the mother's returned to custody as occurs in San Francisco.

In San Francisco, any qualified female inmate who desires to do so can sign up for the Parent-Child Visiting program and then can have direct contact with her children. Both sentenced and pre-sentenced inmates can participate. Although the LASD provides a similar program through the La Puente Hacienda School District, it only serves 10-12 inmates a week. Pre-sentenced inmates are barred from participation. We urge expansion of that program so that substantially more women can take advantage of it.

Our third chapter on women in the jail considers the quality of the Department's response to inmate complaints. We found that the LASD does a good job resolving routine complaints from women about conditions of confinement and a poor job resolving complaints about medical services. The Department received 214 medical complaints between December 2006 and May 2007, the majority of which centered upon treatment delays. Of these, nearly one-third had not been completed at the time of our review and only 38 percent of the remaining complaints were completed within a ten-day period. Additionally, we found that the referral of 41 complaints by Custody was unnecessarily delayed, that the level of detail on many medical dispositions was insufficient to determine whether the complaint was adequately resolved, and that the majority of complainants appear never to have been noti-

fied of the result of their complaints as required by Title 15. Finally, the use of the category "Request for Service - Routine" to describe nearly every medical complaint, as well as the failure to make even a token effort to investigate system or staff performance issues, renders the complaint system incapable of providing LASD management with any meaningful information about systemic problems with the delivery of medical services at the facility. Our key recommendation is that all complaints about medical evaluation and treatment or delays in the provision of same must be transmitted to Medical Services within 24 hours and that Medical Services be required to respond to the complaint within 24 hours. Personnel complaints against medical staff should be investigated within the normal ten-day deadline.

Litigation

After six months reviewing the last six full years of litigation against the Department, from fiscal year 2001-02 until fiscal year 2006-07, we find that the LASD has experienced a welcome reduction in the number of new lawsuits filed against it in recent years, strongly suggesting that the Department's risk management activities, in the main, have successfully thwarted new litigation, thus reducing injury, risk, and financial exposure—all for the benefit of the general public and County taxpayers.

The number of new force-related lawsuits, as well as the number of closed force-related lawsuits resulting in a payout, has also trended downward. Force-related litigation comprises less of the Department's total liability than it once did. In the 2006-2007 fiscal year, force-related litigation represented about 35 percent of overall liability, down significantly from 2001-2002, when force-related litigation constituted a full 66 percent of the Department's total liability. Yet gains in the reduction of force-related litigation must be balanced against increases in litigation arising from custody.

We examined in detail the 17 lawsuits in the 2006-07 fiscal year that settled for more than $100,000. Of those, six involved in-custody injury or death. These six cases alone accounted for $5.635 million, or more than half (51 percent) of the Department's total civil liability across all lawsuits for the 2006-2007 fiscal year. Plainly, the LASD has to do a better job preventing avoidable injuries and death in the custody setting. The deeply disturbing apparent facts in each of the six cases are discussed at length in the Litigation Chapter.

Finally, we want to acknowledge a high degree of cooperation from the LASD and its personnel in connection with this Report, particularly with regard to the Department's review and critique of drafts of the chapters in this Report. The dialogue was extremely useful and approached constructively by all. Our special thanks in this regard to Chief Alexander Yim, Chief Dennis Burns, Captain Michael Kwan, Lieutenant Roger Ross, Nurse Kathleen Braman, Nurse Barbara Marshall, Sergeant Bob Blanks, Lieutenant Shaun Mathers, and Sergeant Charla Harris.

Delivery of Medical Care 1

Introduction

In this Report, we look at medical care of female inmates in the Los Angeles County Jail, focusing specifically on the issue of timeliness of evaluation and treatment. We were very pleased to find that, in the past year, the facility where the women are housed has made great improvements in its Inmate Reception Center (IRC) medical screening process, bringing it for the first time into substantial compliance with screening provisions of a 2003 Memorandum of Agreement with the United States Department of Justice. This means that women with mental health issues are screened within 24 hours of their arrival at the jail during the week or 72 hours on the weekend. This is a significant accomplishment.

The same does not hold true for women who want to see a doctor or nurse after the screening process has been completed. As much as we acknowledge and saw firsthand the dedication of many nurses, the LASD was unable to demonstrate in the majority of cases that it provides access to nurses within 24 hours (72 hours on weekends) after the inmate has requested to see one, in derogation of authoritative, medical standards in a jail setting. Delays in the provision of medical services are not even tracked, contrary to good practice as defined by the medical profession. As a result, the LASD lacks the basic data about delays that are necessary to hold medical personnel accountable for them.

Women are currently housed at the Century Regional Detention Facility (CRDF) in South Los Angeles near the intersection of the Harbor and 105 Freeways. Applicable law requires that jails provide emergency and basic health care to all of its inmates, including medical screening upon intake, daily sick

call, and provision of medically restricted diets. At the Los Angeles County Jail, which maintains an average daily population of approximately 19,000 inmates, of which approximately 2200 are women, and which processes about 31,000 women inmates every year, the massive task of evaluating and treating sick inmates falls to the LASD's Medical Services Bureau (MSB), an in-house department of the Custody Division that operates physician and nurse clinics at each facility as well as the Twin Towers Correctional Treatment Center (CTC).[1]

We found that although CRDF has a competent and dedicated medical staff, each nurse clinic serves an average of about ten inmates per day per floor, which may house up to 496 inmates over four modules. We saw module sick call lists with the names of ten to 25 inmates waiting to see the nurse, only two to four of whom would typically be seen that day, and we reviewed many complaints from inmates claiming to have waited weeks or even months for medical treatment. We also found that, because the Department does not keep records of inmates' sick call requests, it is impossible to accurately measure how long inmates are waiting to be seen. Given the frequency of complaints of delay, and without evidence to the contrary, it is more probable than not that inmates utilizing the sick call process frequently experience delays longer than the essential standard of 24 hours (72 on the weekend) before they are seen by a nurse.[2] Because the sick call visit is also the mechanism for referral to a physician, delays in the sick call system result in even longer waits to see a doctor.

1 Several previous Semiannual Reports have looked at the issue of medical care in the Los Angeles County Jail. In our **Seventh, Eighth,** and **Thirteenth Semiannual Reports,** we looked at issues and improvements in the jail's medical record-keeping system and its implications for inmates' health care. Our **Eighth, Ninth,** and **Seventeenth Semiannual Reports** contain a discussion of IRC and medical screening processes, and our **Eighth, Thirteenth,** and **Seventeenth Semiannual Reports** focus on inmate medical complaints. Medical staffing is discussed in our **Ninth** and **Twelfth Semiannual Reports,** and examinations of liability and medical malpractice trends appear in our **Eleventh** and **Twelfth Semiannual Reports.**

2 According to accepted national standards developed by the National Commission on Correctional Health Care (NCCHC), sick call requests should be triaged daily and the inmate should be seen by a qualified medical professional within 24 hours (72 hours for a weekend). NCCHC Standard J-E-07.

In our examination of wait times, we looked at three components of the jail's medical care delivery system—medical screening during intake, sick call, also referred to as nurse clinics, and standardized procedures certification—in terms of their effectiveness, efficiency, and impact on the overall timeline for medical treatment, and found the following:

- When CRDF first opened as a women's jail and inmate reception center, many inmates awaiting medical evaluation during intake faced long stays in holding cells without beds or access to showers. Under the direction of Captain Kwan of the Medical Services Bureau, the Department recently implemented a new IRC medical screening module in which inmates are housed in two-person cells, where they have access to a bed and shower. The Captain monitors the number of inmates awaiting medical screening through daily reports from the facility, and states that they are now being seen within 24 hours.

- The facility operates five nurse clinics to provide an opportunity for inmates to see a nurse during a daily sick call. Yet because the sick call sign-up and call-out process is, in most cases, managed entirely by deputies, nurses do not have the capacity to prioritize requests before meeting with the inmate, a capacity which NCCHC recommends for correctional facilities. The Department maintains no record of how long inmates wait to be seen by a nurse, but it appears likely that many are not seen on the day that they make the request. Accepted national standards require that inmates are seen by a medical professional within 24 hours.

- The Department has developed a comprehensive set of standardized procedures that expedites medical care for many inmates by allowing nurses certified in the procedures to perform protocols traditionally reserved for physicians. These standards were revised in 2007, requiring recertification of all nurses in the new procedures in five segments—Series I, II, III, IV,

and V. At the time of our first visit in mid-January 2008, only 19 nurses had been certified in Series I and only nine nurses had been trained in Series II. Accordingly, there were too few trained nurses, and many inmates had to be denied service and be referred to a physician for the designated treatment at a later time. Since January, there has been marked improvement. As of May 21, 2008, as a result of a sustained effort to provide training at CRDF, 35 more nurses in the facility had been trained in at least one of the two series of standardized procedures. This leaves 15 who have not been trained in Series I and 24 who have not been trained in Series II. Due to staffing and other constraints, the Department has not yet begun training in Series III-V.

According to MSB, female inmates at CRDF as a group tend to be in better overall shape than men, possibly because of the greater likelihood that they were insured prior to their incarceration. Indeed, a review of medical complaints filed by inmates at CRDF revealed relatively few complaints by inmates claiming to have severe illnesses or conditions requiring emergency care. Nonetheless, the demand for medical services at that facility is significant and constant. Between May 2007 and April 2008, 16,092 CRDF inmates, a little more than half of the approximately 31,000 women who are processed through the jail each year, were seen at least once during their period of incarceration by nurses conducting intake screening or medical call. Five thousand and ten were evaluated by a physician, and an average of 1360 inmates received prescription medication every month.

During the past six months, we reviewed the LASD's policies and procedures to ensure a timely response to inmates' medical requests. We reviewed inmate medical complaints, many of which referenced lengthy delays in care; visited the main clinic and two nurse clinics; interviewed nurses, deputies, and management staff; consulted legal standards; and compiled written policies on medical screening and the delivery of medical care.

1. Background

A. Legal Standards

Sentenced inmates have a constitutional right to adequate medical care under the Eighth Amendment, which entitles convicted inmates to "humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter and medical care."[3] Because pretrial inmates retain, under the Fourteenth Amendment, "at least those constitutional rights… enjoyed by convicted prisoners," the standard for sentenced inmates applies to all inmates in the Los Angeles County Jail, whether sentenced or unsentenced.[4]

The Department is also bound by state standards, codified in Title 15 of the California Regulatory Act, which include the following requirements:

> **Section 1200. Responsibility for Health Care Services**
> [T]he facility administrator shall have the responsibility to ensure provision of emergency and basic health care services to all inmates… Each facility shall have at least one physician available to treat physical disorders.
>
> **Section 1207. Medical Receiving Screening**
> With the exception of inmates transferred directly within a custody system with documented receiving screening, a screening shall be completed on all inmates at the time of intake. This screening shall be completed in accordance with written procedures and shall include but not be limited to medical and mental health problems, developmental disabilities, and communicable diseases, including, but not limited to, tuberculosis and other airborne diseases. The screening shall be performed by licensed health personnel or trained facility staff.
>
> **Section 1208. Access to Treatment**
> The health authority, in cooperation with the facility administrator, shall develop a written plan for identifying, assessing, treating and/or referring any inmate who appears to be in need of medical, mental health or developmental disability treatment at any time during his/her incarceration subsequent to the receiving screening. This evaluation shall be performed by licensed health personnel.

3 *Farmer v. Brennan,* 511 U.S. 825, 832-833 (1994) (quoting *Hudson v. Palmer*, 468 U.S. 517, 526 (1984).
4 *Bell v. Wolfish,* 441 U.S. 520, 545 (1979).

Section 1211. Sick Call

There shall be written policies and procedures developed by the facility administrator, in cooperation with the health authority, which provides for a daily sick call conducted for all inmates or provision made that any inmate requesting medical/mental health attention be given such attention.

Title 15 provides leeway to each agency in determining the nature of its healthcare delivery structure and in designing its screening and sick call mechanisms. It also stops short of requiring that inmates be evaluated and treated within a specified period of time. Nonetheless, the accompanying guidelines, in discussing sick call processes, specify that the "guiding principle should be that any inmate requesting medical/mental health attention must receive that attention as soon as reasonable and possible."[5]

Although they do not have the force of law, the National Commission on Correctional Health Care (NCCHC) "Standards for Health Services in Jails" are widely considered the benchmark standards for effective and constitutional jail health care. Originally developed by the American Medical Association, the standards are now maintained by the NCCHC, which also operates an accreditation program for correctional facilities. According to those standards, inmates should be able to request medical care on a daily basis, and sick call requests should be prioritized on a daily basis. No matter how prioritized, all inmates requesting care should receive a face-to-face sick call visit within 24 hours of making the request on a weekday, or within 72 hours on weekends. For large jails with a daily inmate population of more than 200 inmates, sick call should be held at least five times a week.[6] **We urge and recommend to the Department that it seek accreditation by NCCHC and, in the interim, voluntarily adhere to the NCCHC 24 and 72 hour time limitations.**

5 "2005 Title 15 Health Guidelines," pg 45.

6 "J-E-07: Nonemergency Health Care Requests and Services," *Standards for Health Services in Jails,* National Commission on Correctional Health Care, 2008.

B. Inmate Medical Complaints

As part of our examination of the treatment of inmates at CRDF, we reviewed all complaints made by inmates at the facility between December 2006 and May 2007, including complaints made through the Department's grievance procedure and those made through the American Civil Liberties Union (ACLU). That review, discussed in greater detail in Chapter 3, "Inmate Complaints," found that of the 214 medical complaints included in the sample, 85, or approximately 40 percent, directly complained of delays in service, such as lengthy waits to see a doctor or nurse, obtain a test result, or receive appropriate medication or diet. For reasons explained in that chapter, the percentage of complaints about delay may in fact be higher.

The Inmate Complaint Form provides a space for inmates to write down their complaint in their own words. The form asks inmates to provide some specific information: "Explain your complaint. Include dates, times, and names of persons involved." Nonetheless, many complaints contained vague or incomplete information about the nature of the inmate's grievance, sometimes failing to include the date the inmate had first requested treatment or a clear description of any medical attention received. As such, it was difficult to assess average wait times or to identify what, if any, remedial steps had been taken prior to the complaint being filed. Complaint dispositions, many of which were never completed, generally offered no additional detail about the length and cause of these delays. **The form should include data fields asking inmates to provide specific information about the complaint; the date on which help was requested; treatment, information, or other aid already provided; the names of involved employees; and the remedy requested. Regardless of the form's format, however, the person investigating the complaint should be required to collect and document any such information from the inmate and to make some effort to verify that information by researching the medical record.**

Some inmates did provide clear accounts of their long waits for medical care. In the files that we reviewed, inmates complained of a variety of delays in receiving attention. Some complained of waiting on the sick call (nurse clinic) list, while many others mentioned that they had seen a nurse and were waiting to see a doctor or an off-site specialist. Others complained of delays in receiving medication, diets, or tests that they claimed had already been ordered.

In this Report, we focus primarily on evaluation and treatment provided by Registered Nurses (RNs). We do so because nurses, both during IRC screening and sick call, serve as the initial point of contact with the inmate and are, in many cases, the conduit for other levels of care. When certified to perform standardized procedures, they may also preempt the need for further referral. As such, the sick call list or inmate request form usually represents the first, and sometimes the only, documented instance of an inmate's request for medical attention.

II. Intake Screening Process

Unlike male inmates, who go through the Inmate Reception Center (IRC) at the Twin Towers Correctional Facility (TTCF) in downtown Los Angeles regardless of their eventual housing placement, female inmates are booked and screened directly at CRDF. Upon entry, a reception Deputy, with the help of a nurse, sorts out inmates based on their apparent health status and ability to move directly to an appropriate housing unit. Inmates who require immediate medical attention will not be booked and are to be transported to Los Angeles County-University of Southern California Medical Center (LCMC) or another nearby hospital. Inmates who are medically appropriate for booking but who possess identifiable health problems receive further medical evaluation.

IRC staff use a 17-question classification screening tool that includes three medical questions:

- Are you pregnant?
- Are you taking prescription medication that you seriously need within the next six hours?
- Do you need medical care?

If an inmate responds "no" to all of these questions, along with a question regarding suicidal thoughts, she will proceed through the booking process. A nurse or trained Custody staff person will administer an over-the-counter medical/mental health screening questionnaire that asks more specific questions about the inmate's medical or mental health history and any current conditions. If the inmate answers "no" to all these questions, she will be asked to sign the sheet stating that she denies any medical or mental health problems. She is then given a chest x-ray to screen for tuberculosis, and is placed in a holding cell pending housing placement. According to IRC staff, inmates with no identified medical or mental health problems are usually placed in a housing module within approximately one hour.

An IRC screening Registered Nurse (RN) then reviews the questionnaire, the Arrestee Medical Screening form, and any other medical information the inmate provides during the initial screening process. Inmates who require time-sensitive, non-emergency medical attention are given "expedite" status and will be seen in the CRDF Reception Center Clinic for further treatment. An entry in the Medical Services Database will be opened and Custody personnel will be notified that this inmate is to be placed in the "expedite" holding area. Some of the symptoms or medical conditions that will result in expedited medical screening status include: self-reported insulin diabetes, cancer, symptomatic hypertension, shortness of breath or cardiac conditions, pregnancy of 20 weeks or more, violent or combative behavior, suicidal ideation or 5150/5250 paperwork, HIV/AIDS, communicable diseases, open or draining wounds, surgeries within the last week, and "any other significant medical condition referred by the nurse."

Following the initial assessment, all inmates needing medical attention will receive a physical and, if indicated, a psychiatric evaluation, and medication, treatment, and special housing, as necessary, at the CRDF Reception Center Clinic. The inmate is then referred back to the IRC custody staff to complete the booking process.

IRC Housing

When we first began our review of CRDF, we found that inmates needing medical or mental health evaluation waited for a lengthy period of time before they were seen, due to backups in the system. A review of the time spent in intake for inmates who entered the jail between June 2006 and May 2007 shows that although the average time spent in intake was approximately six hours, large numbers of inmates waited significantly longer. In fact, 5084 women were in intake for more than 24 hours; 831 of those spent between two and three days in intake, and 27 spent between three and four days.[7]

These lengthy stays at IRC prompted serious concerns from jail management and outside observers, including the ACLU, due to the holding cells in which these inmates were housed. CRDF was not originally designed as a reception center, meaning that the booking area was designed to take inmates who had already been through the intake process. Its holding cells are not meant to house inmates for a significant period of time, and thus contain only narrow metal benches for inmates to sit on. Although inmates can sit or lie on the floor, this is obviously hellish, and overcrowding makes this alternative even more difficult or uncomfortable. Another concern was that inmates in the IRC—many of them coming directly off the street—had no access to showers or a change of clothes, often causing them to stay in crowded, uncomfortable,

7 An additional 42 inmates are listed as having been housed in the intake modules for more than four days, with a few waiting for significantly longer. For example, one inmate is listed as having spent 145 days in intake, clearly as a result of a clerical error. We have chosen not to include those records indicating an intake stay of longer than four days due to the possibility of such errors; however, it is possible that some inmates were, in fact, at the IRC for a longer period than four days.

and foul-smelling cells for several hours or even days. Such circumstances also present a potential security and operational management issue for Custody staff.

According to several people we interviewed, the miserable condition of the IRC holding cells resulted in an overburdened nurse clinic system. Because it was widely known that answering "yes" to one of the three classification questions could result in a lengthy stay in an IRC holding cell, inmates learned not to identify their medical needs during intake, preferring to be transferred to a housing module immediately. Instead, they would wait to sign up for nurse clinic when they were settled in a regular housing area, increasing wait times for an appointment, delaying needed medical care, and potentially putting other inmates at risk of communicable diseases.

In response to a similar situation at the larger IRC for men at the Twin Towers Correctional Facility, the ACLU received a temporary restraining order that prevents the jail from housing men in holding cells for more than 24 hours at a time. This order does not apply to the IRC at CRDF, but we are pleased to see that over the past several months, the Department has been actively working to find a creative solution to the problem of intake housing at that facility.

In mid-2007, the Custody staff at the CRDF IRC began monitoring inmates awaiting medical evaluation to ensure that they did not spend more than 18 hours in an IRC holding cell. Instead, inmates were moved on a nightly basis to a special housing area—1200—where they could sleep on a bed in a two-person cell and receive access to a shower. That area, which can accommodate up to 96 inmates, was not part of the women's jail proper, but had been part of a complex used to house male arrestees who were booked through the Century Station and were awaiting transfer to IRC downtown. Deputies used a running list to ensure that inmates did not wait past the maximum time; inmates who spent the night would be transferred back to the holding cell in the morning to await medical or mental health evaluation, with their 18 hours beginning again.

This system was improved in January 2008 with the conversion of the 1200 housing module to a permanent medical screening area. Under the current system, inmates requiring medical attention are moved immediately to that module to await screening on-site, where they remain in relative comfort until they are ready to be processed into regular housing, without having to shuttle back and forth between the screening module and a holding cell. Medical Services Bureau has set up several workstations with computers where nurses can interview and evaluate inmates, enter information in their medical record, and set up appointments and referrals. When we visited in January 2008, we found the screening area staffed with several nurses; only a few inmates were awaiting attention.

In October 2007, Captain Michael Kwan also began monitoring the number of inmates waiting to be triaged to ensure that they were being seen in a timely fashion. He is sent a daily report noting the following information:

- Number of inmates waiting to be triaged
- Number of inmates triaged
- Number of inmates waiting to be data based
- Number of inmates with data base completed
- Number of inmates waiting to be seen by an MD/RNP
- Number of charts with orders to be transcribed
- Number of inmates waiting to be seen by mental health

According to the Captain, wait times in IRC screening have generally been reduced to well under 24 hours, and medical staff assigned to intake are often able to assist screening at the IRC for men through the Department's tele-medicine program during their downtime. In February 2008, the facility was inspected by an audit team for the US Department of Justice, which monitors the Department's compliance with a 2002 Memorandum of Agreement (MOA) relating to mental health care at the jail. In its report, the team found that

"reception screening operations are, for the first time, in substantial compliance with the requirements of the MOA. In addition, CRDF now has completed unit 1200 and opened it for beneficial occupancy and operations, facilitating the timely completion of follow-up mental health evaluation after 15-question screening."

We applaud the Sheriff's Department for taking proactive steps to address the problem of lengthy waits for female inmates during intake and are very pleased to find that the new system has brought them into substantial compliance with the reception screening requirements of the MOA. Inmates may now wait for medical attention in much-improved accommodations, with access to a bed and a shower, while the increased turnaround time should ensure that appropriate housing placements are made in a reasonable amount of time, and that serious medical issues are evaluated and treated in a timely fashion.

We will be interested to see whether inmate response patterns change as a result of the new procedures, increasing the number of those requesting medical attention upon entry and decreasing demand for the nurse clinics. In general, the nurse clinics should be focused on routine medical issues that come up during incarceration, rather than attempting to manage more serious conditions that should be addressed upon entry.

III. Sick Call

CRDF provides access to several levels of medical care to inmates, depending on the type of treatment or assessment needed. The primary on-site medical facility is the Main Clinic, a busy 24-hour unit that takes inmates requiring immediate attention and where physicians and Registered Nurse Practitioners (RNPs) see inmates referred to them. Inmates may also be sent to the Main Clinic for special tests or to be assigned an observation bed if needed. Due to space constraints, the Main Clinic also houses one of the five

Nurse Clinics—the facility contains one for each housing tower floor at CRDF—which operates regular sick call for that floor. Inmates requiring more intensive care may also be transferred to the Correctional Treatment Center (CTC) at TTCF or the jail ward at LCMC (or, in an emergency, the nearest hospital). For those inmates who need them, appointments with specialists in neurology, ophthalmology, oncology, and other specialties will be made at LCMC.

Along with the intake screening process, the Sick Call/Nurse Clinic system is the primary conduit for inmates needing access to most types of non-urgent care. While inmates in theory should all receive a full evaluation, necessary referrals, and medication upon entry, in practice some inmates rely on sick call as the first step in the process of getting medical care. Designed to provide inmates with basic treatment as specified by written Standardized Procedures—discussed in the next section—as well as over-the-counter medication and needed referrals to physicians or RNPs, an efficient nurse clinic system is crucial to the provision of adequate medical care at the facility.

Each nurse clinic (save for the one housed in the Main Clinic, which uses a counter and lab space there) consists of a small room with a window at which inmates may speak to the assigned RN or, if necessary, come in for tests. The nurse on clinic duty must share the space with staff members managing pill call and those providing dressings and other treatments, leaving little space to spread out or for privacy. There is currently no space for an additional clinic nurse. Each clinic is open during one eight-hour shift, from 6:00 am to 2:00 pm, Monday through Friday, although it usually does not operate for the full eight hours due to lunch, set-up, and close-down. A nurse clinic generally serves between eight and 12 inmates, with an average of approximately ten inmates per shift.

This average is taken from a review of 108 CRDF Nurse Clinic Reports over a four-month period. We reviewed all available reports for the month of January 2008 and one-fifth of the available reports for October through

December 2007. Four reports from February were included in the files we requested and were also included in our analysis. We found that the majority of nurse clinics—approximately two-thirds—served between eight and 12 inmates, for a total average of 9.9 inmates per shift. One-sixth of the clinics saw fewer than eight inmates and one-sixth saw more than 12, with a high of 17 inmates. Although they were not included in our statistical analysis, we also visually reviewed a number of clinic reports from the month of June 2008 and found that the numbers served fell within the same range. Clinics were open for an average of 6.5 hours per day, with only five clinics in our sample operating for a full eight hours.

We also found that in January, the month for which we reviewed all available reports, there was only one day for which five reports—one for each CRDF clinic—appeared in the file as expected. For the 20 service days in January for which there were reports, there were four days for which four reports were filed, eight days for which three reports were filed, six days for which two reports were filed, and one day for which one report was filed. There were no reports for three weekdays in January. It is not clear whether the missing reports were the result of careless reporting or filing, or whether they are a signal that all five clinics were not operating regularly. We were pleased to see that, as of June 2008, the Nurse Clinic Report filing system had been much improved, with updated forms, fewer errors, and a full five reports for each day. It is imperative that the nurse clinics be monitored closely to ensure that they are operating regularly and that they see an adequate number of inmates each day.

In general, nurse clinics operate on a first come, first served basis. Each of the five housing floors of the women's jail houses one nurse clinic that serves the entire area's population, with four modules and up to 496 inmates on some floors. Inmates sign up for treatment by writing their names on a "sick call" list, sometimes pinned to the bulletin board near the front desk of each module,

which holds up to 25 names (per module). Each module deputy oversees the list and, when told that the nurse clinic is accepting from that module, sends inmates to the nurse clinic in the order their names appear. (Inmates may also request treatment using an Inmate Request or Complaint Form, which is collected by a Custody supervisor, transferred to a Medical supervisor, and assigned to the Main Clinic or a nurse clinic, as appropriate.) The clinic works by rotating modules, a few patients from each module at a time. As a result, the clinic is able to see an estimated two to four inmates per day from each module.

A. Staffing and Capacity

In looking at the current nurse clinic system and staffing levels, it is clear that some delay in medical care, as described in inmates' complaints, is inevitable. During our visits to housing modules, we found full sick call lists that, according to one deputy, can take up to two weeks to close out, due to the clinic's inability to keep up with demand. This is much longer than the 24 hours recommended by the National Commission on Correctional Health Care. In some cases, it may take even longer to see a nurse due to court dates, work assignments, and housing moves. For many, the nurse clinic is the first step (and bottleneck) to obtaining a referral and appointment to a doctor or RNP, adding an extra delay for those in need of additional levels of care.

The Department's ability to increase the daily capacity for nurse clinics is limited by staffing and space constraints and by the nurse's responsibility to open a database record for inmates who are being seen for the first time. Because some inmates use the nurse clinic system rather than the intake screening process to obtain initial medical services, the assigned nurse must open up a computer medical database record for these inmates. This process, in which the nurse records basic information and vital signs, lengthens the duration of the visit and limits the number of inmates that can be seen.

We hope that the implementation of the 1200 screening module will change this dynamic by removing a disincentive for inmates to request medical attention during intake.

Each facility is authorized to provide sixteen hours of nurse clinic—over two shifts—per day, with more if demand increases. Although MSB eventually plans to add a second, afternoon/evening nurse clinic shift per floor each day at CRDF, they have not been able to do so due to staffing constraints. (Because of a lack of space, only one RN can staff each clinic at a time.) Not only would the additional shift potentially double the number of inmates who are seen per day, it would increase access by accommodating inmates who are unavailable during the day due to court dates or other obligations.

We must note our frustration and disapproval with the performance of the LASD in this regard. Since we first looked at medical problems in the jails more than ten years ago, we have time and again pointed out chronic and intractable nursing shortages. **We recommend that the Department move immediately to implement an adequate number of clinics to see and treat all persons signing up for sick call within 24 hours during the week and 72 hours during the weekend.**

In response to our concerns, the Bureau has committed to implementing changes to ensure that all inmates are seen in the Nurse Clinic within the recommended time period by improving productivity and adding extra hours to the Nurse Clinic as needed. According to Bureau management, the number of inmates seen per shift should be higher than twelve. It will take a careful look at productivity to see how the number of inmates seen during each shift can be increased through higher expectations and accountability, additional training, or improved coordination with Custody staff.

Some of the challenges in the delivery of medical care—particularly for the nurse clinics, which are relegated to small, shared spaces that offer little room for privacy—are the result of physical constraints posed by CRDF's design.

We hope that the Department learns the lessons from the problems at CRDF and plans how to prevent them when and if the female inmates are moved to a new facility.

B. Sick Call Process

Currently, nurses on clinic duty have very little control over the sick call process, which is usually operated by module deputies. (In some of the lock-down modules, sick call is conducted by the pill call nurse, who will go around to each cell to assess which inmates need to attend nurse clinic.) During our tour of each module at the facility, we found that the sick call sign-up process varies widely among modules and deputies. In general, however, the deputy on AM shift creates a daily sick call list, which she will either maintain at her desk or post for inmates to sign up on. She is tasked with ensuring that inmates whose names appeared on the previous day's list, but did not see a nurse, place their names at the top of the new list in similar order. In some cases, however, the list may begin anew, with no priority given to inmates waiting from the day before. The deputy may also simply keep a running list of inmates requesting sick call, which is posted until all inmates on the paper have been seen. All previous sign-up sheets are discarded, leaving no record of inmates' previous requests for medical attention.

Deputies have some responsibility for ensuring that inmates with very urgent needs receive immediate attention. If an inmate clearly needs immediate treatment, the deputy can put her at the top of the sick call list or, if necessary, send her to the main clinic. However, deputies are not medical professionals and may not have the training to discern problems requiring priority attention. Additionally, since the inmates sometimes simply write their name on a list, the deputy may have no way of identifying a serious problem unless she approaches the inmate directly. The deputy also does not have access to the inmate's medical records to see how recently she was seen or what her status

is, or, for inmates moving from another module, how long she's been waiting. As such, although the current system is "fair" in treating inmates in the order they sign up, it does not provide the nurse on duty with any way to prioritize or effectively manage the list of inmates awaiting attention.[8]

We recommend that CRDF implement a sick call system that preserves the nurse clinic while providing the nurse on duty with a way to track and prioritize inmate requests by date and urgency. Such a system could include, instead of a posted list, a dated sick call slip process that allows inmates to privately describe their medical complaint. As we discuss in the next section, all sick call requests should be tracked in some way, perhaps on a spreadsheet, that allows nurses to see how long inmates have been waiting and what their needs are. While the first come, first served system should be generally maintained, new requests that appear particularly urgent should be moved to the top of the list. Submitting sick call requests from all four modules can further ensure that inmates are seen in order, and that inmates in modules with shorter lists are not seen more quickly than those in modules with longer lists.

C. Data Collection

The large number of complaints referencing delays, along with the fact that nurse clinics serve about 8-12 inmates per day, suggests that inmates often face long wait times before they can be seen by a nurse or doctor. However, the length of these wait times is nearly impossible to quantify, because the Department maintains no record of inmates' requests for service, other than the complaint form. By the time an inmate files a complaint, she may have

8 The written Standardized Procedure for Nurse Clinic requires that the RN "[o]btain from Custody the Nurse Clinic-Inmate Sign Up Sheet…of inmates who have signed up for Nurse Clinic. The list will have the date and approximate time of receipt. The assigned facility Clinical Nursing Director II may decide if necessary." The policy does not specify the criteria for determining whether this procedure is necessary, but it appears that it is not considered necessary at CRDF.

been waiting to be seen for weeks or even months. Although the inmate may attempt to quantify the length of time she has been waiting, there is no way to verify her account, which is often vague in the first place.

As discussed, inmates who have already been placed in a housing module can request medical attention in three ways: the daily sick call list, the Inmate Request Form, and the Inmate Complaint Form. Both the sick call list and the request form are discarded upon "completion." Accordingly, there is no way to verify that all requests have been completed, just as there is no way to know how long the inmate waited before being seen.

This lack of data is problematic for several reasons. First, it leaves the Department effectively blind in assessing the level of staffing needed to match demand, and the extent to which those staff levels should be adjusted or maintained. While staff members and inmates are able to offer some estimate of the wait time, there are no real data to back those estimates up.[9] Second, it robs management of a major tool for keeping its staff accountable. When lists and requests can simply be discarded without any need to prove that they have been addressed, there is no way to identify staff members who are not following procedure, failing to keep up with their responsibilities, or simply ignoring requests. Third, it hinders the medical staff in effectively managing demand and ensuring that inmate requests do not fall through the cracks, particularly when they are moved or repeatedly miss sick call. Finally, it prevents MSB from conducting substantive investigations of inmates' complaints of undue delays or delivery failures. Indeed, we discovered very little effort to research whether such claims are valid or to find the source of the delays.

Failing to adequately collect data on the dates and substance of inmates' medical requests does not exempt the Department from ensuring that inmates receive treatment in a reasonably timely fashion, though it does make it more

9 Fortunately, the Department has recently switched to an electronic appointment system for physician referrals, eliminating the "doctor's line." Because these referrals are entered electronically, the system ostensibly allows LASD to track the length of time inmates wait to see a physician once they have been referred. The Department should do so also with regard to sick call.

difficult. While the lack of a tracking system may preclude inmates from proving that they face unreasonable delays in receiving care, it nonetheless exposes the Department to risk by depriving it of evidence that it is systemically working to ensure that no such unreasonable delays occur. As the 2005 Title 15 Health Guidelines note:

> [I]t can prove extremely helpful to retain sick call slips or sick call sign-up sheets. Clear policy and procedures calling for permanent filing of request forms affords early protection against charges of impeded medical care or ignoring health care needs. In some facilities, the sick call slip is added to the inmate's medical record and includes a space for the health provider to note date, time, initials and disposition or treatment, directly under the inmate's request. Such slips do not take the place of actual charting…; however, these slips afford excellent documentation that health care personnel are addressing inmate needs.[10]

The LASD obviously is out of compliance with this Guideline. The LASD should immediately implement this Title 15 Guideline by filing copies of inmate requests and sick call slips in the medical chart following each visit. We further recommend that the Department immediately implement a system for tracking these slips, preferably by computer. Such a system need not be complicated—it could be as simple as a spreadsheet that is updated by a nurse or another staff member—but it should be maintained centrally for a specified period of time, perhaps for two years after the inmate has been released. It should include a way for nurses to "check off" when an inmate has been seen and to easily search for requests that have not been addressed.

As we discuss in Chapter 3, "Inmate Complaints," the Custody Division is in the process of implementing a new Complaint/Request system. As part of the new system, the Department began

10 "2005 Title 15 Health Guidelines," pg. 17.

assigning reference numbers to all but the most minor Inmate Request Forms, including those requesting medical care, on May 1, 2008. Although this will no doubt impose an additional data entry burden on Custody staff, we endorse this plan, which will provide an additional layer of accountability and ensure that there is some record of each inmate request made.

IV. Standardized Procedures Certification

As mentioned earlier, a primary role of the nurse clinic is to provide an initial screening and physician/RNP referral to inmates needing medical care. As a result, delays in seeing a nurse will compound the length of time an inmate must wait to see a doctor or RNP. However, RNs who have been certified in certain standardized procedures may avoid this extra step by providing some basic care themselves. As a result of the Nursing Practice Act (NPA), enacted by the California Legislature in the 1973-74 session, RNs have been authorized to perform certain procedures that had previously belonged within the scope of medical practice: "Once the nurse has observed signs and symptoms of illness, reactions to treatment, general behavior, or general physical characteristics and determined the presence of abnormal characteristics, the nurse may administer treatment in adherence to a standardized procedure that authorizes the nurse to treat."[11]

Known as "Standardized Procedures," these detailed protocols must be carefully developed and documented by "organized health care systems," such as LASD's Medical Services Bureau, along with a comprehensive education and certification process. Nurses who have not been certified by proving that they understand and can adequately perform the relevant functions may not do so. The procedures must be revised on a regular basis.

11 Scope of Nursing Functions, Board of Registered Nurses.

At the LASD, the standardized procedures are developed by the Interdisciplinary Practice Committee (IDPC), comprising the Unit Commander, Chief Physician, Clinical Nursing Directors, Chief Pharmacist, Nurse Practitioners, and RNs. They encompass basic treatment procedures for conditions over five training series:

- Series I: Nurse Clinic, Pain Assessment, Angina Pectoris, Asthma
- Series II: Acne Vulgaris, Dermatitis, MRSA, Common fungal infections
- Series III: Allergic Reactions, Bee sting, Scabies, Common colds
- Series IV: Diarrhea, Constipation, Gastritis, Hemorrhoids
- Series V: Dental Problems, Dysmenorrhea

Having nurses on nurse clinic duty performing these procedures can eliminate an extra referral step for inmates complaining of these conditions, allowing them to be treated in a more timely fashion. Otherwise, the inmate would have to wait an additional amount of time, on top of the time she spent waiting to see the nurse, to see a doctor for treatment.

At the time of our visit on January 22, 2008, however, the majority of registered nurses within the CRDF Medical Services Bureau were not certified to perform the LASD standardized procedures. According to Department policy, which requires that the procedures be reviewed every three years, the IDCP revised the policies in 2007, meaning that all RNs had to be recertified in the new procedures. On that date, of 69 nurses, 19 had been certified in Series I and nine had been certified in Series II. As a result, until they could be certified, nurses on clinic had to revert back to referring patients to a physician for those services.

The Department began offering training for the new procedures in September 2007; to date, it has only offered Series I and II. The training for each procedure takes two hours, for a total of eight hours (four for Series V) a day. Because all nurses—649 systemwide—have to be trained in the proce-

dures while ensuring that the jails are adequately staffed, certification will be a lengthy process. Getting the CRDF nurses trained has been a special challenge as a result of the facility's location, away from the main jail complex downtown.

Since our visit, MSB has conducted a sustained push to train the nurses at CRDF, including holding seven classes at the facility to increase attendance. Nurse Managers at the facility are responsible for scheduling nurses for the training, ensuring that the facility is adequately staffed and that the classes are scheduled while on duty. As of May 21, 2008, 35 additional nurses had been trained in Series I and 24 in Series II. However, 15 nurses have yet to complete Series I and 24 must complete Series II; no nurses have yet been certified in Series III through V. Although these Series appear to encompass less common issues—as evidenced by inmate complaints, at least—we hope that these trainings occur in a relatively short time frame to ensure that nurses are able to perform those procedures.

There has been some progress in increasing the number of RNs who are certified for Series I and II standardized procedures. We recommend that MSB continue to make it a priority to ensure that all RNs become certified in all of the standardized procedures as soon as possible. While scheduling nurses for the training is no doubt a drain on the facility, regularly offering the training on-site at CRDF, perhaps in shorter sessions, might make it easier for more nurses to attend between shifts or responsibilities. We suggest that, in scheduling staff for sick call/nurse clinic, Nurse Managers pay special attention to ensuring that assigned nurses have been certified in all available procedures. The Department may also want to consider offering the full range of standardized procedure trainings in an expedited fashion to RNs who will be assigned to nurse clinic.

Pregnant and Parenting Inmates 2

Introduction

In a year's time, more than 1400 pregnant women enter the Los Angeles County Jail system. As many as 60 pregnant women will be in the jail at any given time. All of them will require prenatal care. The LASD, surprisingly, does not keep track of how many women deliver children while in custody, although the Department guesses that there are no more than 30 births in a year. Some women deliver at the jail itself. Others deliver at the jail treatment center or at County USC Hospital.

Few of the policies and programs relating to pregnancy are documented in the Department's written materials. As a result of this failure to have written policies, as well as a compartmentalization of roles, we encountered understandable but ultimately unacceptable confusion about actual policies, particularly those relating to the transportation and restraint of women in labor and shackling during delivery. We also found inconsistencies in or confusion about the provision of pregnancy tests and the timing of commencement of prenatal care, as well as about postpartum care. San Diego County does have written policies that address many of these concerns, and a sample of those are attached to this chapter as Appendix A.

Although many aspects are praiseworthy, Los Angeles County lags behind San Francisco and San Diego Counties in key areas. In San Francisco, women are allowed contact with their babies after they return to the jail post-delivery. In Los Angeles County, there is no such program. In San Francisco, children wanting to visit their mother are given specific appointment times. The LASD,

in contrast, is more like a lottery. Visitors are taken on a first-come, first-served basis. Children may sit all day and never get to see their mother. If they come back the next day, it starts all over: There is no preference given for children who were unable to see their mother the previous day. A small child could sit in a jail all day for two days straight and not get to see their mom.

In San Francisco, any qualified female inmate who desires to do so can sign up for the Parent-Child Visiting program, formerly known as Prison MATCH, and then can have direct contact with her children. Both sentenced and pre-sentenced inmates can participate and there is no parenting class requirement. Although the LASD provides a similar program, called TALK, through the La Puente Hacienda School District, it only serves 10-12 inmates a week. Pre-sentenced inmates are barred from participation, and women must attend at least three parenting classes before they become eligible for TALK.

Because the LASD does not provide certain services itself, it has coordinated with volunteer and contracted community service providers. We acknowledge and commend the excellent work of the Harriet Buhai Center, Center for Children of Incarcerated Parents, Friends Outside, and the Hacienda La Puente School District.

I. Background

As a result of the rapidly growing number of women in jails and prisons nationwide, researchers and correctional managers have begun to look at the question of how best to meet the unique needs of female inmates.[12] Because women have always composed a minority of jail populations—in Los Angeles County, they make up approximately 11 percent of all inmates—administrative policies and procedures generally do not differentiate between male and

12 In 2006, the number of women in prison nationwide increased by 4.5 percent, which is higher than the 2006 growth rate for men (2.7 percent), as well as the average growth rate for women between 2000 and 2005 (2.9 percent). William J. Sabol, Heather Couture, and Paige M. Harrison, "Prisoners in 2006," Bureau of Justice Statistics, US Department of Justice Office of Justice Programs, 2007.

female inmates. This approach is appropriate for most areas of jail practice, in that it ensures equitable treatment for both genders, but it may ignore significant gender-specific needs.

The primary area in which women in jail differ from men is, of course, biological. Records for the Los Angeles County Jail show that, between June 2006 and May 2007, 1409 women who entered the jail system were pregnant. Not being just a medical issue, pregnancy raises a host of complex policy issues, including prenatal diet and education; appropriate housing and restraint; access to abortion; transportation and security during labor, delivery, and recovery; child custody; and visiting.

Issues pertaining to the children of incarcerated parents are, though not entirely gender-specific, much more likely to affect women than men. While approximately 55 percent of men in jail have children under the age of 18, female jail inmates are even more likely to be mothers to minor children. One study estimates that a full two-thirds of women in jail have children under age 18.[13] Moreover, nearly 85% of these women either had dependent children in their care at the time of arrest or report plans to live with their children after they are released, and incarcerated mothers are also predominantly their families' primary caretakers and wage-earners.[14] The plight of the children of inmates is a concern that has traditionally been outside the scope of correctional policy. Nonetheless, a growing body of research on the negative effects of incarceration on children of prisoners, and on the positive effects of the parent-child relationship on prisoner recidivism, has prompted many agencies to implement programs that strive to maintain or even improve the bond between parents and their children.

In this chapter, we consider those policies, procedures, programs, and practices that relate to pregnancy, reproductive care, and parenthood for women

13 Mumola, Christopher, "Incarcerated Parents and Their Children." Bureau of Justice Reports, August 2000.
14 Id.

in the Los Angeles County Jail. To that end, we compiled and consulted written LASD policies, regulating standards and state law, and outside research; interviewed custody, medical, and program staff; and reviewed six months' worth of inmate complaints at the Century Regional Detention Facility (CRDF).

II. Inmate Pregnancy and Childbirth

To get a picture of LASD policy and practices for the custody and treatment of pregnant inmates, we requested and reviewed the written policies contained in the LASD Custody Division Manual, the CRDF Unit Orders, Medical Services Bureau general policies, and the Medical Service Bureau's CRDF-specific policies. We also received and consulted some pregnancy-related policies from the LASD's Correctional Treatment Center (CTC), a licensed medical facility at Twin Towers that houses inmates in need of more intensive supervision or care, including female inmates considered to have a high-risk pregnancy. The CTC policies provide a great deal more detail about reproductive care procedures, but do not directly apply to inmates housed at CRDF, as the CTC is authorized to provide a higher level of care. We also spoke to several LASD, contract, and hospital staff members about various pregnancy-related policies and procedures, including medical care, the delivery process, programs and classes, and child custody procedures.

LASD has several important services in place for pregnant inmates, including three full-time OB-GYN physicians, one of whom focuses primarily on prenatal care, and a prenatal education program provided by the Center for Children of Incarcerated Parents. However, we found that only a few of the policies and programs relating to pregnancy are well documented in the Department's written materials. As a result of this lack of documentation, as well as a compartmentalization of roles, we encountered confusion about some

policies, particularly those relating to the transportation and restraint of women in labor or delivery. In the following sections, we describe those written policies that are in place, our understanding of processes that are not documented, and recommendations for improvement.

A. Statutory Requirements

The Los Angeles County Jail must comply with Title 15 of the California Code of Regulations, which sets forth the "Minimum Standards for Local Detention Facilities," as well as the guiding Penal Code sections on which they are based. In general, current standards relating to the care and treatment of pregnant inmates are both broad and brief.

Title 15, which was last revised in 2005, requires that the health authority (in this case, the Los Angeles Sheriff's Department) "set forth in writing, policies and procedures in conformance with applicable state and federal law, which are reviewed and updated at least annually and include but are not limited to: …(f) provision for screening and care of pregnant and lactating women, including postpartum care, and other services mandated by statute." It also specifies in the section on nutritional requirements for inmates that pregnant women are to receive four servings of dairy per day, above the general requirement of three servings.

These requirements are primarily drawn from Penal Code (PC) §4023.6, which states that: "Any female prisoner in any local detention facility shall have the right to summon and receive the services of any physician and surgeon of her choice in order to determine whether she is pregnant… If the prisoner is found to be pregnant, she is entitled to a determination of the extent of medical services needed by her and to the receipt of such services from the physician and surgeon of her choice. Any expenses occasioned by… services that are not provided by the facility shall be borne by the prisoner."

Although abortion is not mentioned in Title 15, the Penal Code specifies

that pregnant inmates are entitled to an abortion as provided by law. According to PC §4028, "No condition or restriction upon the obtaining of an abortion by a female detained in any local detention facility, pursuant to the Therapeutic Abortion Act …, other than those contained in that act, shall be imposed. Females found to be pregnant and desiring abortions shall be permitted to determine their eligibility for an abortion pursuant to law, and if determined to be eligible, shall be permitted to obtain an abortion."

Assembly Bill 478

The Corrections Standards Authority (CSA) of the California Department of Corrections and Rehabilitation (CDCR), the agency responsible for the development, maintenance, and enforcement of state standards for local facilities, draws its authority from PC §6030. In 2005, at the time of the most recent revision of Title 15, §6030 did not explicitly address the issue of pregnant inmates, requiring only that the standards set forth requirements for "health and sanitary conditions."

In 2005, however, the California State Assembly passed Assembly Bill (AB) 478, which details new standards for the treatment and care of pregnant prisoners. The bill passed both houses and was signed into law by the Governor. Most of these changes in the new law are directly addressed to state prisoners in the custody of CDCR, but it also amends PC §6030 to explicitly require the CSA to include specific standards in Title 15. The amendments to that section state:

(e) The standards shall require that inmates who are received by the facility while they are pregnant are provided all of the following:
   (1) A balanced, nutritious diet approved by a doctor.
   (2) Prenatal and postpartum information and health care, including, but not limited to, access to necessary vitamins as recommended by a doctor.
   (3) Information pertaining to childbirth education and infant care.
   (4) A dental cleaning while in a state facility.

(f) The standards shall provide that at no time shall a woman who is in labor be shackled by the wrists, ankles, or both including during transport to a hospital, during delivery, and while in recovery after giving birth, except as provided in Section 5007.7.[15]

Although PC §6030 instructs the CSA to include these provisions in its standards by January 1, 2007, those changes have not yet been made, apparently due to the Authority's long revision process. There is also some question as to whether the provision regarding the shackling of pregnant women will be adopted at all. The CSA holds that it lacks jurisdiction over agencies "once the jail gate closes and the inmate leaves the jail premises," (in this case, when the inmate is in transit or at an outside medical facility), since the standards apply only to local correctional facilities. Nonetheless, it has included in its Proposed Amendments to Title 15 a recommendation to update the standards to include guidelines for the treatment of pregnant inmates that comport with PC §6030.[16]

Regardless of the vagaries of the Title 15 revision process, the intent behind AB 478 and the amendments to PC §6030 is clear and should be considered state policy. Indeed, the CDCR has already implemented the new policies for California state prisoners. The Los Angeles Sheriff's Department should do the same. **Accordingly, we recommend that the LASD adopt verbatim Sections (e) and (f) of the Amendments to §6030.**

B. Pregnancy Screening and Prenatal Care

As required by Title 15, the Medical Services Bureau maintains a written policy for the screening of potentially pregnant inmates. During the reception process, inmates are asked whether they are pregnant and given the opportunity to request medical care. At this stage, or at any point during their

15 PC 5007.7 allows for shackling of the inmate when it is "deemed necessary for the safety and security of the inmate, the staff, and the public."

16 Private correspondence with Rebecca Craig, Title 15 Field Representative.

incarceration, inmates who suspect or allege pregnancy are to be given a QuickVue urine pregnancy test, similar to a home pregnancy test, which yields results within three minutes. If the test is positive, the inmate will be referred to a physician.

CRDF has three full-time OB-GYN physicians on staff. One primarily covers the IRC, another is focused on prenatal care, and the other works in the clinic on gynecological care. Because there is an OB-GYN attached to the IRC, inmates who receive a positive pregnancy result during intake will be immediately referred for a full prenatal appointment and will not be transferred to regular housing until the appointment is completed. Inmates whose pregnancy is established during nurse clinic will be scheduled for an appointment with a physician and should generally be seen within one week. In a few cases, the inmate may see a Registered Nurse Practitioner (RNP) for her initial assessment. An inmate whose pregnancy has been confirmed will receive a new wristband from Custody that reflects the word "pregnant."[17]

The first prenatal visit will include a full evaluation of the inmate's condition and pregnancy using the Problem Oriented Perinatal Risk Assessment System (POPRAS) form. POPRAS is a comprehensive assessment tool that collects information about the inmate's medical history, past pregnancies, risk factors, and current status, including weight and vital signs. It also includes questions about paternal medical history and about the inmate's family.

The physician will order lab tests as appropriate, with all pregnant inmates being offered an HIV test, and the clinic is fully equipped with an ultrasound machine. Inmates will also be provided with education and counseling about nutrition, risks, and what to expect. A prenatal diet, including diet and vitamins and, if necessary, medications, will be ordered at that time. The written policy does not describe the prenatal regimen, but it appears that pregnant inmates

17 Medical Services Bureau Policy #333: Pregnancy, CRDF Policies and Procedures Manual, Medical Services Bureau: QuickVue+One Step hCG Urine Pregnancy Test.

will receive, at a minimum, an extra container of milk. The extent to which any additional dietary changes are necessary, as well as the composition of the prescribed vitamins, is determined by the physician.

If a pregnant inmate exhibits or describes any conditions indicating distress or a possible high-risk pregnancy during intake, medical clearance for booking will not be given, and the inmate must be transported to LCMC for further evaluation.[18] Such conditions include: experiencing labor or threatening abortion; diabetes; hypertension; bleeding; fever of 100 degrees Fahrenheit or greater; trauma to abdomen; seizure within last three months; fractures, dislocations, or other bodily trauma; questionable viability of the fetus/infant; symptoms of drug or alcohol withdrawal, previous C-section; or dental abscess.

All pregnant inmates are to receive follow-up visits with their OB-GYN physician, who will schedule regular appointments based upon duration of pregnancy and special need. Because follow-up treatment is determined on a case-by-case basis, it is not described in detail in the written policy. In general, inmates in the earlier stages of pregnancy will see the physician approximately once a month; as they get close to giving birth, appointment frequency will be increased to about once a week. In some cases, the attending physician may decide to transfer the inmate to the CTC, which, as a licensed medical facility, can provide a more intensive level of care to inmates with higher-risk pregnancies. Inmates requiring hospitalization will be transferred to the Women and Children's Hospital at LCMC, where they will be housed on the 7th or 8th floor until delivery.

Housing considerations for pregnant women do not appear in the Department's written policies. However, general practice requires that pregnant inmates be assigned to a lower bunk to avoid the risk of injury. They are restricted from joining any work crew except the sewing crew, and may not be placed in the safety chair or—unless absolutely necessary—medically ordered restraints.

18 Medical Services Bureau Policy #201: CRDF Reception Center Health Screening – Female.

Any inmate who experiences a miscarriage, also known as a spontaneous abortion, is to be transported to LCMC via paramedics.

1. Inmate Complaints

In our review of six months' worth of inmate complaint files, which we discuss in more detail in Chapter 3, "Inmate Complaints," we found 15 complaints, described below, that related to pregnancy screening or the delivery of prenatal care. Six of these complaints had not been addressed or completed by medical staff at the time of our review and contained no information about the validity of the complaint. It is difficult to envision a legitimate reason for these delays in resolving inmate complaints.

- Four inmates complained that they had not received a pregnancy test, and had thus not been able to obtain prenatal care. Another inmate complained that she had first been told that it was too early for the test, and that her second test had gotten lost. It is not clear from any of the complaints whether the initial request for a test had been made during intake or through some other process; it is also unclear how a QuickVue test, which provides on-the-spot results, could have been lost. At the time that we reviewed the complaints, only two of these had been completed by medical staff. In both cases, the responses said only that the inmates' tests had come back negative, with no other information as to whether the test was delayed or lost.

- Five other allegedly pregnant inmates complained that they had not been able to see a doctor about their pregnancy.[19] Four of those complaints had been completed, with one noting that the inmate's pregnancy test had come up negative, and the other three stating that the inmate had seen a physician. There was no information about how long each inmate had been asking to see

19 One of these inmates filed a second complaint about not receiving prenatal care; that complaint is included in the four files discussed below.

a doctor, whether and on what date a pregnancy test had been given, and whether a delay occurred.

- Four inmates complained that they had not yet received a prenatal diet or vitamins. Two of these complaints had not been completed by medical staff at the time of our review, although one contained a note from the Custody investigator that a pregnancy test had been given four days before, and that it took seven days for the results to come in. Again, this appears inconsistent with the Bureau's written policies on pregnancy testing. The other two complaints had been completed, with both stating that the inmate had since been seen by a physician and that prenatal care was initiated. One of these responses also noted that the regular prenatal "diet" (for pregnant inmates with no complications) simply consists of the regular diet with "extra milk/juice."

- An inmate complained of being assigned to a top bunk, even though she was pregnant. The complaint was resolved within one day by a Custody sergeant, who had her moved to a lower bunk and told the staff that pregnant women should never be assigned an upper bunk. While it is a good practice, we could not find this policy in any of the written materials we obtained.

2. Written Policies

These complaints brought up several questions about the policies for the screening and care of pregnant women at CRDF. The primary policy addressing these issues is MSB Policy #333, included at the end of this chapter, which states that "[a]ll female inmates who report being pregnant will be given a pregnancy test. When positive results are obtained, the inmate will be provided medical care and counseling." An accompanying policy from the CRDF manual describes the procedure for giving the test.

Although the document, which is only two pages long, describes the screening and evaluation process in very general terms, it lacks detail about

the immediacy and frequency of medical evaluations, the process for ordering prenatal diet and vitamins, or the nature of the prenatal "counseling." For example, it requires a referral by the initial screener to a physician/RNP, who will perform an evaluation and "order appropriate medication, lab, and follow up appointment with the OB/GYN physician." Yet there is no discussion of a recommended schedule for these appointments or information about the initiation and character of the prenatal regime.

Some of the responses to inmates' complaints that we reviewed also seem to indicate that a 7-day pregnancy test is required before care is initiated. In fact, the QuickVue test should be offered on the spot when requested, and the results should be immediately available. Because they are considered to be "medical" orders and are part of the inmate's individualized care plan, the prenatal diet and vitamins must be ordered by a physician. **The process should be clarified to require that inmates claiming to be pregnant receive both the QuickVue test and result during the intake screening or nurse clinic visit, at which point she is considered to be pregnant. As a result of the Clinical Laboratory Improvement Amendments, nurses administering a urine pregnancy test must receive additional training and show competency. All nurses who conduct nurse clinic or IRC screening should be so certified.** A second, blood test will be given by the assigned OB/GYN physician to confirm that pregnancy, but this should not delay basic prenatal care or affect referral to a physician. **We also recommend that the policy clearly set forth a timeline for the evaluation process and for the initiation of those components of a prenatal regimen that do not require a case-by-case physician approval.**[20]

The written policies also contain little information about non-medical treatment of pregnant women. Once an inmate has received a positive

20 PC §4023.6 requires that pregnant inmates be allowed to obtain treatment from the physician or surgeon of their choice, at their expense. It is unlikely that many inmates in the county jail will have the resources to do so, but the pregnancy policy should nonetheless include a provision for such a case

pregnancy test result, she is to be assigned a yellow wristband marked "Pregnant." Yet although considerations for pregnant inmates do appear in policies from time to time, there is no comprehensive list of special accommodations or considerations for inmates with this designation. Those policies that do specifically discuss pregnant inmates are:

- "Medically Ordered Restraint Devices": The use of these devices (which include 3 and 4-point restraint systems, soft ties, padded belts, and restraint boards) on pregnant inmates is limited to "the most compelling circumstances and then only after consulting with personnel."
- "Safety Chair": This restraint device may not be used on pregnant women.
- "Inmate Workers": Pregnant inmates may "only be assigned to the sewing crew."

We came across no policies that address housing accommodations, such as bunk assignments; general and transport restraint considerations; or prenatal, childbirth, or parenting education, although at least some of those policies do exist in practice. We recommend that the Custody Division develop a specific and comprehensive policy, in accordance with Title 15 and PC §6030, that addresses each of these areas. As we discuss in the following sections, the policy should also include information about procedures for steps to take when an inmate goes into labor, is transported to a hospital for delivery, and returns to the facility.

C. Abortion

Female inmates have the right to terminate pregnancy by abortion.[21] An inmate can request an abortion by signing the Department's Therapeutic Abortion Request form during nurse clinic. She will be referred to the OB/GYN

21 Medical Services Bureau Policy #333.3: Therapeutic Abortions

physician for proper dating of gestation by ultrasound, and to a registered nurse practitioner for abortion counseling, where she is provided information about abortion procedures, options, and what to expect.

Inmates who are identified with severe mental disorder are referred to the facility Mental Health Unit for evaluation and to determine competency of a written informed consent. A physician, registered nurse, or registered nurse practitioner will perform this evaluation.

The registered nurse will facilitate contact between the inmate and an outside clinic—generally Planned Parenthood—by setting up a phone call in a private area. The RN informs the clinic staff that the caller is an inmate and hands the phone over to the inmate to discuss scheduling arrangements. Once the arrangements have been made, the RN schedules the abortion, then contacts the custody medical liaison to obtain a court order—generally obtained by fax on the day of request—permitting transport of the inmate to the clinic.

Abortions are usually performed at a nearby Planned Parenthood clinic and require one or more visits, depending on the duration of the pregnancy. Once the court order has been approved, an appointment will be scheduled for the inmate to go to the clinic for the abortion or insertion of the laminaria. For abortions that require insertion of the laminaria one or more days before the procedure, the inmate will return to CRDF overnight. There, she will be assessed by an RN, who will contact the on-site physician for an evaluation; in most cases, the inmate will be moved to one of the observation beds in the Main Clinic overnight. The next day she will be returned to the clinic for completion of the abortion procedure. She will again be assessed by a nurse and evaluated by a physician, and will be admitted to the Main Clinic, usually for at least 24 hours, so that she can be monitored for bleeding and complications.

We reviewed only one inmate complaint relating to access to abortion.

In that case, the inmate complained of repeated delays in obtaining an abortion, culminating in the designated outside clinic refusing to perform the procedure due to a missing court order. Absent other complaints, there is no evidence that such delays are a systemic problem. However, because the process requires several steps—including the initial request, appointments with an OB/GYN and RNP, approval of a court order, and scheduling with the outside clinic—the potential for delay is significant. Current California law states that abortions may only be performed on a viable fetus (generally 24 weeks or more) if a physician judges that the mother's life or health is at risk.[22] While abortions after 15 weeks are relatively rare, it is crucial that inmates not be made to wait past the point where they can legally obtain the procedure.[23] **In general, the Department should ensure that inmates can be scheduled for the procedure within a reasonable period of time by expediting requests and setting forth a written timeline for completion of the abortion.**

D. Prenatal and Postpartum Education: MIRACLE

Approximately 50-60 pregnant women are housed at CRDF at any given time. The LASD has coordinated with the Center for Children of Incarcerated Parents (CCIP), a non-profit group that promotes and facilitates family reunification for inmates with minor children, to provide a prenatal and neonatal educational program for pregnant inmates, known as MIRACLE. An estimated 20-30 women are enrolled in the individualized program at any one time. MIRACLE operates on multiple funding strings, including public grants and money from private foundations, and does not receive any money from the Inmate Welfare Fund. The program offers individualized educational sessions

22 Cal. Health & Safety Code §§ 123464 - 123468

23 According to the Centers for Disease Control, only 5.1 percent of all abortions nationwide were performed after 15 weeks. ("Abortion Surveillance—United States, 2004," Centers for Disease Control, 2007.)

as well as group courses, which provide information on breastfeeding, basic childcare, and nutrition.

MIRACLE provides three levels of service to pregnant women in Los Angeles County jails:

- **Classes for all pregnant women.** All pregnant women at CRDF are eligible to attend classes. Since 2007, MIRACLE has offered prenatal and child development classes on every other Monday, held from 8:00-10:30 am. Classes alternate Mondays with mothers' support groups, also held 8:00-10:30 am. All pregnant women may receive these services; enrollment in MIRACLE is not a prerequisite.

- **Individualized Family Services.** MIRACLE offers family advocacy through direct assistance at the jail. Advocates visit inmates once a week and provide hour-long meetings during which they provide prenatal education and assistance with health and social services needs. After an inmate is released, an advocate continues to visit at least once a week in the former inmate's home, drug treatment program or mother-child prison program in order to continue case management and child development services. The organization provides Family Services for up to five years after the birth of the inmate's baby.

- **Individualized Transitional Services.** MIRACLE provides sentencing advocacy by working with the courts, treatment programs, prison system, and mother-child prison programs to help inmates get sentenced to a program where they can live with their infant. MIRACLE also transports inmates from the jail to program sites when the Community Transition Unit (CTU) places them in a community treatment program. The program also provides advocacy for child placement and custody by assisting inmates who give birth while incarcerated with identifying appropriate infant placement and help to avoid foster care placement.

Because the program seeks to reunify inmates with their newborn children, MIRACLE strives to assist program participants with housing and rehabilitation services, education and job training in anticipation of their release. Program managers and teachers refer interested inmates to the LASD's Community Transition Unit (CTU) for assistance in connecting with DCFS and appropriate child welfare services. CTU also assists inmates in keeping abreast of court-ordered classes and visits in order to fulfill requirements for child reunification post-release.

For those pregnant women or new mothers who are being transferred from jail to a state prison, MIRACLE provides assistance during their transition, and inmates enrolled in the program while in jail are given priority placement in the California Institute for Women. This state correctional center provides unique mother-child reunification services, including contact visits between mothers and infants.

MIRACLE is a well-designed program that provides a much-needed service to expecting and new mothers in the jail. In doing so, it also fulfills the state's requirement that the facility offer prenatal and childbirth education to pregnant women. Although basic prenatal education is also provided by the inmate's OB/GYN physician, the MIRACLE program enhances that service by providing additional support for women preparing to give birth. However, information about the program, and its eligibility and enrollment process, does not currently appear in the department's written policies. Nor do outreach procedures.

CRDF nursing staff is responsible for compiling a weekly list of inmates who have received a positive pregnancy test and referring it to the CTU, whose staff will follow up by approaching the inmates directly. The CTU includes information about the program in its information packet, and inmates may also learn about this program's existence through other non-profit inmate advocacy organizations (such as the Harriet Buhai Center for Family Law and

Friends Outside). Inmates may also request to attend the weekly information or monthly enrollment session, to which they will be escorted by Officer Rivera of the CTU. Although it appears that pregnant inmates who want to participate are able to either receive individualized counseling or attend the class, there is currently no system to track which inmates are receiving services, which inmates do not wish to participate, and which inmates wish to participate but are unable to. **We recommend that the Department implement such a tracking system.**

We also recommend that the purpose, structure, enrollment procedures, and outreach process for MIRACLE be specifically outlined in the LASD's pregnancy policy. Since healthcare workers are a primary source of outreach for MIRACLE, the MSB pregnancy policy should also be modified to include procedures for informing inmates about the program and facilitating access to it.

E. Labor and Delivery

Because of short stays, very few inmates actually give birth while in the custody of the Los Angeles County Jail. Between May 2007 and April 2008, three inmates gave birth at CRDF. Although the Department does not keep statistics for births that occur outside the facility, CRDF and hospital staff estimate that no more than one or two deliveries occur each month, and that during some months there are none at all. AJIS data show that of the approximately 1400 pregnant women who entered between June 2006 and May 2007, about 75% were released within 30 days; 50% were released within ten. Of the remaining inmates, only seven inmates—less than one percent—were in custody for over 180 days.[24] Maintaining statistics on births and birth outcomes should thus not be a difficult task. **We recommend that the Department**

24 Thirty-six pregnant inmates had not been released at the time we received the data set and are not included in this calculation.

track the number of inmates who give birth by location of delivery, type of delivery, and length of stay in the hospital. It should also track birth outcomes, including any information about premature births or infant mortality.

No clear or detailed written policies on managing inmates in labor, childbirth, or recovery currently exist for CRDF. As a result, the information in this section has primarily been compiled through interviews with LASD, contract, and hospital personnel.

In general, inmates do not give birth at CRDF or, for those housed there, at CTC. When an inmate shows signs of labor, a deputy will escort the inmate to the health clinic where her and her fetus's heart rate will be checked (either by a physician or qualified nurse practitioner). Once her condition is diagnosed, she will be transferred by paramedic to LCMC. If, however, delivery is imminent and travel time does not permit transport to LCMC, she will be taken to the nearest hospital (usually the St. Francis Medical Center), and in some cases, the delivery may even occur at the facility. During transport, the inmate is in the custody of the accompanying CRDF deputy, who is responsible for all security decisions. Upon arrival at the LCMC, the inmate is usually taken to the 5th floor maternity ward, rather than the jail ward. Depending on staffing, a hospital deputy may take custody of the inmate, or deputies from CRDF may continue to maintain custody throughout the birth and until the inmate returns to the facility.

There appears to be no clear restraint policy for any step of this process, and we could find nothing written on the subject other than general restraint policies for inmates at the hospital. These require that hospitalized inmates be shackled to the hospital bed:

> While at the hospital, the deputy providing security shall ensure that the inmate is secured to the bed with handcuffs and/or the issued leg chain. Should it become necessary for the inmate to move from the bed due to

> medical treatment, exercise, or to use the restroom, both of the inmate's feet shall first be secured with the issued leg chain. If one of the legs cannot be secured for medical reasons, then the leg chain shall be attached from one leg to the opposite hand with the minimum amount of slack necessary to allow movement.[25]

Although the policy does not mention women who are in labor, delivery, or recovery, the Custody staff that we spoke to said that they avoid restraining inmates during delivery, and that decisions are made based on security and at the deputy's discretion in consultation with the doctor. However, a delivery nurse at the Women's Hospital said that leg chains, which are heavy but long enough to allow the inmate to get to the bathroom, are often present during childbirth. All other medical decisions are made by the inmate and the attending physician, and inmates are entitled to receive the same medical care as any other patient.

Following birth, the inmate will remain at the hospital for as long as is medically necessary, which may be from 24 hours up to a week. During that time (and during the delivery), she may not receive any visits; any family member or friend who shows up at the hospital is asked to leave.[26] In many cases, the family does not find out about the birth until after the inmate has returned to jail. While in the hospital, the inmate will be allowed to visit with and nurse her infant at the deputy's discretion and under the supervision of the nurse. According to hospital staff, deputies generally approve such requests. Throughout the hospital stay, the inmate is supervised by a Custody deputy, who generally sits outside her locked room, and is usually restrained using the leg chain.

25 Inmate Detentions at Hospitals 5-03/100.00 Custody Division Manual.

26 In San Diego County, jail inmates who give birth while in custody are assigned a "doula," a trained birthing assistant who provides non-medical emotional and physical support during delivery. The doula is assigned upon arrival to the hospital and may not have contact with the inmate after birth. San Diego County may also allow visits with approved family members at the hospital before the inmate returns to the facility. We recommend that the LASD consider implementing such a policy.

As previously mentioned, current Title 15 standards do not address restraint issues for pregnant women. However, PC §6030, from which those standards flow, does. It states: "The standards shall provide that at no time shall a woman who is in labor be shackled by the wrists, ankles, or both including during transport to a hospital, during delivery, and while in recovery after giving birth, except as provided in Section 5007.7." Section 5007.7 allows for such restraint when necessary to maintain security. **As stated earlier, we recommend that the LASD immediately and explicitly adopt this policy, which was endorsed by the American College of Obstetricians and Gynecologists (ACOG) and California Medical Association.** According to the ACOG, "Physical restraints have interfered with the ability of physicians to safely practice medicine by reducing their ability to assess and evaluate the physical condition of the mother and the fetus, and have similarly made the labor and delivery process more difficult than it needs to be; thus, overall putting the health and lives of the women and unborn children at risk." The California Medical Association concurs: "[S]hackling of a prisoner during childbirth may be unnecessarily uncomfortable and dangerous for the female inmate, while providing little additional public safety protections."[27]

The LASD restraint policy should define the term "shackling" and clearly indicate the circumstances under which restraints may be used on inmates who are in labor, delivery, or recovery. We recommend using the same criteria as that for use of medical ordered restraints for pregnant women: "In considering the use of restraint devices on pregnant inmates, personnel shall first establish articulable facts to demonstrate that the inmate poses an immediate threat of great bodily injury or death to herself, her fetus, others, or who display behavior that results in the destruction

27 Office of Assemblywoman Sally J. Lieber, October 5, 2005, http://democrats.assembly.ca.gov/members/a22/Press/p222005023.htm.

of property." The policy should also direct that restraints only be used under the supervision of medical personnel.

CRDF should also maintain full medical and custody procedures for inmates who go into labor, including delivery procedures for when the birth takes place at the facility. For example, CTC's medical policies go into substantial detail about procedures for precipitate delivery—when there is no time to get the inmate to a hospital in time for the birth. Three inmates gave birth at CRDF during our review period, but there is no such policy for that facility. Clear policies for custody deputies about how to manage an inmate who appears to be going into labor may even decrease the number of deliveries that take place at the facility.

The policies should also include postpartum procedures, as required by statute. According to CTC documentation, following release from the hospital, inmates who have given birth are to be admitted to the CTC for at least a 24-hour observation period, and should not be given a work assignment for eight weeks. This policy should be incorporated into the CRDF-specific policy as well. Upon return to the facility, according to Medical Services management, the inmate can request to pump and store milk at the Main Clinic, to be given to the family during visiting. However, this procedure does not appear in written policies and is not well known. According to CRDF staff, no inmate has taken advantage of the nursing option within the past year. Title 15 requires the maintenance of policies for lactating inmates, and the Department should fully document this policy and encourage inmates to use the process. The United States Surgeon General recommends that infants be breastfed for the first six months of life, and allowing inmates to pump milk while in custody will allow them to breastfeed when they are released from jail.[28]

28 U.S. Department of Health and Human Services. "HHS Blueprint for Action on Breastfeeding, Washington, D.C. U.S. Department of Health and Human Services," Office on Women's Health, 2000.

F. Transfer of the Newborn

After she has given birth, the inmate will complete a "Release of Newborn" form, provided by the hospital's social worker. The inmate will designate a guardian for the infant. If an inmate does not have any child abuse-related charges or prior children in DCFS custody, the hospital social worker will approve any guardian designated to take custody of the infant. After the inmate's hospital stay is complete, and she is returned to CRDF, the social worker will notify the designated guardian of the inmate's new infant and the guardian may then go to the hospital to obtain custody of the newborn. Guardians may not be notified of the infant's birth while the inmate remains in hospital custody.

If the inmate's charge is related to child abuse or domestic violence or if she has any children in DCFS custody at the time she gives birth, Child Protective Services (CPS) will oversee the infant's placement in foster care or with an approved inmate-designated guardian. A social worker and CPS will only conduct an investigation on the designated guardian's suitability under these circumstances.

While decisions made at or soon after the time of delivery may cause the inmate stress and confusion, short jail terms and the high likelihood that a pregnant inmate will be released before she delivers often renders any process for pre-arranging the infant's custody unnecessary. Furthermore, the social welfare system's poor record of successfully maintaining or facilitating family reunification for female inmates prompt some inmate advocates to recommend against inviting Child Protective Services or social workers into an inmate's familial matters unnecessarily. Absent evidence that the procedures now in place are not working, we do not recommend making any changes to the current policy.

There is currently no policy in place allowing special visiting for inmates and their newborn infants once they leave the hospital. As discussed in the next

section, inmates' only avenues for visiting with their children are public, non-contact visiting and structured contact visits through the TALK program. Although infants are eligible for participation in that program, eligibility is limited to sentenced inmates, vastly restricting the number of mothers who can participate. In contrast, many corrections agencies, including the California prison system, have special programs for new mothers to live with their newborns. For example, inmates who give birth while incarcerated at the Riker's Island jail in New York City may apply to live in a 25-bed nursery facility with their babies for up to one year.[29]

The LASD may want to consider implementation of an infant visitation program for women who give birth while in custody, similar to the "Baby Visits" program in San Francisco or the nursery facility at Riker's Island. Administered by the Northern California Services League, "Baby Visits" provided for contact visits for inmates and children who are in the "toddler stage" or younger. This program had no parenting class requirements and eligibility was determined on a case-by-case basis. Inmates in high security jails, or under restraining orders or charged with child abuse are automatically barred from this service. Because San Francisco's current parent-child visiting program now allows for inmates to see their children up to 16 with no parenting class requirement, the Baby Visiting program is no longer necessary at that facility.[30]

G. Recommendations for Improvement

As evidenced by the recent passage of AB 478, legislators, medical professionals, and correctional managers are increasingly concerned about the treatment of and services provided to pregnant inmates in California jails and prisons.

29 "Facilities Overview: An Overview of NYC DOC Facilities," New York City Department of Correction. http://www.nyc.gov/html/doc/html/about/facilities_overview.shtml

30 Phone interview with Karen Levine, San Francisco Sheriff's Department, June 19, 2008.

The rising numbers of incarcerated women and the attendant growth of in-custody births have focused attention on the need for specially designed prenatal and postpartum treatment and services, as well as clear guidelines for the transport and restraint of inmates who are in the process of giving birth. At present, the Los Angeles County Jail appears to be in basic compliance with most Title 15 standards; in some areas, such as in the provision of prenatal education and postpartum assistance, it is even ahead of the curve. However, its policies and practices are not well documented and, as such, lack transparency and are not fully in compliance with the state health manual standards. The lack of comprehensive written policies may also lead to confusion about what are the Department's policies, such as those involving shackling of women in labor, leading to practices that do not reflect state law or best practices in the field. We thus recommend that the Sheriff's Department devise a set of detailed written policies and procedures—both medical and custody-related—for prenatal, delivery, and postpartum procedures, services, and care.

III. Parenting in Custody

It is estimated that more than two-thirds of all women in custody have children under the age of 18 who were living with them prior to incarceration.[31] The effects of the incarceration of their parent on these children, which can include emotional difficulties, separation from home and family, and involvement with the public dependency system, can be devastating. Many correctional facilities, particularly those that house female inmates, have begun to develop programs and services targeted at maintaining and improving the bond between an incarcerated parent and his or her child. For example, as a result of AB 478, female state prisoners who give birth while incarcerated may be eligible for transfer to an alternative community program where they can reside with their infants.

31 "Women in Jail: Facility and Planning Issues," National Institute of Corrections, U.S. Department of Justice, 1997.

The Los Angeles County Jail established itself as an early leader in this area through the development of a structured contact visiting program called Teaching and Loving Kids (TALK), an excellent program that has been replicated in many other facilities. Enrollment in this program, however, is effectively capped at about 10 inmates, leaving very few opportunities for meaningful contact between inmates and their children. In this section, we detail policies and procedures for visiting at CRDF, both general and through the TALK program, and offer recommendations for improvements. We also discuss some of the challenges faced by inmates whose children are involved in the dependency court system. Although that system is outside the control of the Sheriff's Department, we make suggestions for steps that can be taken by the Department to facilitate communication and compliance with the court.

Effects of Parent-Child Separation on Young Children: The Benefits of Contact Visits

Much of the current body of research on the effects of parent-child separation has been conducted by Denise Johnston, Executive Director of the Center for the Children of Incarcerated Parents (CCIP), the organization that administers the MIRACLE prenatal program in the Los Angeles County Jail. In her article, "Children of Incarcerated Parents,"[32] Johnston explores the emotional and physical effects of parent-child separation on young children whose parents are incarcerated. She reports the suddenness of separation characteristic of a parent's arrest often produces persistent separation anxiety among children. When separation is prolonged, children risk becoming "excessively dependent and fail to develop appropriate self-confidence," while the separation-induced emotional stress frequently leads to other forms of anxiety, aggression, anger, grief and withdrawal. Infants who are separated from their incarcerated parents at such a young age often experience long term

32 Denise Johnston, "Effects of Parental Incarceration," in *Children of Incarcerated Parents,* Eds. Katherine Gabel and Denise Johnston, Lexington Books, New York (1995).

attachment difficulties and lack of security. Children of incarcerated parents also experience shame and stigma, often perceiving parental arrest and subsequent incarceration as rejection or bearing a sense of responsibility for their parents' detention.

In another article, Johnston discusses the ameliorating effects on children's separation anxiety and its attendant problems when children have the opportunity to visit their incarcerated parents in jail.[33] The degree of improvement bears a strong correlation to the stability of the parent-child relationship prior to incarceration and the duration of time the child resided with his or her incarcerated parent before detention.

A. General Visiting Procedures

Inmates may receive visits from the public from 8:30 am to 3:30 pm and 5:30 pm to 7:30 pm on Saturdays, Sundays, and holidays. Visits are first come, first served. Each visit can last up to half an hour, and each inmate may only have one visit per day, or two per weekend. In general, visiting children under the age of 16 must be accompanied by a guardian at all times, although minors over 12 may, upon request by the inmate and approval by the captain, be allowed to attend the visit alone. A maximum of two children (and one guardian) can visit each inmate at any given time, and inmates and their visitors are separated by glass at all times.

The potential for meaningful visits between mothers and their children under this system is limited. Younger children must depend on a guardian to bring them to the facility and to wait with them, and they do not have the opportunity to spend time alone with the parent. Depending on the relationships among the child, parent, and guardian, this may be a good thing, but a sour relationship between the guardian and the inmate may also cause more

33 Denise Johnston, "Parent-Child Visitation in the Jail or Prison," in *Children of Incarcerated Parents,* Eds. Katherine Gabel and Denise Johnston, Lexington Books, New York (1995).

stress for the child. The lack of physical contact and short visiting period may prove even more painful for young children with a limited understanding of the circumstances.

The first come, first served policy observed for public visits may also pose a significant burden for visitors, particularly children, who may sometimes spend the entire day waiting at the jail for their "turn." On particularly busy visiting days, some may not even get the chance to visit, thus rendering their day-long wait in Lynwood a waste of time. Because the first come, first served process begins anew the very next day, children who missed their turn to visit on the previous day have no guarantee that their second day waiting will end with a visit with their mothers. Furthermore, this lack of guarantee creates another deterrent for foster parents or other guardians who are not committed to bring their charges to the jail to visit their biological mothers.

We recommend that the LASD consider implementing a reservation system, used at facilities such as the San Francisco County Jail, for minors visiting their parents or legal guardians at CRDF and other facilities. Appointed, guaranteed visiting times might encourage temporary guardians or foster parents to bring children to visit with their mothers. **Furthermore, permitting children to visit with their mothers in the designated attorney/social worker meeting rooms—during professional hours between Monday and Thursday, if necessary—would afford families a greater degree of privacy when actual contact visits are impossible.** Because visiting a parent in jail could be a traumatic experience for young children, the added privacy of the attorney meeting rooms might help to alleviate some of the children's anxiety and stress. **We also encourage the Department take into account the needs of children when designing visiting facilities at the future facility for female inmates.** For example, the facility could include a children's play area in the waiting room, child-size furniture for the visiting area,

friendlier colors and surfaces, and even open—if non-contact—visiting for nonviolent inmates and their children.

B. TALK: Teaching and Loving Kids

Teaching and Loving Kids (TALK), a program funded and operated by the Hacienda La Puente School District, allows parenting inmates, both men and women, to have weekly contact visits with their children who are under the age of 12. It is modeled after a program called Prison MATCH (Mothers, Fathers and Their Children), which began at the Federal Correctional Institution at Pleasanton, California. The program founders' goal was to work in cooperation and consultation with institutional staff and inmates to maintain family ties between inmate parents and their children. MATCH places emphasis on "developing, through appropriate play and learning activities, the bonds between parents and children." The program's central component includes facilitating a four hour contact visit between incarcerated parents and their children once a week in a warm, instructive setting.

In order to participate in the program, inmates must have attended at least three parenting classes, also provided by Hacienda La Puente, after which they can submit an application for TALK. At least one parenting class per week should be offered to each module within the general population, during which the teachers disseminate information about and application materials for TALK. Word-of-mouth is the most common form of advertisement for the program.

Inmates must also meet several eligibility requirements, including having been sentenced to the county jail for at least one charge. While unsentenced inmates and inmates that have been sentenced to state or federal prison are free to attend the parenting classes, they are ineligible for TALK. Applications are processed by the LASD Custody Assistant (CA) assigned to the program, who usually takes about a week to process each application. Generally, inmates' children who are in custody of the Department of Child and Family Services

(DCFS) do not participate in TALK. According to jail staff, most foster parents are unable or unwilling to escort the children to the Lynwood facility. While there is no written policy preventing an inmate from applying or participating when their children are in DCSF custody, the Custody Assistant contends that the nature of foster care and the absence of jail visits from a foster parent's enumerated obligations create a de facto barrier to contact visits.

The CA takes about a week to process TALK applications. Inmates who have been arrested or convicted of child abuse or endangerment will be interviewed on an individual basis, after which the Sheriff's Department determines participation eligibility. Inmates who have been in disciplinary housing two or more times during their current arrest will not be interviewed by the Sheriff's Department.

Once the CA approves an inmate for participation, on the Wednesday before the TALK program that the inmate wishes to attend, the inmate must make arrangements with her children's guardian to bring the children to CRDF.

Outreach and Inclusion of Children's Guardians

Although the CA does not provide outreach to inmates' relatives and children's guardians, she does contact them on the Wednesday before the TALK program to confirm each child's plans to attend the session. The CA also discusses the logistical details and content of the TALK program and fields questions from guardians of first-time TALK attendees.

Before the start of the 8:00 am program and before the inmates enter the TALK classroom, guardians of first-time participants are given the opportunity to meet the TALK teacher and survey the classroom. During the actual program, guardians are prohibited from contact with inmates and must wait for the program to end (at 11:00 am) before they can retrieve the children. One teacher, one deputy and two officers remain in the classroom during the entire program. After the children leave, inmates clean up and have the

opportunity to debrief and discuss the day's events.

The designated TALK classroom accommodates 10 – 12 inmates and about 15 children each week. Although there is no official cap for either inmates or children, these space and staffing restraints, combined with the strict eligibility requirements and application process, effectively limits the number of participants. According to a California Department of Corrections and Rehabilitation (CDCR) 2006 Jail Profile Survey, a very small minority of the average daily female population at CRDF (approximately 15 percent) has been sentenced.[34] This low proportion of sentenced inmates, coupled with restrictions on TALK applicants with "heavy" charges, histories of child abuse, and children in foster care account for the low number of participants. With an estimated 85% of incarcerated women who have dependent children at the time of arrest, a large portion of CRDF inmates and children who stand to benefit from this program are barred from participation.

The Sheriff's Department is justifiably proud of TALK. By all accounts, it appears to be a well-planned, thoughtful program that provides an opportunity for inmates to have a genuinely meaningful visit with their children. It is focused on helping to rebuild and maintain that relationship by teaching inmates how to better interact with their children, to express their feelings, and to help the children understand what is happening with their parent. It is unfortunate, then, that the capacity of the program is so small.

We recommend that the Department work to expand TALK. Limiting eligibility to sentenced inmates is a quick way to keep numbers down, but it also prevents the majority of inmates in the jail from participating. Other such programs, such as the Parent-Child Visiting Program (formerly Prison MATCH) in San Francisco, do not summarily exclude all unsentenced inmates.[35]

34 http://www.cdcr.ca.gov/Divisions_Boards/CSA/FSODocs/2006_jps_Q4_full_report.pdf.
35 Phone interview with Karen Levine, San Francisco Sheriff's Department, June 19, 2008.

The Department should consider whether there are unsentenced inmates who could benefit from the program without compromising security and work to expand eligibility to those inmates. It is likely that demand is, or will become, higher than current participation. In collaboration with Hacienda La Puente, it should thus work to determine the true capacity of each TALK session in terms of staffing, space, and funding constraints and to assess whether additional sessions on other days could be added. Adding one or more alternate sessions might also improve enrollment by providing guardians, who may not be able to bring the child at the current time, with more options.

Funding constraints may render a "Baby Visit" program (akin to the program offered in San Francisco County) unrealistic. However, we mention it in this Report as part of an overarching goal to improve the likelihood of family reunification and to reduce childhood stress and trauma related to incarcerating parents.

While it may be that announcements and inmate word-of-mouth are effective advertising tools, we nonetheless recommend postings of MIRACLE, TALK, and parenting classes and their eligibility requirements on all General Population module bulletin boards. These postings should be placed in plain view of the common area, where all resident inmates can read and access the service offerings and schedules. This will help inmates understand the options available to them and, where possible, allow them to plan around those programs that would benefit them.

C. Dependency Court and Other Legal Issues

There are currently no statistics about the number of inmates at CRDF with pending cases in juvenile dependency court, but it is believed that the

proportion is significant. While some parents may first become involved in the system as a result of their incarceration, many others may already be in the process of losing, or working to maintain, their parental rights. For these inmates, communicating with the court and social workers, following their case plan, and attending court dates while in jail may prove complicated and bewildering, their ability to comply affected by circumstances outside their control. Other inmates may also face other family-related legal issues, such as custody battles, a child support obligation, or involvement in a domestic violence situation.

LASD has already taken some steps to provide legal education services to inmates with dependency cases and other family issues by contracting with two community organizations, the Harriet Buhai Center for Family Law and Friends Outside. Although its staff may not provide specific legal counsel, the Harriet Buhai Center provides regular, comprehensive courses to inmates at CRDF on the following topics:

- **Dependency Court:** Provides inmates with an overview of the dependency court system and tools for navigating the system, including authorizing a caregiver, communicating with a social worker, and obtaining legal services.
- **Domestic Violence, Life Skills and Health:** Assists inmates in identifying domestic violence and provides referrals and information on obtaining a restraining order.
- **Paternity and Child Support:** Explains the process for determining paternity and obtaining child support and details child support obligations for the inmate.

Friends Outside is a community organization that focuses on facilitating communication between inmates and family members, outside organizations and agencies, and even jail staff. Saranella Schulman, the organization's case manager at CRDF, serves as an all-purpose information manager, fielding

requests from inmates about everything from medical care to transitional help. Many of these requests relate to inmates' dependency court cases, and she works to help inmates contact social workers, get information about court dates and deadlines, and obtain credit on their case plan for courses attended in jail.

We were quite impressed by the competency and experience evinced by both these organizations and by the Harriet Buhai Center's clear, comprehensive course and referral materials. The Sheriff's Department is to be commended for realizing the importance of these programs and for maintaining them year after year. **The effectiveness of these services, however, would be improved with the addition of an outreach and tracking component for inmates with dependency cases. We recommend that inmates be screened for their involvement with the court upon intake and that a list of involved inmates be sent to the Harriet Buhai Center for purposes of outreach. We also recommend that the Department consider creating a designated dependency court liaison position, which would be tasked with helping inmates communicate with their social worker and comply with the case plan and court requirements.**

COUNTY OF LOS ANGELES
SHERIFF'S DEPARTMENT
MEDICAL SERVICES BUREAU

Policy # **333**	Effective Date: 09/24/01
Subject: **PREGNANCY**	**REVISED: 11/08/07**
Unit Commander: **MICHAEL KWAN**	
Chief Physician: **SANDER PECK**	
Clinical Nursing Directors: **KATHY BRAMAN, BETTY BRENNAN, JOEL KELLOGG, ARLENE MARTINEZ, DEBORAH McLEAN, JANE VOLPICELLI**	

Purpose: To provide appropriate screening and medical treatment for pregnant female inmates while in custody. The purpose of this procedure is to outline the screening of alleged pregnancies, and the processing of patients with a positive finding for pregnancy. Registered Nurses and Nursing Assistants under the guidance of a Registered Nurse will perform the task.

Policy: All female inmates who report being pregnant will be given a pregnancy test. When positive results are obtained, the inmate will be provided medical care and counseling.

Performed: Registered Nurses
Nursing Assistants
Registered Nurse Practitioner
Physician

Procedure:

A. Screening of reported pregnancies:

1. All inmates who report being pregnant will have a medical data base completed: including fetal heart tones if applicable by trimester.

2. Perform Quick Vue testing, if positive refer to physician/registered nurse practitioner for evaluation.

3. Physician/RNP will perform an evaluation of the pregnant female and order appropriate medication, lab, and follow up appointment with the OB/GYN physician.

4. High risk pregnancy will be referred to Los Angeles County + USC Medical Center as deemed necessary by the care provider.

B. Positive Test Results: Patient will be advised of the result and the following will be initiated:

5. Problem Oriented Perinatal Risk Assessment System (POPRAS) form filled out.

1. Request for wristband change sent to Custody - new wristband will reflect word "Pregnant."

2. All pregnant females will have follow up evaluations conducted by the OB/GYN practitioner throughout the course of their pregnancy.

3. All pregnant inmates who present with active signs of labor or prematurely deliver while still in the custody facility will be transported via paramedics to Los Angeles County + USC Medical Center.

4. All female inmates who have spontaneous abortion are transported to Los Angeles County + USC Medical Center via paramedics.

San Diego County Sheriff's Department
Medical Services Division
Policy and Procedure Manual

Date	Dissemination	Category	Number
9/22/2006	Medical Services	Medical & Psychiatric Care Services	MSD.F1.
Subject: FEMALE INMATE CARE			Page 1 of 2
Related Sections: DSB P&P: M.11 & M.38; MSD P&P: P.6			
In Compliance With: CA Penal Code Sections 4023.6 and 4028; CCR Title 15, Section 1206, CA H&S Code 25950-25957			

I. PURPOSE:
To protect the rights and provide quality medical care to all pregnant and post partum inmates/patients (I/P).

II. POLICY:
A. All pregnant I/Ps shall be provided with information regarding prenatal care, rights to receive an abortion, post partum care and family planning.
B. Penal Codes 4023.6 and 4028 shall be posted in a conspicuous place accessible by all female I/Ps.

III. PROCEDURE:
A. Prenatal Care/Abortion:

1. When an I/P is suspected of being pregnant, the medical staff shall initiate evaluation by obtaining urine for pregnancy testing. If the urine test is negative and pregnancy is still suspected, the I/P shall be referred to the OB/GYN for assessment/need for further testing.
2. I/Ps testing positive shall be scheduled for the next physician's sick call to confirm pregnancy by exam and to discuss options with regards to keeping or terminating the pregnancy.

    a. I/Ps who wish to continue with the pregnancy shall be started on a prenatal care program as ordered by Medical Services physician.
    b. I/Ps who are interested in terminating their pregnancy shall be referred to Planned Parenthood for further information, as to all options available to them.

3. Abortions for I/Ps may be approved at County expense in accordance with CA Heath and Safety Code 25950-25957.
4. I/Ps may request to see their own physician at their own expense to determine continuation of pregnancy or elect abortion. Refer to MSD P&P: Private Physician.

B. Post Partum/Family Planning:
1. After discharge from the hospital I/Ps are housed in the infirmary. Uncomplicated vaginal deliveries shall be housed in MOB for a

minimum of 24-hours. C-section deliveries shall be housed in MOB for a minimum of 24-hours or up to 72-hours from time of delivery.

a. I/Ps shall be scheduled for sick call at week one and week six post partum.
b. Plastic breast pump may be used by I/P for milk collection for breast feeding. See NSG.B.3.
c. Sanitary supplies shall be available as needed.
d. When external perineum care is prescribed by a physician, the supplies will be given to the I/P.
e. After any abortion is performed, the I/P shall be returned for evaluation and housing designation by medical staff and follow-up care as ordered by the Physician.
f. Family planning services shall be offered to each and every female I/P at least 60 days prior to a scheduled release date in accordance with Penal Code 4023.5.
g. Planned Parenthood Clinic is available in LCDF.

C. Postpartum Psychosis:

During Intake Screening, any female I/Ps who have had a birth in the last 12 months shall be screened and referred to Mental Health or Counseling staff when the penal charges indicate murder or attempted murder (P.C. 187 & 664) of their infants.

D. Psychiatric Referrals:

All female I/Ps prior to receiving psychotropic medication shall undergo pregnancy testing.

E. Personal Care Items:

Sanitary supplies shall be made available to all female I/Ps.

Implemented: 12/90
Revised: 4/1/92, 4/1/94, 5/24/95, 1/29/96, 9/19/97, 9/18/98, 8/11/99, 7/31/00, 8/18/03, 3/22/05, 9/22/06
Reviewed: 9/17/96, 8/10/01, 9/18/02, 8/9/04, 8/12/05, 7/31/06, 7/30/07

Frequently asked Questions

Here are some Frequently Asked Questions about having a baby while you are in jail. We hope this is helpful and if you have more questions, ask the doctor you see, a nurse or ask to see a social worker.

How will I be cared for during my pregnancy while I'm in jail?

You will receive your medical care at Las Colinas. An obstetrician will be seeing you on a regular basis to care for you and help you get ready to have your baby.

What happens when it's time to deliver my baby?

When it is time for your delivery you will be taken to a local hospital that has been selected by the Sheriff's Department. A guard will be with you at all times and you will be required to wear restraints during your hospital stay. While you are at the hospital you may be seen by a hospital social worker to help you and answer questions you may have about your baby's care. At the hospital you may ask to get help from a Birth Assistant called a Doula (doo-lah) who can provide you continuous, one-on-one physical, emotional, and informational support during your labor and birth of your baby. A doula has no medical responsibility and no other patients, so she can stay with you for the entire labor and delivery and help you to be as comfortable as possible, answer questions and accompany you until your baby is born. If you are interested in learning more about this help, ask you doctor at Las Colinas about the program. (If you are note interested at this time, but change your mind once you are at the hospital, you can still request a doula).

Can I have visitors while I'm in the hospital?

Anyone who wants to visit you, including your family, will need to be approved by the Sheriff's Department before they can visit you. The Watch Commander at Central Jail approves all visitors and has the final say on who can visit. Permission to visit is given to each individual wanting to visit and must be issued the same day that the visit takes place. In addition, all visitors will need to follow the hospital rules about visiting you and your baby. Call 619-615-2770, to arrange for a visit.

What can I take with me to the hospital?

You won't be able to take anything with you from the jail. The hospital will provide all of the personal hygiene items that you will need during the time you are there, so all of your personal items must be left here at Las Colinas and will be stored for safekeeping until you return .

How do I plan for someone to take care of my baby after it's born?

Before your delivery date we'll help you make plans for someone to take care of your baby after it's born. This might mean short term or long term care by a family member, foster care, or adoption. We'll start helping you with your baby's care by asking you to fill our a couple of forms so that arrangements can be made ahead of time. These forms are called "Authorization for Temporary Custody" and Information on Pregnant Inmate". Someone from the medical service at Las Colinas will help you with these forms and, if you need it, help you make a plan for someone to care for your baby. It is important that you choose an appropriate and responsible person to care for your infant at home.

What forms do I need to sign at the hospital?

When you go to the hospital they will ask you to sign "Admission Forms" and a "Minor Release Form" so that the plan you made for you baby's care can be carried out.

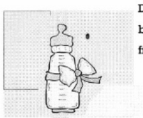
The person you select will be checked out by the hospital before they give them your baby to care for. It is always up to the staff at the hospital to decide if they need to contact CPS (Child Protective Services) at the time of your delivery.

What if I don't have a plan for my baby yet?

If you haven't spoken to someone about a plan for your baby a least one month before your expected delivery date, please send a n "Inmate Request Form" to Medical Services and ask for "Pregnancy Information".

What happens after I deliver my baby?

After you have your baby you will be brought back to the infirmary at Las Colinas and we'll provide your follow-up care. At the same time, your baby will be discharged to the person you planned to care for them as permitted by hospital. The hospital has a small gift made available be the Soroptimist Club of San Diego for your baby upon release from the hospital.



What about breast feeding my baby? Expression of breast milk for the purpose of consumption by your baby can be arranged. There are regulations around the pumping, storage and pick– up of breast milk, so ask your nurse in the facility for details, before you deliver, if you are interested in this program.

We hope that by providing you with some information it will make your situation a little less stressful. If you have any other questions, please be sure to speak to your Medical Staff.

San Diego County Sheriff's Department Medical Services Division

Your Baby's Birth: Questions and Answers

Introduction

The LASD does a good job resolving routine complaints from women about conditions of confinement and a poor job resolving complaints about medical service. The Department received 214 medical complaints between December 2006 and May 2007, the majority of which centered upon treatment delays. Of these, nearly one-third had not been completed at the time of our review in December 2007, and only 38 percent of the remaining complaints were completed within the recommended ten-day period. Additionally, we found that the referral of 41 complaints by Custody was unnecessarily delayed, that the level of detail on many medical dispositions was insufficient to determine whether the complaint was adequately resolved, and that the majority of complainants appear never to have been notified of the result of their complaints as required by Title 15. Finally, the use of the category "Request for Service – Routine" to describe nearly every medical complaint, as well as the failure to make even a token effort to investigate system or staff performance issues, renders the complaint system incapable of providing LASD management with any meaningful information about systemic problems with the delivery of medical services at the facility.

I. Background

As part of our examination of the LASD's ability to meet its female inmates' basic needs, we reviewed six months of inmate complaints from CRDF. In accordance with Title 15 of the California Code of Regulations,

which regulates local detention facilities, LASD policy states that any inmate may "submit an appeal, and have grievances resolved, relating to any condition of confinement."[36] Generally referred to as "complaints," these grievances are to be collected from each module on a daily basis and logged into a database, after which they should be investigated, resolved, and discussed with the inmate promptly. The Department also accepts complaints from third parties and the American Civil Liberties Union (ACLU). The manual notes that "whenever possible," all complaints should be completed within ten days.

The objectives of our review were to learn the types of issues that inmates complained about; evaluate whether the response by LASD personnel was fair, thorough, and timely; and assess the effectiveness of the system for tracking and analyzing the complaints. We have previously praised that system, based in a database known as the Facilities Automated Tracking System (FAST), for its ability to provide the Department with information about potential systemic problems at each facility but had concerns whether the data was being entered accurately and promptly.

In this current review, we found that approximately 38 percent of the files contained complaints or questions about basic conditions of confinement. Most of these complaints were relatively minor and were easily resolved by jail Custody staff. While we have some suggestions for improving the investigation of complaints, particularly those involving allegations against staff, and although we questioned some dispositions, we were on the whole satisfied with the prompt and appropriate resolution of these complaints.

In contrast, the classification, investigation, and disposition of medical complaints failed to meet the standards set by the Department or by Title 15. To be sure, the Medical Services staff at CRDF, as at every other LA County Jail facility, is in a difficult position. As we noted in Chapter 1, "Delivery of Medical Care," insufficient nursing staff and space, bureaucratic hurdles, and

36 LASD Custody Division Manual, Section 5-12/000.00 "Inmate Complaints and Requests," Revised December 15, 2001.

a disproportionately needy population combines to create a situation in which delays in treatment are inevitable. However, this does not absolve the Department of its obligation to provide legally mandated adequate medical care. It must also work to continuously monitor and respond to areas of risk in order to reduce its own liability and the potential for inmate suffering or death.

II. The LASD's Inmate Complaint Process

Title 15 of the California Code of Regulations, "Minimum Standards for Local Detention Facilities" requires each facility to "develop written policies and procedures whereby any inmate may appeal and have resolved grievances relating to any conditions of confinement, included but not limited to: medical care; classification actions; disciplinary actions; program participation; telephone, mail, and visiting procedures; and food, clothing, and bedding."[37] According to the Title, inmates must be afforded the opportunity to appeal the response to their grievance and are entitled to a written response at every step of the process, for approvals as well as denials. Such notification must be documented in writing.

The LASD has devised a complex complaint policy in response to this standard.[38] It has designed a form—a copy of which is included at the end of this chapter—that provides space for the inmate to write down the complaint and for the investigating supervisor to document the findings of the investigation. The form also contains a line for the inmate to sign that she has been advised of the findings, in order to satisfy Title 15 requirements. Each Unit Commander is responsible for ensuring that each assigned housing unit has an adequate supply of Inmate Complaint Forms available, and that the

37 "Minimum Standards for Local Detention Facilities, Title 15 – Crime Prevention and Corrections, Division 1, Chapter 1, Subchapter 4, Section 1072." California Code of Regulations, 2005.

38 The policy, as well as the complaint form itself, is currently undergoing revision. We discuss possible changes to the policy later in the chapter.

inmates have unrestricted access to them. (Regardless of the availability of the forms, staff members are directed to accept complaints on any piece of paper.) Each module must also have a locked box into which inmates may deposit their complaints without interference.

All complaint forms must be collected and reviewed by a supervisor at least once per shift. "Priority complaints" that include mental or mental health emergencies or other urgent threats to the "inmate's safety and/or well-being," are supposed to be acted upon immediately; in the case of a medical emergency, the inmate should be taken directly to the main clinic.[39] Each complaint should be assigned a reference number from the facility-wide logging system, which also logs inmate injuries, assaults, searches, uses of force by staff, requests for mental observation, tours, and hospital runs, crime reports, and inmate incident reports, and should be entered into the Facilities Automated Statistical Tracking (FAST) system.

Complaints concerning Medical Services, Mental Health Services, or Food Services should be forwarded "without delay" to the appropriate units, with mental health complaints first going to Medical Services. The Custody unit should still obtain the reference number and initiate the entry into FAST. In many of the complaints that we reviewed, the supervisor also took initial steps to investigate or even resolve medical complaints, a practice we commend. All other routine and jail conditions complaints should be delivered to a designated Inmate Complaint Coordinator, who assigns them for investigation and resolution.

Upon completion of the inquiry or referral, the supervisor should fill out the "Inmate Complaint Disposition Data Form" (included in the Appendix) by coding each complaint according to type and assigning a disposition code. The dispositions are "referred," "founded," "unfounded," or "unresolved," or a note stating that the inmate had already been released. For cases

39 LASD Custody Division Manual, Section 5-12/000.00 "Inmate Complaints and Requests," Revised December 15, 2001.

involving more serious allegations, an administration investigation in theory may also be opened. (As described below, none of the 346 complaints we reviewed led to administrative investigation, no matter how grievous the allegations were.) The supervisor also briefly notes the findings on the back of the complaint form itself and advises the inmate of the results in person, obtaining her signature on the form. The complaint package must be approved by the Watch Commander and the Captain or her designee, after which the disposition is entered into the FAST system.

A. Medical Complaints

Medical complaints are received by Custody and then referred over to Medical Services. The fact of referral is noted in FAST. Custody refers complaints about medical services to a designated Complaint Coordinator at Medical Services, who is then responsible for classifying, researching, and resolving the grievance using the Medical Services Data Disposition Form reproduced in the Appendix. Similar to the Custody Division's disposition sheet, this form requires the coordinator to code each grievance according to type—for example, "Service–Delay," "Request for Service–Routine," and "Complaint Against Staff"—and then to assign a disposition. Unlike the Custody Division, Medical Services does not distinguish between founded, unfounded, and unresolved cases, although it does provide a "Complaint Not Valid" option. Instead, dispositions focus on the treatment result, such as "Examination–Treatment provided" or "Examination–No Treatment necessary." The form also designates the medical area involved, such as Nursing, Physician, or Dental. Finally, it provides a box for the coordinator to mark whether the complaint was resolved in a timely fashion within ten days of receipt.

Medical dispositions are then entered into the FAST system using the special Medical Complaints Module. Each medical complaint will thus have two dispositions within FAST, one for the Custody referral to Medical Services and another for the final disposition.

B. ACLU Complaints

Along with using the LASD form and lockbox, inmates may also make complaints directly to the ACLU by collect phone call or during a personal interview with ACLU staff. The ACLU forwards a written summary of the complaint to Custody Support Services (CSS), where a reference number is pulled and the complaint entered into FAST. Non-medical complaint files are then forwarded to the facility, while medical complaints are referred to the Medical Court Order Unit, then to the facility medical complaint coordinator. Completed complaints are then returned to CSS, stopping at the Medical Court Order Unit along the way for entry into FAST, and, ultimately, the ACLU for final review.

C. The FAST System

We have praised the Facilities Automated Tracking System (FAST) database in several previous Reports for its ability to provide LASD management with at least rudimentary information about risk-related trends at LASD facilities and to track the Department's response to significant incidents. We have also made important recommendations about improving FAST, which have since been implemented.[40] Designed by Sgt. Richard Myers and Deputy Arlan Mulford in 1997, FAST captures information on several types of incidents, including the use of force by Custody staff; inmate escapes, injuries, and deaths; over-detentions and early releases; and inmate complaints. We focus here on the complaint modules, but a more in-depth discussion of

40 In our **Seventeeth Semiannnual Report**, we recommended that the FAST database be modified to: "(1) identify those officers who are named in inmate complaints against staff, and (2) specify the type of allegation made against the officer (e.g., excessive force, discrimination, and the like)." These changes were made, although the database includes only the following categories of alleged misconduct: "force," "demeanor," "service," and "other." However, its use as a management tool is limited by the fact that the information is not easily tracked or reported. The Custody Operations Division acknowledges this limitation and is working to improve the system's management capabilities.

FAST, including its history, an overview of the system, and recommendations for improvement, is contained in our **Seventeenth Semiannual Report.**

The database has four complaint modules: Inmate Complaints, ACLU Complaints, Medical Complaints, and Food Services Complaints. When a complaint is first received, it is entered either into the Inmate Complaints module (for non-ACLU complaints) or the ACLU complaint module. Upon completion (for custody-related complaints) or referral, the classification and disposition are entered into the original module, but the database does not track detailed information about the substance or findings of the complaint. Those complaints that are referred to Food or Medical Services receive additional entries in their respective modules, similarly noting receipt, classification, and disposition.

The database offers a number of reports that summarize the number and type of complaints by facility, classification, and disposition for each module. Other reports list the number of outstanding forms for each module, as well as those complaints that were referred to one unit by another but never completed.

III. PARC's Complaint Review Process

For this review, we looked at all complaints by female inmates between December 2006 and May 2007, based on the date the reference number was pulled. Because they made up the largest proportion of inmate complaints, and because they tended to be of a more serious nature, we reviewed the response to medical complaints at both Custody and Medical Services. We did not review the final dispositions of complaints referred to other units, such as Food or Inmate Services.

In all, we reviewed 346 complaint forms ("complaints"), which included a total of 377 complaint types. These included the following:

- One hundred thirty-two non-medical complaints. These were reviewed at the CRDF Custody administration office and included 45 non-medical complaints referred by the ACLU.
- One hundred forty-two medical or mental health-related complaints that were collected by Custody staff and, after some initial follow-up, referred to Medical Services, including six complaints that included both non-medical and medical complaint types. We reviewed all of these at Custody, but were able to locate only 79 completed files at Medical Services Bureau (MSB). The remaining 63 had not yet been closed out or sent to MSB headquarters, and were listed as incomplete or missing in FAST. We were thus able to evaluate the content of the complaints as well as any actions taken by Custody staff, but not the final disposition by Medical Services.[41]
- Seventy-two medical complaints referred by the ACLU, which bypassed the Custody staff at CRDF altogether. Fortunately, as a result of the rigorous tracking efforts of Nurse Singh, who manages ACLU complaints at the Medical Court Orders Unit, all of the ACLU complaints had been completed and filed.

IV. Non-medical Complaints

In the selected six-month period, female inmates at CRDF filed 132 non-medical complaints about jail policies, staff conduct, or other conditions of confinement. These ranged from grievances about the size or condition of their jail-issued clothing or the taste of their food to complaints about access to showers and use of force by staff. A complete breakdown of the categories of complaints we reviewed is included in Table 1. Thirty-seven of these complaints were more appropriately handled by another unit, such as

41 Following our review, Nurse Gonzaque, the new Medical Complaint Coordinator at CRDF, worked to locate and close all outstanding complaints and concluded that most of the inmates were nonetheless evaluated and treated by Medical staff before release.

Food Services or Inmate Services, and were promptly forwarded, while the remaining 95 were completed by Custody staff. Our analysis focuses on five aspects of Custody response in these cases: resolution of inmate concerns, timeliness, investigation of complaint causes, investigation and adjudication of complaints against staff, and inconsistent dispositions.

A. Resolution of Inmate Concerns

The majority of Custody complaints, though minor, were quickly resolved, disposed of in a timely manner, and well-documented in terms of the nature of the complaint, the actions taken, and the response to the inmate. We also found that the tone of the complaint responses, including when the inmate's request was denied, appeared respectful and unbiased, and that investigators were diligent in responding even when the complaint was very minor. Some examples of these complaints and their response by Custody are described below:

- An inmate complained that her clothes were too small, making her uncomfortable. Her clothes were exchanged for a larger size.
- An inmate said she had no toilet paper in her cell. This fact was confirmed by the deputy; toilet paper was located and given to the inmate.
- An inmate claimed to be receiving inadequate exercise/recreation time. The sergeant checked the Uniform Daily Activity Log (UDAL) for the module and found that inmates had received 16 hours of recreation in the past week, exceeding the 3 hours mandated by Title 15, and informed the inmate of this fact.
- An inmate had money in her possession upon going to jail, but it had not appeared in her jail account. Her money was located and deposited into her account.

Table 1 **Classification by Complaint Type**

Complaint Type	Number
Clothing/Hygiene	20
Complaint Process	1
Contract Vendor	2
Discipline/DRB	4
Exercise	3
Facility Condition/Sanitation	12
Housing Location/Reclassification	10
Inmate Programs	8
Inmate Work Assignment	2
Mail	12
Meals/Food	21
Medical Services*	216
Mental Health Services	15
Miscellaneous	6
Money/Inmate Accounts	3
Policy/Procedures/Enforcement of Rules	2
Release Information/Sentence	3
Religion/Church	4
Showers	6
Stores/Vending Machines	4
Telephones	1
Visiting	1
Request for Info - No response	1
Property – Missing (Search)	1
Property – Other	3
Complaint Against Staff**	16
Total Complaint Types ***	377

* Two of these complaints were completed by Custody and were not referred to Medical Services.

** Includes three complaints about a medical staff member. All other complaints including an allegation against a medical staff member were classified as "Medical Services."

*** Complaints may contain more than one complaint type. We reviewed a total of 346 complaint forms.

- An inmate said she never received a receipt for silver rings taken from her during intake. The investigator found the receipt for the property and gave it to her.
- An inmate complained that a deputy was mispronouncing her name, which she felt was disrespectful. The investigator documented speaking to the deputy and explaining that the "J" in the inmate's Spanish name should be pronounced like an "H."

Documentation of the complaint and any actions taken in response was also, on the whole, good. We found that, with a very few exceptions, complaints were classified properly and that the brief summaries describing actions taken, including a description of any interviews with the inmate, were clear and complete. We also found that the investigator almost always obtained the inmate's signature after informing her of the action taken in response to her grievance, unless the inmate had been released or the complaint was anonymous. **As this step is meant to satisfy Title 15 requirements, investigators must ensure that the notification occurs in every case. If an inmate has already been released, the investigation should still be conducted to the extent possible and the reason for the lack of notification clearly marked on the form.**

B. Timeliness

Completion of non-medical complaints was commendably timely. Sixty-three percent of these complaints were disposed of within three days from the initial complaint by the inmate; nearly a quarter were completed the very same day. Twenty-two complaints (approximately 18 percent), however, were not completed within the expected ten-day period, without sufficient explanation. The majority of these, 16 of the 22, were complaints referred by the ACLU; on average, ACLU complaints took nearly four times as long to complete as

non-ACLU complaints, taking up to 42 days in one case. This is not due to any particular complexity in the substance of these complaints. The delay appears to originate during the assignment process, rather than in the investigation phase, and should be eliminated immediately. While the ACLU referral process can reasonably be expected to be slightly longer, it should take no more than two days for the complaint to find its way from CSS to the assigned investigator, after which it should be completed as quickly as any other complaint. As for the other six complaints that exceeded the ten-day guideline, it does appear that the allegations, four of them against a staff member, merited a longer investigation period. Nonetheless, we urge investigators to clearly document the reasons that an investigation takes longer than ten days.

C. Focus on resolution, not investigation, of complaints.

Although the resolution of complaints, overall, was generally satisfactory, the investigation of personnel or systemic complaints could have been improved in approximately one-fourth of the complaints. In those cases, investigators focused on solving the inmate's problem without addressing potential mistakes or misconduct by staff, or practices that failed to adhere to department policy. This was true for minor complaints as well as the more serious ones, and was especially apparent in complaints against staff. For example:

- A group of inmates contacted the ACLU to complain that the inmates in their module were not receiving enough menstrual pads. The investigator went to the module and found an adequate supply of pads available, and marked the complaint unfounded. A more thorough investigation would have involved talking to at least a few inmates to find out whether they were having trouble receiving pads and, if so, why and for how long.
- An inmate claimed that she had not had shoes or a bra for five days.

Approximately a month later, the investigator spoke to her and was told that she now had shoes and a bra. There was no indication that the investigator made any effort to find out how long the inmate had actually had to wait for those items and the reason behind any delay. The complaint was deemed unfounded.

- An inmate complained about not being allowed to attend Bible study. The investigating sergeant spoke to the deputy, who claimed to be unaware that inmate had not been able to attend this class and said that it would be permitted in the future. The sergeant marked the complaint "founded" and told the inmate to let him know if this reoccurred, but the complaint mentions nothing about why the inmate was prevented from going in the first place, or whether any personnel action, such as counseling, occurred.
- An inmate claimed that a deputy had repeatedly opened her cell door for such a short time that she and her cellmate were unable to get out before it closed again. She claimed to have missed at least one meal and a pill call, and that she had tried to file a complaint but was told by a deputy that she would have to wait until the next day. The supervisor spoke to the inmate and said he would be monitoring the situation for two days, and that she should let him know if it happened again, but there was no indication that he interviewed the cellmate to verify the claims. He also told the deputy to let him know if the inmate had "trouble leaving" her cell in the future. Although the file briefly noted that the inmate did not miss a meal or pill call, there was no further detail or documentation to support this claim, and there was no mention whatsoever about the relatively serious allegation regarding the deputy's refusal to take a complaint, saying she had to wait until the next day. The complaint about the missing meal and pill call was determined to be unresolved.

D. Complaints Against Staff

Fifteen complaints were about staff.[42] While the majority of these were relatively minor and involved complaints about a bad attitude or deputies not following procedure, two involved allegations of force and five complained of unfair use of authority. It is a credit to CRDF's staff and management that the rate is so low. Nonetheless, the complaints that were made were not always investigated with vigor, and that adjudications, most of which were either "unfounded" (11 complaints) or "unresolved" (3 complaints), were not always adequately supported, as demonstrated in the examples below.

- A group of inmates submitted a complaint alleging that a deputy was showing favoritism, including allowing particular inmates out of the cells to wander around and play basketball, facilitating sex, and divulging confidential information. They also claimed that this was the third such complaint about this deputy. For such a serious complaint, the investigation was extraordinarily brief. The supervisor noted only that based on his own contact with the deputy, he believed the claims had no merit. He also said that there were no related problems in her file or in the PPI, and that at least one of the inmates was complaining because she wanted a bunk change. The complaint was marked "unfounded," with no apparent effort to interview any of the complaining inmates or otherwise look into the allegations. There is also no mention of any attempt to locate previous complaints on the same topic.
- An inmate complained that a deputy placed her hands on her, pushing her and telling her to "hurry up and go." The file notes only that the "facts of the investigation determined that the allegation is unfounded," without any reference to what the investigation entailed or why the claims

42 Thirteen of these were classified as "complaints against staff," one was classified as being about the "complaint process," and the other was categorized as "exercise."

were found to be without merit. Again, this alleged use of force, though relatively minor, should have been more thoroughly and carefully evaluated.

In all, we found seven complaints against staff that should have been more thoroughly investigated. **We recommend that investigating supervisors pay better and more detailed attention to complaints involving problems with jail practices, especially those that may indicate a failure to meet Title 15 standards. Complaints against a particular jail staff member should be investigated thoroughly and explained completely.**

We also urge supervisors to be vigilant in reviewing complaints for allegations that should be referred for an administrative personnel investigation either at the unit level or by Internal Affairs. In cases where the allegations are sufficiently serious but are believed to be frivolous or clearly false, the rationale for not making a referral, along with any supporting evidence, should be well documented. The complaint about a deputy showing favoritism and facilitating sex among inmates is an example of a case that should have been handled as a personnel complaint.

The complaint that was perhaps the most serious involved a corroborated use of force against an inmate who was classified as a "keepaway," or K-10. She claimed that a deputy grabbed her arm while she was waist-chained, causing bruising that was verified by medical staff, and that she was told, "We will see you down here next time. We won't forget who you are and this is our house." The complaint disposition noted that the inmate had been treated for her injuries and that another inmate had corroborated her claim, adding that she had seen the deputy pull the other inmate's hair. This resulted in an injury report, and a note that the sergeant was opening a separate inquiry about the incident.

We requested a copy of that investigation and found that the assigned

investigator had conducted interviews of the complainant and the involved deputy, as well as with one deputy and three inmate witnesses. All of those interviewed noted that the involved inmate had given a different deputy permission to remove a sock—used as a hair tie—from her hair and that she had then exclaimed that the deputy was hurting her. This was followed by some arguing between the deputies and the inmate. Although all the witnesses generally agreed that the involved deputy touched or held the inmate's arm following the inmate's exclamation, descriptions of the level of force used varied, including one inmate's statement that the deputy "did not use enough force to hurt [the inmate]." The investigator also viewed the bruising on the inmate's arm, which he said looked like "two fingers applied pressure to each side of the bicep area" and "was not consistent with a firm grip, [which]… would have markings from the thumb and four fingers."

As a result of that evidence, the conflicting witness statements, and a belief that some collaboration on the part of the inmates had occurred, the investigator concluded that the inmate's account was "less than truthful." There was no real investigation of the inmate's claims that the deputy had made threatening remarks. There was also no discussion—in view of the fact that there was some bruising and that the deputy had actually put her hands on the inmate—of the appropriate level of force for such a situation. As such, the investigation was not as thorough as it should have been. Nonetheless, the investigator documented that he had counseled all of the deputies present about notifying a supervisor immediately when faced with an "uncooperative, insubordinate inmate," so that the situation could be monitored if necessary.

The complaint was marked "unresolved," but there is no explanation of that finding, nor is the use-of-force inquiry included in the file. **When a complaint is investigated via another process, the related investigation and its finding should be fully documented in the original complaint file along with the secondary file.**

E. Inconsistent Dispositions

Thirty-seven of the 143 non-medical complaint types were referred to another unit. In six cases, the inmate had been released before the complaint was investigated. Of the remainder, 21 (15 percent) were deemed founded, while the remainder were determined to be unfounded (68) or unresolved (11). The "unfounded" classification proved to be used inappropriately in some cases. We found 13 complaints that were marked "unfounded" because the problem had been resolved, not because there had never been a problem to begin with. For example:

- An inmate had been charged for a hygiene kit more than once (inmates are charged a token amount for the kit if they have money in their account). The extra charges were removed, and the complaint deemed unfounded. The brief summary does not, however, explain why the inmate was charged more than once and whether this was the result of human error.
- An inmate claimed she should have been assigned a lower bunk because she had six rods in her back, and that her medical chart said as much. The investigator noted simply that she was moved to a lower bunk as a result of the complaint, without any discussion as to whether the deputy or deputies involved had refused to change her assignment, whether there were orders for the lower bunk in her file, and how long she had been trying to get a change. Despite evidence that her claim was valid—she had indeed been assigned to a top bunk—the complaint was inappropriately considered unfounded.

The Custody Division is in the process of revising its complaint procedures to include a wider group of disposition options, which will be similar to those currently used for complaints made by members of the public about LASD service in the community, known as Service Comment Reports. In that complaint system, the terms "founded" and "unfounded" are reserved for

formal administrative investigations of allegations that are serious enough to result in discipline. Lower-level complaints, to which most inmate complaints are analogous, do not result in formal discipline but may merit other corrective action such as counseling or training. For these, investigators can use the following findings: "employee's conduct should have been better," "employee's conduct could have been different," and "employee's conduct appears reasonable." These findings are all incorporated into the revised form, which also includes a new finding of "resolved."

We support these changes, which, if used properly, will provide managers with a clearer picture of potential problem areas while allowing supervisors to take appropriate, non-disciplinary corrective action. However, we stress that the finding of "resolved" should be clearly defined and carefully circumscribed; it should not be used for complaints that reference any potential error, misunderstanding, or misconduct on the part of staff.

V. Medical Complaints

Inmates at CRDF filed 214 medically related complaints between December 2006 and May 2007. Eighty-five alleged delays in being seen by medical staff and requested prompt evaluation and treatment.

In this section, we assess the adequacy of the three components of the medical complaint process: response by Custody staff; the transfer between Custody and Medical Services; and response by Medical Services Bureau (MSB) staff.

A. Processing by Custody

The majority of inmate complaints, medical or otherwise, are made directly to the Department using the Inmate Complaint Form. A Custody supervisor, generally a sergeant, is responsible for collecting and reviewing these forms

from locked boxes, located in each module, at least once per shift. Priority medical complaints require a prompt response; in the case of a medical emergency, the inmate should be taken directly to the main clinic. Non-priority medical complaints that do not require an immediate response should simply be referred to Medical Services. Regardless of to whom the complaint is referred, the assigned Custody supervisor is responsible for pulling a reference number, completing the disposition sheet, and notifying the inmate about the referral of her complaint. During our review of these complaints, we considered whether the investigator properly followed up on medical complaints requiring a quick response and whether the complaint was processed and referred to Medical Services in a timely manner.

1. Initial Inquiry by Custody Staff

One hundred and forty-two medical complaints were processed and completed by Custody. We were pleased to find that in 38 cases, the investigating supervisor went out of his or her way to conduct an initial inquiry into the inmate's alleged problem before referring it to Medical Services. This type of follow-up occurred for both urgent and non-urgent complaints. We found that although the Custody supervisor was generally unable to immediately resolve the inmate's problem, the inquiry process was useful in providing preliminary information about the validity and urgency of the complaint to the Medical Services staff person receiving the complaint. Because Custody staff was fairly consistent in following the notification process, it also served to keep inmates informed of the status of their medical treatment.

- An inmate's mother filed a third-party complaint claiming that the inmate, who only had one kidney, had an infection and that her life was in danger. The investigating sergeant immediately contacted the nurse in the main clinic, who looked up the inmate's chart and found that she had already

been seen by medical staff on several dates and that lab results were pending. The sergeant went ahead and sent the inmate to the main clinic, documenting all of her medical treatment up until that point in the complaint file. He also contacted the mother directly and informed her of the status of her daughter's treatment.

- An inmate complained that she had a needle in her left arm that needed to be removed, and that her transfer to state prison, where the removal procedure was supposed to occur, had been repeatedly delayed. The investigating sergeant spoke to a nurse, who verified the needle's presence and said that the procedure had been scheduled at LCMC. The complaint had not been completed by Medical staff at the time of our review, and the file contained no follow-up to see whether the needle was, in fact, removed at LCMC.
- An inmate complained that she had been signing up for the dentist for three weeks and had a great deal of pain in her tooth. The sergeant followed up and discovered that she had been placed on the doctor's line and had been scheduled for a dentist appointment within 3 days. The Medical disposition noted that she was indeed seen by a dentist three days after her complaint.

Unfortunately, for every case in which the Custody investigator made an initial follow-up before referring the complaint, we found nearly three for which no such follow-up had been conducted. While most of these did not appear to require immediate attention, twenty-one complaints appeared somewhat urgent, including the following:

- An inmate claimed to have been experiencing bleeding for two weeks and passing blood clots. She had spoken to several nurses but had not yet seen a doctor. The complaint was referred directly to Medical Services, but was not completed until after our audit. The inmate was never evaluated or treated.

- An inmate complained of having her menstrual period continuously for two months, a urine infection, diarrhea, and pain when using the restroom. She worried that she might have gallstones, an ulcer, or need a hysterectomy. The inmate was released before the complaint was completed two and a half months later. The complaint disposition noted only that she had had a "post-op" exam a month after her complaint, and that she had had no complaints at that time.
- An inmate complained of bad allergies, which caused her to break out in hives, itching, and swelling. She had been waiting to see someone about it for two months, and had talked to a nurse twice within the last three days. In each case, the nurse had said someone would come to see her, but no one did. The complaint was referred directly to Medical Services, but the inmate was not seen until more than a month after her complaint was made.

We recommend that the Custody investigator be required to conduct initial follow-up for every medical complaint, regardless of apparent urgency. This preliminary inquiry can ensure that urgent problems are promptly addressed, that important information is passed along to Medical Services, and that the inmate receives any available information about the status of her treatment. It is likely that in many cases, a lack of information is the most frightening and frustrating aspect of the inmate's situation. Finding out that an appointment has been scheduled, or that lab results are on their way, may allay some of the anxieties that prompted her to file the complaint. **At the same time, we emphasize that this preliminary phase should not delay referral of the complaint to Medical Services, which should take no more than one day. If the process requires a longer time period, it should continue after the complaint has been referred.**

2. Timely Referral

In terms of disposition and referral, we found that all of the complaints appear to have been properly referred to Medical Services, regardless of whether there had been appropriate initial follow-up. In general, this process was timely; in 63 percent of the cases, the complaint was completed and ostensibly referred to Medical Services within two days. However, we were very concerned to find two distinct time periods during which processing of medical complaints was significantly delayed by Custody staff. Specifically, we discovered two large sets of complaints for which the reference number date, assignment date, and completion date were identical.[43] Each set contained complaints going back up to over a month, making it appear that nothing had happened to them until the day that the reference number was pulled. Most of the dispositions and comments were identical as well; in some cases, the inmate's name was handwritten into a blank spot in the comments, and the inmate's signature was often missing. We also found that for eight complaints, someone (likely the Custody investigator) had crossed out the word "Complaint" and written "Request," then sent the form off to Medical Services without obtaining a reference number. (Requests are currently not assigned reference numbers and are not entered into FAST; they are simply discarded upon "completion.") Unsurprisingly, these two sets of complaints make up the majority of those for which no follow-up was done before referral. Overall, there were 41 medical complaints that took more than ten days to be completed by Custody. These delays often resulted in even longer waits, or no treatment at all, such as in the following cases:

- On December 13, an inmate complained of a rash on her face that was spreading, and that this was her second complaint about not being able to

43 Each reference number is composed of 3 sets of numbers: the facility identifier, the date which the reference number was pulled, and a sequential identifier that is reset each day.

see a doctor. The complaint was completed by Custody on January 25, received on February 8, and completed on March 2. The final disposition noted that the inmate was released on February 8 without having been seen.

- On December 22, an inmate complained that she had been waiting over a month to be seen for a yeast infection, insect bite, and an infection of her female organs that was causing "pain day and night." The complaint was completed by Custody on January 25, received on February 8, and completed on February 27. The final disposition noted only that she had been seen on January 19. There was no explanation given for the delay in processing the complaint. Nor is there any indication that the inmate's underlying medical problem had been resolved on January 19 or at any other time. There was no indication that the inmate had been contacted between February 8 and February 27 to see if the inmate's problem had been resolved in the interim.
- On May 1, an inmate complained of unbearable tooth pain. The complaint was completed by Custody on May 16, received by Medical on May 18, and the inmate was released on May 26, without ever being seen. The complaint was completed on June 2.

When we inquired about these complaints, we were told that the delays were the result of confusion on the part of certain investigators, who believed that medical complaints should simply be referred without any action on the part of Custody. **Whatever the reason, such processing delays should never occur. We urge CRDF's management to conduct regular trainings about complaint processes and to hold supervisors accountable for the timely and thorough disposition of medical complaints.**

B. Transfers

The transfer of inmate complaints between Custody and Medical Services currently lacks any accountability for delay and, not surprisingly, is the source of lengthy delays in the response by CRDF to inmate medical complaints. Current practice is at odds with the policy delineated in the Custody Division Manual (CDM), which states the complaint is to be time-stamped in the upper-right-hand corner, photocopied, and delivered to the on-duty supervisor of those units.[44] By contrast and inconsistently, CRDF Unit Order 5-12-010, which specifies complaint procedures, does not require the time-stamping or in-person delivery described in the CDM. As such, CRDF complaints to be referred are simply placed into a Medical Services tray without a time stamp. **In view of lengthy delays in the completion of medical complaints, we recommend that the Unit Orders be revised to match the CDM and that the practice of time-stamping and in-person delivery be instated immediately.**

The FAST system was designed to ensure accountability at each step of the complaint process. When complaints are referred to Medical Services (or another non-Custody unit) for completion, an entry noting such is supposed to be entered into the main complaint module in FAST, along with the name of the person the form was given to. The person receiving the complaint, generally the Medical Complaint Coordinator, should also make an entry into FAST, this time into the Medical Complaint Module. FAST is set to automatically record dates in order to prevent inaccurate data entry. If followed properly, this procedure would serve to encourage quick transfer and completion of medical complaints while allowing managers to pinpoint problems when they occur. Unfortunately, the database is only as good as the information entered into it. Because Custody investigators simply drop the complaints

44 5-12/010.00 "INMATE COMPLAINTS," Custody Division Manual, June 2006.

into a tray, they do not enter the name of the person receiving the forms, and there is no incentive for the receiving person to immediately enter them into FAST. In fact, since the 10-day "clock" effectively begins at the moment that the person "receives" the complaint, there is actually a disincentive for doing so.

Our review found that only 28 percent of the 142 complaints referred to Medical Services by Custody between December 2006 and May 2007 were "received" within 10 days of the listed Custody completion date.[45] One case took 51 days to make the trip from office to office. Even worse, 44 percent of the referred complaints were never completed at all. Forty-five of the medical complaints completed by Custody between December 2006 and May 2007 were listed by FAST as "missing." This means that no one at Medical Services ever entered them into their FAST module, and that the complaints were not acted upon until after our review was completed. By that time, all but two inmates had already been released. Most of those complaints were found at Medical Services, but had they been discarded, there would have been no way to know which unit or staff member was responsible.

The implications of this failure are serious. While we were relieved to find that most of the inmates were eventually evaluated and treated by medical staff at some point, such visits appear to have occurred despite the complaint process, not because of it. In many cases, the intervention came weeks or months after the initial complaint was made, and for 15 inmates, none came at all.

- On December 19, 2006, an inmate with a seizure disorder complained that she was having problems due to receiving a lower dosage of her seizure medication than she required. The complaint was completed and ostensibly referred to Medical Services that same day, but was not recorded as "received" until February 8, 2007. The complaint was then completed on March 8, 2007, noting only that she was evaluated and treated.

45 This number includes two cases that are presumed to have been transferred within one and two days and three that are presumed to have taken longer than ten. Missing or confusing dates make it impossible to know the exact time.

- On January 12, 2007, an inmate, who was missing one leg and confined to a wheelchair, complained that the module shower was not wheelchair-accessible and that she had fallen down trying to use it. She requested to be transferred to the clinic, but was told by a nurse to get a basin and wash in her cell. The Custody investigator spoke to a nurse, who said she would look into getting her in line for a transfer to the Correctional Treatment Center at Twin Towers, and referred the complaint to Medical Services on January 14. The form was then "received" and completed on February 6 and noted that a nurse had evaluated the inmate and determined that she should remain in general population and continue to use her wheelchair in the shower. There was no response to the inmate's assertion that the shower in the module was not wheelchair accessible.
- On May 14, 2007, an inmate complained of waiting for treatment for a yeast infection for over a month, and said she had a sore throat, earache, and headache. The Custody sergeant followed up with the main clinic and learned that the inmate had been put on the doctor's line, but that the nurse could not tell her when she would be seen. The complaint was referred by Custody to Medical on May 15 but was never acted upon. The inmate was released on June 9, more than three weeks later, without ever receiving treatment.
- An inmate with pinkeye was given an antibiotic by a nurse, but due to her own training as a Certified Nurse's Assistant, the inmate decided not to put it in her eye as directed. She then asked for Extra-Strength Tylenol but was given something else, which she believed caused an allergic reaction (she said she was allergic to aspirin). She then asked for Benadryl, but her request was denied, and she was told to put herself on the doctor's line. She claimed that she had done so a month and a half ago but had not yet been seen. The complaint was referred to Medical Services, but was not completed until after our review. A follow-up found that the inmate was released without being evaluated.

The process for referring complaints to Medical Services, as well as other units, must be tightened up immediately. Not only does the Department have an obligation to respond to inmate's concerns within a reasonable period of time, ignoring the complaints, particularly those regarding potentially serious medical problems, exposes the Department to unnecessary liability. Current practices make it difficult to assign responsibility for long wait times, and it is evident that there was very little, if any, oversight of the process during the relevant time period. In response to our queries, the Medical Services unit at CRDF quickly moved to locate all of the missing complaints and to close them out. While we commend them for their prompt action in this matter, it must be noted that some of the complaints were over a year old, and that all but two of the inmates had already been released.

We urge the Department to immediately implement the following procedures for medical complaints:

- **All medical complaints inquiries should be completed by the assigned Custody investigator and referred to Medical Services within one day of receipt. Any action or investigation required beyond that day, such as when the complaint includes both a medical and non-medical complaint, must continue after the initial referral to Medical Services.**
- **Referred complaints should be delivered in person to the Medical Complaint Coordinator or on-duty supervisor, who should sign their names at the bottom of the complaint. The new complaint form already has a space for this purpose. Each form should be time-stamped on the top-right-hand corner and photocopied. Leaving the photocopy, the Custody investigator should take the original to be filed in the Custody office. The transfer of the form should be logged into FAST on the same day, with the name of the person receiving the complaint form entered at that time.**

- **All inmate complaints should be entered into FAST within 24 hours of receipt. Receipt should be defined as the moment Custody personnel pick up complaint forms on a regular, frequent, hourly basis each day. Absent good cause being shown and approved by a lieutenant or captain, all inmate complaints shall be resolved within 10 days and its resolution presented to the inmate for acknowledgment and signature within the same 10 days. The exception will be for inmates whose complaint includes a request for medical attention or asserts delays in the receipt of medical attention. Those inmates must be seen by medical staff within the recommended 24-72 hours. To the extent that Medical Services has given itself 10 days to respond to such complaints, that practice shall be abolished.**
- **When the complaint needs to be returned to Custody for a correction or because a reference number was not pulled, this should be done promptly and should not stall the complaint process. The Medical Complaint Coordinator should act on all complaints, whether or not there is a reference number.**
- **All complaints, particularly medical complaints, should be audited on a regular basis to ensure that this process is being followed and that completion, referral, and receipt dates match.**

In contrast to the referral process at the facility, the referral of ACLU medical complaints was timely and well-documented. Because the complaints are faxed from Custody Support Services to the Medical Court Order Unit, then to the Medical Complaint Coordinator, each file contained a clear record of the dates of each referral. Perhaps as a result, ACLU complaints were completed much more quickly than those referred by the facility Custody staff.

C. Response by Medical Services

All inmate medical complaints are referred to a designated Medical Complaint Coordinator within Medical Services. Like his or her counterparts at Custody, the coordinator should research the complaint, resolve the grievance if appropriate, and complete a form—the Medical Services Data Disposition Form, or disposition sheet—that describes the type of complaint and disposition of the complaint. This should occur within ten days of receipt of the complaint, where possible. The process for completing a complaint referred from the ACLU is the same except that, upon completion, the coordinator is to fax the disposition back to the Medical Court Orders Unit so that it can be forwarded on to the ACLU. We examined 151 medical complaint disposition files for this review, 72 of which were referred by the ACLU. As discussed above, an additional 63 medical complaints had not been completed at the time of our review, and we were not able to evaluate their disposition. Our review considered the following factors: resolution of inmate concerns, classification and investigation, and timeliness.

1. Medical Complaint Response

Seventy-one percent of the 214 complaints referred to CRDF Medical Services were complete at the time of our audit. Disposition documentation in these cases was minimal, making it difficult to assess the adequacy of the response. This was compounded by the fact that the inmate's signature was missing in 87 percent of the cases, leaving no evidence as to whether the inmate was consulted about her concerns, notified of the finding, or left satisfied with the response. In fact, in almost none of the cases did it appear that the action taken was done so as a result of the complaint. Instead, it appears that most of the information for the disposition was taken directly from the inmate's electronic chart, with the following findings:

- In 46 percent of the cases, the inmate was seen by a doctor or nurse between the date that she made the complaint and the date that the complaint was completed. For 29 complaints, this occurred before the coordinator received the complaint. An additional 15 complainants were listed as having been evaluated, but the date was not documented.
- In 12 percent of the cases, the inmate had been seen by a doctor or nurse before their complaint was made. No further action was taken.
- In 11 percent of the cases, a judgment about the inmate's complaint was made by looking at her electronic chart; for example: "Chart review shows inmate is receiving medication ordered by physician."
- In 7 percent of the cases, a chart review revealed that the inmate had been referred to either a physician at CRDF or outside specialist and was still awaiting treatment. In 12 percent of the cases, the inmate was released before any action was taken.
- One complaint was marked as "not valid."
- For one complaint, referred by the ACLU, the complaint coordinator clarified department policy on treatment for colds.

With a few exceptions, descriptions of inmates' medical treatment consist of dates seen and a comment that treatment was provided or appropriate medication provided. This does not necessarily provide information about whether the inmate's grievance was addressed, however, particularly in cases where she is alleging inadequate or incorrect treatment. There is some reason to keep the description of inmates' medical treatment and findings brief; the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws set forth strict regulations about patient confidentiality. But this does not prevent the coordinator from describing his or her response in much greater detail, including the interview with the inmate, action taken as a result of the complaint (such as scheduling, chart review, discussion with other team members, corrective action), and implications of the findings. Also, the

parameters of the confidentiality afforded the inmate in complaint investigations are unclear and should be clarified.

We found only four dispositions that described an interview with the complaining inmate, and only 19 dispositions documented that the inmate had been informed of the result of her complaint. This lack of contact with the inmate is problematic. We reviewed many complaints that were rambling, poorly written, or otherwise confusing. Others lacked important information about the problem or the desired resolution. It is incumbent upon the complaint coordinator to fill in these gaps, generally through a brief interview with the inmate, and to make sure that the complaint is fully understood. The inmate must also be notified of the outcome of the complaint; this process is required by Title 15 and allows the inmate to appeal the result. Even if the inmate is only making a simple request to see a doctor, she should sign off on the form noting that her complaint was addressed during the visit. **We recommend that the Department require an inmate interview for every medical complaint, and that it fully enforce its notification requirement. In those cases where the inmate is, in fact, released before one or both of these occur, the delay should be explicitly justified in the complaint disposition.**

We also urge complaint coordinators to clearly describe other action taken in response to a complaint, including, where applicable, the implication for the client. While many of the complaint dispositions listed information such as dates seen or the results of lab tests, it is difficult to ascertain from the written summaries whether treatment was provided as a result of the complaint or some other process. In those cases where the inmate was seen before the complaint was received or even made, there is no explanation of why this is considered an adequate response to the complaint. In some cases, the written response failed to discuss what the final result of the complaint was. For example:

- In the case of an inmate who claimed to not be regularly receiving an anti-nausea shot with her Interferon injection, the disposition only notes that she was supposed to be receiving this shot. It does not describe what action was taken to determine whether the order was being followed or to ensure that she received the shot in the future.
- An inmate complained that she had not received a renewal of her Benadryl or a muscle rub, even though the nurse told her she would. The complaint disposition states that the medication was never prescribed in the first place, failing to mention why the inmate thought she was entitled to that treatment, why the treatment was not merited, or what her actual treatment plan was.
- An inmate complained that she was not receiving the correct medication. In the disposition, the complaint coordinator notes only that a "[c]hart review shows inmate is receiving medication ordered by physician." Again, there is no follow-up with the inmate to find out why she believed her medication was wrong or any apparent consideration of the merits of her complaint.

While it does appear that most of the complainants in the cases we reviewed were seen by medical staff after making the complaint, the lack of detail about the disposition, combined with an apparent failure to discuss the complaint with the inmate, makes it difficult to assess whether that response was adequate and appropriate. **We urge complaint coordinators to make a full record of all actions taken in response to each inmate complaint, including its final result, in every case. We also suggest that the Department begin requiring supporting documentation of the finding, such as a record of dates the inmate was seen by the doctor or received lab results.**

We understand that patient confidentiality rights must be considered in the documentation and storage of inmate complaint files. However, we must

point out that while many of the complaint dispositions were exceedingly brief, noting only that the inmate was "evaluated and treated" on a particular date, others were more descriptive, describing test results and other medical findings. To our knowledge, there are no clear guidelines about the extent to which privacy concerns apply in this situation, particularly considering the fact that the internal disposition files are housed within the Medical Services Bureau. **We recommend that the Department consult with County Counsel to develop procedures for the proper documentation, storage, and auditing of the response to medical complaints without a sacrifice of accountability.**

2. Classification and Investigation

Each inmate medical complaint is sub classified according to the nature of the grievance. Because they have already been classified by Custody, in most cases, as "Medical – Referred," the sub classification should provide more detail about the inmate's allegation or request. This is the only description of the complaint that goes into FAST, and can be used by management to get a quick picture of the types of complaints the facility has been receiving. The complaint coordinator can choose among the following types:

- Service – Omission
- Service – Delay
- Service – Incorrect
- Service – Inadequate
- Request for Service – Routine
- Mental Health Issues
- Complaint Against Staff
- Commendation

All but two of the complaints we reviewed were classified as "Request for Service – Routine," a result which, considering the content of the inmates' complaints, is difficult to believe. In fact, we determined that two thirds of the completed complaints we viewed were misclassified, including the following:

- An inmate complained that she was supposed to have had hand surgery a month before, but had not yet even been seen by a doctor.
- An inmate claimed that she was not receiving her medication for her thyroid and an enlarged heart, which she was supposed to get four times a day. She complained that she had already filed three complaints and had been waiting on sick call for five days.
- An inmate reported blood clots in her legs that caused swelling, and said that although a doctor had ordered a wheelchair for her, this order had been cancelled by a nurse.
- An inmate claimed that she had been on the doctor's list three or four times over the past two and a half months, but had not yet seen a doctor for her severe tooth pain.
- An inmate complained that she had been charged for seeing the doctor although she had not seen one yet, despite having been on the doctor's line for over a month. She also claimed to have filled out several requests for service and one prior complaint.
- An inmate complained that it had taken her two months to find out that there was no eye doctor at CRDF, and was concerned that her vision would be "totally gone" if she did not get help with her eye problem soon.
- An inmate complained of "abdominal pain, back pain, headaches, and blood spotting" and said that although she had had her vaginal discharge tested a month earlier, she still had not received her results.
- An inmate complained that she had not seen a doctor since entering the jail over a month ago, and that her back ailment had gotten worse, to the point that she was now confined to a wheelchair.

- An inmate claimed that she had already complained twice before about not being able to get medication for her itchy feet and that the nursing staff was giving her attitude about it.

It is not clear why these and other cases were labeled and treated as routine requests for service, even though they include complaints about service delays, serious medical needs, improper medication or treatment, problems with the complaint process, and inappropriate staff behavior. It may be a reflection of the complaint findings, such as the staff's assessment that an inmate's ostensibly urgent problem is actually routine, or that a certain delay in obtaining treatment is to be expected. Nonetheless, the classification of a complaint should not include such considerations and should refer only to the nature of the grievance itself; findings of fact should be reflected in the disposition field instead. An example of this would be if an inmate complains of being prescribed the wrong medication and is referred to a doctor, who examines her and finds that her medication is correct. The complaint should properly be classified as "Service – Incorrect," even though her complaint is ultimately unfounded. An appropriate disposition would be "Complaint Not Valid," with an explanation of how that was determined.

The largest category of misclassified complaints were those that referenced lengthy delays in seeing a doctor or otherwise receiving treatment. As we discussed in the preceding chapter, such delays represent business as usual at CRDF, as a result of large numbers of inmates requesting treatment, space constraints, and a relatively small medical staff. Yet while long waits to see a nurse or doctor may be the norm, it is nonetheless important for the Department to register and track complaints about these delays. Doing so allows the Department to collect data about how long inmates are actually waiting, and to identify those cases involving unusually long delays or lapses in regular procedure. **We recommend that the Department develop a reasonable timeline for the evaluation, treatment, and referral of**

inmates by both nurses and physicians, and that it use the complaint process to flag and explain those instances where an inmate's wait time exceeded these timelines. Where the delays are the result of procedures or staff mistakes, managers can then move to take corrective action or to adjust procedures as necessary. The complaint coordinator should also ensure that any inmate whose complaint contains a request for service be seen within 24-72 hours of receipt of the complaint, as recommended by the NCCHC standards.

A second category of misclassified complaints is smaller but nonetheless significant: those alleging incorrect treatment or medication, or that otherwise complain about the performance or demeanor of medical staff members. It is imperative that these allegations be fully investigated and adjudicated. It is not enough to simply correct the problem and consider the matter resolved. While it may be that such complaints are the result of inmate confusion or dissatisfaction, the Department is accountable for the full investigation of such claims. We were dismayed to find that although there were very few (only 25) complaints against medical staff, not one of these appears to have been properly pursued, including the following:

- An inmate with AIDS claimed that although she had been prescribed Darvoset four times a day, a particular nurse (whom she described but was unable to identify by name) had refused to give it to her more than once a day and that he had told her that "as long as he's working here, [she] will only get it once a day." Before referring it to Medical Services, the Custody sergeant made some inquiries and discovered that the inmate's description of her prescription was correct. This complaint was not completed until after our audit; the eventual disposition stated that the inmate was evaluated and treated before release. There was no indication that the apparent highly inappropriate and health threatening conduct of the nurse was investigated and proper action taken.

- An inmate complained that she was not always given an anti-nausea shot before her Interferon injection as part of her treatment for Hepatitis C, and that this had caused her to refuse one or more injections. This complaint was classified as a routine request for service, and the final disposition noted only that the inmate was, in fact, supposed to be receiving the anti-nausea shots. There was no discussion of why she had not gotten the shots or who was responsible.
- An inmate's attorney reported to the ACLU that the inmate was given an unnecessary knee x-ray without her consent, was not issued tampons during her period, and had a red rash that needed attention. Custody staff originally marked this as a complaint against staff, but then changed it to a medical referral, apparently because it involved medical staff. At Medical Services, the complaint was classified as a request for service, and investigation of the complaint was minimal. The inmate was released before the complaint was ostensibly received (nearly three weeks later); subsequent investigation consisted of looking at her chart to see whether she had actually received an x-ray (she did). The other issues listed in the complaint were apparently ignored.[46]

We urge medical complaint coordinators to be vigilant for grievances that make allegations against medical staff, or that complain of mistakes or incorrect treatment. These should be accurately classified and carefully investigated. While most of the inmates also include a request for treatment, ignoring clearly articulated complaints about the provision of medical services cannot be tolerated. Judgments about the merits of the complaint

46 This complaint file contained several revisions. The original response stated that "Complaint received 2-14-07, inmate released 2/5/07 prior to receiving complaint. Per medical record bilateral knee xrays were taken 1-11-07." It was revised with the following note: "3-23-07 no order for bilateral knee xray." A third comment was added by Nurse Singh at the Court Orders Unit to say: "*Contents noted; Bilateral knee x-ray 1-11-07 per powerchart." An attached printout of the powerchart showed that the x-ray had been given on that date. However, there was no investigation of the inmate's claim that the test was unauthorized.

should be reserved for the disposition process, and should be fully supported by a thorough and well documented investigation.

3. Timeliness

In general, timeliness of the disposition of medical complaints at CRDF was poor. As noted previously, 44 percent of the complaints referred to Medical Services by Custody between December 2006 and May 2007, or 29 percent of all medical complaints, were not completed until after our audit in December 2007. This is an unacceptable result. That these complaints were outstanding was a fact easily discovered by any manager with access to FAST, and any missing complaint forms could have been quickly replaced by Custody. Fortunately, a follow-up by the new Medical Complaint Coordinator found that the majority of the complainants managed to get seen by a nurse or doctor at some point before their release, but the potential for liability, should just one seriously ill inmate fall through the cracks, is significant.[47] **Medical Services Bureau already has a procedure in place to track and collect outstanding complaints; we recommend that the unit act quickly to strengthen this mechanism to ensure that such a situation does not reoccur. We also urge the Department to immediately review inmate complaint statistics for other facilities and make sure that all complaints over one month old are completed immediately.**

Even when the complaint was completed, disposition was often less than prompt. Again, Department policy states that, whenever possible, complaints should be completed within ten days of receipt by the medical coordinator. However, we found that only 38 percent of dispositioned complaints were completed within this time frame, with an average length of approximately 15

47 For seventy-three percent of complaints closed after our review, the inmate was found to have been evaluated by a medical staff member. In ten percent of the cases, the inmate was released without being seen; in eight percent the complaint was missing altogether. The remainder of complaints were referred to another unit or determined to be invalid.

days. (Those statistics do not include complaints that were still open at the time of our audit; when they are included, the proportion of timely dispositions falls to only 27 percent.)

Considering the nature of medical complaints, most of which contain requests for service, such delays are alarming, particularly when compounded by referral and service delivery delays. Interestingly, 30 of the late complaints had apparently been mooted within the ten-day period, but there is no evidence that the complaint coordinator knew this before completing the complaints. The files contain no mention of any preliminary review and triage of the grievances by medical staff, and there is no clear pattern that differentiates timely dispositions from untimely ones. As such, and without any written explanation for the delays, we cannot conclude that the delays were justified by a lack of urgency, a shortage in resources, or any particular complexity. In fact, some of the complaints with the longest delays appeared relatively serious, such as the following:

- On December 4, 2006, the ACLU forwarded a complaint from an inmate who claimed that although she had a court order for evaluation by a doctor for cysts, lymphoma, and a hernia, she had only been able to see a nurse. The complaint, now overdue, was resent on January 24, and the inmate was evaluated on January 28. The complaint was closed on February 2.
- On May 3, 2007, the ACLU referred an inmate's complaint that she was supposed to have had an MRI several months before due to "headaches accompanied by lost control of left side of body, throbbing blood vessel in the back of head, [and] worsening eyesight and eye pressure." The complaint was not completed until July 18, stating that on June 19 the inmate had refused to go to a neurology appointment at LCMC and had signed a release of responsibility. The disposition also noted that this was her initial appointment and that there was no record of a previous MRI appointment. There is no description of what action (if any) was taken

during the more-than-month-long period between the complaint and the LCMC appointment, why the inmate had refused the appointment, or what her current situation was. It is also not clear why it took more than a month from the date of her appointment to close out the complaint.

There was a statistically significant difference between the average completion length for Custody-referred complaints and that of a complaint referred by the ACLU. Approximately 57 percent of ACLU complaints were completed within 10 days (with an overall average of 13 days), while only 20 percent of Custody-referred complaints were completed within that timeframe (with an overall average of 18 days, excluding outstanding complaints). More importantly, all of the ACLU medical complaints had been completed at the time of our audit. We attribute this variation to the ACLU complaints being subject to more rigorous accountability, with both Nurse Singh at the Medical Court Orders Unit and, ostensibly, the ACLU tracking their response and disposition. Indeed, those ACLU complaints that took the longest time to complete bore evidence that they had been marked "overdue" and resent to CRDF by Nurse Singh. While she is to be commended for doing her job well, there is no reason why Custody-referred complaints should not be tracked in the same manner.

Each medical disposition form has an area in which the complaint coordinator must mark whether the disposition was timely (i.e., within ten days of receipt). Accordingly, only about 38 percent of the complaints had been marked timely, although these did not always correspond with those complaints completed within ten days. The disposition forms contained no explanation or justification of the delays, and we could find no evidence of any follow-up by managers. **We recommend that the Department policy require that all medical complaint investigations and resolutions be completed, and the resolution presented to the inmate for acknowledgment and signature, within ten days. An exception should be made for**

inmates whose complaint includes a request for medical attention or asserts delays in the receipt of medical attention. In these cases, the inmate must be seen by medical staff within the recommended 24-72 hours. To the extent that Medical Services has given itself 10 days to respond to such complaints, that practice should be abolished. We also urge the Department to conduct regular audits to ensure that complaints are being completed in a thorough and timely manner.

VI. Conclusion

Our overall assessment of the effectiveness of CRDF's inmate complaint system is mixed. The primary goal of the LASD's inmate complaint system, of course, is to provide inmates with a mechanism for the fair resolution of grievances about conditions of their confinement. For those grievances that we reviewed, we were first struck by the low number (only 40) of those that allege misconduct, deliberate indifference, or even significant mistakes on the part of CRDF Custody or Medical staff. Accordingly, we commend the staff and management at CRDF for their excellent record. Second, our review found that, on the whole, inmates' requests were properly considered and usually granted. This is especially true for Custody-related, non-medical complaints, which were almost always resolved promptly and appropriately by a Custody supervisor. While inmates with medical complaints were usually examined and treated by a medical professional, this did not always occur in a timely manner, and not necessarily as a result of their complaint.

While the resolution of inmate complaints was generally good, we found that the complaint system was not as effective in achieving its other goals: the thorough investigation of potential personnel or systemic issues, and the accurate tracking of risk, particularly in the delivery of medical care, at the

facility. Specifically, the assigned staff member often failed to look beyond the inmate's immediate request in order to find and correct the cause of the situation. The poor classification and disposition of the medical complaints rendered FAST less than effective in pinpointing problems or areas of risk at the facility. By failing to fully investigate and document the causes of the inmate's complaints, the Department hinders its ability to move proactively to avoid further problems and reduce liability.

Finally, at the time of our review, the process for transferring, addressing, and disposing of medical complaints lacked accountability and oversight, resulting in large numbers of complaint forms that were simply ignored. Many of those that were completed took weeks or months, and some disposition summaries lacked sufficient information to determine the adequacy of the response. These deficiencies must be corrected immediately. While we understand that the person responsible for completing medical complaints has since been replaced, we must emphasize that it is ultimately the facility and Bureau management who are accountable for ensuring that complaints are disposed of promptly, appropriately, and thoroughly.

As previously mentioned, the Custody Division is currently revising its inmate complaint procedures. Expected changes include the combining of the request and complaint forms, clear guidelines about the classification of requests and complaints, revised dispositions, and procedures for the documentation of transfers between units. The new forms will be printed in triplicate, allowing inmates to keep a copy of the complaint for themselves. We expect that these revisions will improve the inmate complaint process and in theory will address many of the concerns brought up in this Report. However, maintenance of a high standard by the chain of command will be integral to the success of the new system.

LOS ANGELES COUNTY SHERIFF'S DEPARTMENT

INMATE COMPLAINT FORM

REFERENCE NO. _____ DATE ASSIGNED _____

ASSIGNED TO _____

A REFERENCE NUMBER MUST BE DRAWN BY THE STAFF PERSONNEL RETRIEVING THIS COMPLAINT FROM THE COMPLAINT BOX. THIS INCLUDES ALL MEDICAL AND FOOD SERVICES COMPLAINTS.

NAME / *NOMBRE* _____

BOOKING # / *EL NUMERO DEL PRISONERO* _____

HOUSING LOCATION / *EL NUMBERO DE SU CELDA* _____

DATE/TIME OF OCCURRENCE / *LA FECHA Y LA HORA DEL INCENTE* _____

TODAY'S DATE / *LA FECHA DE HOY* _____

EXPLAIN YOUR COMPLAINT. INCLUDE DATES, TIMES, AND NAMES OF PERSONS INVOLVED. / *EXPLIQUE SU QUEJA O SU PREGUNTA. INCLUYA LAS FECHAS, LAS HORAS, Y LOS NOMBRES DE PERSONAS IMPLICADO.*

ATTACH ADDITIONAL PAGES IF NEEDED / *PONGA OJAS ADICIONALES SI ES NECESARIO*

☐ F.S. ONLY ☐ M.S. ONLY

SIH-J-420 Rev. 04/01

DO NOT WRITE ON THIS SIDE OF THE PAGE / *NO ESCRIBA EN ESTE LADO DE LA PAGINA*

INQUIRY CONDUCTED BY:_____ EMP. #:_____

FINDINGS:_____

ACTION TAKEN:_____

REVIEWED BY:_____/_____ APPROVED BY:_____/_____
(WATCH COMMANDER) *(DATE)* *(UNIT COMMANDER)* *(DATE)*

INMATE GIVEN A WRITTEN / VERBAL REPLY ON:_____
BY:_____
(CIRCLE ONE)

THIS COMPLAINT HAS BEEN DISCUSSED WITH ME AND I HAVE BEEN ADVISED OF THE FINDINGS

ESTA PREGUNTA / QUEJA A SIDO DISCUTIDA CONMIGO Y ME HA SIDO ADVERTIDA DE LOS RESULTADOS

NAME / *NOMBRE* _____ DATE / *FECHA*
_____

LOS ANGELES CO. SHERIFF'S DEPARTMENT
INMATE COMPLAINT DISPOSITION DATA FORM

☐ **INMATE COMPLAINT** ☐ **REFERRED THIRD-PARTY COMPLAINT**

Reference #_____ (Any related URN number:_____)

Facility Receiving Complaint:_____ Courtesy Inquiry: Y N If Yes, For Which Facility :_____

This Complaint is: [ ] Individual Inmate [ ] Recurrent [ ] Group of Inmates (how many?): _____

Inmate's Last Name:_____ First :_____ Bkg. #: _____

Sex: M F Release Date:_____ Date/Time of Occurrence: _____ Shift: AM PM EM ALL N/A
Date Inmate Submitted Complaint: _____

Housing Loc.:_____ Housing Type (Circle Type): 1) General Population 2) Discipline/Admin Seg 3) Pro Per
4) Gang 5) High Power 6) K-11 7) K-12 8) 288 / Sexual Predator
9) Medical 10) Suicide Watch 11) Inmate Worker 12) None 13) Other

ID #	X	COMPLAINT TYPES	DISPOSITION CODE
1		BEDDING	
02		CLOTHING/HYGIENE	
03		COMPLAINT PROCESS	
04		CONTRACT VENDOR	
05		DISCIPLINE/DRB	
06		EXERCISE	
07		FACILITY CONDITION/SANITATION	
08		HOUSING LOCATION / RECLASSIFICATION	
09		INMATE INFORMATION SYSTEMS	
10		INMATE PROGRAMS	
11		INMATE WORK ASSIGNMENT	
12		JUSTICE DELAYS (PRO PER, LAW LIBRARY, ETC)	
13		MAIL	
14		MEALS / FOOD	
15		MEDICAL SERVICES	
16		MENTAL HEALTH SERVICES	
17		MISCELLANEOUS	
18		MONEY / INMATE ACCOUNTS	
19		POLICY / PROCEDURES / ENFORCEMENT OF RULES	
20		RELEASE INFORMATION / SENTENCE	
21		RELIGION / CHURCH	
22		SHOWERS	
23		STORES / VENDING MACHINES	
24		TELEPHONES	
25		TELEVISION	
26		TRANSPORTATION	
27		VISITING	
28		WRISTBAND BAR CODE	
29		REQUEST FOR INFO - NO RESPONSE	
40		PROPERTY - DAMAGED (SEARCH)	
41		PROPERTY - MISSING (SEARCH)	
42		PROPERTY - TAKEN (CONTRABAND)	
43		PROPERTY - OTHER	
44		COMPLAINT AGAINST STAFF	

DISPOSITION CODE NUMBERS
01 UNFOUNDED
02 FOUNDED
03 UNRESOLVED
04 UNIT LEVEL INVESTIGATION
05 I. A. B. INVESTIGATION
06 RELEASED PRIOR TO INQUIRY
07 REFERRED - MEDICAL
08 REFERRED - COURT SERVICES
09 REFERRED - FOOD SERVICES
10 REFERRED - OTHER FACILITY
11 REFERRED - OTHER
12 I.C.I.B. INVESTIGATION
99 NOT APPLICABLE
FOR UNIDENTIFIED COMPLAINANTS, USE A BOOKING # OF 0000000.

(Please complete the reverse side of this load sheet)

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LOS ANGELES CO. SHERIFF'S DEPARTMENT
INMATE COMPLAINT DISPOSITION DATA FORM (CONTINUED)

PAGE TWO

Reference #_____ (Any related URN number: _____)

Date Assigned:_____ Date Completed: _____

Investigator's Name / Title:_____ Emp #:_____

Disposition or Comments: _____

Watch Commander Approval: _____ Date:_____

Unit Commander Approval: _____ Date: _____

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Litigation 4

After six months reviewing the last six full years of litigation against the Department, from fiscal year 2001-02 until fiscal year 2006-07, we find that the LASD has experienced a welcome reduction in the number of new lawsuits filed against it in recent years, strongly suggesting that the Department's risk management activities, in the main, have successfully thwarted new litigation, thus reducing injury, risk, and financial exposure—all for the benefit of County taxpayers. The number of new force-related lawsuits, as well as the number of closed force-related lawsuits resulting in a payout, has also trended downward, validating the combined efforts of LASD leadership and external civilian oversight that Special Counsel and the Office of Independent Review (OIR) in different roles provide.

These trends have not, however, coincided with decreases in the total dollars paid out in litigation or in the average amount paid out per closed case. Particularly troubling in this regard are six cases involving in-custody injury or death that accounted for $5.635 million, or more than half (51 percent), of the LASD's total civil liability across all lawsuits for the 2006-2007 fiscal year. The Department's liability, in terms of money paid out, has gone up recently. While the inability to reduce the overall financial cost to County taxpayers should give the LASD pause, and should precipitate more effective risk management in the jails, it does not, for reasons set forth below, imply that the LASD has not made significant strides in other areas.

We have noted frequently since the **Kolts Report** that measuring trends in litigation reflects the Department's progress in mitigating personnel misconduct and managing risk. Consideration of the volume of lawsuits

brought against the Department, the size of judgments and settlements, and the nature of the cases generating liability can reveal substantive areas in which the LASD can or should improve and issues that it must address. We return here to consideration of trends in liability through litigation and the implications for future efforts to manage effectively the risk of that liability.

I. Scope of the Review

For the present report, we reviewed overall trends in litigation since the 2001-2002 fiscal year through the 2006-07 fiscal year. The County's fiscal year runs from July 1 of one year through June 30 the next.

Litigation is an imperfect indicator of the efficacy of risk management because it is a "trailing" indicator. Lawsuits often are not filed until well after an incident has occurred and often take significant time to work their way through the court system to a resolution. By the time that a lawsuit is settled or resolved via verdict, it is not uncommon for several years to have elapsed. Aggregate statistics on litigation-related liability for each fiscal year thus provide only a delayed snapshot—rather than a contemporaneous assessment—of the Department's liability risks. A risk manager studying litigation must accordingly factor in changes in policies, procedures, and culture that may have lowered the apparent risk in the interim.

Litigation is, similarly, an imperfect indicator of the level of overall officer misconduct to the extent that the legal system, through pre-trial motions or the inclusion or exclusion of particular evidence, can alter the risk management calculus such that settlement is more cost effective for the Department even if the Department believes that the case has no merit. That is, the Department may settle to mitigate costs, and the evaluation of the aggregation of such settlements for a specific timeframe may reveal only the strength of the Department's advocates in court or the legal soundness of the Department's

position related to evidence rather than the overall level of officer misconduct.

Litigation does, however, still reveal much. As we noted in our **Fifteenth Semiannual Report,** "often, with regard to an instance or allegation of police misconduct, it is litigation that produces the fullest record," as the litigation process differs from internal investigations about an incident—such as citizen's complaint investigations, force reviews, and administrative investigations—because litigation is external and adversarial. (Fifteenth Semiannual Report, 85). Because it introduces external and adversarial parties to the truth seeking process and includes the likelihood of deposition and cross-examination under oath, litigation may be more likely in many instances to test and challenge asserted facts than a limited internal investigation might.[48] Litigation, however, is a bed of roses only for those who don't mind sharp thorns. Positions harden, war chests are raised and then rapidly depleted, faces must be saved, and emotions arm wrestle with pragmatism.

Nonetheless, litigation, in common with external civilian oversight, has the potential to examine a law enforcement agency and its practices with more professional skepticism than internal forms of review. Accordingly, a department's demonstrated ability to learn from litigation by reducing potential sources of liability will be reflected in fewer total lawsuits, fewer lawsuits in the higher risk categories, less total exposure, and fewer taxpayer dollars spent on judgments and settlements. These trends are a fundamental sign that systemic reforms in the realm of policy, procedure, and training are taking hold.

Our **Fifteenth Semiannual Report** in July 2002 set forth substantial concerns about the Department's risk management programs and their inability to identify and apply lessons learned from incidents that generated financial liability in the past to prevent similar incidents in the future.

48 Some cases brought against the Department may inevitably be based on fraudulent claims. In such instances, litigation may prove to be a less efficient process for determining facts while costing the Department disproportionately more to resolve.

We noted then that the Department tended both to settle cases too liberally, in order to dispatch of them at or below the anticipated cost of trial, and not liberally enough, refusing to acknowledge internally that, in some instances, the Department was more clearly at risk of substantial liability and that such a case should be dispatched as cheaply and quickly as possible.

Our **Nineteenth Semiannual Report** in February 2005 followed up and reported that, in the intervening period, the LASD began to address these concerns by introducing new management practices in the Civil Litigation Unit of the Risk Management Bureau. These practices included a commitment to settling lawsuits quickly where appropriate, in order to minimize attorney's fees and the likelihood that a plaintiff will "dig in their heels" for a large settlement or await a generous verdict, and the mounting of a vigorous defense if a Critical Incident Analysis meeting—an evaluation of pending litigation for more major or complex lawsuits involving risk management staff, County Counsel, the Office of Independent Review ("OIR"), the involved commander, and others—deems the Department to be not at fault or a plaintiff's demands unreasonable or excessive.

It is our understanding, through interviews with the Civil Litigation Unit, that these commitments have endured in the more than three years since our last, in-depth look at litigation and the Risk Management Bureau. We applaud the spirit behind these commitments.

Currently, it is also our understanding that all claims that the Civil Litigation Unit receives are subject to a preliminary investigation and recommendation to deny, pay, or settle by a sergeant or deputy within the Unit. The Lieutenant in charge of the Unit reviews the preliminary materials, reviews the recommendation, and makes direct recommendation to Los Angeles County Counsel. Recommendations of settlement in amounts greater than $100,000 require the concurrence of the Division Chief and Undersheriff. The Lieutenant also recommends whether the case should be the subject

of a Critical Incident Analysis Meeting. Generally, cases that the Lieutenant determines are likely to result in a judgment against the Department or settlement in excess of $100,000 are recommended for review in a Critical Incident Analysis meeting.[49]

We do note that the process for determining precisely who makes recommendations as to how best to proceed with a given lawsuit—whether to settle sooner, settle later, or go to trial—is an inherently nebulous and variable one, at least on the LASD end, as the processes utilized for review are informed by the hopefully critical judgment of Civil Litigation Unit investigators, leadership, and those who convene in the context of the Critical Incident Analysis Meeting. While the business of risk management, insofar as it relates to making decisions as to how to proceed with lawsuits that might generate financial liability, inherently involves people with different perspectives commonly exercising good judgment, the Department and the Risk Management Bureau should take great pains to ensure a reasonable uniformity process for determining who reviews what cases when.

We focus on lawsuits rather than on claims for multiple, related reasons. First, only a small fraction of the Department's overall financial liability stems from money paid in claims. For instance, in the most recent, 2006-2007 fiscal year, money paid in claims constituted just 1.9 percent of the Department's total liability. Second, liability that is addressed via litigation, rather than through a claims process, almost always involves at least the assertion, whether or not they lead to ultimate payment or settlement at all, of more serious accusations. Finally, and given the often more serious nature of the facts and situations at issue within lawsuits, a lawsuit is more likely to result in a significant liability, whether in the form of a sizeable settlement or award, for the Department than a claim, by its basic nature, could.

49 Lawsuits are also reviewed through a County Counsel Roundtable while they are pending. Such meetings involve representatives of the Risk Management Bureau, County Counsel's office, and the County's Chief Executive Office and attempt to keep all major players current as to the status of ongoing litigation.

We do note briefly, however, that the trends in claims (excluding lawsuits) against the Department are encouraging. The number of new claims (848) against the Department in 2006-2007 is down compared to the number six years prior, in 2001-2002 (or 1,077)—though the number of new claims has gone both up and down over the past several years. Also heartening is a steady decrease in money that the Department paid out in claims since the 2003-2004 fiscal year. The total paid for claims against the Department in 2006-2007 ($209,214.14) was, in fact, less than one-third what it paid in 2003-2004 ($692,709.46). Still, because such sums constitute such a small percentage of the Department's total liability, we do not consider the claims process further at present.

II. Aggregate Trends in Litigation

The trends in liability generated from litigation since the start of the 2001-2002 fiscal year are mixed. The overall amount paid out in settlements and judgments is, in both comparisons of single years and clusters of years, somewhat higher recently. The average amount that the Department pays per closed lawsuit is, similarly, higher recently. Nonetheless, the number of new lawsuits filed against the Department is down, and the numbers for a significant sub-class of litigation—those relating to excessive or improper use of force—have been pointing in a positive direction in recent years.

A. Overall Amount Paid in Settlements and Judgments

The LASD's liability from litigation increased slightly, from nearly $10.6 million in 2001-2002 to $10.8 million in 2006-2007.[50] (See Table 1). Also, the

50 As the Civil Litigation Unit has observed, direct comparison between 2001-2002 and 2006-2007 may not be the most useful or accurate for judging overall trends, as such a comparison does not take into account basic inflation nor the general expansion of the LASD in terms of overall budget, enterprise, and potential for liability given such expanded activity.

amounts paid in settlements and judgments in the years since 2001-2002 have fluctuated significantly. The Department enjoyed a significant reduction in litigation-related liability in 2003-2004 and 2004-2005, with approximately $5.5 million paid out in each of those years. Nonetheless, liability spiked significantly in 2005-2006, to $15.1 million, and remained higher in 2006-2007, at $10.8 million.

Table 1 **Overall Litigation Trends**

	Number of New Lawsuits	Closed Lawsuits	$ Paid in Settlements/Judgments	Average Paid per Closed Lawsuit
2006-2007	208	233	$10,818,987.07	$46,433.42
2005-2006	224	220	$15,115,445.85	$68,706.57
2004-2005	261	247	$5,428,663.72	$21,978.40
Three-Year Average (2004-2005 through 2006-2007)	**231**	**233.33**	**$10,454,365.55**	**$44,804.42**
2003-2004	236	307	$5,698,351.97	$18,561.41
2002-2003	325	328	$13,428,424.35	$40,940.32
2001-2002	282	265	$10,592,543.27	$39,971.86
Three-Year Average (2001-2002 through 2003-2004)	**281**	**300**	**$9,906,439.86**	**$33,021.47**

Individual deviations from year to year, and rudimentary comparisons between given years, may be deceptive, however, as a given year's overall totals in the amount paid in judgments or settlements might be artificially high as the result of more isolated, "outlier," or high-impact cases that may not represent the Department's broader risk management capabilities undertaken or in effect during that year.[51] Accordingly, we compared the most

51 For instance, in the fiscal year 2000-2001, which we do not consider as part of the data set that forms the foundation for the present report, the overall amount paid in settlements and judgments was nearly $19 million; $13 million of that liability stemmed from a single lawsuit that originated from 1984. The significant magnitude of the Department's financial liability related to litigation in that fiscal year certainly does not necessarily relate directly, then, to the Department's management of risk in that year.

recent three-year period (fiscal year 2004-2005 through 2006-2007) with the prior three-year period (fiscal year 2001-2002 through 2003-2004). Such aggregated time periods, because they reflect a larger number and array of cases, may reflect broader trends better to the extent that the effects of a statistical outlier—a big-ticket settlement—may be situated in a broader context.

For the most recent three-year period, the Department's total litigation-related liability averaged about $10.5 million per year. For the earlier three-year period, the total average payout per year was $9.9 million. The level of the Department's overall, litigation-related liability has, therefore, increased slightly recently.

B. Amount Paid per Closed Lawsuit

The average amount that the Department pays out per lawsuit that it closes—by settlement or verdict at trial—has also increased in recent years. Analysis of average amounts paid per closed case takes into consideration factors overlooked by a simple comparison of total amounts paid over given fiscal years to the extent that the averages take into account those lawsuits that were dismissed, in which the Department's liability was nothing, as well as those that were settled for relatively small amounts, which can provide a more realistic statistical context for otherwise potentially distorting higher or lower settlement or verdicts.[52] [53]

The average amount paid per closed lawsuit at $46,433.42 was higher in 2006-2007 than it was six years earlier at $39,971.86 per closed lawsuit, in 2001-2002. The Department did manage to get its average per closed lawsuit

52 For instance, in a lawsuit that the Department settled in the 2006-2007 fiscal year, in which the plaintiff alleged being involved in a traffic collision with a deputy sheriff, the settlement totaled $3.96.

53 The simple consideration of the amount paid per closed lawsuit does not take into account the effects of the reduction in the number, or volume, of lawsuits that we detail in Section C, below. For simplicity of analysis, we do not endeavor the more complicated statistical analysis necessary to control for deviations in overall litigation activity over the years compared. Still, the amount paid per lawsuit does partially, though not entirely, help mitigate against the effects of statistically outlying, or abnormally large or small, litigation outcomes.

down to $18,461.41 in the 2003-2004 fiscal year. That both the average amount per closed lawsuit, and the total amount paid across all lawsuits, have been higher in the last two fiscal years (2005-2006 and 2006-2007) than in the two before them (2003-2004 and 2004-2005) is somewhat concerning.

A broader comparison of the most recent three-year period to the similar preceding period also indicates that the average amount paid per closed lawsuit has been higher recently. The average amount that the Department paid out for the 700 cases closed in the three years between 2004-2005 and 2006-2007 was $44,804.42. The average amount paid out for the 900 cases closed between 2001-2002 and 2003-2004 was $33,021.47.

C. Number of New Lawsuits

A good deal of a law enforcement agency's success in risk management may be said to reside in the number of lawsuits not filed—those instances in which policies, protocols, and training have eliminated what otherwise would be a high risk of exposure. Accordingly, the number of new lawsuits filed going down would suggest that the law enforcement agency is making strides in mitigating its exposure to liability.

With small variations, the number of new lawsuits filed against the LASD has gone down since 2001-2002. In that year, 282 lawsuits were filed against the Department; in 2006-2007, 208 lawsuits were filed. More importantly, in the past three years (fiscal year 2004-2005 through 2006-2007), the Department averaged about 231 new lawsuits per year, which constitutes a nearly 18 percent drop in the number of new lawsuits from the previous three-year period (fiscal years 2001-2002 through 2003-2004, in which there were an average of 281 new lawsuits per year). This drop in the number of new lawsuits generated each year strongly suggests that the Department's risk management strategies are making a difference, the magnitude of which is hard to determine from the facts at hand. A more precise analysis would attempt to correlate

the reduction in lawsuits to other possible causes, including the crime rate, the number of arrests, the number of contacts by deputies with the public, the frequency of in-service training, and the like—an analysis we did not have the resources to perform.

D. Force-Related Litigation

One area of litigation that has historically generated significant liability for the Department is force-related litigation. Such litigation can generate high costs, large settlements, and significant publicity, and it has, consequently, been a consistent concern since the **Kolts Report** some sixteen years ago. We have highlighted the Department's force-related liability in numerous Semiannual Reports since. Recognizing the importance of such litigation to its liability exposure, the Department's Civil Litigation Unit includes a separate, specific summary of force-related litigation in its reports.

The number of new force-related lawsuits appears to have been trending down. There were 78 new force-related lawsuits in 2001-2002 and 66 in 2006-2007. (See Table 2). In the intervening time, the numbers have moved both up and down. A comparison of three-year averages, however, reveals that, generally, the number of new force-related lawsuits has trended down, with the Department seeing an average of 62 new force-related lawsuits per year in the most recent three-year period as compared to approximately 68 in the preceding three-year period—a nine percent decline.

Significantly, the number of force cases requiring an ultimate payout by the County also appears to have gone down. While, again, the overall numbers of cases requiring payment have fluctuated over the past years, the Department lost or settled an average of nearly 23 cases per year for the most recent three-year period as compared to about 30 per year for the similar preceding period.

More importantly, the percentage of force cases that the County closes, whether by dismissal, verdict, or settlement, that require at least some payout to the plaintiff, appears to be trending down. The average percentage of cases that required payment, due to settlement or verdict against the Department, was about 35 percent in the three-year period from fiscal year 2004-2005 through 2006-2007, as compared to the nearly 44 percent of cases that required payout in the preceding three-year period from 2001-2002 through 2003-2004. Further, the percentage of cases requiring payout are down significantly from the early part of the decade, when nearly half of closed cases involving force, in both 2001-2002 and 2002-2003, resolved in a manner that required payment. Since 2002-2003, the percentage of force-related litigation that ultimately required the County to pay has not risen above 39 percent of closed cases.

Part of the decline may be attributable to a more aggressive litigation strategy. More cases have gone to trial and the County has prevailed in a greater percentage of them.[54] The County has averaged about 8 verdicts in its favor per year in the most three-year period compared to approximately 5 per year for the prior three-year period. In the context of closed cases overall, about 5 percent more cases were closed with the County prevailing at trial during the most recent three-year period than the preceding such period.

The Department's overall financial liability stemming from this lower level of force-related litigation has been trending down. (See Table 2). Although the Department paid out more than $3.7 million in settlements and verdicts in force-related lawsuits in the 2006-2007 fiscal year, which is the highest amount in raw dollars since the 2002-2003 fiscal year, the Department has paid much less in litigation involving claims of excessive force over the past

54 The Department taking more cases to trial and prevailing could also suggest that the procedures related to documentation and investigation of use of force, and the existence or intervention of the Office of Independent Review ("OIR"), have provided sounder factual foundations from which to give input on whether to try or settle a case.

Table 2 **Force-Related Litigation Trends**

	New Cases	Closed Cases	Won/ Dismissed	Lost/ Settlement	Percent of cases requiring payout
2006-2007	66	65	41	24	36.92%
2005-2006	51	67	41	26	38.81%
2004-2005	69	59	41	18	30.51%
Three-Year Average (2004-2005 through 2006-2007)	**62.00**	**63.67**	**41.00**	**22.67**	**35.41%**
2003-2004	57	81	55	26	32.10%
2002-2003	68	83	42	41	49.40%
2001-2002	78	48	24	24	50.00%
Three-Year Average (2001-2002 through 2003-2004)	**67.67**	**70.67**	**40.33**	**30.33**	**43.83%**

	Number of Verdicts Won (at trial)	Percent of Closed Cases with Verdict	Total Paid in Force-Related Litigation (in Judgments and Settlements)	Percentage of Overall Liability Stemming From Force-Related Litigation
2006-2007	7	10.77%	$3,739,500.00	34.56%
2005-2006	6	8.96%	$2,443,821.00	16.17%
2004-2005	10	16.95%	$1,623,680.00	29.91%
Three-Year Average (2004-2005 through 2006-2007)	**7.67**	**12.22%**	**$2,602,333.67**	**26.88%**
2003-2004	8	9.88%	$1,893,300.00	33.23%
2002-2003	5	6.02%	$3,687,500.00	27.46%
2001-2002	3	6.25%	$7,015,435.00	66.23%
Three-Year Average (2001-2002 through 2003-2004)	**5.33**	**7.38%**	**$4,198,745.00**	**42.31%**

three years than in the similar, previous time period.[55] For the most recent three-year period, the Department paid out an average of $2.6 million per year in force-related lawsuits; for the previous three-year period, the Department paid an average of nearly $4.2 million. That Decrease amounts to a drop of some 38 percent.

Force-related litigation comprises less of the Department's total liability than it once did. Although 2006-2007 saw force-related litigation representing a larger portion of the Department's liability, or about 35 percent of overall liability, than it had in the previous fiscal year, where force-related liability was 16 percent of total liability, the levels were still down significantly from 2001-2002, when force-related litigation constituted a full 66 percent of the Department's total liability. The associated three-year averages show force-related lawsuits to be making up for less of the Department's overall liability, with such lawsuits on average representing nearly 27 percent of liability in the three most recent fiscal years compared to over 42 percent in the previous three-year period.

In sum, that new force-related lawsuits are trending down and the number of such lawsuits requiring payout is also trending down suggests that, in the area of force, the Department has made strides in managing its risk. A more sophisticated analysis would attempt to correlate the reduction in force lawsuits to other possible causes, including the crime rate, the number of arrests, the number of contacts, use of force to arrest ratios, the increased reliance on new force instrumentalities, etc.—an analysis we did not have the resources to perform at this time.

55 The Department has noted that the $3.7 million cited here includes, by their estimation, $2.8 million related to sexual misconduct cases. We concur that such cases should not automatically be considered to be force-related. Our criteria for inclusion in the category of force-related, however, is the Department's own, with all such cases reflecting some allegation of "excessive force" within the Personnel Performance Index (PPI) database system. In its Civil Litigation Summaries, generally published quarterly with an annual review of the most recent fiscal year, the Department does appear to include many sexual misconduct cases as "force-related," as our data obtained from the PPI closely follow the data previously presented in these reports. In the absence of comprehensive qualitative consideration of all force-related litigation over the past six years, our analysis defaults to the Department's categorization. We recommend that the Department change its classification or coding criteria, for purposes of the PPI, if it believes that a class of cases involving sexual assault should not necessarily be coded within the system as also involving "excessive force."

III. Litigation in the 2006-2007 Fiscal Year

For the most recent fiscal year, from July 1, 2006, through June 30, 2007, the total amount paid in settlements and judgments was a little more than $10.8 million over the 233 total lawsuits that were closed—or resolved via verdict, settlement, or discontinuation of legal action—during the fiscal year. The County paid at least some amount in 69, or about 30 percent, of those closed lawsuits. Of the 69 closed lawsuits in which there was a payout, 62 were settled and seven closed as a result of a judgment for the plaintiff.

In 52 of the closed lawsuits, the County paid less than $100,000; in the remainder, or 17 cases, it paid more than $100,000. The average award was $160,999.80, with payouts ranging from $3.96 at the least to $2.8 million at the most.

In the 17 lawsuits that closed for amounts over $100,000, six involved in-custody injury or death. Four involved auto liability, three involved excessive force against individuals not in custody, three involved sexual assault, and one involved harassment. Accordingly, in-custody injury or death contributed, across categories, to the largest number of the cases that closed for the highest sums. The Department does not, however, currently classify, either in its publications or within the Personnel Performance Index ("PPI"), deaths or injury that occur to an individual in its custody as such. As we indicate below, we strongly recommend that it add this extra detail for a more accurate representation of where the Department's liability risk ultimately resides.

The six cases settled for more than $100,000 that involved in-custody injury or death alone accounted for $5.635 million, or more than half (51 percent) of the Department's total civil liability across all lawsuits for the 2006-2007 fiscal year. By comparison, the four cases settled for more than $100,000 involving auto liability cost the Department $736,596.64 (or 7 percent of the Department's total liability), the three cases involving excessive force against parties not in custody cost $375,000 (3 percent of total liability), the three

sexual assault cases cost $2.8 million (one-quarter of total liability), and the harassment lawsuit $325,000 (3 percent of total liability).

In-custody injury and death accounted, then, for an undeniably significant portion of the Department's civil liability in the 2006-2007 fiscal year. While the statistics cited here account for those cases that ended during the 2006-2007 fiscal year, they involved litigation commenced in 1999, 2003, 2004, 2005, and 2006. Lawsuits relating to in-custody injury and death that have resulted in significant payments to plaintiffs are not a relic of the past but rather point to an ongoing and continuing source of liability.

In-custody Death and Injury Settlements in 2006-2007

We examined the six cases involving in-custody injury and death that closed in 2006-2007, all of which resolved via settlement. In four cases, we reviewed memos from Los Angeles County Counsel to the County Claims Board seeking authority to settle each case. Such memoranda summarize the factual record and offer County Counsel's evaluation of the case and settlement recommendation. In two cases, this sort of documentation was not available to us, as memoranda referencing the case are deemed attorney-client communications from County Counsel directly to the Board of Supervisors.

1. In April 1998, Long Beach Police arrested a man on an outstanding warrant for failing to complete court-ordered counseling pursuant to a previous criminal matter. The man was placed in LASD custody at the North County Correctional Facility.

   In November 1998, the man was discovered dead in his cell. A subsequent autopsy, homicide investigation, and Inmate Death Review all determined that the man died from a ruptured aneurysm. The man's family hired a forensic pathologist who indicated that he located a "micro-fracture of the neck, caused by blunt force trauma, that preceded and

caused the ruptured aneurysm." Two experts hired by the County squarely disagreed with him.

The man's 12-year-old nephew and 13-year-old niece testified later at deposition that "after a visit with their uncle on the day of his death, they saw him being hit and choked by a Sheriff's Deputy," though such information "was never reported to the homicide investigators."

County Counsel concluded the case to be "of questionable liability" considering that the county's "experts are definite" that the man did not suffer a fracture of the neck and the "suspect" testimony of the man's niece and nephew. Still, noting that a jury might believe "the expert testimony form the plaintiff's pathologist" and conclude that the man "died at the hands of another," the memo recommends a settlement of $110,000, which is the amount for which the county ultimately settled.

2. A 71-year-old man with a "long history of heart disease" and "in a wheelchair," who brought several medications with him, was placed in LASD custody in March of 2002.

   Two and a half weeks after coming into LASD custody, on March 28, 2002 at 8:20 A.M., the man "was found on the floor of his cell." He complained to LASD personnel that he was experiencing shortness of breath. Later in the day, "the personnel noted that [the man] was having a crackling sound in his lungs and that his urine had become dark."

   The personnel did not "transfer the inmate" to the Los Angeles County USC Medical Center, or LAC+USC, for medical treatment.

   Later that night, at 10:10 P.M., the man "was again found on the floor of his cell," where, "by 11:52 P.M., the inmate was suffering from shortness of breath and low blood pressure." On this occasion, "medical treatment

was administered and an order was placed to transfer the inmate to LAC+USC" for medical treatment. An ambulance arrived at 12:25 A.M. The man was transported at 12:40 A.M. The man arrived at the medical facility at approximately 1:00 A.M. The man "was pronounced dead" later that day, at 2:56 P.M.

Because of the failure to respond appropriately to the inmate's medical emergency, the Claims Board approved a $475,000 settlement.

3. On September 21, 2003, a 62-year-old man was arrested for assault with a deadly weapon and spousal abuse. The man was under the custody of the LASD within the Inmate Reception Center.

   On the morning of September 24, 2003, LASD nursing personnel examined the man. During the examination, the man "was unable to state his name and age," and nursing personnel "noted that Mr. Wilson was suffering from… hypertension." The nursing personnel recommended that the man "undergo a more thorough medical evaluation." Later on the same afternoon, a mental health nurse examined the man, observing him to be "anxious, confused, and suffer[ing] from poor judgment and delayed speech." "Despite the fact that [the man] was scheduled to undergo a more thorough medical evaluation," the man "was discharged from IRC" without such examination. On the next day, September 25, medical personnel "realized that [the man] had not been seen by a physician as planned." While nursing staff "placed an order for the inmate to be examined," they "failed to contact the inmate's housing unit" to ensure that the order was carried out.

   The man's wife visited him at the jail on October 10, 2003, and she represents that "she saw her husband grab his chest and double over." She claims that "one of the Deputies…assured her" that her husband "would be seen at the clinic." He was not.

On October 14, 2003, the man experienced pains in the chest. By the time that medical personnel arrived, the man was "lying on the floor." Paramedics were called, and they continued attempts to resuscitate the man begun by personnel as they transported him to the Los Angeles County USC Medical Center. The man died in transport.

An autopsy revealed the cause of death to be blood clots in the lungs attributable to deep vein thrombosis, or the amalgamation of blood clots in deep blood vessels in the legs. In her lawsuit, the man's wife claimed that, had LASD medical personnel more carefully and thoroughly examined the man, as their own orders revealed that they should have, "his serious medical conditions would have been diagnosed and he would have been placed under the appropriate medical care, which would have prevented the condition which led to his death."

Given that a jury might return with a verdict for the plaintiff, finding that medical staff were deliberately indifferent to the man's care, the County approved a settlement of $700,000.

4. A man sentenced to 180 days at the Pitchess Detention Center was "assaulted by four inmates" on May 24, 2004. "The assailants were angry at [the man] because he had taken the personal property" of one of the men. The attackers "took [the man] to an area" of the dormitory facility "where they knew it would be difficult for Deputies to monitor their activities."

   When the incident occurred, the Deputy assigned to the Dormitory Control Office had left, believing that a replacement Deputy was on his way to take the assigned Deputy's place. He was not, which left the "post…vacant for approximately 20 minutes."

   An inmate alerted another Deputy to the disturbance. When the Deputy

responded, the man was found unconscious. The man sustained "significant neurological damage" resulting from head injuries suffered during the attack. He reported to also suffer from "blurred vision, slurred speech, impaired balance, and impaired judgment" prior to the attack, though county experts were prepared to "refute the extent of [the man's] injuries" in court.

Given that the incident occurred when the assigned Deputy had left the post unattended, the County approved a settlement of $750,000.

5. A 41-year-old man accused of child molestation was placed in a dormitory at Men's Central Jail in December 2003 despite jail personnel issuing a special order for the man to be held separate from the general population. The man was assaulted by a group of prisoners when they learned of the nature of the allegations against him, and he suffered extensive injuries that require lifelong care.

   The Board of Supervisors voted unanimously to settle the man's lawsuit for $2.8 million, which was the most sizeable settlement that the Board has approved for a case involving in-custody injury.

6. A man was placed in a locked room with 29 high-risk inmates at Men's Central Jail. Two inmates attacked the man, knocking him to the ground, stomping on his head, neck, and chest, and beating him with metal food trays.

   The case was settled for $800,000.

It is troubling that six large settlements that stem from in-custody injury and death constituted a majority of the Department's liability in 2006-2007. The events that precipitated such lawsuits occurred in an environment designed to give the Department, and its officers, maximum control over the

individuals occupying or housed within it. Unlike the largely uncontrollable environment in the "field" or "the real world," the Department and its employees exert far more direct control of variables when an individual is under and within its custody.

To manage its risk effectively in the future, the Department must recognize the significant, fundamental, and distinctive exposure that it encounters by virtue of taking and holding people in custody for extended periods of time. The first step in doing so is for the Department to give a supplemental designation of "in-custody" litigation to, lawsuits or claims stemming from incidents that occurred when an individual was in custody. Under current practice, the six cases outlined above are classified in the Risk Management Bureau's most recent "Civil Litigation Summary" for the fiscal year 2006-2007 under at least two categories: "wrongful death" and "failure to protect an inmate." Both categories are appropriate. An additional classification for "in custody death or injury" will bring more focused attention on the particular circumstances causing liability in the jail context.

IV. Conclusion

We applaud the Department and the Risk Management Bureau for the recent and relatively stable decreases in new lawsuits brought against the Department. We commend Lt. Shaun Mathers for his excellent leadership. We applaud the Department for encouraging recent trends in force-related litigation and urge the Department to ensure that these trends continue. These decreases in new and force-related lawsuits have not yet translated into enduring decreases in the overall amount paid out per year in settlements and judgments, and this should be some grounds for concern. We are, however, confident that unrelenting high-quality investigation, active risk management, and fair and decisive personnel decisions will benefit the Department financially and otherwise.

Table A **Total LASD Shootings**

	2002			2003			2004		
	On Duty	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*
Hit [1]	22	0	22	24	1	25	36	1	37
Non-Hit [2]	16	0	16	20	1	21	19	1	20
Accidental Discharge [3]	12	1	13	12	2	14	8	3	11
Animal [4]	35	5	40	35	3	38	28	1	29
Warning Shots [5]	0	0	0	0	0	0	1	0	1
Other Shooting Incidents [6]	1	0	1	0	0	0	0	0	0
Total	**86**	**6**	**92**	**91**	**7**	**98**	**92**	**6**	**98**

	2005			2006 [7]			2007		
	On Duty	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*	*On Duty*	*Off Duty*	*Total*
Hit [1]	28	0	28	26	2	28	18	1	19
Non-Hit [2]	18	2	20	18	2	20	21	0	21
Accidental Discharge [3]	1	1	2	3	2	5	3	3	6
Animal [4]	34	0	34	29	1	30	49	1	50
Warning Shots [5]	1	1	2	0	0	0	0	0	0
Other Shooting Incidents [6]	0	0	0	0	0	0	0	1	1
Total	**82**	**4**	**86**	**76**	**7**	**83**	**91**	**6**	**97**

1 **Hit Shooting Incident:** An event consisting of one instance or related instances of shots (excluding stunbags) fired by a deputy(s) in which one or more deputies intentionally fire at and hit one or more people (including bystanders).

2 **Non-Hit Shooting Incident:** An event consisting of one instance or related instances of shots (excluding stunbags) fired by a deputy(s) in which one or more deputies intentionally fire at a person(s), but hit no one.

3 **Accidental Discharge Incident:** An event in which a single deputy discharges a round accidentally, including instances in which someone is hit by the round. Note: If two deputies accidentally discharge rounds, each is considered a separate accidental discharge incident.

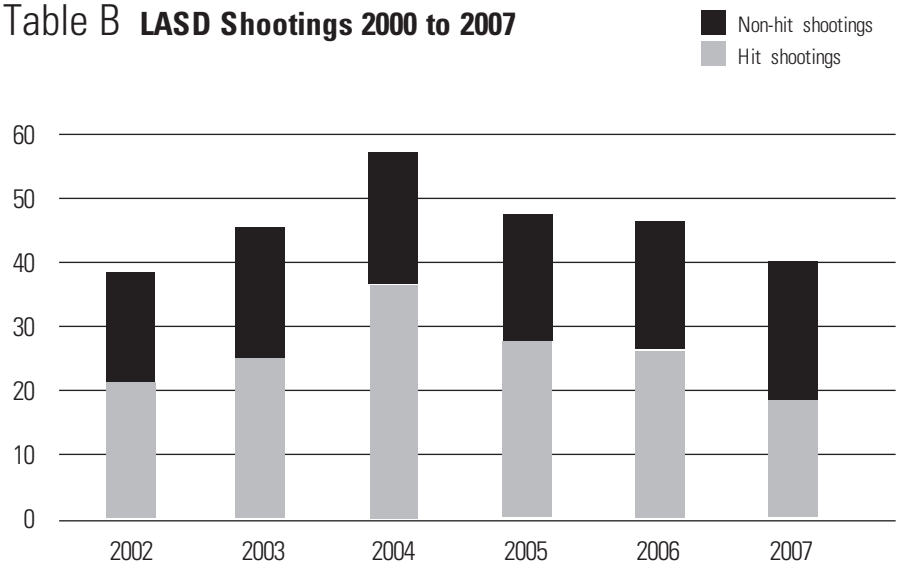
4 **Animal Shooting Incident:** An event in which a deputy(s) intentionally fires at an animal to protect himself/herself or the public or for humanitarian reasons, including instances in which a person is hit by the round.

5 **Warning Shot Incident:** An event consisting of an instance of a deputy(s) intentionally firing a warning shot(s), including instances in which someone is hit by the round. Note: If a deputy fires a warning shot and then decides to fire at a person, the incident is classified as either a hit or non-hit shooting incident.

6 **Other Shooting Incident:** An event consisting of an instance or related instances of a deputy(s) intentionally firing a firearm but not at a person, excluding warning shots (e.g., car tire, street light, etc.). Note: If a deputy fires at an object and then decides to fire at a person, the incident is classified as either a hit or non-hit shooting incident.

7 **Revised.** One on-duty shooting was reclassified from "accidental discharge" to "hit shooting" by the Executive Force Review Committee.

Table B **LASD Shootings 2000 to 2007**



Source: Internal Affairs Bureau

Table C **LASD Hit Shootings by Unit**

	2002	2003	2004	2005	2006[g]	2007
Number Of Incidents	**22**	**25**	**37**	**28**	**27**	**19**
Altadena Station	0	0	0	0	0	0
Carson Station	2	0	1[b]	1	1	1
Century Station	5	2[b]	10[e]	5[b]	3	5
Cerritos Station	0	0	0	0	1	0
Community Colleges Bureau	NA	NA	NA	1	0	0
COPS Bureau	NA	NA	NA	NA	1	3
Compton Station	0	6[c]	6[e]	2	3	2
Court Services Bureau	0	0	0	0	1	0
Crescenta Valley Station	NA	NA	0	0	0	0
East Los Angeles Station	0	0	0	2	2	1
Industry Station	1	1	1	1	2	0
Lakewood Station	1	1	4	1	2	1
Lancaster Station	1	0	1	1	0	1
Lennox Station	2	0	6	1	1	2
Lomita Station	0	0	0	0	0	1
Lost Hills/Malibu	0	1	0	0	0	0
Major Crimes Bureau	0	2	0	0	0	0
Marina Del Rey Station	NA	NA	1	0	0	0
Men's Central Jail	NA	1[d]	0	0	0	0
Mira Loma Facility	0	0	0	0	0	0
Miscellaneous Units	0	0	0	0	0	0
Narcotics Bureau	0	1[b]	0	0	0	1
North County Correctional Facility	0	0	0	0	1[bd]	0
Norwalk Station	1	1	2	0	1	0
Operations Bureau	NA	NA	1[e]	0	0	0
Operation Safe Streets[a]	1	4[c]	3[e]	3	1[b]	1
Palmdale Station	3	0	0	2	3	0
Pico Rivera Station	1	1	1	1	0	0
San Dimas Station	1	0	0	0	0	0
Santa Clarita Valley Station	0	0	2	1	1	0
Special Enforcement Bureau	0	3	0	2[f]	2	0
Temple Station	1	1	0	2	1	0
Transit Services Bureau	0	1[c]	1	1[b]	1[d]	0
Walnut Station	0	0	0	0	0	0
West Hollywood Station	0	0	0	1	0	0
Number of Suspects Wounded	11	12	12	16	18	14
Number of Suspects Killed	11	16	27	12	11	5

a. Formerly Safe Streets Bureau.
b. Includes one incident in which more than one person was shot.
c. One shooting (7/8/03) involved three units (Safe Streets Bureau, Compton Station, and Transit Services Bureau).
d. Off duty shooting.
e. One shooting (1/5/04) involved four units (Century, Compton, Operation Safe Streets and Operations) and resulted in the deaths of two suspects.
f. Both shootings occurred while assisting outside agencies (2/8/05 Downey Police Department; 6/7/05 California Highway Patrol).
g. Revised. One on-duty shooting was reclassified from "accidental discharge" to "hit shooting" by the Executive Force Review Committee.

Source: Internal Affairs Bureau

Table D **LASD Non-Hit Shootings by Unit**

	2002	2003	2004	2005[d]	2006	2007
Number Of Incidents	**16**	**21**	**20**	**20**	**20**	**21**
Carson Station	1	0	1[b]	1	0	0
Century Station	3	4	5[b]	3	3	5
Century/Compton Transit Services	0	0	0	0	0	0
Cerritos	1	0	0	0	0	0
COPS Bureau	NA	NA	NA	NA	1	1
Compton	2	4	3	3	1	0
Crescenta Valley Station	NA	NA	1	0	0	0
East Los Angeles Station	1	2	0	2	0	2
Gang Murder Task Force	NA	NA	NA	2	1	0
Homicide Bureau	NA	NA	NA	1	0	0
Industry Station	2	2	0	1	0	0
Lakewood Station	0	1	0	0	0	0
Lancaster Station	1	1	1	0	2	2
Lennox Station	1	2	1	2	3	2
Lost Hills Station	NA	NA	1	1	0	0
Marina del Rey	0	0	0	0	0	0
Men's Central Jail	0	1[a]	0	0	1[a]	0
Narcotics Bureau	0	0	0	0	1	0
Norwalk Station	2	1	0	0	0	3
North County Correctional Facility	0	0	0	0	1[a]	0
Operation Safe Streets[c]	0	1	3	4	4	4
Palmdale Station	0	1	0	0	0	0
Pico Rivera	0	0	0	0	2	0
San Dimas Station	0	0	0	0	0	1
Santa Clarita Valley Station	0	0	1	0	0	0
Special Enforcement Bureau	0	0	1	0	0	0
Temple Station	1	0	0	0	0	1
Transit Services Bureau	NA	NA	2	0	0	0
Twin Towers	0	0	1[a]	0	0	0
Walnut Station	0	1	0	0	0	0

a. Off-duty shooting.
b. One shooting (2/6/04) involved two units (Carson and Century).

Incidents Resulting in Force/Shooting Roll-Out	2001	2002	2003	2004	2005	2006	2007
	87	**92**	**89**	**115**	**93**	**82**	**83**

Source: Internal Affairs Bureau

Table E **LASD Force**

Department Wide*	**2002**	**2003**	**2004**	**2005**	**2006**	**2007** **
Force Incidents (Total)	2399	2645	2643	2772	2944	2875
Total Force/100 Arrests	2.60	2.81	2.69	2.58	2.52	2.29
Significant Force: Hospitalization/Death/100 Arrests	0.02	0.01	0.01	0.02	0.01	0.01
Significant Force: Visible Injury/100 Arrests	0.63	0.68	0.78	0.76	0.73	0.73
Significant Force: Complaint of Pain/100 Arrests	0.37	0.38	0.42	0.43	0.37	0.33
Significant Force: Other/100 Arrests	0.42	0.40	0.28	0.28	0.24	0.24
Less Significant Force Incidents/100 Arrests	1.16	1.34	1.19	1.09	1.17	0.97
OC Spray/100 Arrests	0.41	0.46	0.71	0.65	0.70	0.56

Field Operation Regions (FOR)	**2002**	**2003**	**2004**	**2005**	**2006**	**2007** **
Region I Force Incidents	401	406	496	527	559	598
Per 100 Arrests	1.40	1.40	1.44	1.31	1.36	1.22
Region II Force Incidents	568	589	634	638	581	570
Per 100 Arrests	1.96	2.1	2.35	2.23	2.00	1.69
Region III Force Incidents	271	356	354	362	323	346
Per 100 Arrests	0.96	1.17	1.16	1.19	1.05	1.03
Office of Homeland Security (OHS) Force Incidents	NA	NA	NA	NA	NA	129
Per 100 Arrests	NA	NA	NA	NA	NA	2.23
FOR and OHS Total Force Incidents	1240	1351	1484	1527	1555	1643
Per 100 Arrests	1.45	1.55	1.61	1.54	1.46	1.34

Field Operation Regions (FOR)	**2002**	**2003**	**2004**	**2005**	**2006**	**2007** **
Regions I, II & III and OHS Significant Force Incidents,	700	699	782	850	826	978
Per 100 Arrests	0.82	0.80	0.85	0.86	0.77	0.80

* Includes all patrol stations and specialized units, including custody and court services.

** CAASS Arrest Data.

Source: Management Information Services

Table F **LASD Force/100 Arrests All Patrol Stations**

Station	2002	2003	2004	2005	2006	2007 **
Altadena	1.87	1.68	1.31	1.89	1.47	1.21
Crescenta Valley	0.53	1.40	1.15	2.03	1.67	1.71
East LA	1.38	1.11	1.14	1.46	1.27	1.35
Lancaster	1.39	1.63	1.54	1.34	1.28	1.03
Lost Hills/Malibu	0.67	1.11	1.21	1.36	1.94	1.17
Palmdale	1.81	1.85	1.37	0.77	1.24	1.07
Santa Clarita	1.42	1.55	1.95	1.96	1.49	1.64
Temple	1.28	0.79	1.39	1.40	1.39	1.36
Region I Totals	**1.40**	**1.40**	**1.44**	**1.31**	**1.36**	**1.22**
Avalon	1.43	2.04	2.49	3.26	6.04	1.49
Carson	1.44	1.56	1.77	1.80	1.86	1.55
Century	2.29	2.16	3.18	1.98	2.06	1.44
Community College	NA	7.14	7.03	7.27	14.29	9.32
Compton	2.59	3.04	1.86	1.85	1.97	1.46
Lomita	2.32	0.87	1.17	0.66	1.29	0.86
Lennox	1.41	1.80	1.24	1.89	1.73	1.84
Marina del Rey	2.17	2.12	1.29	1.23	1.24	1.25
Transit Services Bureau*	1.71	2.06	4.53	1.79	NA	NA
West Hollywood	2.29	2.29	2.71	2.41	2.43	2.04
Region II Totals	**1.96**	**2.10**	**2.35**	**2.23**	**2.00**	**1.69**
Cerritos	1.65	1.16	1.73	1.24	1.29	1.10
Industry	0.71	1.06	0.97	0.84	0.72	0.74
Lakewood	1.39	1.61	1.41	1.38	1.24	1.18
Norwalk	0.90	1.20	1.26	1.45	1.23	1.41
Pico Rivera	0.67	0.81	0.95	1.07	0.79	0.73
San Dimas	0.83	1.13	0.62	0.66	0.65	0.97
Walnut	1.03	0.80	0.87	1.15	1.66	1.13
Region III Totals	**0.96**	**1.17**	**1.16**	**1.19**	**0.05**	**1.03**
Transit Services Bureau*	NA	NA	NA	NA	1.64	0.9
Metro-link Bureau	NA	NA	NA	NA	1.28	0.41
Office of Homeland Security Totals	**NA**	**NA**	**NA**	**NA**	**1.62**	**2.23**

* In 2006, Transit Services Bureau was moved from Region II to the Office of Homeland Security.

**CAASS Arrest Data

Source: Management Information Services