County of Sacramento
Office of Inspector General

2008 Annual Report

Safeguarding the Public Trust
~ Integrity, Accountability, Transparency ~

County of Sacramento Office of Inspector General

~ Calendar Year 2008 Annual Report ~

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Executive Summary

Following an external audit of the Sacramento Sheriff's Department (SSD), the Office of Inspector General was commissioned by the Board of Supervisors in October of 2007. The Inspector General has broad oversight of the SSD internal disciplinary process and discretionary powers including evaluation of the overall quality of law enforcement, custodial, and security services and the authority to encourage systemic change.

Sacramento County's first Inspector General, Mr. Lee Dean, entered public service as a Los Angeles Police Officer after serving in the United States Army. His career path led to the Sacramento Sheriff's Department (SSD) and promotion through the ranks to Chief Deputy. He then served as Chief of Police in the central and southern California cities of Vacaville and San Bernardino, working closely with civic and community groups to reduce crime and improve the quality of life. Mr. Dean has lectured and taught extensively, combining practical experience with the study of community policing, leadership, internal investigations, and organizational development. He is a member of the State Bar of California and a graduate of the Dale Carnegie Institute.

Outside oversight is an emerging concept for members of the Sheriff's Department. Thus, the approach has been to examine areas which align with essential service. The citizen complaint process and jail operations represent two such areas which will remain the subject of ongoing evaluation. During calendar year 2008 the Office of Inspector General (OIG):

- Opened its public office at 520 9th Street Suite 205, Sacramento, California;
- Created a web-site located on the Sacramento County Public Safety page;
- Met with community groups, special interest representatives, and individuals to gain insight, screen complaints, and field inquiries;
- Finalized *Operational Guidelines*;
- Responded to and/or monitored a number of critical events;
- Networked data collection with the Sheriff's Department, County Risk Management, and Office of Information Technology;
- Processed a total of 23 complaints and inquiries from the public;
- Conducted audits of the SSD Internal Investigations Unit, Homicide Unit, and Court Liaison Unit;
- Facilitated a workshop on uniform discipline standards at the behest of Sheriff McGinness for Command and Executive staff;

- Facilitated a workshop for the Sheriff's Outreach Community Advisory Board on community-based service benchmarks;
- Reviewed all complaints of excessive use of force;
- Kicked-off *Project Horizon,* a multi-disciplinary "think-tank" aimed at redirecting causative behavior linked to claims, lawsuits, and complaints;
- Developed a Bi-Annual report framework to encompass a comprehensive assessment of the Sheriff's Jail Facilities;

The first year of operation for the OIG has been a case of first impression for many trying to work through a new and sometimes uncertain process. One lesson learned from this experience, is that independent oversight through the OIG will increase in value, when it is coupled with a measure of synergy responsive to specific findings and recommendations; these include:

Conduct and Discipline

- Establish and adhere to uniform standards for evaluating misconduct complaints;
- Track overdue disciplinary cases through an exception reporting model to significantly improve the timely administration of internal discipline;
- Initiate an ongoing forum to identify patterns of conduct which expose the SSD and individuals to liability in order to engage preemptive strategies *(Project Horizon)*;
- Assess the impact of on-board cameras in patrol vehicles in relationship to an earlier study completed by the Department on race and vehicle stops;
- Consider integrating in-car video surveillance recordings with an alternate dispute resolution forum for early resolution of racial profiling complaints;
- Promulgate internal policy to vitiate an expectation of privacy by employees in the content of wireless messages (e-mails, cell phones, and text messages) sent electronically on the Department's time and equipment.

Correctional Services

- As an urgency matter, direct a report back on short-term strategies and long-range remedies to address population pressures at the Sheriff's jail facilities;
- Revise Correctional Health Services policy to define the steps required following in-custody deaths;
- Provide for response by SSD homicide detectives to in-custody deaths, other than those resulting from natural causes;
- Prioritize acquisition of an electronic health records system to meet industry standards for inmate medical care;

- Revisit priority of capital improvement request for tier-enclosure to prevent suicide "jumpers" at the main jail. Utilize the California Department of Justice data bank to evaluate best practices;
- Continued due diligence by the Jail Suicide Prevention Task Force to implement prescriptive measures. Assess viability and need in terms of expanding in-patient Jail Psychiatric Services (JPS);
- Provide for space on appropriate medical intake form for inmates to list any missing organs which may impact medical care;
- Organize inmate grievances, incident reports, and disciplinary reports for each Correctional Services Division into a viable tracking system to assess systematic issues, and where needed, corrective action;
- Add "Leadership Development" to the annual reporting template for Correctional Services with a deliberate focus on first-line supervisors relative to their critical role in preempting adverse actions involving subordinate personnel.

Field Services and Investigations

- Issue individual audio-packs to all field officers to capture audio track corresponding with digital recording from on-board cameras and clarify expectations concerning deployment of this equipment;
- Establish policy to accommodate a walk-through of critical incident scenes by the Sheriff's Legal Advisor, Inspector General, and Risk-Management designee;
- Benchmark working conditions and incentives with industry standards to attract and retain a stable cadre of experienced SSD homicide detectives, and standardize advanced investigations training within the homicide unit;
- Take full advantage of information technology to increase the efficiency and effectiveness of SSD homicide detectives;
- Provide for a dedicated polygraph examiner and information technology analyst on staff for ready access by homicide detectives;
- Revise and update internal SSD policy on the Court Liaison function to ensure viable procedures and accountability which reflect the current structure and needs of the Department.

The Coming Year

Emerging issues related to transparency and stewardship of the public trust will serve to further define the road ahead. In October 2008, Sheriff McGinness published a five-year strategic plan for the Sacramento County Sheriff's Department; *http://www.sacsheriff.com*. This plan is a forward looking, well crafted document which chronicles what the SSD seeks to accomplish in terms of crime reduction strategies, community policing, leadership development, delivery of services, community relations, homeland security, enhanced correctional services and overall efficiency. *This prospectus will be an important focal point for the OIG in benchmarking progress and outcomes tied to community outreach and essential services.*

Purpose of Report

Community members are the ultimate consumers of local law enforcement services. As such, this report is one means by which the diverse communities-served throughout Sacramento County can gauge the effectiveness of service rendered by the Sacramento Sheriff's Department.

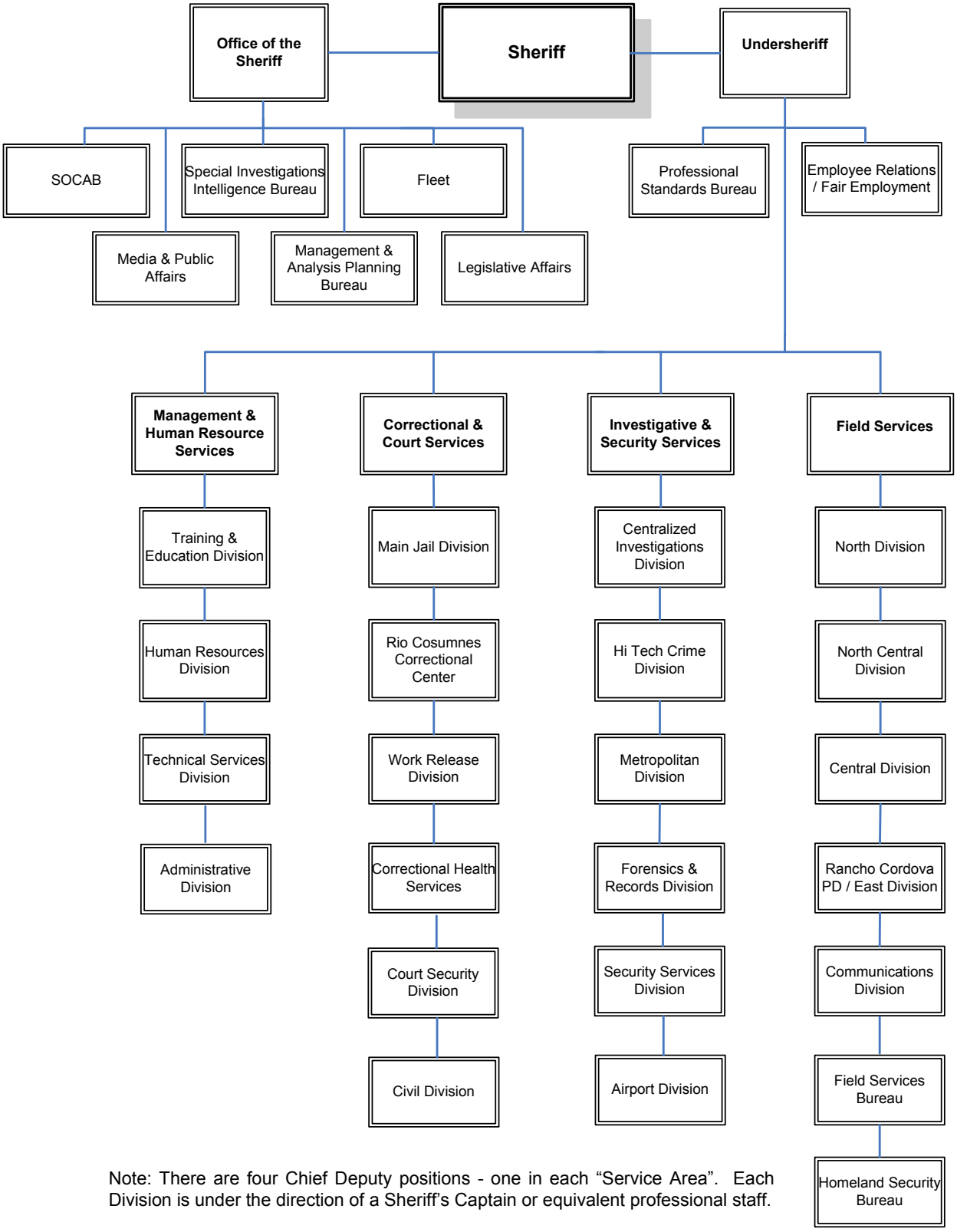
This annual report to the Sheriff, County Executive, Sacramento County Board of Supervisors, and the citizens of Sacramento County provides statistical information on misconduct complaints filed against employees of the Sheriff's Department. Also covered are certain critical functions performed by the Sheriff's Department which are central to law enforcement. Thus, a forum is provided for analysis and feedback in support of recommendations to enhance the overall quality of law enforcement, custodial, and security services under the jurisdiction of the Sheriff's Department.

In monitoring Sheriff's Department operations, the Office of Inspector General (OIG) evaluates levels of compliance with internal policies, as well as competency to industry standards. Systemic concerns are addressed in relationship to their potential impact on stewardship, transparency, and operational effectiveness. Isolated conduct as well as widespread patterns or practices are evaluated based on whether and to what extent they promote or hinder:

- Accountability;
- Constitutional protections;
- Receipt, investigation, and judicious resolution of citizen complaints;
- Risk reduction systems and strategies;
- Promotion of best practices in view of industry standards and internal assessments;
- Adherence to technical assistance letters, judicial decrees, or executive directives;
- Management and supervisory practices which support professional standards;
- Overall effectiveness.

This report chronicles community-based input designed to help integrate the *Sheriff's 2008-2013 Strategic Plan* with community perceptions of organizational excellence and optimal service; (infra, page 13). The themes of accountability, clear direction based on need, and corrective follow-through will continue to serve as guideposts for the OIG in benchmarking programs and charting direction. In this regard, a useful frame of reference relative to how the SSD organizes services can be gleaned from its Table of Organization:

Sacramento Sheriff's Department Table of Organization



Note: There are four Chief Deputy positions - one in each "Service Area". Each Division is under the direction of a Sheriff's Captain or equivalent professional staff.

SSD Table of Organization: Functional Responsibilities

Office of the Sheriff

Community Advisory Board (SOCAB):
Citizen group appointed by the Sheriff, Board of Supervisors, and local municipalities, who advise the Sheriff on matters of community interest; published agenda, open to the public.

Special Investigations Intelligence Bureau:
Conducts sensitive, often complex investigations requiring undercover operations and networking of diverse resources.

Fleet:
Oversight of Sheriff's marked and unmarked vehicles (budgeting, acquisition, and sustainment).

Media & Public Affairs:
Public information and affairs for the Sacramento Sheriff's Department.

Management Analysis & Planning Bureau:
Oversight of the strategic planning process and related analysis functions.

Legislative Affairs:
Tracking, assessment, and analysis of current and prospective legislation pertinent to law enforcement and the SSD.

Office of the Undersheriff

Professional Standards Bureau:
Conducts misconduct investigations through the Internal Affairs Unit and provides legal advice to the sheriff and staff on day-to-day operations of the Department.

Employee Relations / Fair Employment:
Responsible for addressing all activities involving Equal Employment Opportunity policy, administrative regulations, and statuses imposed by local, state, and Federal authority.

Management & Human Resource Services

Training & Education Division:
Provides services related to the Sheriff's training academy, in-service training, emergency vehicle operations course, and firearms training.

Human Resources Division:
Provides services that relate to personnel and payroll, fair employment, employee relations, modified duty/worker's compensation, pre-employment, and recruiting.

Technical Services Division:
Responsible for supporting the Department's information technology systems.

Administrative Division:
Manages fiscal affairs, facilities, purchasing, bingo compliance, alarm ordinance, and fleet management.

Correctional and Court Services

Main Jail Division:
Primary custodial facility for short-term inmates within Sacramento County.

Rio Cosumnes Correctional Center:
Primary custodial facility for long-term inmates within Sacramento County.

Work Release Division:
Provides management of participating non-violent offenders to work in supervised programs to benefit the community, redress jail population pressures, and reduce expense to taxpayers.

Correctional Health Services:
Primary health service provider for inmates within the Sacramento County correctional system.

Court Security Division:
Security and law enforcement services throughout the Sacramento County courts.

Civil Division:
Administers civil process in the manner prescribed by statute.

Investigative & Security Services

Centralized Investigation Division:
Provides centralized investigations for the crimes of homicide, burglary, sexual and elder abuse, child abuse, sexual assault, auto theft, and real estate fraud; oversight of major crimes and narcotics units.

Hi Tech Crimes Division:
Provides centralized investigative resources targeting internet crimes against children and identity theft, and oversight of the Sacramento Valley Hi-Tech Task Force.

Metropolitan Division:
Specialized units consisting of the violence suppression bureau, air operations, explosives ordinance bureau, and the major case narcotics bureau.

Forensics & Records Division:
Essential support functions to include the property bureau, records bureau, and identification bureau.

Security Services Division:
Provides security services throughout Sacramento County.

Airport Division:
Patrol and security services at and in the vicinity of the Sacramento International Airport.

Field Services

Patrol, investigations, crime analysis, crime prevention, public counter, and community policing services throughout Sacramento County.

North Division-East & West Areas:
Station serves Rio Linda, North Highlands, Elverta, Fair Oaks, Antelope, North Carmichael, Gold River, Foothill Farms, and Organgevale.

North Central Division:
Station serves Arden Arcade and south Carmichael.

Central Division / South Bureau:
Station serves Fruitridge Vista, Florin, The Parkways, south end of Oak Park, Rancho Murieta, Wilton, Herald, Sherman Island, Walnut Grove, Hood-Franklin, Courtland, Thorton, and the out-skirts of the cities of Galt and Isleton.

East Division:
Station serves the contract City of Rancho Cordova and the Rosemont, Larchmont, Churchill Downs, Vintage Park, and Mather areas.

Communications Division:
Communications services throughout Sacramento County for all Sheriff's operations.

Field Services:
Specialized services such as reserve forces, K-9, and mounted units.

Homeland Security Bureau:
Develop and implement first responder strategies and capabilities, and optimize protection of critical infrastructure as well as disaster preparedness.

The Office of Inspector General

Mission Statement:

The mission of the Office of Inspector General (OIG) is to promote a culture of integrity, accountability, and transparency throughout the Sacramento County Sheriff's Department in order to safeguard and preserve the public trust. One of the hallmarks of our system of government is that law enforcement officers are entrusted with unparalleled responsibility and authority. They make countless decisions daily which both impact members of the community and shape public opinion. It follows, that the role of law enforcement is tied directly to sustaining the public trust as both an essential and renewable resource.

Although the practice of independent oversight is not new to government, it is nonetheless an emerging concept for law enforcement. Such assessment exemplifies progressive governance based on stewardship and accountability. Within the context of local law enforcement, providing for a continuum of independent oversight just makes good sense in the interest of promoting accountability and transparency. These are the primary goals for the OIG.

Responsibilities:

The Inspector General independently monitors specified areas of interest, recommending ways to strengthen and improve law enforcement services and the citizen complaint process. Open-door counsel to members of the community as well as employees of the Sheriff's Department through the OIG is encouraged. The Inspector General in consultation with the Sheriff reports directly to the Sacramento County Board of Supervisors. Established in September of 2007, the OIG has oversight of the Sheriff's Department internal disciplinary process, and broad discretionary powers to evaluate the overall quality of law enforcement services. The OIG may conduct audits of investigative practices and other audits or inquiries deemed appropriate; related duties include:

Oversight:

- Accept complaints directly from or assists members of the public as well as Sheriff's Department employees in filing complaints of misconduct involving Sheriff's Department employees;
- Monitor select allegations of employee misconduct, to include all investigations alleging excessive or unnecessary use of force;
- Receive all documents, reports or any other items necessary to audit select investigations and conduct systemic reviews of the disciplinary system to ensure fairness and equity;
- Interview or re-interview complainants and witnesses as required to ensure that investigations are fair, unbiased, factually accurate and complete;
- Monitor or independently investigate any other matter as requested by the Sheriff or as directed by the Board of Supervisors.

Reporting:

- After consultation with the Sheriff and County Counsel, publish an annual report to the Board of Supervisors containing statistical information on the number of complaints filed; making recommendations for improvements in the complaint process; evaluating the effectiveness of existing policies, practices, and regulations; analyzing issues, trends, and patterns; and identifying pervasive and emerging problems.

Community Liaison:

- Provide complainants with timely updates on the status of investigations, excluding disclosure of any information which is confidential or legally protected;
- Serve in a public relations capacity in various community forums, and provide information on pending and completed investigations within the legal and ethical limits of confidentiality;
- Serve as a conduit to community leaders and the public for information about administrative investigations, the policies and procedures of the Sacramento Sheriff's Department, or the practices of law enforcement in general;
- Mediate or facilitate resolution of disputes between the Sheriff's Department and community members upon invitation of the Sheriff.

Community Liaison

Complaints and Inquiries

During calendar year 2008, the Office of Inspector General (OIG):

- Processed twenty-three complaints/inquiries directly from the public and facilitated follow through from allegations of misconduct involving Sheriff's Department employees;
- Reviewed all investigations alleging excessive or unnecessary use of force;
- Received documents, reports, or other items necessary to monitor/audit select misconduct investigations to ensure a thorough, objective, and fair investigation;
- Interviewed or re-interviewed complainants and witnesses in select cases relative to the underlying investigation being factually accurate and complete.

Quite often, the OIG serves an intermediary role to facilitate the screening of an initial complaint. Formal complaints are then directed to the Sheriff's Professional Standards Bureau, and monitored by the OIG. Contact is maintained with the complainant to ensure that status reports follow and questions are addressed. In order to fulfill this function, the OIG maintains a close working relationship with the Sheriff's Professional Standards Bureau (Internal Affairs).

Sheriff's Outreach Community Advisory Board

The Inspector General participates in monthly meetings of the *Sheriff's Outreach Community Advisory Board* (SOCAB). Established initially at the behest of prior Sacramento County Sheriffs and continued thereafter, SOCAB was formally established by County Ordinance S.S.C. 2.25 in 2008. SOCAB has since worked to establish procedures and a web-site designed to facilitate open and direct communication between community members and the Sheriff's Department. Board members are allocated for appointment by each County Supervisor, the Sheriff, and the governing body for participating municipalities within Sacramento County. Ex officio members may be appointed by majority vote of the members.

Note: A list of SOCAB members and corresponding biography for each member will be available at *http://www.socab.saccounty.net/default.htm.*

SOCAB Constituent Input

In October 2008, at the invitation of SOCAB chair Dr. Ralph Carmona and fellow Board members, the Inspector General facilitated a workshop to determine community-oriented *benchmarks of excellence* to coincide with publication of the *Sheriff's Department's 2008-2013 Strategic Plan*. The results are a measure of community perceptions around SSD culture and service arising from day-to-day activities and interaction.

The following topics were presented to SOCAB members in advance with a request that each member solicit and report on constituent input, first relative to what the SSD does well, and secondly, where improvement is needed:

Sacramento County Sheriff's Department Strategic Plan 2008-2013
Strategic Direction 2: ***Organizational Excellence***

Discussion Topic: What matters most to community members concerning whether they see a culture of excellence within the SSD:
What do they see the Department doing well in this regard? <u>Customer Service</u> ➢ Targeted enforcement of "crime challenged" areas, working collaboratively with POP officers, code enforcement and special units, to prevent degradation of living conditions, and promote community safety. <u>Community Outreach</u> ➢ Community Service Centers and monthly meetings provide positive forum for interaction off the streets; ➢ Movement toward openness and transparency throughout SSD has been increased, i.e.: SOCAB activities and similar community-based outreach. <u>Workforce</u> ➢ SSD maintains a highly visible, professionally uniformed presence on patrol.

Where do they see room for improvement?

Customer Service

- Strive for uniformity and equality in terms of excellent service throughout *every* service area, and incorporate cultural training by individuals with the background and qualifications needed to deliver the topic;
- When a "customer" contacts the Department for assistance, facilitate ease of initial contact, as well as follow through, with the right person the first time.

Community Outreach

- Crime prevention via cultural awareness and active liaison within all ethnic and immigrant minority business communities;
- Communicating good things that occur (positive events in field services and correctional services) and not just the negative stuff; i.e. manage the perception which the community has of the Department (perception is reality);
- Develop a cadre of qualified individuals to serve as a ready-resource to provide cultural liaison link and assist as able with sensitivity training.

Workforce

- Diversity in the higher ranks and representative outreach by current SSD Incumbents which is seen by some as lacking any real substance;
- Effective use of bi-lingual and culturally skilled officers through incentives and performance measures which emphasize and reward community involvement;
- Proactive recruitment of under represented groups with fixed responsibilities and well publicized contact information to ensure follow through; (for example, no one applied for the $3,000 Vu Nguyen Memorial Scholarship sponsored by the Council of Asian Pacific Islanders Together for Advocacy & Leadership (CAPITAL) because there is no promotion of law enforcement as an honorable career within the Asian and Pacific Islander community by SSD;
- Cultural integration for new officers with an emphasis on how "field" training socializes new deputies in either a positive or negative manner in terms of community policing and the principle of behavioral accountability;
- Consider reorientation of deputies transferring to field service, focusing specifically on community policing and the importance of building sound relationships with the communities served.

Discussion Topic:

What matters most to community members assessing whether the SSD is working to strengthen trust, partnerships, and good-will:

What do they see the Department doing well in this regard?

Customer Service

- Continue to improve response times to emergency calls for service.

Community Outreach

- Outreach to the community via meetings is an important aspect of building good will; continue and expand your outreach efforts;
- Continue and expand current efforts of effective outreach with community-based organizations to effect better outcomes;
- Continue proactive Public Information Officer outreach and media access to high visibility matters of community interest and programs i.e.: Sobriety Checkpoints in Rancho Cordova PD area.

Where do they see room for improvement?

Customer Service

- Expand on and structure the use of volunteers through organized activities such as churches and other community-based organizations;
- Develop a specific service plan for the Gold River community which integrates a balanced approach between and among the Rancho Cordova Station, SSD patrol services, and on-site private security. Work collaboratively with the private security sector in similar venues throughout the unincorporated jurisdiction.
- Follow through with victims in providing feedback on the status of any ongoing investigation, apprehension of suspects, and measures to prevent further victimization; *don't just take a report and leave;*
- Concerning the business community and *property crimes*, there is uncertainty after a crime occurs in how to appropriately report it.

Community Outreach

- Building reciprocity through consistent and ongoing contact with leaders of constituent groups in order to advance community policing and create mutually supportive relationships;
- Use advisory committees for their intended constituent purpose, versus a means of insulating the Department, and screen appointees according to their respective community standing;
- Outreach to identified groups within the community via liaison and trust relationships established with leaders and principals within the respective groups;
- There are a lot of programs targeting the younger aged kids and college-aged groups, but not high school students. This age group may not get access to programs until they get into trouble. There needs to be a focused effort by the Sheriff's Department to "sell" the programs currently available, and where feasible, integrate other like programs for high-school age youth;
- Deal forthrightly with the topic of racial profiling in terms of community relations, perception, and education with concerned organizations and individuals;
- Encourage representation of minority faith-based community in the Law Enforcement Regional Chaplaincy Program.

Workforce

- A specific, focused effort is needed at the line-level (patrol officers and detectives) relative to building trust and reciprocity with the community (i.e. not everyone is a suspect, and they should be treated accordingly).

Note: Public release of the Sheriff's Strategic Plan occurred in conjunction with the SOCAB workshop; the plan can be found in it entirety at *http://www.sacsheriff.com*.

Complaints and Discipline

Introduction

Every California law enforcement agency must by law have an internal process for investigating complaints of misconduct against its employees. The Sacramento County Office of Inspector General (OIG) provides independent oversight of this process within the Sacramento Sheriff's Department (SSD). Complaints made during calendar year 2008 are set forth on the data pages which follow. The disposition and outcome for these complaints is also reported in the interest of transparency.

While officers must be free to exercise their best judgment and to initiate law enforcement action in a lawful and impartial manner, without fear of reprisal, they also have a special obligation to observe the rights of all people. In this regard, misconduct investigations serve to safeguard the integrity of the Department by determining real or potential causes of problems. Importantly, no set of written directives can possibly cover every contingency an employee may encounter. Within a given context, policies and procedures will be subordinate to discretion and sound judgment, which become the primary measures for evaluating conduct.

Dealing forthrightly with conduct which violates the public trust and holding accountable those who tarnish the image of law enforcement is essential. Sustaining misconduct based on facts and exonerating those innocent of wrongdoing are on equal footing in terms of importance. Therefore, at the very core of accountability, is the principle that due diligence and due process goes hand-in-glove. The burden is on the Department to be unequivocal in its findings and expectations.

Wireless Technology

An emerging issue for law enforcement agencies charged with investigating allegations of misconduct is the use of wireless technology. Specifically, the question is whether employees using this technology (e-mails, cell phones, and text messages) have an expectation of privacy within the context of personal messages they send electronically on the Department's time and equipment. This question was answered during the summer of 2008 in the Ninth Circuit, U.S. Court of Appeals case of Quon v. Arch Wireless Operating Co. June 18, 2008. In summary, the Court found that in the facts specific to this case from the Ontario Police Department, there was a constitutionally protected expectation of privacy with respect to such messages.

While the SSD has not historically recognized an expectation of privacy of the sort in question, the OIG recommended through the Department's Legal Advisor with advice and counsel from the Sacramento County Counsel's Office, that internal policy be promulgated to vitiate any expectation of privacy in the content of messages sent using the Department's equipment. Such policy was advanced, but to-date has not been adopted. The OIG believes that adoption of said policy is central to the Department's ability to carry out its

mandate of investigating complaints of misconduct, and urges prompt action to adopt and disseminate the revised policy.

Internal Audit

The OIG in concert with the Sheriff's Professional Standards Bureau facilitated an audit of the Sheriff's Department disciplinary system for calendar years 2006 and 2007. This audit focused solely on whether the administration of misconduct investigations occurred within the timelines specified by internal policy. Timelines are set to help ensure that misconduct investigations are resolved expeditiously. *In this regard, it was determined that the time allotted by policy for resolution of complaints was routinely exceeded. This is significant in that untimely or failed discipline erodes both public trust as well as the core values of the Department; (See Audits, page 58).*

With the concurrence of Sheriff McGinness, and with assistance from the Professional Standards Bureau, an exception reporting model has been established to track and report weekly on the status of *all* misconduct investigations, including those delinquent under policy. The end-in-mind is to bring all misconduct investigations into compliance with policy, and to establish a shared expectation with respect to the importance of maintaining this posture.

Uniform Standards

At the behest of Sheriff McGinness, a workshop to establish uniform disciplinary standards was facilitated by the Inspector General. This eight-hour workshop was attended by the Sheriff and Undersheriff, and by members of Command and Executive Staff. The workshop examined hypothetical disciplinary scenarios within the context of uniform benchmarks for assessing discipline; (see page 19). *While these benchmarks are beginning to weave themselves into the investigative findings completed by Command and Executive Staff, a concerted effort is needed here in terms of consistency between and among* ***all*** *Divisions and Service Areas.* In this regard, efforts to embrace Correctional Health Services (CHS) as an integral part of the Sheriff's Department, including adherence to SSD disciplinary procedures, will serve to reinforce and support efforts being made within this Division to raise the bar in terms of professional standards.

Preventive Strategy

The Commander of the Professional Standards Bureau has initiated a proactive strategy to deter and prevent recurring misconduct. At the conclusion of sustained cases, the Bureau Commander in concert with the concerned Division Commander conducts an assessment of preemptive measures to deter future conduct of the same or similar nature. Supervision, training, policy, procedure, or other prescriptive steps are part of this assessment. This forward-thinking process is an important step in preempting the adverse consequences of misconduct.

Sacramento Sheriff's Department
DISCIPLINARY ASSESSMENT BENCHMARKS

A. To what extent are organizational core values impugned?
Acts which by definition violate your organization's core values, (i.e. dishonesty, criminal conduct, moral depravity, etc.), represent one end of the disciplinary spectrum. Such conduct implicates both the *Peace Officers Code of Ethics* and the *Oath of Office.* Public trust and confidence in the Department are put at issue when this sort of conduct occurs, and often remain tenuous throughout the investigation and disposition phases. While there are obviously gradations here, sustained violations of this sort merit strict scrutiny in terms of discipline.

B. Was the conduct intentional, reckless, negligent or purely accidental?
The employee's state of mind is a factor in discipline. While there are sometimes difficult degrees of separation here, this is of threshold importance.

C. What sanction/corrective action is needed to address the reasons for discipline? i.e.:
- Punish the conduct,
- Correct the behavior,
- Reaffirm expectations within the organization and deter further misconduct.

Where the weight is placed between and among these three reasons depends on the nature of the conduct in question, and the context in which it occurs. The notion that higher rank equates to greater accountability is also at issue here.

D. Are there mitigating/aggravating circumstances which tilt the balance toward one end of the sanction range or the other?
- Extent to which conduct discredits the agency/law enforcement; notoriety and nature of conduct.
- Adverse impact on agency efficiency and effectiveness.
- Nature and extent of resulting harm.
- Nature and degree of risk to the public.
- Nature and degree of risk to fellow employees.
- Cooperative versus uncooperative response by employee.
- Prior conduct by the employee.
- Context within which the conduct occurred; i.e., contemporaneous with an enforcement action, isolated event, etc.
- Other facts or circumstances unique to the occurrence which either aggravate or mitigate.
- The extent to which corrective intervention is both viable and appropriate; i.e., prior steps taken to correct the behavior.

Complaint Data

The OIG tracks all misconduct complaints, and has established a quarterly reporting model specifically for this purpose. Only those cases which are closed during the calendar year are included for data purposes; cases opened but not closed during the year will be reflected in data for the following year. Special thanks go to Sheriff McGinness for his support, and to his Professional Standards Bureau staff for their unfailing assistance in helping to make this project a reality. Importantly, this comprehensive picture of the SSD disciplinary system will enable tracking and trending of misconduct as one means of evaluating corrective and preventive measures.

A sense of context is important when viewing complaint data. For example, the Sheriff's Department has a noteworthy overall sustained rate of 58%. This means that misconduct was found to have occurred in approximately 1 out of every 2 investigations. Also, 50% of these investigations were initiated internally. *In other words, SSD managers and supervisors appear willing to hold employees accountable for their actions. As noted in this report however, timely administration of the SSD disciplinary system is systematically flawed; (See Audits, page 58).*

The magnitude of services provided by members of the Sheriff's Department during the reporting period is useful to consider. Such services include 617,500 calls for service, 21,997 arrests, 57,000 prisoner bookings, and literally thousands of other contacts between and among the Department's four service areas.

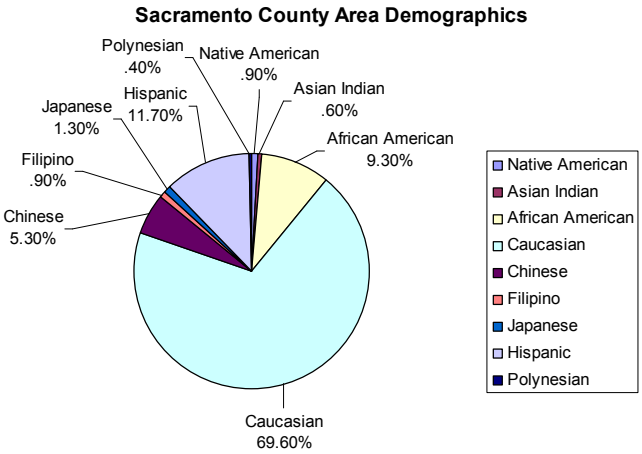
Complaint data (infra, pages 22 to 41) are preceded by a comparison of SSD workforce figures relative to Sacramento County demographics, as a means of benchmarking the Department's efforts to mirror in its makeup the diverse community served.

SSD Work Force and Area Demographics

The Sacramento metropolitan area and the Sacramento Sheriff's Department reflect a diverse make up of cultures, race, ethnicity, and heritage as reflected in current data provided by the Sacramento County Department of Personnel Services and Sacramento County Sheriff's Department Human Resources Division.

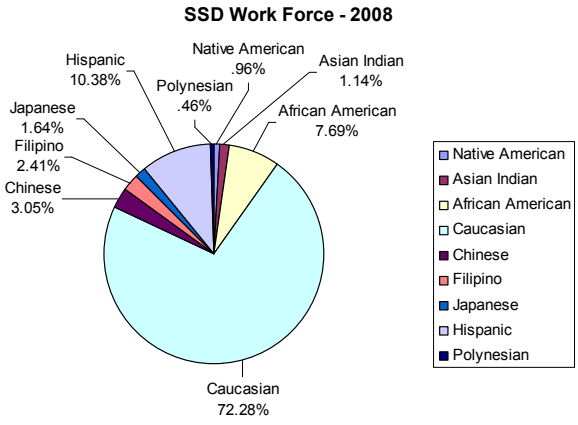
Sacramento County Area Demographics – Current Census

Native American	0.90%
Asian Indian	0.60%
African American	9.30%
Caucasian	69.60%
Chinese	5.30%
Filipino	0.90%
Japanese	1.30%
Hispanic	11.70%
Polynesian	0.40%
	100.00%



SSD Work Force 2008

Native American	21	0.96%
Asian Indian	25	1.14%
African American	169	7.69%
Caucasian	1588	72.28%
Chinese	67	3.05%
Filipino	53	2.41%
Japanese	36	1.64%
Hispanic	228	10.38%
Polynesian	10	0.46%
	2197	100.00%



Note: Total percentages figures are rounded, infra at pages 22 to 40.

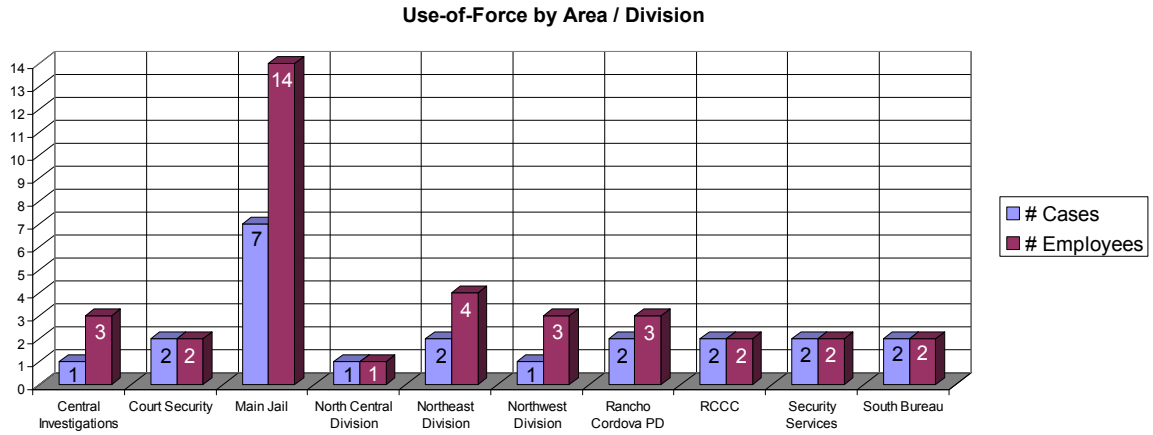
Use-of-Force Complaints

Twenty-two Use-of-Force complaints were investigated by the Sacramento Sheriff's Department (SSD) Professional Standards Bureau and closed during calendar year 2008. SSD General Order 2/11 defines Use-of-Force as:

> *Any use-of-force resulting in a visible or reported injury, or involving the use of firearms, impact weapons, chemical weapons, carotid control holds, or vehicles. This includes any incident as outlined in Section 835a of the California Penal Code, which provides that any peace officer who has reasonable cause to believe that the person to be arrested has committed a public offense may use reasonable force to effect the arrest, to prevent escape or to overcome resistance.*

Employees Involved in Use-of-Force Cases by Assignment

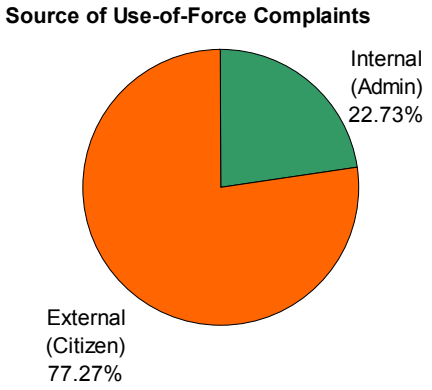
Central Investigations	1 Case	4.55%	3 Employees	8.33%
Court Security	2 Cases	9.09%	2 Employees	5.56%
Main Jail	7 Cases	31.82%	14 Employees	38.89%
North Central Division	1 Case	4.55%	1 Employee	2.78%
Northeast Division	2 Cases	9.09%	4 Employees	11.11%
Northwest Division	1 Case	4.55%	3 Employees	8.33%
Rancho Cordova PD	2 Cases	9.09%	3 Employees	8.33%
Rio Cosumnes Correctional Center (RCCC)	2 Cases	9.09%	2 Employees	5.56%
Security Services	2 Cases	9.09%	2 Employees	5.56%
South Bureau	2 Cases	9.09%	2 Employees	5.56%
	22 Total	100.00%	36 Total	100.00%



Source of Use-of-Force Complaints

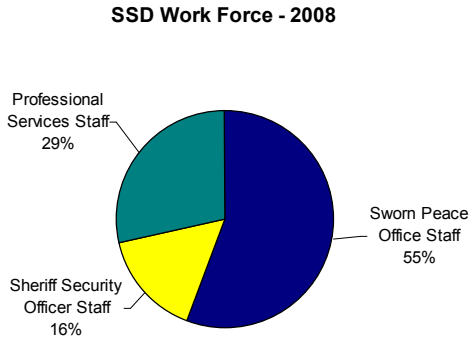
5 cases were internally initiated (administrative) – 22.73%

17 cases were externally initiated (citizen) – 77.27%



SSD Work Force – 2008

Sworn Peace Officer Staff	1218	55.44%
Sheriff Security Officer Staff	352	16.02%
Professional Services Staff	627	28.54%
	2197 Total	100.00%

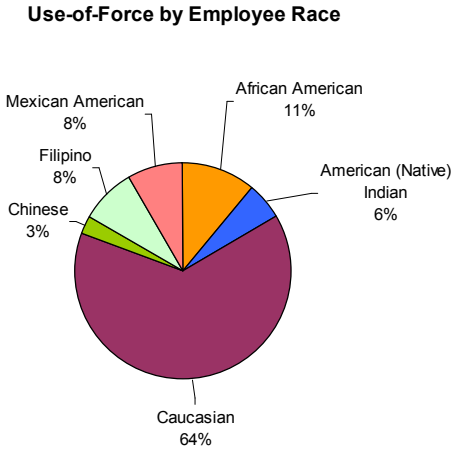


Employees Involved in Use-of-Force Cases by Gender and Classification

Male	35	97.22%
Female	1	2.78%
Deputies	35	97.22%
On-Call Deputies	1	2.78%

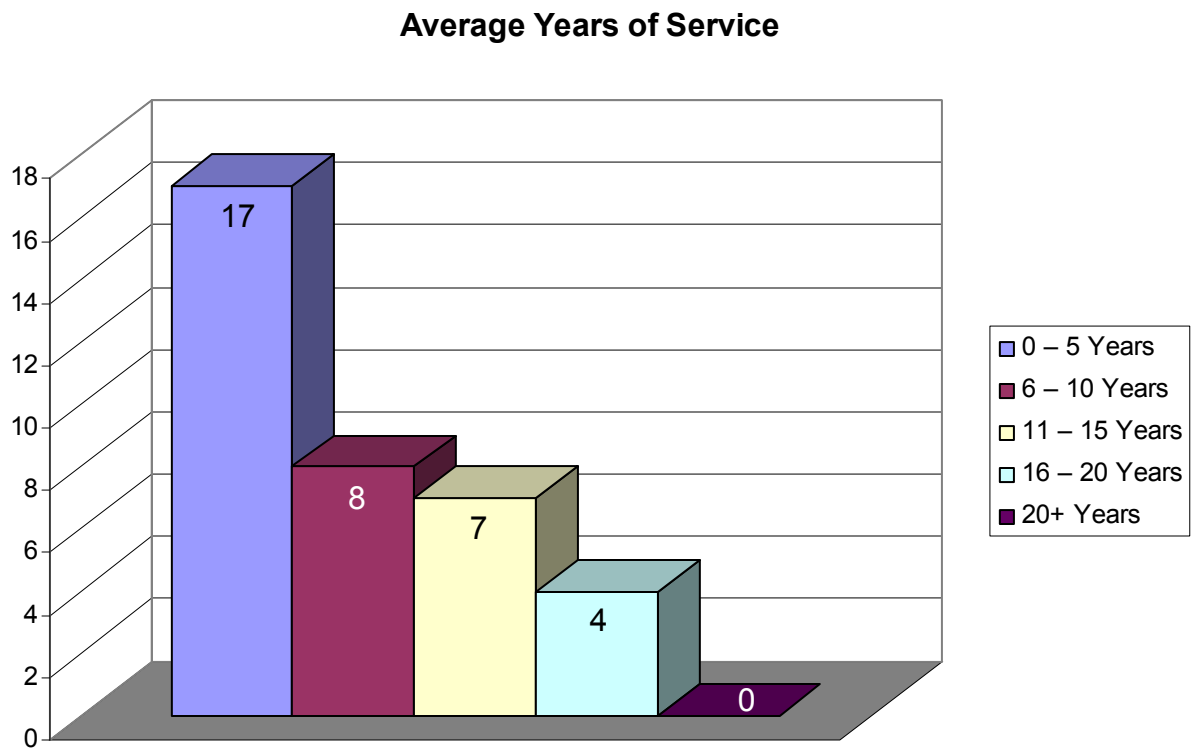
Employees Involved in Use-of-Force Cases by Race

African American	4		11.11%
American (Native) Indian	2		5.56%
Caucasian	23		63.89%
Chinese	1		2.78%
Filipino	3		8.33%
Mexican American	3		8.33%
	36	Total	100.00%

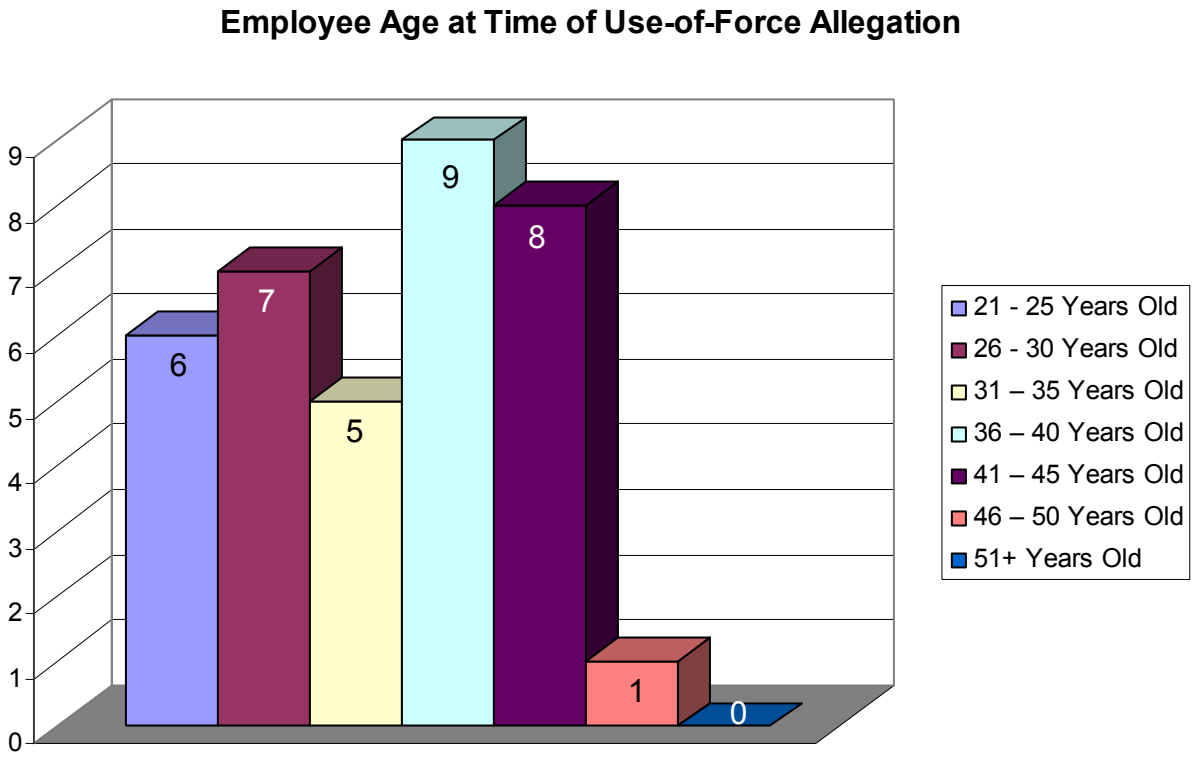


Average Years of Service by Employees Involved in Use-of-Force Cases

0 – 5 Years	17	47.22%
6 – 10 Years	8	22.22%
11 – 15 Years	7	19.44%
16 – 20 Years	4	11.11%
20+ Years	0	0.00%
	36 Total	100.00%



Age of Employee at Time of Use-of-Force Allegation		
21 - 25 Years Old	6	16.67%
26 - 30 Years Old	7	19.44%
31 – 35 Years Old	5	13.89%
36 – 40 Years Old	9	25.00%
41 – 45 Years Old	8	22.22%
46 – 50 Years Old	1	2.78%
51+ Years Old	0	0.00%
	36 Total	100.00%

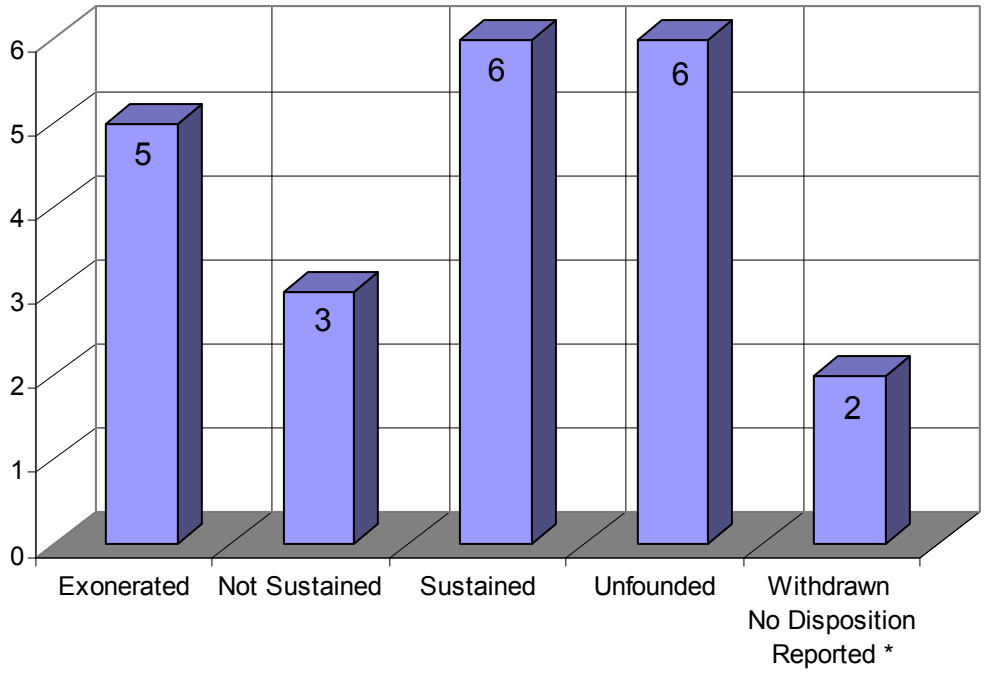


Use-of-Force: Findings

Exonerated	5	22.73%
Not Sustained	3	13.64%
Sustained	6	27.27%
Unfounded	6	27.27%
Withdrawn / No Disposition Reported *	2	9.09%
	22 Total	100.00%

* Complaint was withdrawn by the reporting party and available evidence did not support continuing the investigation.

Use-of-Force: Findings



Definitions:

Exonerated - The investigation indicates the act occurred, but that the act was justified, lawful, and proper.

Not Sustained - The investigation discloses insufficient evidence to prove or disprove, clearly, the allegations made.

Sustained - A preponderance of evidence indicates "that the complained of conduct did occur", i.e.: it is more likely true than not true.

Unfounded - The investigation indicates the act complained of did not occur.

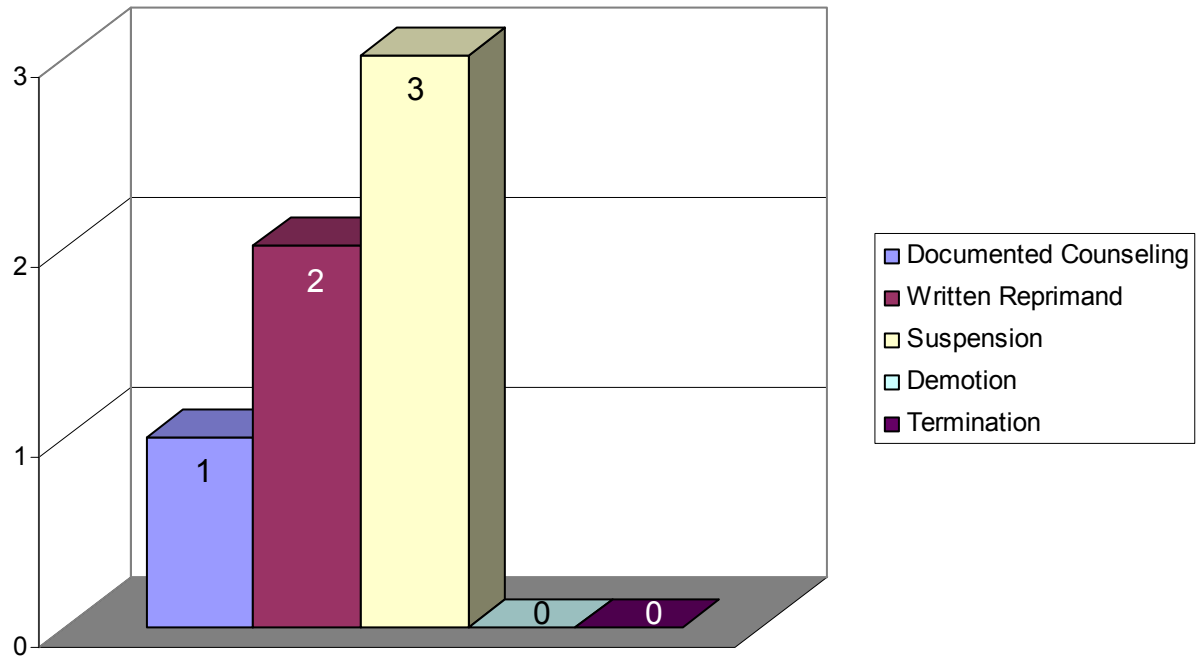
Withdrawn - The claim of misconduct was recanted by the claimant.

Use-of- Force: Sustained Findings - Disposition

Documented Counseling *	1	16.67%
Written Reprimand *	2	33.33%
Suspension	3	50.00%
Demotion	0	0.00%
Termination	0	0.00%
	6 Total	100.00%

* Records of counseling and reprimands are steps in the SSD progressive discipline system which memorialize the incident and outline corrective measures.

Use-of- Force: Sustained Findings - Disposition



Use-of-Force

Sustained Findings Details by Service Area and Division

	Field Services		**Correctional and Court Services**		**Investigative and Security Services**
Misconduct ▼	Northeast	South Bureau	Court Security	Main Jail	Security Services
G.O. 2/11-Use-of-Force	1	1	1	2	1
Totals	**1**	**1**	**1**	**2**	**1**

Professional Standards Bureau (PSB) Investigations, Excluding Use-of-Force

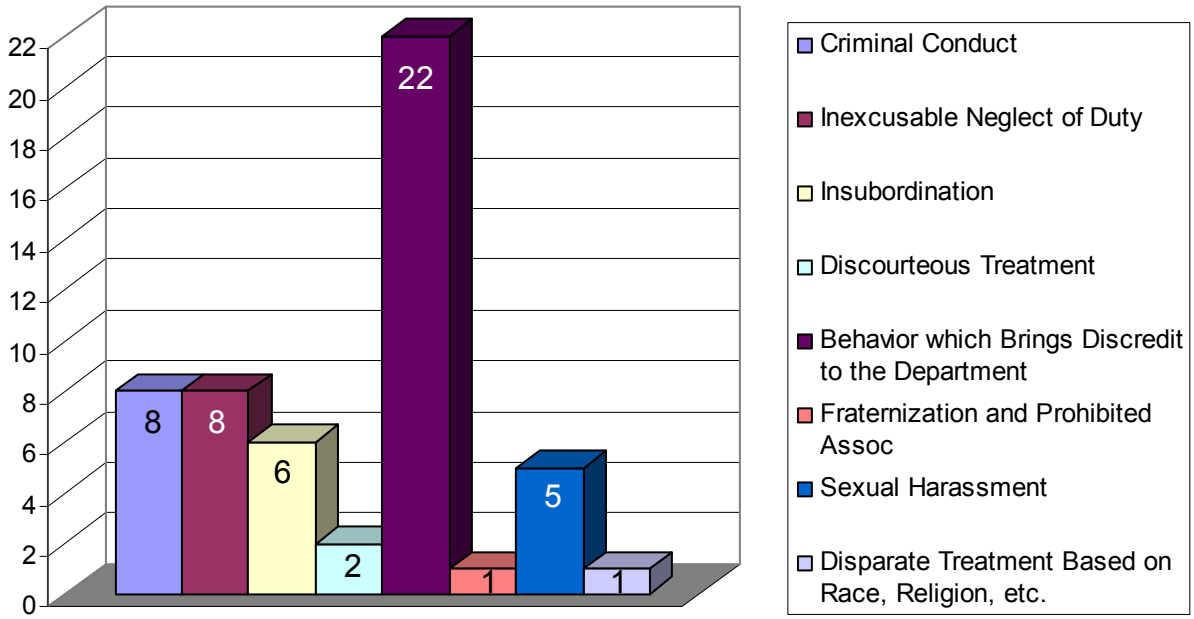
Every complaint of misconduct is investigated by the Department. Internal investigations are completed for allegations of a more serious nature, including all allegations of criminal misconduct. These investigations are conducted by the Sacramento Sheriff's Department (SSD) Internal Affairs Unit or by the Fair Employment Officer (FEO) when disparate treatment based on gender or protected-class status is alleged.

53 employee misconduct cases were closed during 2008. These cases encompass eight distinct allegations involving 52 SSD employees.

Misconduct Allegations

Criminal Conduct	8		15.09%
Inexcusable Neglect of Duty	8		15.09%
Insubordination	6		11.32%
Discourteous Treatment	2		3.77%
Behavior which Brings Discredit to the Department	22		41.51%
Fraternization and Prohibited Assoc	1		1.89%
Sexual Harassment *	5		9.43%
Disparate Treatment Based on Race, Religion, etc. *	1		1.89%
* Investigated by FEO	53	Total	100.00%

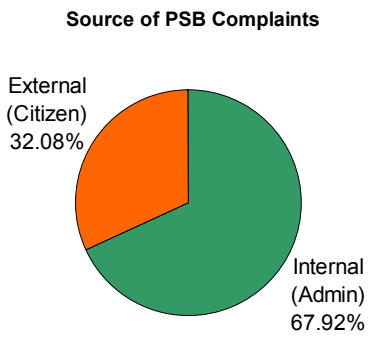
Allegations



Source of PSB Complaints

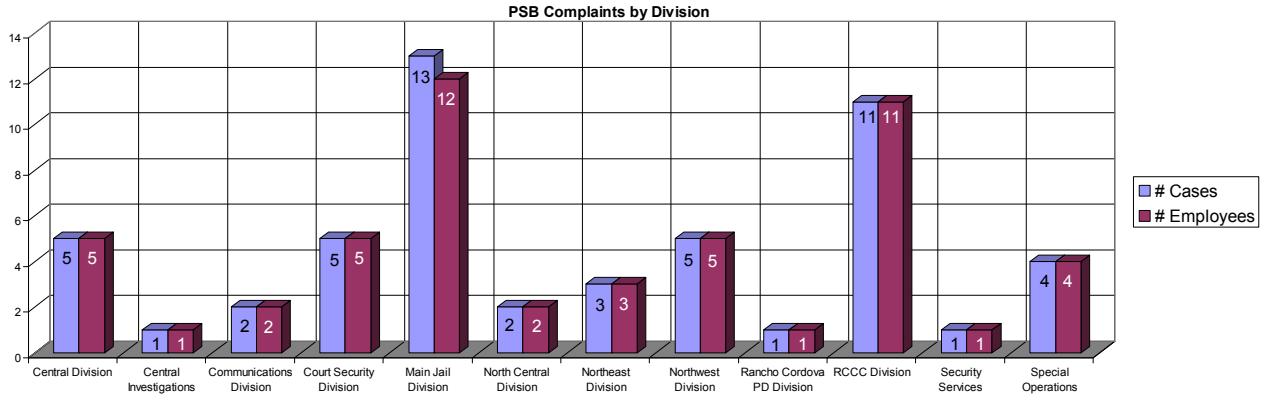
36 cases were internally initiated (administrative) – 67.92%

17 cases were externally initiated (citizen) – 32.08%



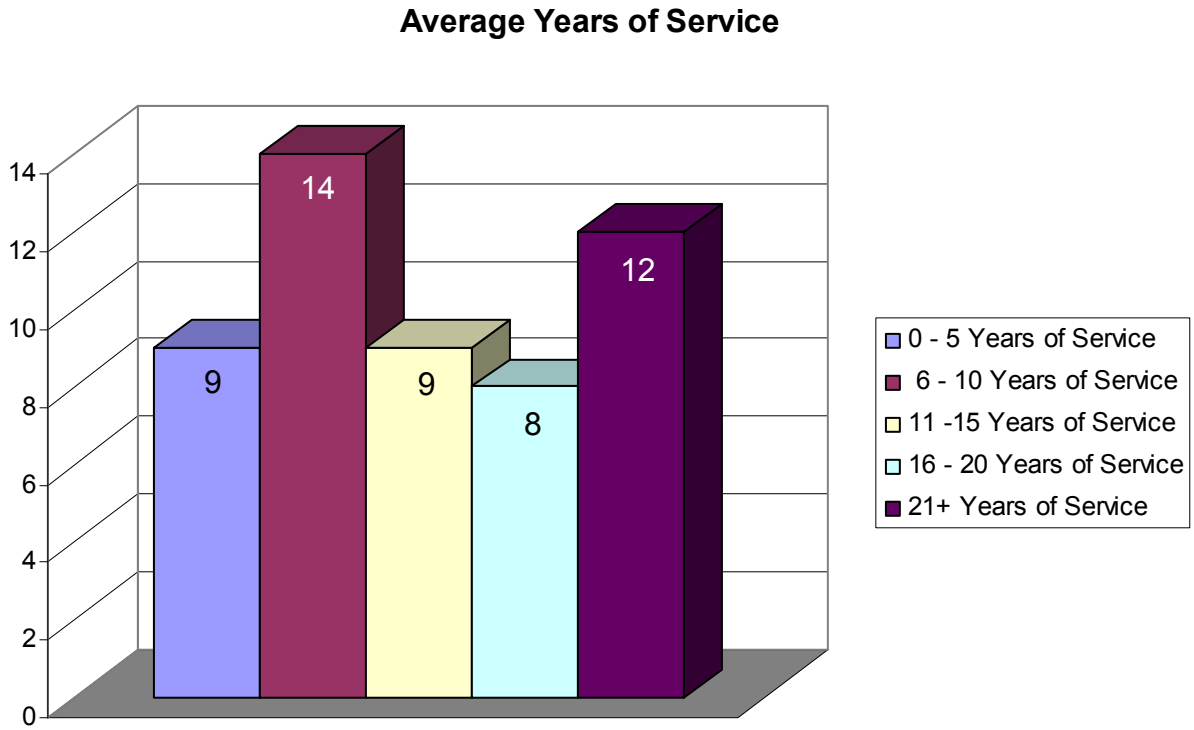
Employees Involved in PSB Complaints by Division

Central Division	5 Cases	9.43%	5 Employees	9.62%
Central Investigations	1 Case	1.89%	1 Employee	1.92%
Communications Division	2 Cases	3.77%	2 Employees	3.85%
Court Security Division	5 Cases	9.43%	5 Employees	9.62%
Main Jail Division	13 Cases	24.53%	12 Employees	23.08%
North Central Division	2 Cases	3.77%	2 Employees	3.85%
Northeast Division	3 Cases	5.66%	3 Employees	5.77%
Northwest Division	5 Cases	9.43%	5 Employees	9.62%
Rancho Cordova PD Division	1 Case	1.89%	1 Employee	1.92%
Rio Cosumnes Correctional Center (RCCC)	11 Cases	20.75%	11 Employees	21.15%
Security Services	1 Case	1.89%	1 Employee	1.92%
Special Operations	4 Cases	7.55%	4 Employees	7.69%
	53 Total	100.00%	52 Total	100.00%

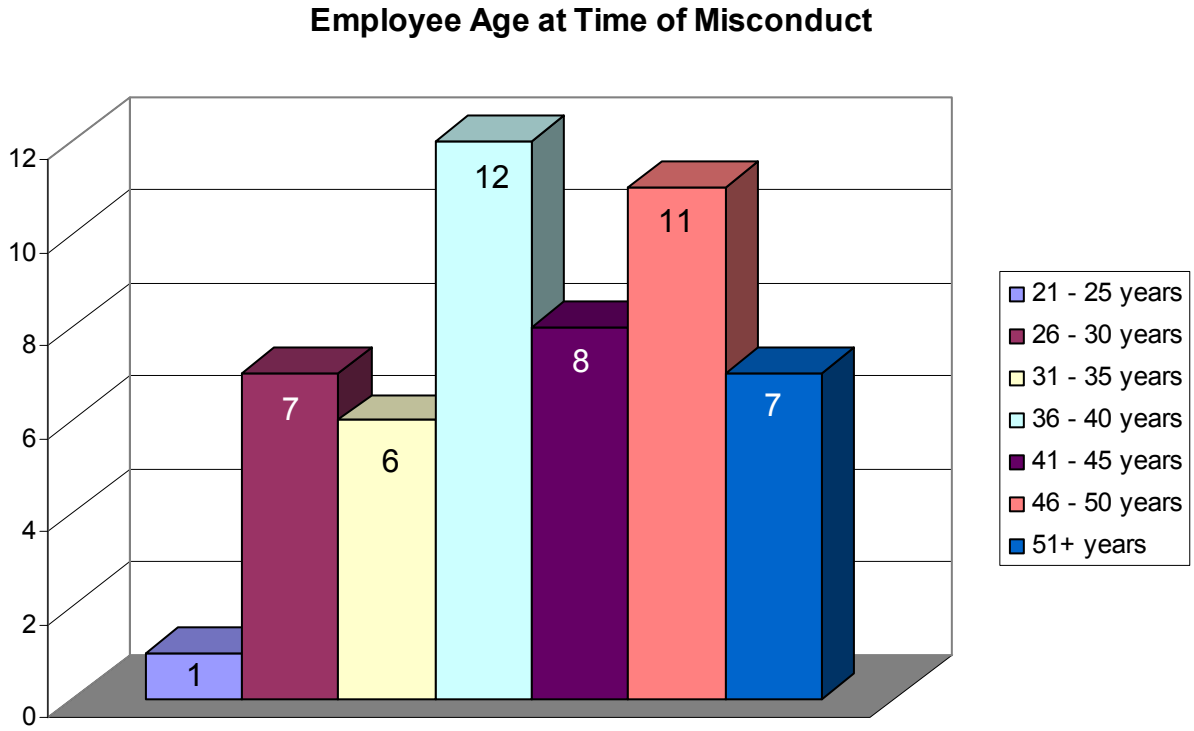


Average Years of Service by Employees Involved in PSB Complaints

0 - 5 years of services	9	17.31%
6 - 10 years of services	14	26.92%
11 -15 years of services	9	17.31%
16 - 20 years of services	8	15.38%
21+ years of services	12	23.08%
	52 Total	100.00%



Age of Employee at Time of Misconduct		
21 - 25 Years Old	1	1.92%
26 - 30 Years Old	7	13.46%
31 – 35 Years Old	6	11.54%
36 – 40 Years Old	12	23.08%
41 – 45 Years Old	8	15.38%
46 – 50 Years Old	11	21.15%
51+ Years Old	7	13.46%
	52 Total	100.00%

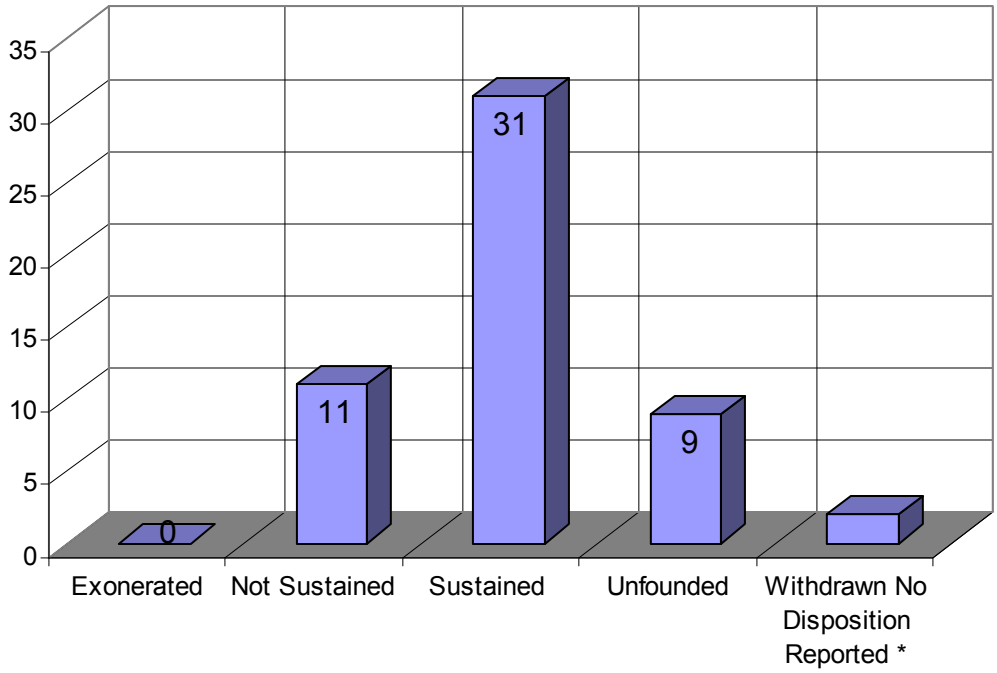


PSB Complaints: Findings

Exonerated	0	0.00%
Not Sustained	11	20.75%
Sustained	31	58.49%
Unfounded	9	16.98%
Withdrawn / No Disposition Reported *	2	3.77%
	53 Total	100.00%

* Complaint was withdrawn by the reporting party and available evidence did not support continuing the investigation.

PSB Findings



Definitions:

Exonerated - The investigation indicates the act occurred, but that the act was justified, lawful, and proper.

Not Sustained - The investigation discloses insufficient evidence to prove or disprove, clearly, the allegations made.

Sustained - A preponderance of evidence indicates "that the complained of conduct did occur", i.e.: it is more likely than not true.

Unfounded - The investigation indicates the act complained of did not occur.

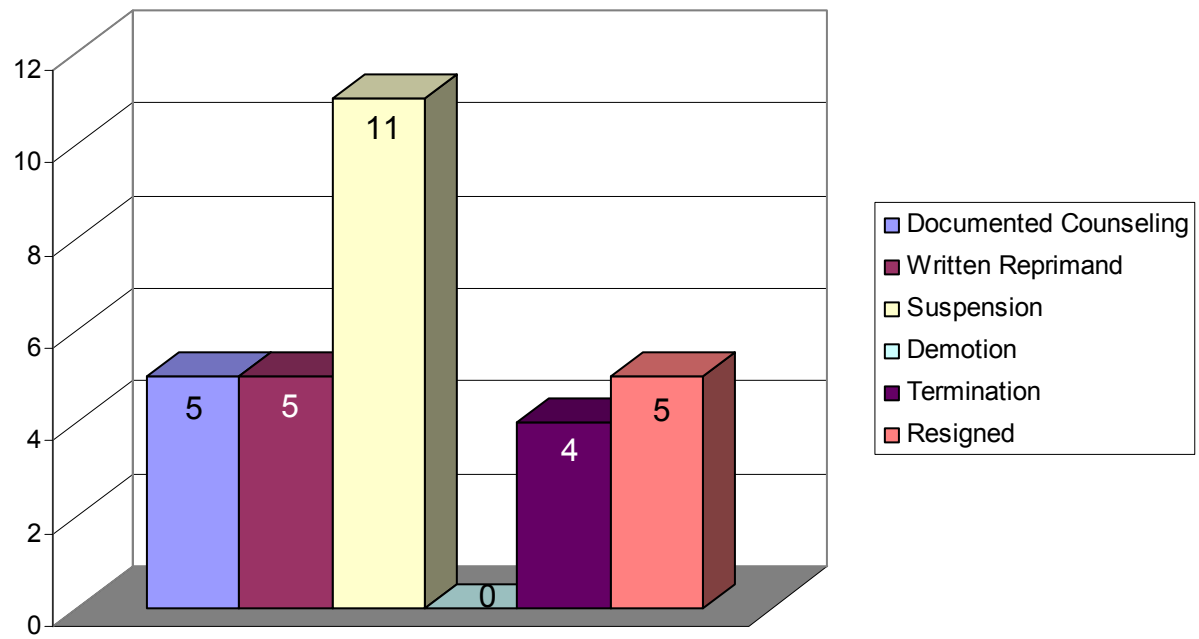
Withdrawn - The claim of misconduct was recanted by the claimant.

PSB Complaints: Sustained Findings - Disposition

Documented Counseling *	5	16.13%
Written Reprimand *	5	16.13%
Verbal Reprimand	1	3.23%
Suspension	11	35.48%
Demotion	0	0.00%
Termination	4	12.90%
Resigned	5	16.13%
	31 Total	100.00%

* Records of counseling and reprimands are steps in the SSD progressive discipline system which memorialize the incident and outline corrective measures.

Sustained Findings - Disposition



PSB Complaints
Sustained Findings Details by Service Area and Division

Field Services

Misconduct ▼	Central	Communi-cations	North Central	North-east	North-west	Special Operations
G.O. 20/03-Fraternization and Prohibited Association						
CSR 11.4(p)-Behavior Which Brings Discredit to Department	2	1				
CSR 11.4(e)-Insubordination						
Criminal Conduct					1	
CSR 11.4(k)-Discourteous Treatment						1
CSR 11.4(d)-Inexcusable Neglect of Duty			1	2	1	
Totals	**2**	**1**	**1**	**2**	**2**	**1***

	Correctional and Court Services			**Investigative and Security Services**	
Misconduct ▼	Court Security	Main Jail	RCCC	Central Investigations	Security Services
G.O. 20/03-Fraternization and Prohibited Association		1			
CSR 11.4(p)-Behavior Which Brings Discredit to Department		7	3	1	
CSR 11.4(e)-Insubordination		1	2		1
Criminal Conduct		2	1		
CSR 11.4(k)-Discourteous Treatment	1				
CSR 11.4(d)-Inexcusable Neglect of Duty	1	1			
Totals	**2**	**12**	**6**	**1**	**1**

* Special Operations Division was dissolved and decentralized in July 2008 under a Department-wide reorganization.

Note: The Management & Human Resource Service Area received no complaints of misconduct during the reporting period.

Divisional Investigations

Divisional investigations generally stem from complaints regarding poor service or below standard job performance, or from internal policy violations. The accused employee's immediate chain-of-command conducts these investigations.

34 employee misconduct cases were investigated by Division Commanders during 2008. Of these cases, seven distinct allegations were made involving 38 Sheriff's employees.

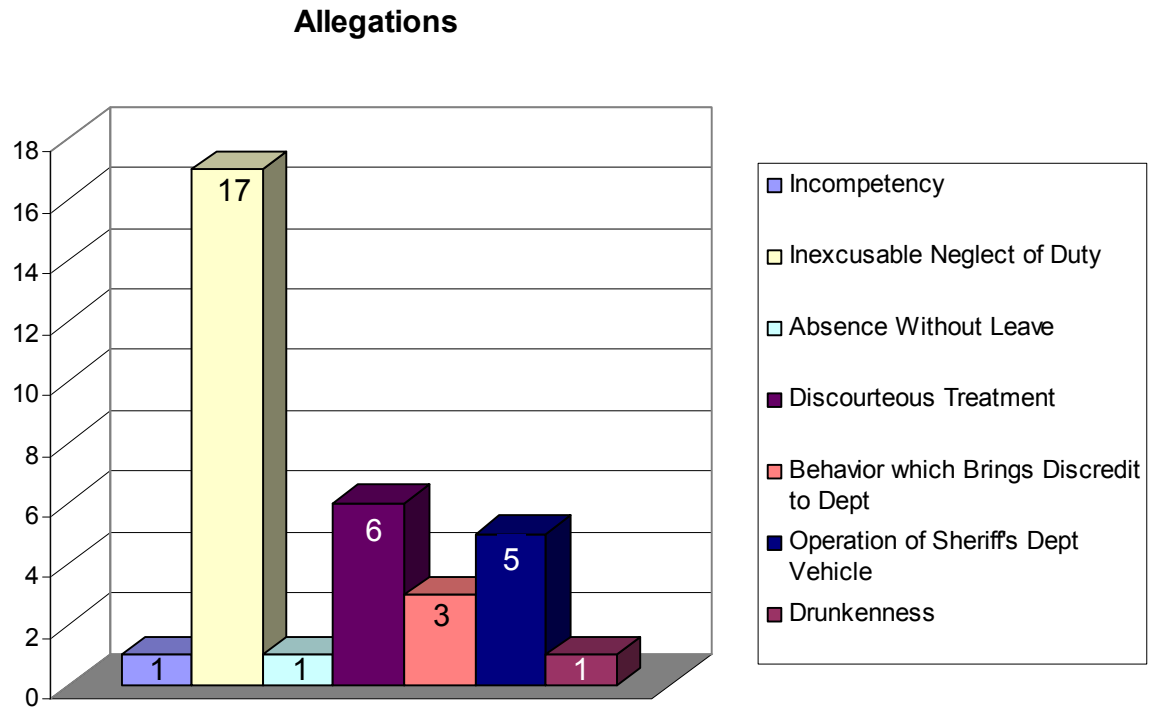
24 cases involve 1 employee and 1 allegation – 70.59%

7 cases involve 1 employee and 2 or more allegations – 20.59%

3 cases involve 2 or more employees – 8.82%

Divisional Investigations Allegations

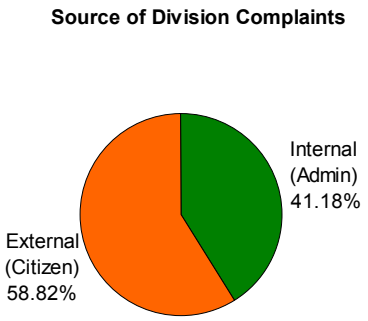
Incompetency	1	2.94%
Inexcusable Neglect of Duty	17	50.00%
Absence Without Leave	1	2.94%
Discourteous Treatment	6	17.65%
Behavior which Brings Discredit to Dept	3	8.82%
Operation of Sheriff's Dept Vehicle	5	14.71%
Drunkenness	1	2.94%
	34 Total	100.00%



Source of Divisional Investigations

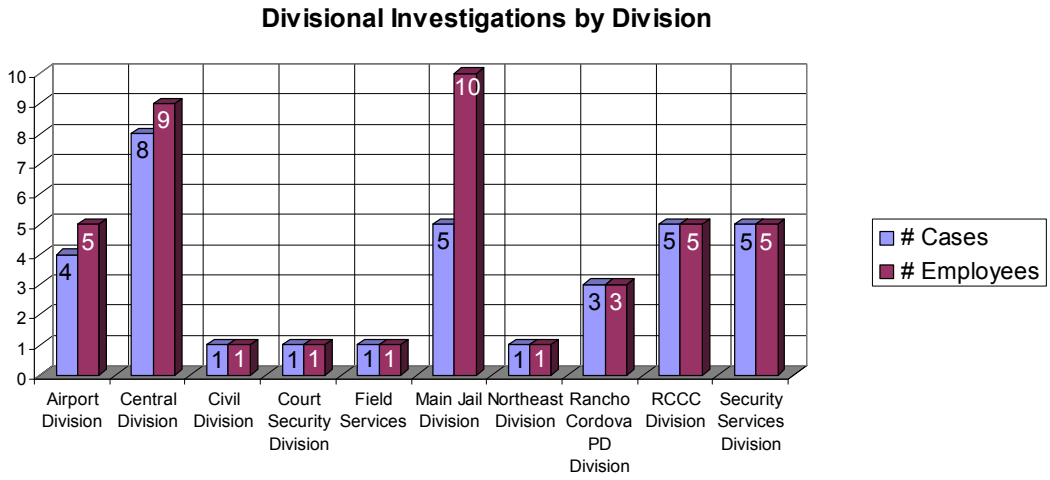
14 cases were internally initiated (administrative) – 41.18%

20 cases were externally initiated (citizen) – 58.82%



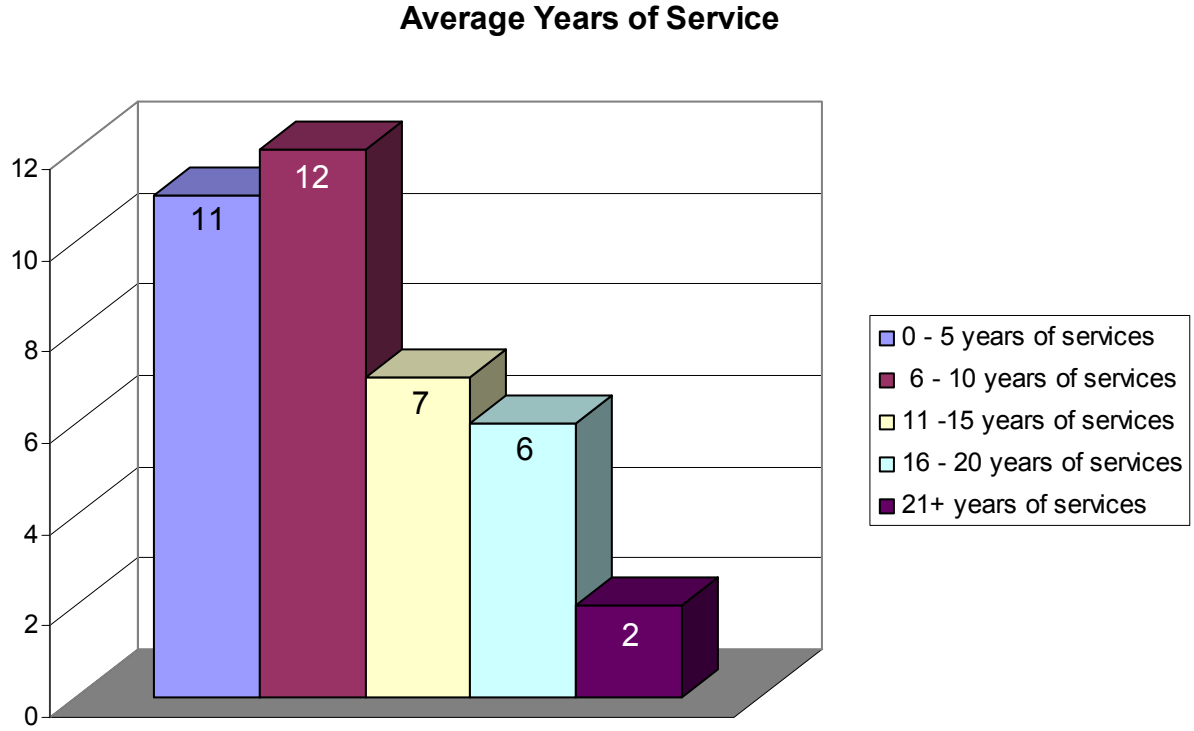
Employees Involved in Divisional Investigations by Division

Airport Division	4 Cases	11.76%	5 Employees	12.20%
Central Division	8 Cases	23.53%	9 Employees	21.95%
Civil Division	1 Case	2.94%	1 Employee	2.44%
Court Security Division	1 Case	2.94%	1 Employee	2.44%
Field Services	1 Case	2.94%	1 Employee	2.44%
Main Jail Division	5 Cases	14.71%	10 Employees	24.39%
Northeast Division	1 Case	2.94%	1 Employee	2.44%
Rancho Cordova PD / East Division	3 Cases	8.82%	3 Employees	7.32%
Rio Cosumnes Correctional Center (RCCC)	5 Cases	14.71%	5 Employees	12.20%
Security Services Division	5 Cases	14.71%	5 Employees	12.20%
	34 Total	100.00%	41 Total	100.00%

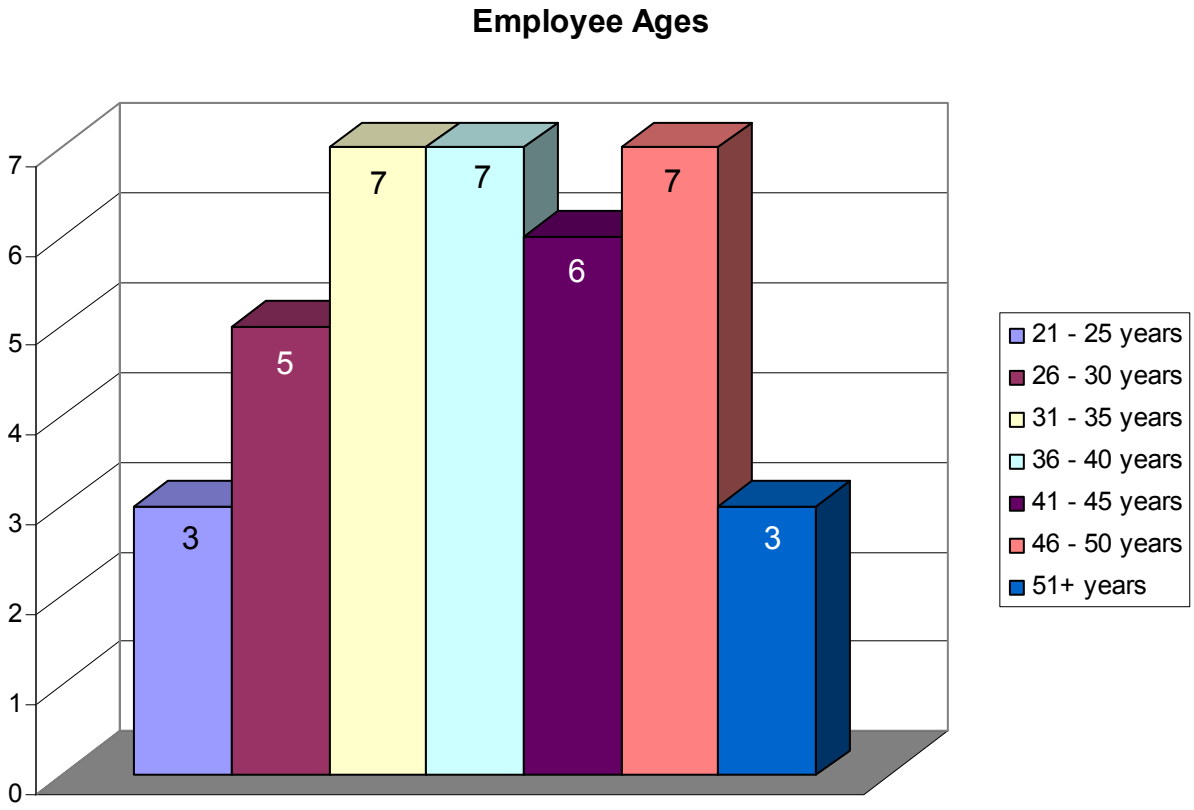


Average Years of Service by Employees Involved in Divisional Investigations

0 - 5 years of services	11	28.95%
6 - 10 years of services	12	31.58%
11 -15 years of services	7	18.42%
16 - 20 years of services	6	15.79%
21+ years of services	2	5.26%
	38 Total	100.00%



Age of Employee at Time of Divisional Investigation		
21 - 25 Years Old	3	7.89%
26 - 30 Years Old	5	13.16%
31 – 35 Years Old	7	18.42%
36 – 40 Years Old	7	18.42%
41 – 45 Years Old	6	15.79%
46 – 50 Years Old	7	18.42%
51+ Years Old	3	7.89%
	38 Total	100.00%

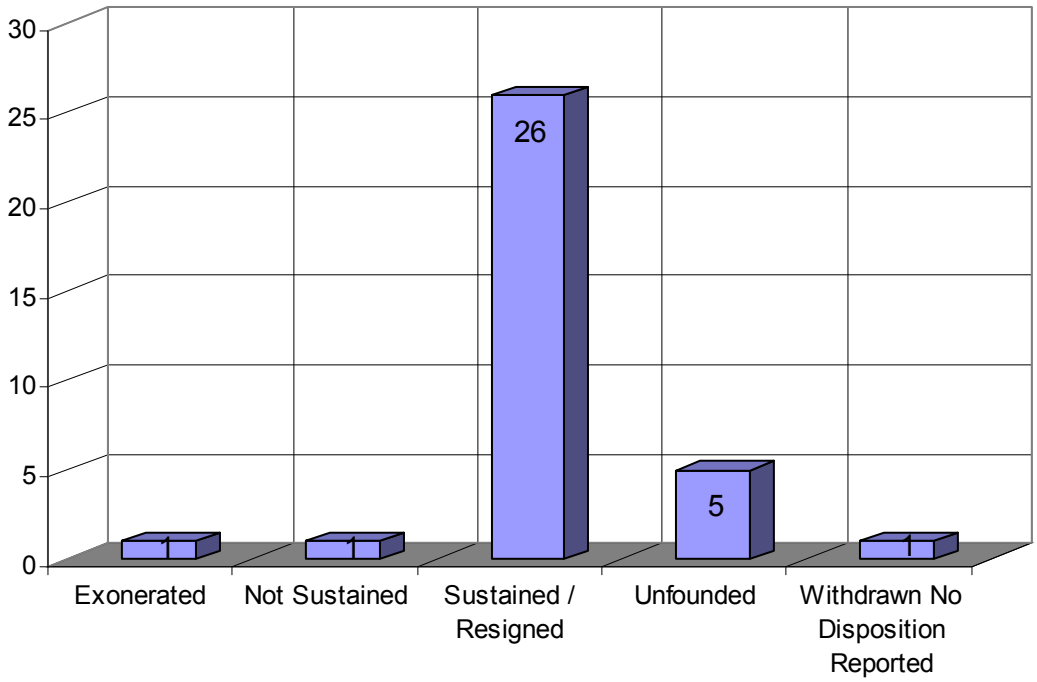


Divisional Investigations: Findings

Exonerated	1	2.94%
Not Sustained	1	2.94%
Sustained / Resigned	26	76.47%
Unfounded	5	14.71%
Withdrawn - No Disposition Reported *	1	2.94%
	34 Total	100.00%

* Complaint was withdrawn By the reporting party and available evidence did not support continuing the investigation.

Findings



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Sustained - A preponderance of evidence indicates "that the complained of conduct did occur", i.e.: it is more likely than not true.

Unfounded - The investigation indicates the act complained of did not occur.

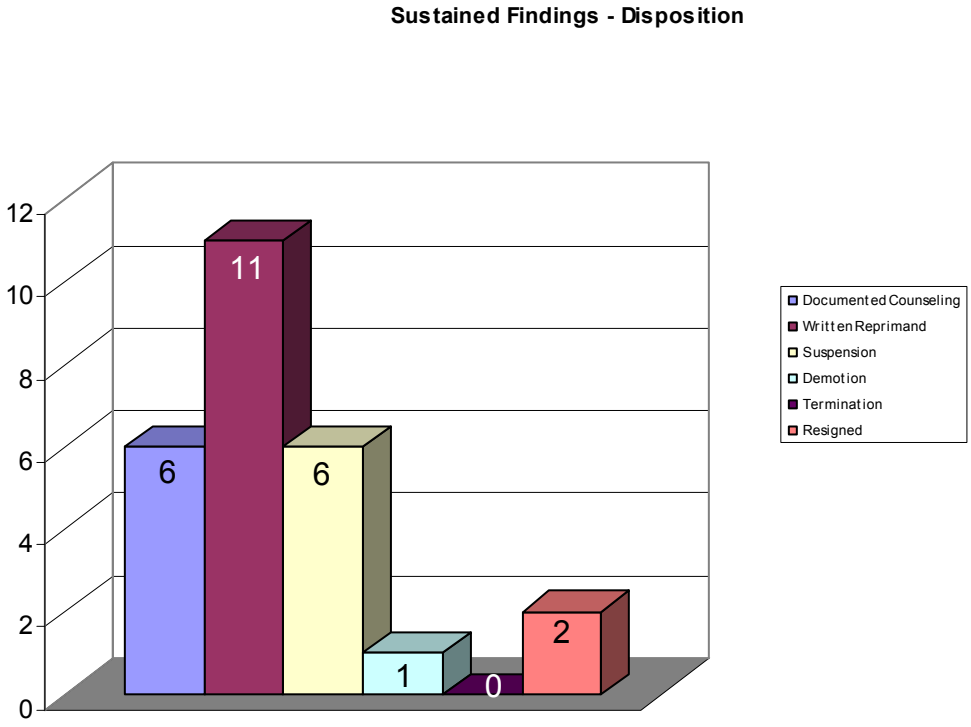
Withdrawn - The claim of misconduct was recanted by the claimant.

Resigned – Accused employee resigned employment prior to disciplinary proceedings.

Divisional Investigations: Sustained Findings - Disposition

Documented Counseling	6	23.08%
Written Reprimand	11	42.31%
Suspension	6	23.08%
Punitive Transfer	1	3.85%
Termination	0	0.00%
Resigned	2	7.69%
	26 Total	100.00%

* Records of counseling and reprimands are steps in the SSD progressive discipline system, which memorialize the incident and outlines corrective measures.



Divisional Investigations

Sustained Findings Details by Service Area and Division

	Correctional and Court Services			
Misconduct ▼	Civil	Court Security	Main Jail	RCCC
CSR 11.4(k)-Discourteous Treatment				1
CSR 11.4(b)-Incompetency			1	
CSR 11.4(I)-Inexcusable Absence Without Leave			3	
CSR 11.4(d)-Inexcusable Neglect of Duty	1			2
G.O. 6/02.1-Operation Of Sheriffs Department. Vehicles		1		
CSR 11.4(p)-Behavior Which Brings Discredit to Department				1
Drunkenness on Duty				1
Totals	**1**	**1**	**4**	**5**

	Field Services			Investigative and Security Services	
Misconduct ▼	Central	East	Field Services	Airport	Security Services
CSR 11.4(k)-Discourteous Treatment				1	1
CSR 11.4(b)-Incompetency					
CSR 11.4(I)-Inexcusable Absence Without Leave				1	
CSR 11.4(d)-Inexcusable Neglect of Duty	6			1	
G.O. 6/02.1-Operation Of Sheriffs Department. Vehicles	1	1			2
CSR 11.4(p)-Behavior Which Brings Discredit to Department			1		
Drunkenness on Duty					
Totals	**7**	**1**	**1**	**3**	**3**

Collaborative Outreach

Project Horizon

In July, the Office of Inspector General (OIG) kicked-off an ambitious venture known as *Project Horizon.* In a nutshell, *Project Horizon* is about understanding and managing complaints, claims, lawsuits, and certain high-risk activities associated with day-to-day operations of the Sacramento Sheriff Department (SSD). Specifically, the goal is to modify behavior in order to preempt adverse outcomes.

The *Project Horizon* steering group includes members from the County Counsel's Office, County Risk Management, SSD Professional Standards Bureau and Legal Advisor's unit, Office of the Sheriff, and the OIG. Preliminary input was solicited from Sheriff McGinness, County Executive Terry Shutten, and County Counsel Robert A. Ryan, all of whom lend their support to this enterprise. The *Project Horizon* mission statement is:

> "*To better serve the community by identifying and tracking patterns of conduct by SSD employees that expose the Department and individuals to criminal, civil, and administrative liability, in order to engage preemptive strategies in the form of policy, practice, training, and education.*"

The steering group is in the assessment phase of its journey, evaluating trends and patterns from historical data organized around types of occurrence and outcomes. It is anticipated that a variety of management, supervisory, line-level, and community expertise will be sought to fashion recommendations which are both pragmatic and practical. In this regard, a primary goal during the coming year will be to develop a functional SSD "early warning" system. Also on the drawing board is the need to fashion a viable approach to facilitating the prompt and equitable resolution of potential damage claims, as both a matter of principle and sound business practice.

Special thanks go to the steering group members for committing their time and talents to this forward-looking endeavor. What they bring to the table in their respective capacities is vital to developing preemptive strategies that actually work.

Uniform Standards

Part of the vision which Sheriff McGinness has for his Department is to sustain momentum around a shared mission and certain core values in order to build integrity and create a reservoir of public trust and goodwill. This parallels the mission of the Office of Inspector General. With this in mind, and at the invitation of Sheriff McGinness, the Inspector General worked collaboratively with the Sacramento County Deputy Sheriff's Association, and with members of the Sheriff's Command and Executive staff, to present in-service workshops on leadership within the organization.

These workshops focused on the critical role of an organization's vision, mission, and core values and on principles of leadership as well as individual character. The end-in-mind was to set a tone of personal and professional accountability by emphasizing that those who work in law enforcement are, and should be, held to a higher standard of professional conduct. In the long run, making the development of others a top priority will inevitably raise peak performance to higher levels, leading to better decisions, superior service, and continuity of leadership.

Race and Vehicle Stops

Constitutional Law and California Statute

The 4th Amendment to the United States Constitution requires that before any individual can be stopped or detained by a law enforcement officer, the officer must have individualized suspicion that the person being stopped is:

- either engaging in unlawful activity;
- is about to engage in unlawful activity;
- or has engaged in unlawful activity.

Law enforcement officers need to have reasonable suspicion or probable cause to search, whether it's a vehicle or a person.

The 14th Amendment to the US Constitution requires that all government officials, including law enforcement officers, go about their business without regard to race. The 14th Amendment is violated when law enforcement officers focus their efforts on one particular ethnic group while ignoring similar unlawful conduct by other ethnic groups. The 14th Amendment is also violated when law enforcement officers use a person's race as a factor in forming suspicion of an individual, unless race was provided as a specific descriptor of a specific person in a specific crime.

California Penal Code Section 13519.4 addresses racial profiling. This statute does not create a new legal requirement on the part of law enforcement. It simply restates existing obligations imposed by the 4th and 14th Amendments to the US Constitution and mandates certain training for law enforcement officers relative to bias-based policing. Importantly, the Sacramento County Sheriff's Department has led the way in training all deputies on the legal and ethical ramifications under this authority.

California Penal Code Section 13519.4 (d-g)

> *(d) The Legislature finds and declares as follows:*
>
> *(1) Racial profiling is a practice that presents a great danger to the fundamental principles of a democratic society. It is abhorrent and cannot be tolerated.*
>
> *(2) Motorists who have been stopped by the police for no reason other than the color of their skin or their apparent nationality or ethnicity are the victims of discriminatory practices.*
>
> *(3) It is the intent of the Legislature in enacting the changes to Section 13519.4 of the Penal Code made by the act that added this subdivision that more than additional training is required to address the pernicious practice of racial profiling and that enactment of this bill is in no way dispositive of the issue of how the state should deal with racial profiling.*

(4) The working men and women in California law enforcement risk their lives every day. The people of California greatly appreciate the hard work and dedication of law enforcement officers in protecting public safety. The good name of these officers should not be tarnished by the actions of those few who commit discriminatory practices.

(e) "Racial profiling," for purposes of this section, is the practice of detaining a suspect based on a broad set of criteria which casts suspicion on an entire class of people without any individualized suspicion of the particular person being stopped.

(f) A law enforcement officer shall not engage in racial profiling.

(g) Every law enforcement officer in this state shall participate in expanded training as prescribed and certified by the Commission on Peace Officers Standards and Training.

Background

At its most obvious, bias-based policing involves initiating contact meant to inconvenience, frighten, or humiliate a member of a particular race or group. A less obvious form of bias is *racial profiling.* Racial profiling takes place when an officer stops or detains a person simply because he or she believes the individual's racial or ethnic group to be frequently involved in crime. Racial profiling de-emphasizes characteristics other than race, such as the citizen's appearance and behavior, the time and place of the officer's encounter with the citizen, or actual crime patterns.

Without being able to assess an officer's actual thought process, it is impossible to determine for sure whether racial stereotyping, profiling, or simply effective policing has been involved. Police officers in some jurisdictions and locations may indeed disproportionately stop members of certain ethnic groups. But, their action cannot automatically be attributed to racial profiling. Crime trends, perpetrator profiles, and targeted deployment of officers to reduce crime and apprehend offenders all play a role.

A number of studies chronicled by the *Police Executive* Research *Forum (PERF)*, the premier law enforcement "think-tank" working under the auspice of the United States Department of Justice, have found that one or more minorities were disproportionately stopped when compared to their representation in the driving-age population. Thus, the concern relative to bias-based policing is raised. In addition, minorities are often found to be searched and arrested more often than non-minorities. After repeated stops, it is difficult for a person to believe he or she has *not* been profiled. This problem is aggravated when law enforcement officers leave the citizen with the feeling that he or she is generally regarded as a suspect.

African-Americans are most likely to be overrepresented in stops of drivers relative to their population. Studies in five jurisdictions found African-American drivers to be overrepresented by a margin approximating 50 percent when compared with their representation in the driving population. These studies suggested that Hispanics had an overrepresentation of about 25 percent compared with their driving population.

Current thinking about race and law enforcement has come to reflect the complexity involved in a police officer's decision to initiate an encounter with a specific citizen. The term "bias-based policing" goes beyond the criterion of sole or predominant reliance upon race in initiating police action. PERF has adopted a working definition of bias-based policing as, *"law enforcement which inappropriately considers race or ethnicity in deciding with whom and how to intervene in an enforcement capacity."* The sole use of race and reliance upon race is set aside in favor of *appropriateness* of race as the test of whether bias does or does not exist. Emerging from this discussion is the possibility that a police officer may use race as an important - though not exclusive - legal authority for stopping a citizen.

Prior Sacramento Sheriff's Department Study

To promote informed public discussion, the University of Southern California (USC) in collaboration with the Sacramento County Sheriff's Department (SSD) conducted a study of vehicle stops by Sheriff's deputies. The resulting report covers three years of data collection (December 1, 2003 through November 30, 2006) and is based on records of 105,698 vehicle stops throughout the County. The objectives of this study were to:

- ensure that accurate data on vehicle stops are available for analysis;
- interpret the data to provide a clear picture of how and why stops are made;
- identify possible training needs, and;
- foster a healthy dialogue between the community and law enforcement.

The study sought to determine whether, in comparison with their representation in the driving age population, minorities are overrepresented among drivers stopped, and whether any overrepresentation found may reflect racial bias. Sheriff's deputies were required to report characteristics of each vehicle stop they made, including the driver's race, age, gender, and residence location, as well as the legal authority for the stop and its duration and disposition. They also reported on whether a search had taken place and, if so, whether contraband was found.

African-Americans were found to be overrepresented among drivers stopped by a margin approximating 50 percent when compared with their driving population; no other racial group appeared to be overrepresented. Major differences were not found among racial groups in likelihood of being searched. When searches took place, contraband was found with approximately equal likelihood in the cars of Hispanic, Caucasian, and African-American drivers.

Caucasian deputies were no more likely to stop African-American drivers than were African-American deputies, and no more likely to stop Hispanic drivers than were Hispanic deputies. The researchers concluded that it cannot be determined from this study whether the overrepresentation of African-Americans among drivers stopped reflects actual bias among Sheriff's deputies. Further analysis taking neighborhood and other contextual factors into account was recommended.

Sheriff's Assessments

Sheriff McGinness candidly acknowledges that deployment of crime suppression resources to effect early intervention, offender apprehension, and violence reduction, particularly in high-crime areas, is in all likelihood a significant factor in the above-described study results. In other words, a collateral outcome of this deployment strategy can be a disproportionate impact on underrepresented groups which may be predominant within the areas of concentration.

From the Sheriff's perspective, a balance must be struck in terms of a compelling concern for public safety, coupled with community expectations of proactive law enforcement. The Sheriff expects that an extension of the initial study would yield much the same results, and would entail a questionable expenditure of public funds. In his judgment, the balance must be tipped in favor of public safety.

There will be those in the community who understandably view this disparate impact as unacceptable under any circumstances, regardless of what might otherwise seem to serve a compelling interest. This will likely remain a work-in-progress in terms of working collaboratively with the community and through the Sheriff's Outreach Community Advisory Board to find common ground.

OIG Recommendations

Near the end of the above-described SSD study on race and vehicle stops, a program to install video cameras in all patrol vehicles was undertaken. The objectives of installing video cameras in officers' vehicles were to enhance officer safety, gather evidence, and promote accountability in encounters between law enforcement personnel and the public. Because the practice is relatively new, assessment of the impact of these cameras has not yet taken place.

Video Camera Assessment

To affect yet another layer of transparency, the Office of Inspector General recommends an assessment of the impact of operating video cameras in Sacramento Sheriff's Department vehicles. This endeavor can either be outsourced or administered internally with appropriate safeguards. (From an efficiency standpoint, it may make sense to reenlist the services of the University of Southern California research team who performed the initial study, in that no additional costs beyond encumbered grand funding would be incurred and the "infrastructure" for such a study is already in place). Possible areas of impact include:

- volume of vehicle stops by officers;
- racial distribution of drivers stopped;
- average time elapsed during stops;
- tendency to search drivers or detain them for an extended time period;
- disposition of stops (for example, warning, citation, arrest).

A "before-after" study of the impact of video cameras is suggested, comparing data collected before and after the cameras went into operation on the above-referenced dimensions. Data already analyzed for the earlier report would serve as a baseline against which to compare vehicle stop data collected after the cameras became operative. Baseline data comprise records of 105,698 vehicle stops that took place between December 1, 2003 and November 30, 2006. Data on these stops would be compared with an expected 45,000 stops during an eighteen month extension of the study. Special analyses could be done within the context of area-specific assignments, demographics, calls for service, crime patterns, etc.

Installation of the cameras should enhance accountability accompanied by no reduction in efficiency or effectiveness. The hypothesis is that officers under surveillance via camera will act no differently than officers working without such monitoring. Absence of change in volume of stops and average time elapsed during a stop would serve as evidence that effectiveness and efficiency were being maintained. On the dimension of accountability a finding of no material change in the racial distribution of drivers stopped would suggest an absence of institutionalized bias-based practices among Sheriff's deputies.

Findings on the impact of video cameras would seem to be important in terms of providing valuable insight to community relations, and for facilitating internal assessment of best practices in this regard. The evaluative process itself would clearly contribute to a sense of openness and transparency. Documentation of the impact of field cameras as suggested may also benefit law enforcement by establishing the initiative in this area as a best practice.

Alternate Dispute Resolution

Finally, the Department may want to consider integrating video surveillance recordings with a voluntary and optional forum for early resolution for racial profiling complaints. While an infrequent complaint category during the reporting period, providing a discretionary venue of this sort for race-based vehicle stop complaints may serve a useful purpose. The emphasis would be on recognizing perceptions as critically important within a setting which serves as the catalyst for reciprocity of understanding around this complex social issue.

Critical Incidents

The Office of Inspector General (OIG) monitors/responds to critical incidents handled by the Sheriff's Department. A Critical event is defined as any occurrence which poses a degree of risk to public or individual safety which is outside the mainstream of day-to-day law enforcement operations. Such events often involve the threatened or actual loss of life or serious bodily injury. Critical events over the preceding year are listed below.

Near the beginning of 2006, the Department approved General Order 2/17 establishing a Tactical Review Board to review all officer involved shootings, custodial deaths, and use-of-force cases as deemed appropriate by Executive Staff. *While there have been a number of cases which fall within the purview of this directive, the Board has not been convened for the past eighteen months. The rational supporting this directive relative to safety and proactive measures to preempt future similar occurrences, is as persuasive now as when it was first written. The OIG strongly encourages consistent, documented compliance with this internal directive.*

Line of Duty Death

November 12, 2008-Rancho Cordova
Tragically, the Sheriff's Department suffered the loss of on-duty motor officer Deputy Lawrence Canfield who was fatally injured in a traffic collision during enforcement action on Coloma Road in the contract City of Rancho Cordova. At 1:55 p.m., the Sheriff's Communications Center received a call reporting that a motorcycle officer was injured as a result of a collision on Coloma Road. In spite of emergency medical response, Deputy Lawrence Canfield, a 13-year veteran of the Sheriff's Department, succumbed to his injuries and was pronounced deceased at Mercy San Juan Hospital. The California Highway Patrol Major Accident Investigation Team (MAIT) stepped forward to handle the investigation.

In addressing the media, Sheriff John McGinness opined that Deputy Lawrence Canfield died doing what he loved, and that the circumstance of his tragic death brings into stark reality the risks inherent in serving as a Peace Officer. Deputy Lawrence Canfield (43), a second generation Deputy Sheriff, is survived by his wife, two children, parents, extended family, and his law enforcement family, all of whom are profoundly impacted by his untimely loss.

Officer-Involved-Shootings

April 6, 2008-Bridge Street
This incident occurred at a popular recreation site at the end of Bridge Street at the American River. A uniformed Sheriff's Sergeant on patrol in a marked unit was hailed by a witness who complained of two male subjects in a vehicle who she believed were about to endanger patrons by driving while intoxicated. The vehicle in question was parked at the end of a street lined with vehicles on both sides, leaving a narrow route of escape.

Attempts to have the driver exit his vehicle were to no avail, and the vehicle abruptly accelerated directly toward the Sergeant who was standing in its path of travel. While attempting evasive action, and fearing for his safety, the Sergeant fired at the oncoming vehicle, striking the driver who died from his wounds. This entire incident was captured by the recently acquired digital recording system which is now operational and on-board the entire Sheriff's marked patrol fleet. This footage and the investigation completed by the SSD homicide unit were reviewed by the Sacramento County District Attorney's Office, and the use of deadly force was found to be justified.

Recommendations:

Issue individual audio-packs to all field officers to enable corresponding audio track with recording made by the on-board digital system, and reiterate expectation relative to its use.

Status: Wireless microphone units, compatible with the in-car camera system, have been purchased and issued to all field personnel assigned to camera-equipped vehicles. Current policy (General Order 10/10) requires the use of all available audio and video equipment. The Department is working toward full compliance; technical issues related to the audio equipment have hampered progress.

Revise policy concerning walk-through of the scene to accommodate the Sheriff's Legal Advisor, Inspector General, and risk management designee.

Status: General order 2/06 has been updated to provide for peripheral scene orientation and subsequent walk-through after the scene has been processed for evidence.

Clarify the Department's position on viewing digital recording of officer-involved shootings by the involved employee, witnesses, or their representatives prior to being interviewed by homicide detectives.

Status: General Order 2/06 has been updated to reflect that the investigative interview will precede viewing of any digital recording capturing the incident.

April 20, 2008-Roseville Heritage Inn

This incident occurred a few minutes before midnight in the Heritage Inn parking lot in the City of Roseville. A parolee-at-large who was a person of interest in a murder/arson earlier that day was tracked to the location by plain-clothes detectives from the SSD Special Enforcement Unit. The parolee exited his room and fled on foot. One of the detectives gave chase, while his partner drove to cut off the escape route. As the parolee fled, he was reaching toward his waistband as he disappeared behind a brick pillar. As the pursuing detective rounded the same pillar, the parolee began to turn toward the detective, who fearing for his safety, shot the subject who died of his wounds. The surveillance cameras on-site did not capture the shooting due to their angle and vantage point. The Roseville Police Department in consultation with the SSD homicide unit conducted a full investigation in this matter. After reviewing all relevant reports and evidence, the Placer County District Attorney's Office found that the use of deadly force was justified.

Recommendation:

Reiterate through appropriate channels the importance of timely notice to allied-agencies concerning SSD enforcement actions within their city or county.

Status: All involved personnel have been debriefed and this topic was addressed and reinforced.

May 8, 2008-East Parkway

At 3:30 a.m., two patrol deputies responded to a vehicle burglary in progress occurring in the parking structure of a large apartment complex adjoining an open field. The deputies approached on foot and there is thus no recording from the on-board digital system. There is likewise no audio recording since neither of the officers deployed with an audio-pack. During the ensuing apprehension, a female suspect driving the get-away vehicle drove directly at the officers who were in the process of apprehending two male suspects. The deputies fearing for their collective and individual safety, and the safety of their suspects, fired at the vehicle to prevent what appeared to be imminent peril. The female suspect sustained gunshot wounds to her leg, and was transported to a nearby hospital for emergency medical treatment. All three suspects were ultimately booked into the Sacramento County jail. After reviewing all relevant reports and evidence, the Sacramento County District Attorney's Office found that the use of deadly force was justified.

Recommendation:

Reiterate through appropriate channels the expectation that available technology (audio-packs) will be utilized whenever conditions permit, as a valuable tool in gathering and preserving evidence.

Status: General Order 10/10 dictates use of all available audio and video equipment.

October 15, 2008 Dry Creek Road

At 4:33 p.m. patrol deputies responded to a man reportedly armed with a handgun in an apartment complex. The caller gave a description of the individual, stating that he was threatening suicide and accosting others in the vicinity. Deputies arrived on scene and encountered a subject in the complex matching the description given who failed to comply with the deputies' verbal directives and retreated into an apartment, followed by the deputies. After repeated verbal attempts to gain compliance failed, one of the deputies fired his taser in attempt to gain control. The 6' 5", 200 pound subject was struck by the taser but was able to overcome its effects and physically "bear-hugged" one of the deputies, in the process unsnapping the officer's sidearm holster and pinning the officer's assault rifle against his upper body. Fearing imminent peril the officer drew his sidearm and fired two shots at close range which struck the subject in the front torso. Paramedics arrived shortly thereafter and transported the subject to a local hospital where he died. It was later determined that the decedent had been paroled from prison the preceding day. A search of

the area failed to produce the handgun which the caller described. This incident was investigated by the Sheriff's Homicide Bureau and Internal Affairs Unit; the use of lethal force was found to be within policy guidelines set by the Department. The Sacramento County District Attorney's Office will issue its findings upon concluding a review of the investigation and applicable law.

Recommendation: None

Note: At the behest of local NAACP Chapter President Betty Williams, and with due regard for safeguarding case integrity, the Inspector General in concert with SSD Professional Standards Bureau staff facilitated a meeting to describe and clarify the factual underpinning to this critical incident. The dialogue was constructive and appeared to serve its agreed-upon purpose.

December 7, 2008-Mather Field Drive, Rancho Cordova

On Sunday, December 7, 2008, Sheriff's Communications received a call reporting two people sitting in a vehicle having an argument that appeared to be escalating. At 9:30 P.M. a ten year veteran of the Sacramento Sheriff's Department assigned to the Rancho Cordova Police Department responded to the disturbance, located in front of a convenience market in the 3300 block of Mather Field Drive, Rancho Cordova. The responding officer arrived at the scene and began talking to the two subjects. Without warning, the male passenger exited the car pointed a handgun at the officer, and fired several rounds; one round struck the officer's protective body armor, which prevented life-threatening injury.

The officer was able to retreat to a position of cover and returned fire. Subsequent investigation by the Sheriff's Homicide Unit revealed that the suspect who shot the officer then shot himself in the head, and died at the scene. Recognizing the subject was injured, the officer requested emergency medical aid. Sacramento Metro Fire responded and pronounced the subject deceased at the scene. The circumstances surrounding this incident will be investigated by the Sacramento County Sheriff's Department's Homicide Unit and the Internal Affairs Unit.

Recommendations: None

In-Custody Deaths

March 17, 2008-Main Jail Suicide

The deceased inmate was pending trial on charges of assault with a deadly weapon (vehicle) while driving under the influence. He had just completed clothing exchange on the upper tier of 300 pod, when he was heard by other inmates to say, "I don't want to be here anymore". He then leaned forward over the waist-high railing just outside his cell and fell head-first to the floor below, hands at his side during the fall. Minutes later he was pronounced dead at the scene.

Recommendations:

Provide for chronology of events and chain of responsibility in Correctional Health Services death review procedures and evaluate jail operations orders for similar inclusion.

Status: Correctional Health Services Policy Number 1112 has been revised to define in detail what steps are required following an in-custody death. This policy specifies that the medical review is a thorough assessment of the conditions surrounding a patient's death which takes into consideration findings of all related intervention, and investigations, including those conducted by custody staff and the Coroner's office.

Actions taken by the Medical Staff after an in-custody death are articulated as follows:

1. *Respond to the incident and participate in all investigations and documentation done by custody;*
2. *Compile all documentation in both the medical chart and mental health chart related to this patient. This can also include emergency room documentation, hospital notes, etc. Chart is secured and kept by Medical Director;*
3. *Participate in a de-briefing with custody personnel where an overall chronology of all events related to the event is prepared;*
4. *Medical Director reviews all documentation and prepares a preliminary medical review document which will become part of the death binder;*
5. *Often this medical review will precede toxicology and autopsy results and the medical review will be amended once the final toxicology and autopsy results are available;*
6. *The Chief of CHS/Medical Director will set up a medical review meeting with the Chief Deputy of Correctional Service, Jail Commander, Asst Jail Commander, Director of Nursing, JPS Medical Director and JPS Program Manager. In this meeting, the preliminary medical review document is distributed and discussed. This preliminary medical review document becomes part of the permanent record;*
7. *The Death Binder is the place where all relevant documentation is kept in relationship to this inmate. The medical chart remains sealed and it kept by the Medical Director (at the administrative office) according to legal requirements.*

Revisit policy on homicide detective response to in-custody deaths.

Status: Operations Order 3/10 regarding in-custody deaths has been revised to require response to the scene by homicide investigators for all in-custody deaths, other than those occurring by natural causes.

Prioritize acquisition of electronic health records system to meet industry standards for inmate medical care.

Status: Work-in-progress with no firm implementation time frame.

The target date to commence cut-over to a combined inmate medical chart is February, 2009. Beyond this, the goal of Correctional Health Services is to obtain an electronic

health records system; the plan and financing have not been secured so transition remains a tentative goal and is anticipated to be a few years away. This is a critical industry benchmark which should remain a top priority.

Revisit priority of capital improvement request for tier-enclosure to prevent suicide "jumpers" at the main mail.

Status: The Sheriff has requested funding for this project in his 2008/2009 budget based on statistical need.

A three-floor configuration has been recommended for tier-enclosure consideration. In addition to the successful suicides chronicled in this report, there were three suicide attempts with serious injury from inmate "tier jumpers". An overarching concern relates to officer-safety, and a growing awareness among inmates relative to the efficacy of inflicting injury or death via a fall precipitated from a tier.

Examine in concert with DOJ, viable best practice options to address "tier jumpers".

Status: The Main Jail Suicide Prevention Task Force is currently exploring viable response options within the industry to address in-custody "tier jumpers". They have learned that the State Department of Justice, Bureau of Justice Statistics just this year began collecting any level of detail with respect to in-custody suicides. The future use of this information resource and contact with other agencies to benchmark preventive strategies will continue under the auspice of the Task Force.

March 27, 2008-Main Jail Suicide
In the early morning hours, eighth-floor jail deputies were alerted by an inmate that his cellmate had hanged himself. Deputies immediately responded to the cell and found the inmate unconscious with a makeshift noose around his neck. The deputies rendered CPR and summoned medical staff, who pronounced the inmate dead at the scene. The inmate was facing two counts of murder related to a double homicide.

Recommendations:

Continued due diligence by the Jail Suicide Prevention Task Force to implement prescriptive measures. Assess viability of expanding in-patient JPS services.

Status: During 2008 the Task Force initiated the following changes in staffing and protocol related to suicide prevention: Staff outpatient psych housing units with stable cadre of nurses and nurse practitioners to acquire specific knowledge of inmates needs; Provide for stable cadre of custody staff on impacted floors to interact with inmates, and to enhance ongoing communication with medical and psych staff; Trimester training to custody, court security, and medical staff on early recognition of triggering events and intervention; Pocket cards issued to custody staff regarding inmate psych referrals and risk factors; Facilitate additional dayroom time and outdoor recreation to inmates; Revamp clothing exchange to prevent hording of clothing.

April 6, 2008-RCCC Methadone Overdose
The decedent was a 50-year-old inmate with a lengthy criminal record and history of substance abuse. At the time of his death he was in custody at the Rio Cosumnes Correctional Center on a parole hold. The coroner determined that this inmate died in his sleep from an overdose of methadone prescribed by medical staff for acute and chronic pain. The prescription was within appropriate parameters given the inmate's history of substance abuse. It was determined however during the autopsy that this inmate had undisclosed missing body organs which affected the absorption rate of the prescribed substance, resulting in methadone intoxication.

Recommendations:

Consider providing space on the appropriate medical intake form specifically for inmates to declare missing organs.

Status: Form modified as recommended. (Note: At the direction of the Medical Director and Chief of Correctional Health Services, methadone has been removed from the approved list of pain medications).

April 19, 2008-Main Jail Suicide
During the afternoon hours while on his way to a social visit, this 62 year old inmate who was housed on the eighth floor climbed over the safety rail and jumped from the upper tier of his unit. Deputies rendered first aid until the arrival of medical staff. Paramedics transported the inmate to a local hospital where he was pronounced dead due to injuries sustained in the fall. The inmate was facing multiple felony counts for child molestation and had been in custody for two days prior to the incident; intake screening was unremarkable concerning suicidal ideation.

Recommendations:

Assessment by Jail Suicide Prevention Task Force relative to preemptive screening/housing procedures in conjunction with certain categories of high risk offenders.

Status: Upon recommendation by the Task Force, cells in the 2-East Housing Unit and booking area have been designated for psych patients with unique needs. These cells are monitored closely for purposes of suicide prevention.

May 31, 2008-RCCC-Seizure
Officers working the honor facility at the Rio Cosumnes Correctional Center responded to an inmate down who they found lying on the ground, conscious but disoriented. They attended to the inmate who had no visible signs of assault and summoned emergency medical help. An ambulance arrived quickly and the inmate was transported to a local hospital where he

underwent a "cat-scan" revealing inoperative intra-cranial bleeding. The inmate died the following day while still at the hospital. A review of this inmate's medical history during incarceration revealed no entries concerning a latent condition of the sort which ultimately caused his death.

Recommendations:

None

July 21, 2008-Main Jail-Seizure

In the early evening hours, a 57-year-old inmate housed on the third floor of the main jail pressed the medical emergency button in his cell. Deputies immediately responded and found the inmate lying on the floor of his cell. Jail medical staff arrived within minutes and administered CPR. Paramedics transported the inmate to a local hospital where he was pronounced dead. The Correctional Health Services Medical Director was advised by the coroner that the cause of death was blood clots in the heart. Medical history for this inmate during his incarceration was unremarkable in terms of precursors related to his death.

Recommendations:

None

September 12, 2008-Main Jail-Homicide

Two protective custody inmates became involved in a physical altercation inside their cell; one inmate died from injuries sustained during the confrontation. These two inmates were about the same age; one was pending sentencing in a double murder case , and the other (the victim) was pending release on drug charges. The suspect inmate was arrested by SSD homicide detectives and charged with the murder of his cellmate. After a review of the case, it was determined that proper procedures were followed, in that the suspect's history of violence while in custody was essentially unremarkable. Aside from this, inmate numbers at the jail require that protective custody inmates be located two per cell, which is in compliance with state regulations governing jail administration.

Recommendations:

None

October 25, 2008-Main Jail Suicide

At 3:30 a.m. a deputy performing routine duties on the fifth floor of the Sacramento County Main Jail was unable to wake an inmate by banging on his cell door. The deputy notified his co-workers, entered the cell and found the inmate unconscious and not breathing. He administered CPR until relieved by medical staff who arrived minutes later. Paramedics

arrived and pronounced the inmate dead at 3:53 a.m. The deceased inmate had been in custody at the Main Jail since November 2005. He was facing charges of murder and domestic violence in connection to the death of his wife. Sheriff's homicide detectives were called to the scene and completed a thorough inmate-death investigation. The Sacramento County Coroner's Office determined the cause of death to be suicide by suffocation. The deceased inmate had secured a plastic bag over his head and bound his hands at his waist via a prefabricated cinch.

Recommendations:

Review contraband procedures (plastic bag) and follow through with corrective measures to help ensure responsive safeguards;

Status: Independent of this recommendation, the main jail implemented a pilot contraband search team in November 2008. Initial reports are promising in terms of contraband removal from the housing units. Tracking of this effort (and any resulting prescriptive measures) should prove beneficial in terms of overall jail safety and pertinent in-service training.

Audits

The Inspector General has broad oversight of the SSD internal disciplinary process and discretionary powers including evaluation of the overall quality of law enforcement, custodial, and security services. In consultation with the Sheriff, the Inspector General may conduct audits of investigative practices and other audits or inquiries as deemed appropriate. During calendar year 2008, the Office of Inspector General (OIG) conducted audits of the Internal Affairs Bureau, the Homicide Unit, and the Court Liaison Unit.

Internal Affairs

Overview

This audit examined the efficiency and effectiveness of the Sacramento Sheriff's Department (SSD) internal disciplinary system. Underlying this assessment is the reality that virtually no one benefits from failed accountability in the form of untimely discipline. This facet of sustaining the public trust through a sense of transparency is central to the role of law enforcement. Special thanks go to the management and staff of the Sheriff's Professional Standards Bureau for making the compilation of data for this audit possible. Together, they are committed to advancing the equitable administration of discipline throughout the SSD.

Data inclusive of calendar years 2006 and 2007 from the SSD Professional Standards Bureau files was researched, encompassing both Divisional Inquiries and Internal Affairs complaints. Divisional inquiries involve less egregious cases of misconduct which do not rise to the level of being investigated by the Department's Internal Affairs Investigators. Such cases are investigated under the direction of the respective Division Commander. They are included here since many of these cases arise from contact with members of the community.

Summary of findings

The goal of any disciplinary system should be to eliminate or at least combat the effect of conditions tending to cause or perpetuate misconduct. Reaffirming admirable behavior, as well as managing discipline and conditions which give rise to misconduct, are ultimately internal functions of supervision and command. Encouraging this direct relationship fosters a sense of intra-agency stewardship related to conduct.

The role of internal affairs as a strong and credible entity is likewise crucial. The internal affairs process ideally translates the Department's core values into reality, thereby encouraging willing compliance and cooperation. This largely turns on whether the process is seen as fair, objective, consistent, and *timely.*

While internal policy sets forth timelines for processing misconduct investigations, these mandates were largely not adhered to during the audit period. On average, the initial investigation by the Department's Internal Affairs Unit took 110 days (versus 75 days set by policy) and the review process for these cases took 31 days (versus 15 days set by policy).

Cases handled at the Divisional level took an average of 123 days to complete (versus 90 days set by policy) Perhaps most troubling is that in a number of instances the administrative statute of limitations contained in the Public Safety Officers Procedural Bill of Rights was allowed to lapse, rendering the sanction in these cases void. Conversely, there are select managers and supervisors who epitomize diligence when it comes to prioritizing the administration of discipline; they are to be commended.

Direction

Sheriff McGinness has taken significant steps to highlight the importance of consistency in administering discipline, to include emphasizing its integral role as part of the SSD culture under his administration. This was the primary focus of a mandatory, full-day workshop for Command and Executive Staff hosted by Sheriff McGinness and presented at his request by the OIG. This critical reaffirmation of expectations is of singular importance in fostering a paradigm of professional accountability through an efficient and equitable system for the resolution of misconduct complaints.

As a result of this audit the Sheriff's Professional Standards Bureau has initiated an *"exception-reporting"* model listing all overdue misconduct cases for weekly review by the Sheriff and his Executive Staff. *Explanation to the appropriate level should be initiated for those cases which have gone beyond the policy guidelines set for their completion. While there has been noted progress in reducing the time it takes to complete the initial investigation, significant improvement is needed with respect to expediting the review process and timely resolution of these cases.*

The OIG will conduct a follow up audit for calendar year 2008 once residual cases initiated during this period reach final disposition; the findings will be reported to Sheriff McGinness. A renewed emphasis here from the office of the Sheriff, administered through the Professional Standards Bureau, will serve to bring about the desired outcome.

Homicide Unit Audit

Overview

Near the beginning of 2008, the Sacramento Bee reported on unsolved homicides within the jurisdiction of the Sacramento Sheriff's Department (SSD). A number of these murders generated a high level of community interest, owing both to the loss of innocent lives and to a growing concern that the perpetrators had not been arrested and brought to justice. At about the same time, the Federal Bureau of Investigation published a well researched study in its *National Law Enforcement Bulletin* on best practices for homicide investigations. The contrast between industry standards chronicled by this study, versus growing challenges confronting the SSD homicide unit, coalesced to make this a matter of public interest.

The OIG in consultation with Sheriff McGinness, and with concurrence from the County Executive, commissioned retired SSD Lieutenant Ray Biondi to work in concert with the SSD Homicide Unit to perform a structured cold-case audit. Lieutenant Biondi, a 31 year veteran,

commanded the Homicide Unit for seventeen years. He is a recognized expert in homicide investigations having directed over 500 murder investigations, to include serial killers, mass murders, and other high profile cases. It was felt that Lt. Biondi's insights would prove invaluable in terms of evaluating systemic challenges facing the SSD Homicide Unit.

A parallel goal was to bring about closure to select cold cases. Privacy interests and the need to safeguard case integrity preclude a discussion here of the individual cases examined during this audit. Suffice to say that suspects have been identified by the SSD Homicide Unit in three of the six cold-cases reviewed, and arrests are expected. Viable leads in the remaining cases will be worked as detectives are able to do so.

Summary of Findings

(Excerpts as reported by Lieutenant Ray Biondi)

- The goal of the Department should be to establish an adequate staff of fully trained, equipped, and seasoned homicide detectives, unencumbered by artificial constraints. Timely closure of viable cases will continue to suffer unless and until adequate resources to sustain investigations and depth of detective experience in the homicide unit are addressed;
- The caseload for SSD homicide detectives is way out-of-balance in terms of best practices and industry standards; (i.e. higher caseloads adversely impact clearance rates);
- In most cases the amount of time spent on the investigation immediately following the discovery of the crime has a direct correlation to the total number of hours spent on the case overall. Attempts to curtail spending by limiting the initial response to homicide investigations is simply a flawed strategy;
- Solving murders in a timely manner helps to assuage the safety and security concerns within the community served, and at the same time, builds goodwill when expressions of "job well done" are forthcoming. It is impossible to put a dollar amount on this dynamic, not to mention the resulting enhancement to the Department's reputation;
- All detectives receive training in basic homicide investigations, and some receive advanced instruction. Beyond these basic skills however, it is critical to have a baseline of sustained competency and proficiency within the unit to ensure the ongoing ability to analyze and interpret crime scenes. The challenge faced by the SSD Homicide Unit is to find and sustain individuals with the background and acquired skill-sets needed to build unit strength;
- At least one detective needs to become an expert with advanced training in blood-stain evidence. Also, all homicide detectives should receive training in basic recognition of blood stain evidence;
- The ability to interview, interrogate, and obtain admissions is paramount. While some detectives have a natural ability, all could benefit from formal training. None of the detectives have attended cognitive interview courses;

- The homicide bureau has experienced a significant decline in the number of detectives applying for the position. Sentiments echoed focus on long hours, frequent call-outs, tedious case preparation, little financial incentive, and disruption to their personal lives as disincentives;
- Because experienced detectives are not interested in working homicides, personnel from patrol move directly into the homicide bureau. By any measure of public trust, this practice should be strictly scrutinized;
- Supervision and management of the Homicide Unit are just as critical as finding detectives with the requisite skill sets. Their ability to work along-side subordinates and their willingness to recognize the personal sacrifices required by dedicated homicide detectives is vital;
- Any and all incentives in the form of compensation, working conditions, or position classification tied to the unique requirements involved with working the homicide unit should be examined. It should not be hard to benchmark what is occurring here industry-wide, and to adopt those incentives which make the most sense for SSD. At a minimum, this inquiry should begin now as an enabling strategy to merge with organizational planning or negotiations at the time appropriate;
- Shootings from pervasive gang problems, and choosing the optimal response to these crimes, is a noteworthy concern for the Homicide Unit. A gang-homicide team is certainly one viable approach. One team knowledgeable of the gang culture and individual players would have a head start;
- Delayed forensics resulting in delayed case closure is a decades-old problem. An interagency funding agreement between and among County law enforcement agencies and the District Attorney's Office to provide priority crime lab work for fresh homicides and aggravated assaults would be a huge step in the right direction;
- Detectives are at the mercy of outside polygraph providers. Being able to conduct polygraphs in-house has meant the difference between solving a case quickly by admission or confession, versus a protracted investigation. Having a polygraph examiner on staff is something which the Department should seriously consider;
- Information technology in the form of lap-tops and digital recorders would increase unit viability. A staff analyst could provide detectives with coherent leads vital to solving cases. If hiring a full-time analyst isn't feasible, perhaps a position in the high-tech crimes unit could liaison to fill this need.

Direction

This audit sets forth corrective measures in the form of recommendations relative to Staffing, Training, and Support Resources. Some of the actions proposed are short-term remedies, while others will only occur over time through persistent and dedicated follow through, backed by adequate resources. To their credit, the Homicide Unit has created an *action matrix* inclusive of priorities in the below-described areas. Clearly, members of the Homicide Unit and their respective command personnel are committed to the task at hand. Additionally, a cold case grant through the National Institute of Justice in the amount of

$392,000 has been awarded to the Department, to run for eighteen months from December of 2008.

Staffing Recommendations:

Benchmark working conditions, case loads, experience levels, and incentives with industry standards and make adjustments as needed in order to attract and retain a stable, experienced cadre of homicide detectives.

Status: This action item has been assigned to one of the homicide sergeants instrumental in developing the unit. Background information will be gathered to assess formal as well as informal mechanisms to bring about the sort of enhancements needed.

Evaluate staffing configurations and alignment of investigative functions to maximize the effectiveness of the homicide unit.

Status: In July 2008 the Homicide Unit implemented a new call-out schedule which allows for additional detectives at the outset of an investigation (one of the critical elements identified in the audit). Also, the teams are now divided up by experience. This new configuration has shown some early success in leading to the prompt closure of cases. The Unit's clearance rate currently surpasses the national average. Since January of 2008, the Homicide Unit has cleared six cases from past years, with three other such cases pending clearance by arrest from DNA hits or investigative follow up. Finally, aggravated assaults have been centralized for purposes of supervision and case management in order to facilitate cross-over investigations with the homicide unit.

Training Recommendations:

Standardize training for all homicide detectives in crime scenes, blood evidence, and interview/interrogation techniques, in addition to the courses already afforded to newly assigned personnel.

Status: All of the training venues recommended by the audit are reflected on the Homicide Unit action matrix as high priority with the goal of uniformity between and among the unit detectives.

Support Resources Recommendations:

Take full advantage of information technology such as digital recorders and lap tops to increase unit viability.

Status: The information technology equipment referenced in the audit is reflected on the Homicide Unit action matrix as high priority. Acquisition of these items either has or will occur as resources permit.

Provide for a dedicated polygraph examiner and information technology analyst on staff for ready access by homicide detectives.

Status: This position is likewise included on the Homicide Unit action matrix, with a projected completion date of June, 2009. The goal is to have an in-house examiner on staff.

Provide for dedicated crime analysts to work priority homicides; (perhaps through an interagency funding agreement in concert with the District Attorney's Office)

Status: This item has been taken under submission by Sheriff McGinness since it entails interagency coordination and will need to be evaluated as part of the budgeting process.

Court Liaison

Overview

The purpose of this audit was to evaluate the efficacy of existing policy and practice governing the Sacramento Sheriff's Department (SSD) Court Liaison Unit. California Penal Code section 1328(c) authorizes law enforcement agencies to designate an agent to receive subpoenas for employees. The Sheriff's Department has designated this agent as the Court Liaison Officer. Each year, the Court Liaison Unit processes about 24,000 criminal subpoenas from the public and private sectors. An access-based subpoena tracker system is used to track subpoenas and appearance dates. This system contains SSD employees' scheduling and contact information.

Summary of Findings

This audit covered a six-month period from December 2007 to May 2008, and was inclusive of the 23 divisions spread throughout the Sheriff's Department. Each division has primary and secondary designees to process and serve subpoenas sent via the Court Liaison Unit. During the month of May 2008 the Court Liaison Unit processed 2,145 subpoenas, which is consistent with anticipated monthly volume; 1,313 of these subpoenas were returned to Court Liaison, reflecting a 39% *non*compliance rate with General Order 8/03 which governs the process and mandates such follow through.

A large disparity was noted between and among the divisions in terms of diligence in serving and returning subpoenas. The most egregious example is illustrated by one division with officers failing to appear for traffic court on 37 occasions during the six-month audit period. The implications here in terms of public service, lost revenue, driver accountability, and the Department's reputation are apparent.

Direction

Prior to this audit, SSD General Order 8/03 which governs the court liaison process was last revised in 1989. Since that time the Department has gone through significant reorganization, now reflected in a decentralized service model comprised of numerous outlying divisions. As a first step in achieving uniform compliance, this directive has been revised effective October, 2008 to correspond with recommendations set forth in the audit. The revised General Order provides for a recurring annual audit of the Court Liaison process. A corresponding training bulletin to explain the updated directive would serve to solidify future expectations.

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Sheriff's Jail Operations

Overview

Correctional Services performed by the Sacramento County Sheriff's Department are administered through the below-described Divisions, each of which provided information for this report consistent with an agreed-upon reporting template. The operation in its entirety is at the same time costly and essential to public safety. The scope and breath of services provided entails an ongoing balancing of resources. Special thanks go to the Correctional Services Executive Staff and Division Commands for their openness in providing the information needed for this report.

The ***Main Jail Division*** is the largest single division within the Sheriff's Department, with 256 deputies and 130 civilian staff. The maximum capacity for this facility, which does not house juveniles, is 2,432 with a daily average of 2,400 inmates. No single jail facility within the State of California surpasses the Main Jail in terms of average bookings per year; (57,000). The Main Jail is the primary custodial facility for pre trial inmates awaiting adjudication from the Sacramento County courts. The facility is also the primary housing unit for newly arrested inmates which includes both misdemeanor and felony arrests, warrants, parole holds, U.S. Citizenship and Immigration Service, Federal, and other arrest categories. Misdemeanor charges, excluding domestic violence, are usually released on notice to appear under Penal Code Section 853.6. In addition, the Main Jail houses inmates enroute to other Federal, state or county jurisdictions. About 170 sentenced inmate workers are part of the daily population at the Main Jail.

The Main Jail is dynamic in that the Lorenzo E. Patino Hall of Justice occupies a portion of the first floor. Consisting of four courtrooms, this facility handles an average of 6,800 court cases per month, mostly from defendants who are in custody and housed at the Main Jail. In addition, the Main Jail seeks to provide required support services for incarcerated individuals. In 2008, the Main Jail implemented a civilian "Ride-Along" program to reach beyond the walls of the jail through on-site community orientation, openness, and partnerships.

The ***Rio Cosumnes Correctional Center (RCCC)*** is the primary custodial facility for inmates sentenced by the Sacramento County Courts. RCCC also houses inmates en-route to other jurisdictions, State prisoners under contract, and reciprocal prisoners from other jurisdictions. Three hundred deputies and civilian staff work around the clock to ensure all inmates receive adequate care while in custody.

The RCCC is the principal reception point for parole violators held pending revocation hearings in the Sacramento Valley Region, and is the central transportation point for all defendants sentenced to State Prison by Sacramento County Courts. Additionally, RCCC serves as the adjunct facility for over-capacity pre-trial inmates from the Sacramento County Main Jail.

The RCCC is unique in that there are several distinctively different facilities in a campus-like setting incorporated into one overall operation. These facilities provide the appropriate level of security to house inmates by their classification. The RCCC includes a women's facility, as well as minimum, medium, and maximum security facilities with daily population levels ranging between 2100 to 2400 inmates. In August, 2008 the Roger Bauman Facility reopened which created 275 new bed spaces for the facility. A variety of support services are incorporated to assist custody staff by providing educational, vocational, medical, and psychological programs for inmates.

The ***Correctional Health Services Division*** provides health, dental, and mental health services to the County's inmate population (approximately 4,500) housed at the Main Jail and Rio Cosumnes Correctional Center at an annual budget of $44 million. This includes on-site care as well as case management of care provided to inmates in off-site facilities. Correctional Health Services operates daily nurse and physician sick-call, providing over 130,000 visits annually. On any given day, approximately 65% of the inmate population is receiving medications, which equates to the administration of over 7,000 individual medications daily.

The ***Work Release Division*** employs a wide array of alternatives to traditional incarceration, thereby reducing both jail population pressures and the enormous cost of incarceration. The program was created in 1978 and has evolved into one of the largest alternative correctional programs in the nation. On average, 1700 inmates participate in the program during any given week.

Work Project inmates perform a variety of tasks for nonprofit and public organizations, including basic landscape maintenance, graffiti cleanup, litter removal, and many other cleanup projects of blighted areas;

The *Sheriff's Toy Project* is the charitable arm of the Sacramento Sheriff's Department wherein participants spend their court-ordered sentence making toys, rebuilding furniture, refurbishing bicycles and donated bicycles. Annual gifts and food are provided to roughly 1500 families and to thousands of children and elderly residents who otherwise would go without;

The *Sheriff's Power Program* is an educational program that operates in partnership with local community college districts to offer education, pre-employment training, and life skills training to offenders in a non-custodial setting, allowing participants to earn college credits while serving their court ordered sentence;

The *Home Detention Program* is an alternative to incarceration. Participants are allowed to continue their employment or education, thereby supporting themselves and their families. Persons whose medical condition would be negatively impacted by incarceration are also

candidates for the program. All participants contribute to their program costs, with fees based on the ability to pay;

The *Center for Corrections Alternative Programs (CCAP)* is an interagency collaborative providing law enforcement, advocacy, and social assistance services to adult offenders in Sacramento County. CCAP serves county offenders, mentally ill offenders, and federal probationers. Re-entry specialists work with participants to determine individual needs and to provide support counseling;

The *Revenue Recovery Warrant Unit* is responsible for enforcing delinquent failure to pay warrants after all other remedies have been exhausted, in order to reinforce public awareness that consequences do in fact exist for failing to comply with court orders. The goal of the project is to reduce the number of misdemeanor warrants resulting from failure to appear or failure to pay fines. The project recently assumed oversight of the DUI First Offender and Check Fraud Programs under the auspice of the District Attorney's Office;

The *Child Support Services Unit* provides contract services to the Sacramento County Department of Child Support Services for civil process. One Deputy is assigned to the unit which serves warrants and civil process related to non-payment of child support fees;

The *Finance and Revenue Collection Unit* began in 1997. Its goal is to foster financial responsibility among convicted offenders for sentencing and related costs. Cost assessments are completed on all Work Project and Home Detention sentences. This year's collections may exceed $7.5 million.

SSD Inmate Population Trends

Planning, organizing, staffing, and directing day-to-day correctional services entails a sense of trends related to the population served. Noteworthy trends reported by SSD Correctional Services include:

Health and Medical

- Increases in chronic disease such as diabetes, kidney disease, and cancer have significantly impacted demand for health services. In the past eighteen months, demand for on-site dialysis services has increased 300%. The incidence of diabetes in the jail population has increased 30% over the last several years, and protocols to manage this expanding chronic care population are being developed;
- The HIV positive population in Sacramento County jails is approximately 2-3% which is double the rate in the Sacramento community. CHS has dedicated resources to the management of the HIV population. CHS partners with the CARES clinic to develop current treatment protocols and management strategies for this population;
- While women only constitute 10% of the inmate population, they utilize services at a much higher rate than men. CHS has developed a Women's Health program to serve the unique needs of women in our facilities;

- Seventeen percent of all inmates receive mental health services while in custody, and this number is increasing.

Classification

- The Three-Strikes inmate population is trending up slightly;
- The average number of inmates in trial or awaiting trail for homicide is on the rise; 158 inmates were in this category in November of 2008;
- The approximate average daily inmate population at the RCCC is trending up; 2006 - 1,704 inmates, 2007- 2,000 inmates. The average daily total population is currently 2,306, representing a 7% increase since January of this year, and an overall increase of 8% from June (2,122) to September (2,306). At this rate the projected year-end population at RCCC will reach 2,490 inmates;
- In June 2008, 52 bunks in the medium security facility were added to house overflow inmates at the RCCC who did not have assigned bunks and were sleeping on the floor. Two deputies were added on dayshift, and one deputy (as a floater) was added to nightshift;
- Weekend commitments at the RCCC are segregated from the general population to prevent recurring problems (i.e., pressure to bring in contraband, intimidation, etc);
- Due to custody population pressures at the Main Jail and RCCC, the Work Release Program is tasked with accepting higher risk offenders with criminal history involving violent crime, sex offenses, drugs, and gang activity. Site officers have reported a higher incidence of defiant program inmates.

Assaults

- The current trend shows an increase in inmate violence at the RCCC. The total number of assaults in 2008 is projected to reach 179, a 22% increase over 2007. Conversely, the number of inmate assaults against staff has declined. In 2007 there were a total of 8 officer-involved assaults, an average of .7 per month. In 2008 there have been only 3 officer-involved assaults, an average of .3 per month reflecting a 57% decrease;
- The combined percentage of state inmates (parole violators and those with state prison commitments) involved in assaults has increased from 18% in June to 24% in August;
- Sentenced inmates represent the largest category of inmates involved in assaults each month; the percentage fluctuates between 45% and 65% of the total assaults.

Executive Directives / Consent Judgments

Correctional facilities are subject to a myriad of regulatory oversight. From time-to-time, intervention is sought through administrative process or the courts in order to ensure compliance with level of care standards. Thus, it is important to monitor the nature and extent of any such intervention within the Sacramento County jail system.

An existing Federal Consent Judgment sets the Main Jail maximum inmate population at 2,432. While no "cap" is set for the RCCC, the facility is rated by the State Corrections Standards Authority at 1603 inmates. All inmates at both facilities are to have an assigned bunk (no sleeping on the floor) and arrestees are not to be housed in the booking area for longer than 12 hours. Other provisions relating to law library access, psychiatric services, and recreation are also covered. No other Executive Directives or Judgments are currently in force.

Synopsis of Ongoing Compliance Audits and Reports

Ongoing inspections of the Sheriff's jail system are conducted by both State and local authorities. At the same time, a number of internal checks and balances are in place. These "systems audits" are designed to help ensure the safe and orderly administration of correctional services. A candid assessment of this ongoing process serves to encourage compliance and elevate public awareness.

Main Jail Division

On May 21, 2008 the Corrections Standards Authority (formerly State Board of Corrections) conducted its biennial inspection of the Main Jail. Areas of non-compliance were noted including insufficient staffing to conduct searches and shakedowns. Also, checks of inmates housed inside the Sobering and Safety cells were not consistently completed or documented. Additional training was provided to booking staff and a standardized method of documenting the officer and medical staff checks was implemented.

Two additional areas addressed by the Corrections Standards Authority (CSA) include fire suppression pre-planning and audio/video monitoring. The Main Jail projects supervisor was assigned the task of overseeing completion of all mandated fire suppression inspections. On June 17, 2007 the Main Jail submitted a Facility Acquisition/Improvement Request to the Sacramento County Department of General Services for an audio monitoring system to be installed in the 'booking loop' cells. As of September 3, 2008 the project was being reviewed by the Sacramento County Facility Planning, Architecture, and Real Estate Department for feasibility and costs.

Rio Cosumnes Correctional Center

On May 22, 2008 the 2006-2008 biennial inspection of the Rio Cosumnes Correctional Center (RCCC) was conducted by the Corrections Standards Authority (CSA). Areas of non-compliance were noted concerning required cell checks, overpopulation in single occupancy cells and dormitories, and inmate ratios in relation to washbasins, toilets, and dayroom facilities. These areas were addressed in a mandated report to the CSA on October 1, 2008. In many instances the conclusion is, *"Absent the construction of a new facility allowing us to significantly reduce the population within all facilities, we will be unable to comply with this regulation… We acknowledge the need to create a proposal to address jail overcrowding…"*

Despite the noted areas of non compliance, the inspection revealed a high level of preparation and attention to detail at RCCC which has raised the bar to a laudable level.

One major area of non-compliance was the California Code of Regulations Title 15 section 1027 covering staffing during movement of inmates. The following steps were documented in the response letter and instituted at RCCC to help alleviate this issue:

- Escort Team implemented on dayshift to more efficiently handle inmate movements;
- Increased staffing in the medium security facility (two deputies on dayshift and one deputy on nightshift) to supervise/manage additional inmates due to 52 bunks being added;
- Formed Medical Escort Teams utilizing retired annuitants to supplement staffing and free up housing unit officers to complete more critical functions;
- Assigned oversight responsibilities to an Operations Commander (Sheriff's Lieutenant) to manage operations throughout the correctional center. Regular audits and inspections will be completed to ensure compliance with regulations;
- Addition of one deputy per shift specifically assigned to Booking to supervise inmates, ensure that safety checks are completed and properly logged;
- Addition of two Security Officers (one per dayshift) at the Gatehouse to enhance security and free up a deputy sheriff for reassignment;
- Creation of staffing plan to address population growth throughout the correctional center.

The RCCC is inspected yearly by the Grand Jury and Health and Human Services for Environmental Health, Medical/Mental Health, and Nutritional Evaluations, and is inspected biennially by the Corrections Standard Authority and State Fire Marshal. With each inspection minor deficiencies may or may not be noted. RCCC then reports any corrective action taken to each of the respective inspectors. At this time all inspections are up to date.

Correctional Health Services

Correctional Health Services has made significant progress with respect to issues identified in the Joseph Brann Report (infra, page 90) and the FY 05-06 Grand Jury Report. The chart below summarizes compliance status:

Issue Identified	FY05-06 Grand Jury	Joseph Brann Report	Current Status
Establish a Forensic Evidence Team		√	Completed – Contract in place for eighteen months
Improve Grievance Response		√	Completed – Dedicated staff in place, all responses are tracked and current.
Change role/expectations of Supervising Registered Nurse (SRN)		√	Completed – SRN role has been redefined as direct supervisor, reduction of administrative duties
Reevaluate staffing levels and workload indicators		√	Ongoing – Staffing patterns are continually evaluated and staff deployed based on inmate need
Address 30% nursing vacancy rate	√		Ongoing - Vacancy rate is currently between 10 – 15%. Recruitment efforts have been successful in reducing use of nursing registry.
Nurses seeing inmates without custody escort	√		Completed – Board approved additional custody resources to provide this valuable service
Install automated pharmacy management system	√	√	In Progress – Project being implemented, "go live" June 2009
Reacquire Institute for Medical Quality Accreditation	√	√	In Progress – Preparation for the reapplication to IMQ is currently underway. Reapplication is anticipated in FY09-10

Medical/Mental Health Audits and Nutritional Standards Audit:

CHS has no outstanding compliance issues as a result of the annual Medical/Mental Health Audit or the Nutritional Standards Audit.

Work Release Division

The Grand Jury recommended additional line staff and a supervisor for the Work Project Program. No additional deputies have been allocated but the Board of Supervisor approved the Sergeant position which was filled in October of 2008.

Sacramento County Courthouse

Inmate Grievances and Incident Reports

Incarcerated individuals must have a viable way to be heard in terms of grievances concerning the conditions of their confinement. This is the essence of the inmate grievance system. There must likewise be an equitable process in place to hold inmates accountable for their actions which put the safety and security of the facility or the wellbeing of others in jeopardy. Incident / disciplinary reports are central to this process. Importantly, this area is a work-in-progress in terms of solidifying reporting expectations. The goal is to encompass inmate grievances, incident reports, and disciplinary reports for each Correctional Services Division, within a viable tracking system to assess systematic issues, historical trends, and where needed, corrective action. In fairness, the agreed-upon annual reporting template for Correctional Services was not established until well into the reporting period. Thus, consistency in this regard is yet to be achieved.

Main Jail Division

Inmate grievances at the Main Jail were compiled for tracking purposes during 2008. While the below-listed categories were tracked, many grievances were not categorized. An overview of the 428 categorized grievances is reflected here. Neither grievance outcomes nor inmate incidents were compiled by the Main Jail during the reporting period. As noted, uniformity of reporting is the goal for 2009.

HEALTH

JPS	Treatment	Meds	Medical	Total
9	60	69	94	232

PROPERTY

Mail	Money	Personal	Tank Prop	Total
7	26	11	3	47

SERVICE

Clothing	Recreation	Phones	Commissary	Food	Total
4	3	0	26	17	50

LEGAL

Attorney	Courts	Law Lib.	Total
1	1	3	5

STAFF CONDUCT

Treatment	Use-of-Force	Misconduct	Total
29	4	0	33

POLICY / PROCEDURES

Discipline	Classification	Security	Facility	Other	Total
24	6	0	4	27	61
				Sub Total	**428**

OTHER

Total
588

OUTCOMES

Denied	Corrective Action	Resolved	Not Grievable	Outstanding	Total
-	-	-	-	-	-

TOTAL GRIEVANCES 2008 Grand Total **1016**

Rio Cosumnes Correctional Center

Inmate grievances at the RCCC are under the oversight of an on-call deputy who maintains a corresponding database and facilitates the grievance process. Potential problem areas are discussed with the Division Commander for appropriate action.

SERVICES

Clothing	Commissary	Food	Laundry	Phones	Recreation	Showers	Visits	Total
9	106	35	1	7	3	9	8	178

HEALTH

JPS	Treatment	Meds	Medical	Total
28	115	90	135	368

PROPERTY

Mail	Money	Personal	Tank Prop.	Total
19	37	28	43	127

PROGRAMS

Education	Religious	Work Project	Total
4	1	4	9

LEGAL

Attorney	Courts	Law Lib.	Total
0	5	12	17

STAFF CONDUCT

Treatment	Use-of-Force	Misconduct	Total
47	2	0	49

POLICY/PROCEDURES

Discipline	Classification	Security	Facility	Other	Total
112	29	2	1	105	249

GRIEVANCES

Denied	Corrective Action	Resolved	Not Grievable	Outstanding	Total
538	118	137	33	171	**997**

TOTAL GRIEVANCES 2008

Incidents

The following chart reflects RCCC documented incidents for 2008. It includes: inmate-on-inmate assaults; inmate assaults on staff; Jail Psychiatric Services (JPS) incidents (most commonly suicidal ideations); medical events and casualties, and unscheduled medical transports to a medical treatment center:

2008	Assault (Inmate)	Assault (Staff)	JPS	Med Casualty	Med Transport
January	10	0	1	2	23
February	11	0	2	1	15
March	11	1	2	5	37
April	20	0	7	2	18
May	13	0	7	5	22
June	26	0	4	5	17
July	16	0	4	3	21
August	17	1	4	3	33
September	13	2	8	5	32
October	18	0	11	6	36
November	19	0	9	8	25
December	13	1	11	3	16
Year Total	**187**	**5**	**70**	**48**	**295**
Mthly Avg	15.6	0.4	5.8	4.0	24.6

Correctional Health Services

Correctional Health Services (CHS) has significantly reduced health related inmate grievances over the past twenty-four months. In July 2006 CHS received about 46 inmate grievances a week between the Main Jail and the RCCC. In June 2008 this figure was reduced to 19 grievances per week. Inmate grievances primarily fall into three categories: access to care, scope of practice/treatment, and medication administration. The chart below shows the breakdown of grievances over the last two years.

Type of Grievance Issue	July 2006 – June 2007 (2540 grievances annually)	July 2007 - June 2008 (1001 grievances annually)
Access to Care	59%	28%
Scope of Practice/Treatment	17%	48%
Medication Administration	24%	24%

There are several changes which contribute to this overall improvement:

Access to Care: A significant improvement has been made in access to care due to effective recruitment and hiring strategies resulting in a substantial increase in clinical hours and the ability to better manage increasing healthcare needs. In addition, the Division has implemented a "no rollover policy" to ensure that inmates are seen within 24 hours of request for sick call. This increased level of service has reduced inmate grievances in this category by 31%.

Scope of Practice/Treatment: Grievances in this category have increased by around 30%, representing an exception to the downward trend. Inmates requesting elective procedures and surgeries make up the bulk of grievances here. Due to limited resources and the increasing demand for mandated services, procedures that are considered elective are not approved.

Medication Administration: This category of grievances has remained stable. A significant decrease in grievances related to medication administration is expected once the automated pharmacy system is fully implemented. The pharmacy project is currently underway, with a target date to "go live" of June 2009.

Rio Cosumnes Correctional Center

Misconduct Complaints

The goal of any disciplinary system should be to eliminate or at least combat the effect of conditions tending to cause or perpetrate misconduct. Reaffirming admirable behavior and managing discipline along with conditions which give rise to misconduct are ultimately internal functions of supervision and command. Thus, having a collective knowledge of on duty adverse behavior becomes a means to an end for the respective Division Commander.

Main Jail Division

Date Received	SSD Case #	Details	Findings
11/26/2007	2007IA-058	Complainant alleges that two deputies assaulted him while removing him from his cell, and that a third deputy assaulted him later when he was being placed back into his cell.	Unfounded
02/04/2008	2008DIV-008	Inmate alleges racial discrimination based on failure to provide medical care.	Unfounded
04/24/2008	2008IA-026	It is alleged Deputies used unnecessary and excessive force against an inmate at the Main Jail.	Investigated as Preliminary Inquiry and Closed
05/12/2008	2008IA-035	Complainant alleges excessive force and unprofessional remarks by officers in booking.	Unfounded
06/05/2008	2008IA-037	Complainant is a Main Jail inmate's mother who alleges that a deputy at the Main Jail injured her son and called him a racial slur.	Not Sustained on Use-of-Force; Sustained on Discourteous Treatment.
06/24/2008	2008IA-042	A Main Jail Sergeant allegedly used unnecessary and excessive force when an inmate failed to comply with orders to keep his hands in his pants.	Unfounded

Date Received	SSD Case #	Details	Findings
08/12/2008	2008IA-047	Complainant is a deputy who alleges his floor partner "played" with the control room taser on several occasions; pointing the laser at inmates and officers. Complainant further alleges subject officer used excessive and unnecessary force on inmates on different occasions.	Sustained
09/12/2008	2008IA-054	Complainant alleges excessive force at MJ.	Investigation Ongoing
09/22/2008	2008IA-056	Complainant alleges deputies assaulted/injured him at the Main Jail.	Investigation Ongoing
10/17/2008	2008IA-065	Complainant is RCCC Administration. Allegation is unlawful and unauthorized use of the SSD computer system.	Sustained

Rio Cosumnes Correctional Center

Date Received	SSD Case #	Details	Findings
02/01/2008	2008IA-016	A deputy refused to cooperate with the Internal Investigators despite being ordered to do so under an administrative admonishment.	Resigned
04/02/2008	2008IA-024	It is alleged a deputy made inappropriate comments toward an inmate and then used excessive force by twisting the inmate's arm.	Exonerated
05/02/2008	2008IA-027	It is alleged a deputy engaged in a prohibited association with a parolee upon his release from custody.	Sustained

Based on misconduct complaints for RCCC there were no specific causative factors, trends, or triggering events that could be identified.

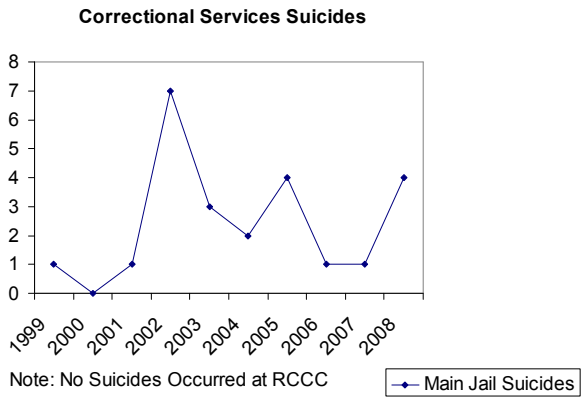
Correctional Health Services

Date Received	SSD Case #	Details	Findings
01/15/2007	2008IA-002	It is alleged that a nurse solicited prohibited business contacts with recently released inmates from RCCC.	Sustained
05/08/2007	2007DIV-020	It is alleged that a nurse at the Main Jail failed to dispense medications to inmates in a timely manner.	Sustained
11/06/2207	2007DIV-047	It is alleged that a clerical employee has an unauthorized visit with an inmate.	Sustained
12/04/2007	2007DIV-052	A nurse allegedly administered medication to an inmate improperly on two occasions.	Sustained
12/04/2007	2007IA-060	A lunchbox belonging to a Health Services staff member, which had controlled substances, was found in the RCCC parking lot.	Resigned

Inmate Deaths / Interventions

At the core of any custodial system is its ability to safeguard the well being of those incarcerated. This challenge is heightened by the reality that desperate people sometimes do desperate things. Sadly, inmate deaths will continue to confront and challenge custody professionals. The inquiry is whether those in charge can point to a proactive, ongoing process designed to evaluate, mitigate, and preempt conditions underlying in-custody deaths.

In-custody deaths which occurred during 2008 at the Sacramento County Jail and the Rio Cosumnes Correctional Center, other than those resulting from natural causes, are reported in the "Critical Incidents" section of this report (supra, page 52).



Quite often, direct intervention by custody staff to prevent death or serious injury to an inmate does occur. Upon request from the Office of Inspector General, these incidents are listed here.

Main Jail Division

Date	Means	Successful Intervention
01/13/2008	Hanging	Booking deputy observed and intervened
01/16/2008	Strangling	Deputy heard banging noises in pod and intervened.
01/17/2008	Cut arm with broken piece of plastic	Deputy observed and intervened during cell checks
01/24/2008	Hanging	Deputy checked welfare while in classroom
01/31/2008	Strangling	Psychiatric nurse reported to deputies the inmate had covered himself with his mattress
02/14/2008	Pulled lines from arm during dialysis causing significant loss of blood	Deputies and nurses intervened
03/13/2008	Strangling	Inmate alerted Deputy who intervened
03/30/2008	Strangling	Booking deputy observed and intervened
04/24/2008	Drank disinfectant cleaner	Deputy intervened, handcuffed inmate and sought medical attention
06/27/2008	Hanging	Deputy observed during count/cell check and intervened
07/07/2008	Strangling	Emergency button by cell mate
07/07/2008	Strangling	Cell check
09/12/2008	Strangling	Cell check
09/30/2008	Strangling	Cell check
10/02/2008	Strangling	Cell check
10/21/2008	Strangling	Emergency button by another cell
10/30/2008	Strangling	Deputy Visual
11/03/2008	Strangling	Deputy Visual

Note: Strangling denotes self-inflicted harm.

Rio Cosumnes Correctional Center

Date	Means	Successful Intervention
07/01/2008	Accidental Choking	A deputy in the Sandra Larson Facility chow hall observed an inmate choking on a piece of food. The deputy administered Heimlich abdominal thrusts to the inmate preventing her from choking.
08/25/2008	Accidental Choking	Two deputies in the Sandra Larson Facility chow hall administered the Heimlich abdominal thrusts to an inmate, preventing her from choking on a piece of food.

ENHANCEMENTS

Sheriff's correctional facilities evaluate ongoing enhancements to safety, security, and quality of care. Realistically, the challenge is to prioritize those things which will do the most good, since not everything which is desirable is likewise feasible given finite resources. A flexible vision, perseverance, and adapting to changing circumstances will no doubt become increasingly important. Recently implemented or currently pending enhancements include:

Main Jail Division

Internal and external security measures have been implemented to include increased screening at the public entrance, creation and staffing of a designated search team, and comprehensive analysis of staffing assignments. Planned external security measures include installing guard shacks at the east and west garage roll-up doors in an effort to increase security by providing direct observation of and communication with all personnel entering the facility garage. Increased screening at the public entrance came as a result of contract employees bringing contraband into the facility.

The 2008 Corrections Standard Authority audit noted excess contraband as well as an overall lack of cleanliness in the Main Jail housing areas. This was in part due to the lack of available staffing and time for officers to complete routine shakedowns and searches, while still accomplishing mandated tasks and services. As a result, the Main Jail created a search team comprised of a Deputy from each of the four respective shifts to conduct contraband searches of the facility and individual cells. The search team coordinates its efforts with information supplied by the Main jail Intelligence Services team and various individual officers. In recent months, the team has located several weapons (metal / plastic remnants with sharpened edges or points), drugs, contraband clothing items, and excess trash in individual cells, resulting in a cleaner and safer environment. Additionally, the Main Jail is examining the efficiency of its current staffing configuration; officers will be redeployed as needed to provide enhanced security.

Rio Cosumnes Correctional Center

The Rio Cosumnes Correctional Center is undergoing numerous changes designed to enhance safety and security throughout the facility, including refurbishing the Roger Bauman Facility, creation of an all new control point/tower for the honor facility, and the addition of video surveillance. In addition to these changes, day-to-day operations have been adapted to fit the need for a timely response to critical events, and to provide for security escorts within the secure areas. Some of the more noteworthy changes are:

Briefing Room: Created multi-purpose room designed for briefings, training, and use as a major incident Command Post. The room includes five LCD televisions, multiple internet and telephone connections, multi-media equipment cabinet, and a command station;

Development of Escort Teams: Four-person escort teams were established utilizing Custody Emergency Response Team members on both day shifts. This has decreased response times to incidents, expanded search capacity, and reduced escort delays;

Medical Escort Team: A four-person medical escort team was developed by using retired annuitants. The escorts work eight hour shifts on weekdays which coincide with the nursing schedules. This has reduced staffing costs and has increased the level of service;

Closed Circuit TV Project: This project included the addition of 294 cameras to the facility. It allows for live video surveillance at all control points. Recordings are retained for approximately thirty days;

Correctional Canine Proposal: A Corrections Canine Unit was approved which will include two dogs trained for the detection of illegal narcotics and contraband (tobacco and alcohol) in the facility. The unit is scheduled to be operational in December, 2008;

Maximum Security Food Ports: All cell doors in the Stewart Baird Facility (SBF) and the Christopher Boone Facility (CBF) were retrofitted to include food ports. This was accomplished by our on-site welding shop and has added to the security of the facility;

Investigative Services Unit (ISU): Two Deputies and a Records Officer were selected for positions in the ISU. The primary responsibility of the unit was redefined to be safety and security. The first Annual Report covering statistics and trends was completed by the ISU in 2007, as a tool to better manage resources on a continuing basis;

Eliminate all contact visits: A construction plan has been submitted to create additional visitation areas inside the indoor recreation hall to facilitate no-contact visits, and thus limit the introduction of contraband into the facility;

Eliminate safety razors on the compound: The Honor Facility is the only existing correctional facility managed by the Sacramento County Sheriff's Department that still uses plastic disposable straight blade safety razors; their removal is pending final recommendation;

Leadership training for corrections: The Sheriff's Department has recognized the need to develop a Leadership training plan for managers and supervisors assigned to corrections. An eight hour training course is on the drawing board;

New Honor Side Tower: A request is pending before the Sacramento County Real Estate Department to design and build a new control point tower for the Honor Facility;

Correctional Health Services

Correctional Health Services is facilitating several enhancements that will improve the quality of inmate care:

Fully Automated "Closed Loop" Pharmacy Project: In June 2008, the Sheriff's Department executed a contract in the amount of $5.4 million dollars with McKesson Provider Technologies to install a fully automated closed loop pharmacy. The project is currently underway and is scheduled "go live" in June 2009. In addition, facilities improvements were made to both the Main Jail and RCCC so that pharmacy licensure could be obtained for both facilities, which was granted by the State Board of Pharmacy in June 2008;

Creation of Inmate Healthcare Hotline: In October 2007, Correctional Health Services established an inmate healthcare hotline. This hotline is open to families, attorneys, and other interested parties with questions or concerns related to inmate healthcare. The hotline can be accessed by telephone or through the Sheriff's website. The creation of this hotline has been popular with family members and the legal community and facilitates timely verification of health services related to inmate healthcare needs;

Establishment of a Nurse Training Program: Correctional Health Services has established a nurse training position which is responsible for coordinating orientation procedures and classes as well as ongoing training. This program has been well received by staff and will further improve service delivery as well as recruitment and retention of quality staff;

Expansion of In-House Specialty Clinics: The demand for access to medical specialists by inmates is increasing rapidly. The availability of specialty appointments in the community is limited and requires the movement of an inmate by custody staff. In order to provide enhanced access to specialty services, CHS is pursuing the expanded use of telemedicine as well as an increase in the types of specialty care provided on-site.

Work Release Division

A number of recently completed and pending improvements to various Work Release programs will help raise the level of service provided:

Work Project: A new Inmate Tracking System is in the works which will create an almost paperless administrative system. Also, bike training for site officers, and designation of a Problem Oriented Policing (POP) position to work closely with district POP officers to cleanup blighted areas, have enhanced the project;

Toy Project: Fundraising events have made it possible to reach financial stability for the Toy Project. We no longer rely on non-profit organizations to help fulfill donation requests;

Home Detention Program: Technology has advanced dramatically and soon each participant in the Home Detention Program will be equipped with a one piece transmitter that can be activated to a GPS tracker. Participants who require alcohol monitoring will be equipped with a trans-dermal unit that detects the presence of alcohol evaporating through the skin;

Finance: Updated collections management software is pending installation in early 2009 to aid with small claims judgments and credit reporting cases against delinquent payers who clearly have adequate assets to pay their costs, but refuse to do so.

Direction and Challenges

Running SSD Correctional Services or any of the Divisions which make up this enterprise is a daunting challenge. Public awareness of the critical challenges which lie ahead ties directly to the stated objective of Sheriff McGinness to add transparency throughout SSD operations. Thus, each Correctional Services Division was asked to give a candid, forward looking assessment of their respective areas of responsibility.

Main Jail Division

The single greatest challenge facing the Main Jail is insufficient housing space. Currently, no misdemeanant remains in custody regardless of the bail amount. For example, repeat DUI offenders and prostitutes are released back into the community with an assigned court date. Frequently, these offenders fail to appear and are rearrested on new charges while out of custody. The implications here in terms of public safety and community well being are self apparent. Regional population increases coupled with proactive law enforcement efforts will predictably add to this dilemma. Thus, future challenges for the Main Jail center around inmate population pressure and sufficient staffing levels.

Internal staffing audits have been completed by the Sheriff's Management and Planning Bureau (MAP) and via independent study through *Joseph Brann and Associates*. The MAP Bureau suggested minimum and ideal staffing levels for the Main Jail, while the Brann audit suggested a comprehensive analysis to determine ideal staffing levels for the facility. The Corrections Standards Authority annual audit suggested inadequate staffing was quite possibly the underlying cause of several noted deficiencies. Plans are urgently needed to address this emerging problem.

Rio Cosumnes Correctional Center

Three major concerns are identified by the facility commander at the Rio Cosumnes Correctional Center; (1) growing inmate population, (2) illicit narcotics/contraband, and (3) assaults. The expanding inmate population has increased the flow of illegal drugs into Sacramento County correctional facilities. Recently, the inmate population has grown faster than proportional staffing levels. This imbalance has created an increased risk of assaults on inmates as well as staff.

In February, 2006 an assessment of the SSD jail system prepared by *Joseph Brann and Associates* highlighted the lack of staffing and supervision at both the Main Jail and RCCC. The auditors recommended a comprehensive analysis of staffing at both facilities to identify critical positions and staffing needs, and to assess the viability of consolidating positions or responsibilities to enhance safety and efficiency. A subsequent internal assessment in June 2007 by the SSD Management Analysis and Planning Bureau identified similar problematic issues regarding projected inmate population growth and parallel staffing concerns. These staffing issues remain acute for the facility. Beyond this, the RCCC Command Staff is engaged with the County Facility Planning, Architecture, and Real Estate Department for implementation plans and costs associated with expansion of the facility.

Correctional Health Services (CHS)

Improvement of the CHS Division medical practice will be contingent on addressing two main issues: (1) the need for an electronic health records system, and (2) rising healthcare costs predicated on inmate population increases.

Electronic Health Record: The volume and complexity of healthcare between and among SSD correctional facilities demands centralized health records access by a wide array of physicians, nurse practitioners, psychiatrists and nurses. CHS will be working to develop a funding strategy for this critical component.

Rising Costs: CHS manages the ever increasing need for inmate services related to chronic disease and acuity of disease. This increased demand has not seen a proportional increase in funding. While the problem is self apparent, the solution is yet to be identified.

Work Release Division

Work Project: Staffing to manage the increase in program participants is the single greatest challenge to the viability of this program. Greater numbers of higher risk offenders are coming into the program due to jail population pressures. Maintaining a high level of supervision, while ensuring officer and participant safety, is seriously stretched by a ratio of approximately 30 inmates to one officer;

Toy Project: As our economy and housing troubles rise, a record number of requests for services are expected. Scrutinizing requests more closely and being more creative with fundraising are a by-product of declining donations due to economic uncertainty;

Home Detention: The Home Detention Program has expanded by approximately 120 inmates over the past couple of years. Staff has increased by two full-time sworn officers and an additional Records Officer. While future expansion will require additional staffing and expanded facilities, the cost savings when compared to incarceration are readily apparent. *An option to explore would be staffing two Home Detention offices, one on each side of the American River;*

Revenue Recovery Warrant Unit: The Warrant Unit is evaluating whether to expand the scope of warrants processed in order to increase revenue, and also examining the suitability of prerelease procedures to facilitate compliance with court directives;

Inspector General Findings and Recommendations

A laudable effort exists in terms of directing SSD Correctional Services. The growing reality of finite resources and the recurring "roll-over" of custody staff inherent in SSD corrections, call for a collaborative of "best thinking" in order to effect desired outcomes in spite of these daunting challenges.

This report and the recommendations which follow are merely a beginning along what will hopefully be a continuum of constructive dialogue and actions designed to improve SSD Correctional Services.

I. Planning:

- As an urgency matter, direct a report back on short-term strategies and long-range remedies to address the population pressures at the RCCC and the Main Jail, as reflected in this report and as identified in the Joseph Bann & Associates Jail Audit as well as the Department's Management Analysis and Planning Study;
- Continue with commendable efforts to raise the bar in safety and security, service delivery, and accountability;
- Integrate Correctional Services as a stakeholder in Project Horizon, a collaborative effort to identify patterns of conduct which expose the Department and individuals to liability in order to engage preemptive strategies (Supra, page 42);
- Continued review by the Professional Standards Bureau Commander and concerned Division Commander to assess preemptive strategies following sustained misconduct, with recordation of same included as part of the case file; *(provide for this review in the SSD General Order on disciplinary procedures)*;
- Organize inmate grievances, incident reports, and disciplinary reports for each Correctional Services Division into a viable tracking system suitable for analyzing systemic issues, and where needed, corrective action;

II. Supervision and Training:

- Add "Leadership Development" to the annual reporting template for Correctional Services with a *deliberate focus on first-line supervisors relative to their critical role in preempting adverse actions;*
- Integrate the *Joseph Brann & Associates* training recommendations (see Appendix page 90) with *Strategic Direction 3.0, "Enhanced Correctional Services," in the SSD 2008-2013 Strategic Plan;*
- Encourage and support proactive in-house training between and among the Divisions as illustrated by current efforts at the RCCC.

III. Recommendations covered in-depth in the "Critical Incidents" section of this report include:

- Revise Correctional Health Services policy to define what steps are required following in-custody deaths;
- Provide for response by SSD homicide detectives to in-custody deaths, other than those resulting from natural causes;
- Prioritize acquisition of electronic health records system to meet industry standards for inmate medical care;
- Revisit priority of capital improvement request for tier-enclosure to prevent suicide "jumpers" at the Main Jail.

- Continued due diligence by the Jail Suicide Prevention Task Force to evaluate and implement prescriptive measures, to include assessing the need for and viability of expanding in-patient Jail Psychiatric Services.

Appendix

Prior Audit Completed by Joseph Brann and Associates and the Public Strategies Group, Inc.

On January 31, 2006, the Sacramento County Board of Supervisors authorized an audit of the Sheriff's correctional facilities to be completed by *Joseph Brann and Associates and the Public Strategies Group, Inc.* The audit was to focus on systemic concerns arising from allegations of mistreatment relative to the handling, processing, and treatment of individuals in custody. The consultant presented recommendations to the Board on June 20, 2006; the Sheriff presented his response to the Board in October 2006, with an update report to follow. In December 2008, a report was sent by Sheriff McGinness to the Board of Supervisors and is available online at *http://www.sacsheriff.com*. Listed below are excerpts from this report:

Jail Operations Orders

Recommendation

Establish a formal review process to periodically update all Operations Orders and ensure this occurs no less frequently than every two years.

> *Status: Review and revision of the Operations Orders for the Main Jail and the Rio Cosumnes Correctional Center has been completed, resulting in combined Operation Orders for consistency between the two facilities. The revised Operations Orders have been published and are available on the Sheriff's Department internal website.*

Training

Recommendations:

Design a formal training curriculum for command staff (Captains and Lieutenants) based on the agency's vision and expectations of those who command jail operations.

> *Status: This project is ongoing. In the interim, Correctional Services has presented to all its supervisors and managers, a 4-hour block of instruction on leadership principles and best practices. This training included general expectations, case studies, and other topics directly related to the correctional environment. Each Correctional Services Division has developed another 4-hour block of site-specific instruction to complement the initial training.*

Allocate sufficient funding in the training budget to support the ongoing development of the critical management and leadership skills that are unique to the corrections environment.

> *Status: This project is ongoing pending allocation of recommended funding. In conjunction with the Sheriff's Strategic Plan, the RCCC has an Employee*

Development and Organizational Excellence class "in progress." Beyond this, mandatory supervisor classes include:

- *Incident Command System Training*
- *Sexual Harassment Training*
- *Supervisor and Management Training Classes*
- *Custody Emergency Response Team Core Classes*

Increase training opportunities for all correctional staff at the Main Jail and RCCC (including resources for offsetting overtime costs for covering shifts).

Status: This project is ongoing pending allocation of recommended funding. In-house training requires staff members to be trained as trainers, and is difficult to accomplish given mandated staffing assignments. The Main Jail training budget is currently $19,000 which is smaller than most other Divisions in the Department, despite being the largest division in the Department. Until recently, the training budget for RCCC has been less than $20,000.00 annually. There are several mandated training courses, including:

- *Jail Operations*
- *Emergency Vehicle Operations*
- *Advanced Officer Training (AOT)*
- *Automated Field Reporting (AFR)*
- *Basic POST Supervisory Course*
- *Basic POST Management Course*
- *Incident Command/Management Courses for Supervisors and Managers*
- *Mobile Field Force Training*
- *Maximizing the Workplace*
- *Sexual Harassment/Discrimination Training*

Ensure that newly assigned Sergeants and Lieutenants attend the first available Jail Operations Course (or refresher training) prior to their promotion and assignment.

Status: In early 2008, arrangements were made with the Training and Education Division to schedule a full Jail Operations Course at the conclusion of each basic recruit academy. This allows timely attendance by Deputies, but also allows the assignment of other department personnel to the course as needed and on a more predictable schedule. Unfortunately, scheduling this training for anticipated promotions is not always practical.

Access to Medical Care

Recommendations:

Correctional Health Services (CHS) needs to establish staffing levels and workload indicators based on the most cost effective/efficient strategies that will enable them to meet service demands.

Status: CHS has pursued an aggressive recruiting strategy for both physicians and nurses. The Division has hired twelve new physicians in the last year and has brought the nurse vacancy rate down by 30%. The Division has established a no-rollover policy which requires that all patients be seen within 24 hours of signing up for sick call. This additional staffing and changes in approach to workload has increased patient visits by over 30% in the last year.

In addition, CHS is pursuing expansion of on-site specialty clinics. This will shorten the time it takes to get patients into an appointment with a specialist and will reduce the reliance on medical transport resources. Overall, significant strides have been made in this area and CHS will continue to review staffing patterns and procedures to optimize service provision while working within our budget constraints.

SSD should strive to recognize the exemplary work and achievements of CHS staff to build morale and a sense of inclusion. Members of CHS feel presentations and recognitions at national correctional meetings have gone unrecognized by anyone beyond CHS administrative staff.

The Sheriff recently revised internal policy to include non-sworn personnel in the Department promotional ceremony. In addition, the Department has promoted inclusion of CHS employees in the annual employee awards ceremony. The CHS Division management has sponsored an annual employee recognition luncheon to celebrate the Division's accomplishments and to recognize the numerous contributions of staff to the mission of the Department.

Establish an automated pharmacy system to reduce the potential for human error, medication oversights, inmate grievances, liability exposure and the potential for litigation.

Status: In June 2008, the Sheriff's Department executed a contract in the amount of $5.4 million dollars with McKesson Provider Technologies to install a fully automated, closed-loop pharmacy. The project is currently underway with a scheduled "go live" date of spring 2009. In addition, facilities improvements were made to both the Main Jail and RCCC so that pharmacy licensure could be obtained for both facilities, which was granted by the State Board of Pharmacy in June 2008.

SSD and CHS should pursue the accreditation of jail medical services through the Institute of Medical Quality (IMQ). The benefits of accreditation include recognition that the SSD is operating in accordance with the current professional standards of inmate health care. It could also enhance risk management efforts by reducing liability exposure.

Status: At the time of the Joseph Brann audit there were two areas that precluded Correctional Health Services from re-applying for accreditation through the Institute

for Medical Quality (IMQ): (1) the need to create a separate forensic evidence team, (2) the need to establish an automated pharmacy process. The forensic evidence team has been created through contract with Valley Toxicology and the automated pharmacy is being implemented through partnership with McKesson Medical Technologies.

In anticipation of completing the pharmacy system, CHS is currently reviewing policies and procedures with the goal of applying for re-accreditation through the Institute for Medical Quality (IMQ) in Fiscal Year 2009-2010.

Establish a Forensic Evidence Collection Team to comply with Title XV regulations governed by the Correctional Standards Authority, the March 2006 Grand Jury Review, and the Institute of Medical Quality (IMQ) Essential Standard 601.

Status: A contract for this service was executed with Valley Toxicology and has been in place for the last eighteen months. The Corrections Standards Authority recently completed their biennial audit and found the medical practice to be in compliance with this requirement.

Inmate Grievances

Recommendations:

Medical and custody staff jointly should examine the unusually high number of grievances concerning health care issues to determine what can be done to reduce these.

Status: CHS has reduced inmate grievances by over 80% in the last eighteen months. There are several changes which contribute to this improvement:

Access to care

Status: A significant recruitment effort has been underway and the practice now has significantly more staff to provide timely care. Access to care represented over a third of all grievances.

No Rollover Policy

Status: A policy has been implemented that CHS medical staff ensure that a patient is seen within 24 hours of the inmate's request for sick call. Again improved access to care has mitigated grievances significantly.

Inmate Healthcare Hotline

Status: CHS established an inmate healthcare hotline which can be utilized to alert the Division to health related issues. This has assisted the division in confirming outside treatment orders and brought to light issues that were not otherwise reported. The hotline handles between 80 - 100 calls per month and covers both medical and psychiatric care.

Staff responsible for the commissary should examine those trends and factors leading to grievances that are routinely resulting in refunds.

Status: The commissary procedures have been audited with several different delivery scenarios tested. A new delivery system to be implemented should considerably reduce grievances as commissary is being double checked at the time of delivery and rectified with the vendor's employee who is present. While this delivery procedure will add some time to the overall process, it should reduce grievances resulting from commissary discrepancies.

CHS should establish a system to ensure all inmate medical complaints are routinely reviewed by medical staff as well as jail management staff.

Status: All medical related grievances are first processed and logged by custody personnel and then sent to CHS for follow-up. Designated staff at each facility review the grievances and resolve any issues that are identified within 24 hours (per CHS procedure). All grievances are responded to in writing within 4 days per SSD procedure.

The role and expectations of Supervising Registered Nurses concerning their management duties versus their responsibility to also serve as a direct service provider requires clarification because of differing interpretations and/or expectations among unit personnel.

Status: The role of the Supervising Registered Nurses (SRN) was returned to a front-line supervision model. The staffing office was expanded to seven days a week so that the SRN can remain focused on daily tasks at the facilities.

Risk Assessment

Recommendations:

Ensure that staffing is appropriate for all medical runs.

Main Jail

Status: At the Main Jail, on-duty personnel are used for all unscheduled or unexpected medical runs for injured or ill inmates. Medical runs are always staffed with two deputies to ensure safety; this leaves the shifts short for other daily operations inside the facility. The Medical Transport Unit handles all pre-scheduled outside medical appointments. It is virtually impossible to predict when an emergency medical transport will occur, so pre-staging staff for this purpose would not be fiscally sound.

RCCC

Status: During the past 10 months RCCC has experienced over 400 unscheduled medical transports. Command Staff allocated two-deputy teams during dayshift.

These officers are first up for medical runs if they are not otherwise transporting inmates to regularly scheduled appointments.

The RCCC Division Commander has published revised staffing guidelines for unscheduled medical runs. The guidelines provide supervisors with direction on where to pull employees from if medical runs are needed. This process was enacted to mitigate adverse impact on the facility.

Minimum staffing levels were evaluated and re-established for each shift. The supervisors have the authority to call in additional employees on a case by case basis when they have an excessive medical runs (or other emergencies) that adversely effect operations of the facilities.

RCCC Population Increases

YEAR	*AVG DAILY POPULATION*
2001	*1132*
2002	*1260*
2003	*1477*
2004	*1688*
2005	*1822*
2006	*1985*
2007	*2139*

The RCCC population has more than doubled in the past 7 years, to include an ongoing average of 700 pre-trial inmates. Due to RCCC taking overflow inmates from the Main Jail, they are experiencing a higher number of inmates with acute medical problems than ever before. Although the population has grown significantly and our medical staff is dealing with more severe acuity, there has been no increase in the number of staff dedicated to medical transportation. Therefore, the shifts bear the burden of staffing unplanned emergency medical runs.

Implement a formal critical incident debriefing process to be employed following any use of force incident, major incidents that are unusual or rarely occur, or those that result in injury to any SSD employee or inmate.

Status: Operations Orders for both the Main Jail and the Rio Cosumnes Correctional Center outline post-incident procedures for most critical events that occur within the jail facilities.

Consider equipping all deputies with digital audio recorders.

Main Jail

Status: At the Main Jail, digital recorders have been issued to all sworn supervisors and to all officers assigned to the Intelligence Unit due to a demonstrated need. It was deemed cost prohibitive to issue these devices to all other sworn staff.

RCCC

Status: Two digital recorders have been made available to supervisors. In addition, handheld video cameras are available at various facility work stations. A recently installed digitally recorded Closed Circuit Television (CCTV) Video Surveillance system contains approximately 350 surveillance cameras throughout the facility; the system does not have audio capabilities.

Utilize the Early Warning System more fully by incorporating an administrative component to track and assess a broader range of performance indicators that can help identify and respond to evolving personnel issues.

Status: The Professional Standards Bureau provides up-to-date case summaries to each Division Commander on a monthly basis. The Commander of Internal Affairs and his investigators communicate with Division Commanders if any concerns arise related to trends that may need to be addressed. The Commanders in turn discuss any concerns with Watch Commanders in order to monitor and evaluate the performance of personnel and ensure corrective action is taken in a timely manner.

On an ongoing basis, review all claims filed against the Department involving jail operations. Disseminate that information to all managers and supervisors to heighten attention to trends and patterns within the facilities, on shifts, in certain commands and otherwise. Based on this regular review, ensure that steps are taken to resolve and prevent future claims.

Status: The Chief of CHS reviews all claims filed with Risk Management and contacts the insurance adjuster to provide any appropriate information. This information is used to track trends in care management and policies are implemented to modify practices when appropriate to mitigate future liability.

Review procedures and systems to improve the handling and protection of inmate property.

Status: Tracking and managing inmate property is a strategic action that has been identified in the Department's Strategic Plan (item # 7.4.2 - Evaluate and pursue technologies to track and manage all inmate property).

RCCC

Status: In February 2008, the old armory was converted to a secure inmate property storage room. Procedures were revised to ensure inmate workers were more closely monitored. These changes have had a significant impact on the number of inmate grievances and claims. A check of recent grievances showed that mishandling of inmate property is not currently an issue at RCCC.

Main Jail

Status: In 2007, the Main Jail received numerous grievances and claims regarding misplaced and lost inmate property. An audit was completed and there were several hundred boxes of property that had not been released when inmates were transferred to other facilities/agencies or released from custody.

Regular audits and revised procedures have been implemented to correct this problem.

Undertake a comprehensive review of nurse safety concerns and consider better use of technological solutions and staffing measures to remedy those concerns.

Status: Both the Main Jail and RCCC schedule On-Call Deputy Sheriffs Monday through Friday to provide security during Nurse's and Doctor's Sick Call appointments. This has resulted in better working relationships between medical and custody staff.

Main Jail

Status: In addition to the deputies assigned to Nurse's and Doctor's Sick Call, the exam rooms throughout the Main Jail are equipped with emergency panic buttons medical staff can push to alert custody staff of any problems. The rooms are also equipped with intercoms which allow medical staff to contact custody staff directly in the control rooms.

Medical staff from the Main Jail are currently researching an electronic personal safety device, and are also working with custody staff to have an emergency "panic" button installed in the dialysis room in the Jail Infirmary.

RCCC

Status: In 2008, correctional health staff (medical and psych) at RCCC were issued Nextel cellular telephones with the push-to-talk feature. This enhanced communication between custody staff and correctional health staff enables a more timely response to emergencies throughout the 66 acre facility.

The Nurse's Station in the Medical Housing Unit (MHU) is equipped with an emergency panic button, as well as hand-held portable personal safety devices which medical staff can use to summon assistance.

The exam rooms throughout the facility are not equipped with emergency panic buttons, however the deputies assigned to Nurse's and Doctor's Sick Call are physically present whenever inmates are seen.

Utilize video surveillance equipment to improve the ability to monitor activity inside the barracks and walkways around the dorm facilities.

Status: The Rio Cosumnes Correctional Center has undergone numerous changes to create a more secure environment at the facility. This includes the addition of closed circuit television cameras throughout the facility. This project included the addition of 294 cameras to the facility. It allows for live video surveillance at all control points and stores all recording for approximately thirty (30) days.

Develop and implement a plan to construct additional sobering cells, safety cells and holding cells at the RCCC facility to meet Title XV guidelines and current needs for these facilities.

Status: In June 2007 the Sacramento County Sheriffs Department, Management Analysis and Planning Bureau conducted an analysis for the Main Jail and RCCC. This independent report identified the aforementioned issues in its assessment of inmate population growth and related staffing concerns.

Efforts by the RCCC command staff to engage the County Architectural Services Division and Nacht and Lewis Architects in developing long term master planning for the facility are on hold due to County-wide budget constraints. In the interim, the Commander has forwarded to the Chief of Corrections a plan to mitigate overcrowding issues absent the development/funding of new construction.

Update technology to improve safety for deputies (e.g. video monitoring, replacing unsafe doors and antiquated door locking mechanisms, control room technology).

Status: In October 2005, the Main Jail completed a comprehensive project to replace the computerized control systems in the entire facility. The project was successfully implemented and numerous issue involving malfunctioning locks and other officer safety issues were resolved.

In November 2005, the Main Jail video recording system was upgraded to a digital system of the entire booking area. All cameras were inspected and replaced if needed to obtain the best video quality. In 2006, additional cameras were added including pan & tilt cameras to the outside of the facility to increase the security and monitoring capabilities of the facility.

In spring of 2009, the Main Jail is scheduled to add an additional 200+ video cameras which will record and monitor the dayroom areas of all floors in the facility. This added security for officers and inmates is a welcome addition to the facility.

The Main Jail is currently evaluating many of the doors leading in and out of the facility in an effort to increase security. The long term plan is to install new lock mechanisms utilizing existing proximity cards for controlled access. The proximity card system allows the administrator of the system to grant access to individual doors by authorized personnel.

Review nurse safety issues. Improve safety measures for all civilian staff (e.g. personal alarms for nurses, kitchen safety for civilian cooks).

Status: There have been several changes in the area of nurse safety. There are custody escorts when the nurses go to the housing units to perform pill call or nurse call assignments. This has been in place for the last eighteen months.

In addition at RCCC, Nextel communication units have been given to key nursing and custody personnel so that information can flow quickly to improve emergency response and overall communication throughout the facility. Custody is also providing safety training for all non-sworn staff as they are hired into the Department. This training has been integrated into the orientation process for all medical staff.

During the summer of 2007, the RCCC Division Safety Officer began teaching a two-hour Safety Orientation class to all civilian personnel. The class includes an overview of the various housing units, the types of inmates housed at RCCC, safety and security tips, as well as information related to key control and employee conduct.

In January 2008, the RCCC Commander issued a directive that the Kitchen Officer shall be physically present in the kitchen anytime inmates are present. This alone has enhanced safety and a more secure feeling for civilian cooks. All trash runs are now escorted by custody staff. Security lanyards were attached to all cutting implements in the RCCC Kitchen to prevent their removal from the inmate work stations.

During the spring of 2008, cameras were added to the kitchen, which allows custody staff to monitor and observe inmates and civilian staff to further enhance safety and security.

Jail Mental Health/Suicides/Interventions

A Sacramento County Jail Suicide Prevention Policy Document should be developed that addresses The National Commission on Correctional Health Care Standards (1987, 1992). The document should detail a comprehensive suicide prevention plan that includes specific documentation including: Identification, Training, Assessment, Monitoring, Housing, Referral, Communication (i.e. a new intercom system), Prevention Levels, Intervention, Notification, Reporting and Review. This recommendation will prove helpful as both a preventative *and responsive suicide prevention resource.*

Status: The Correctional Health Services/Jail Psychiatric Services (CHS/JPS) Suicide Prevention Policy is under constant review to ensure compliance with national standards. When areas of improvement are identified through this review they are integrated into current policy.

SSD and JPS should review existing Training Curriculum Standards to ensure that staff receives at least 8 hours of suicide awareness and prevention training. The training should be formalized into a curriculum based on identified best practices. This recommendation is

particularly important given Sacramento County's high rate of suicides and the need for the SSD to be more proactive in suicide prevention awareness and training.

Status: Both custody staff and Jail Psychiatric Services (JPS) work together on this issue by giving each deputy a full-day orientation in psychiatric issues and suicide prevention as part of jail operations training. In addition, JPS provides an ongoing refresher course of three half-hour trainings to custody staff throughout the year at both the Main Jail and RCCC. Finally, JPS provides eight hours of training in suicide prevention as part of the Basic Recruit Academy.

Consideration should be given to other disciplines (i.e. the medical community, mental health, public health, community organizations, academia etc) for inclusion into the Inmate Welfare Commission (IWC) and the Suicide Prevention Task Force (SPTF). Currently both the IWC and SPTF consist solely of internal staff from JPS and the Main Jail.

Status: The Inmate Welfare Committee General Order is pending revision to reflect contemporary practices which align with current Department structure, process, and terminology. The Suicide Prevention Task Force consists of the following:

- *Commanders of both Main Jail and RCCC*
- *Assistant Commanders of both Main Jail and RCCC*
- *Chief of Correctional Health*
- *Medical Director Correctional Health*
- *Directors of Nursing for both Main Jail and RCCC*
- *Medical Director, UCD Jail Psychiatric Services*
- *Clinical Director, UCD Jail Psychiatric Services*
- *Chair, Department of Psychiatry and Behavioral Sciences, UCD*
- *Chief Administrative Officer, UCD*

The Suicide Prevention Task Force and SSD Management should regularly review suicide prevention standards (i.e. Title 15, ACA, NCCHC etc.) to ensure maximum adherence with these standards. On-going communication with other jail jurisdictions could assist in this process.

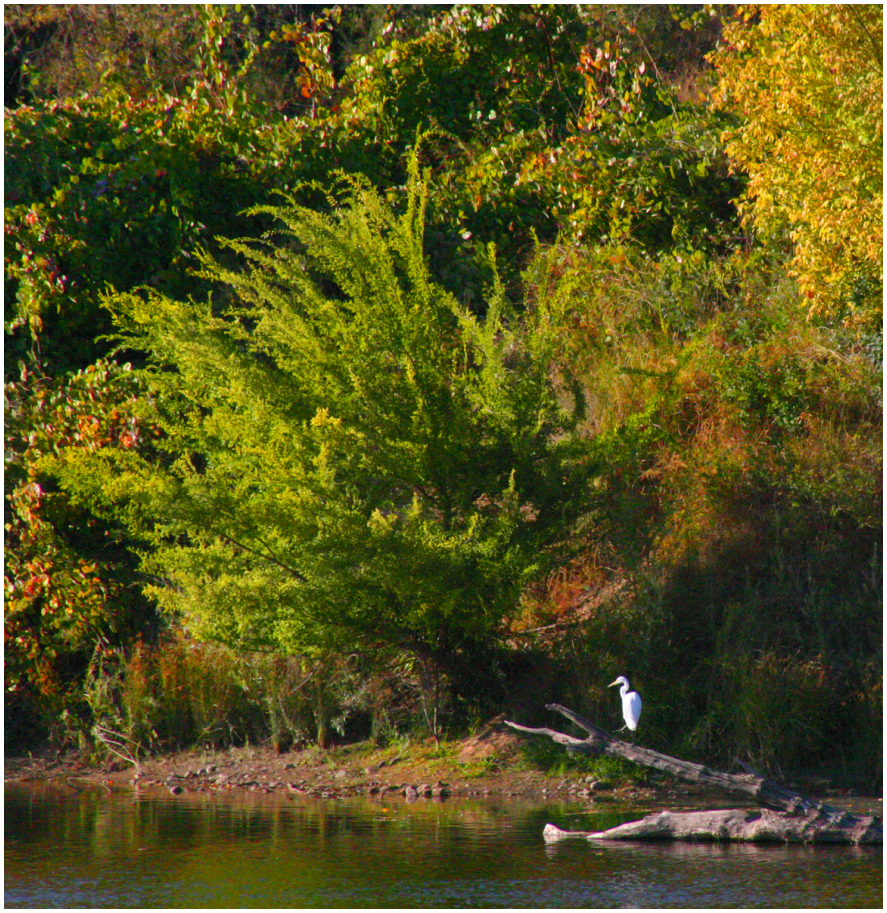
Both CHS and JPS review policies throughout the medical program for compliance with Title 15 and other best practice criteria. Opportunities for improvement when identified are integrated into the medical practice policies and procedures.

Implement an integrated electronic database that combines both custody information and county mental health information, as allowed under federal and state law, to provide more accurate patient information and a better overall standard of mental health care for inmates.

Status: JPS has been utilizing an electronic scheduling and patient database to track all JPS contacts and patients admitted for service to JPS. Patient confidentiality issues preclude inclusion of mental health information in a database accessible by staff other than health care providers. Integration of both medical and psychiatric information into a custody record is prohibited by Title 15 which requires a separate medical record outside of the custodial record.

JPS should have a designated workplace on each floor in order to provide mental health resources in a confidential manner. This will serve to improve the quality of mental health access and care that inmates receive.

Status: Confidential interview space has been designated for JPS services. At the Main Jail, each floor has a classroom which is visible to the control booth for safety yet is confidential as well. Wireless hubs are being installed so that JPS clinicians can electronically chart their notes and order medications while interviewing their patients. At RCCC, depending on housing units, JPS either has designated interview rooms or can utilize the attorney's booths to interview patients. A combination of hard-wired Internet access as well as wireless hubs will be available to allow both charting and medical orders while conducting interviews.



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