

OFFICER-INVOLVED INCIDENTS

Summary

The 2002-2003 Sonoma County Civil Grand Jury reviewed three officer-involved incidents, called, Critical Incident Reports; of which one was incomplete. One concerned an officer-involved shooting, and two investigated the deaths of jail inmates. Each report was found by the Jury to be a thorough, detailed investigation. In two of the reports, the District Attorney concluded that the officers involved in the incidents were not guilty of any criminal wrongdoing. The Jury concurs with these findings. In the third incident which occurred January 16, 2003, the District Attorney had not yet written the summary statement for the investigation. For that reason, the Jury reviewed only the Sheriff Office's Internal Administrative Review, and found it to be complete and objective.

Reason for Investigation

The Grand Jury has historically reviewed Critical Incident Reports issued during its term to determine compliance with County law enforcement protocol and appropriateness of law enforcement behavior during critical incidents.

Background

A "Critical Incident" is defined in the Sonoma County Law Enforcement Chiefs' Association "Officer Involved Critical Incident Protocol" (the Protocol) as "A specific incident occurring in Sonoma County involving one or more persons, in which a law enforcement employee is involved as an actor, injured person or custodial officer when a fatal injury occurs." The Protocol provides for a task force, consisting of a member of the District Attorney's Office and appropriate law enforcement agencies (other than the one by which the officer was employed) to conduct a thorough investigation. The District Attorney works with other agencies throughout the investigation and based on the evidence gathered, establishes the presence or absence of criminal liability.

The District Attorney summarizes the incident and his/her recommendations and submits them to the agency involved as well as to the Sonoma County Civil Grand Jury.

Investigative Procedures

The Grand Jury:

1. Reviewed the following:
 - Complete critical-incident reports
 - An officer-involved shooting on October 23, 2001 in Petaluma
 - An inmate death on May 8, 2002
 - A Sonoma County Sheriff's Department Administrative Review of an inmate death that occurred January 16, 2003
 - Protocol: 93-1, *Officer Involved Critical Incident Protocol*, Sonoma County Law Enforcement Chiefs' Association.

Findings

F1. The Officer Involved Critical Incident Protocol requires that investigations be conducted "free of conflicts of interest." For that reason the investigations were conducted by a law enforcement agency whose employees were not involved in the incidents. The District Attorney's Office also participated in the investigations and had the authority to investigate separately.

- F2. Upon completion of each incident investigation, the District Attorney's Office reviewed the physical evidence, the transcribed witnesses interviews, appropriate photographs and all other evidentiary material.
- F3. Based on the evidence, the District Attorney reached his conclusions and issued a Critical Incident Report for two cases. In each, the District Attorney concluded that there was insufficient evidence for criminal liability.
- F4. The agencies that employ the involved officers conducted their own administrative investigations of each incident. Administrative investigations have a purpose different from the criminal investigation. They seek to determine if the agency's policies and procedures were followed in the incident and whether there could be improvement in those policies and procedures. They also make a determination as to whether any disciplinary action can be imposed against a particular individual or individuals.
- F5. In addition to the two complete Critical Incident reports, the Jury examined an administrative review by the Sheriff's Office of an inmate death and found it to be a thorough, objective determination about what happened, how it happened and what lessons there were to be learned. The focus of The Sheriff Department's review focused on preventing such incidents from occurring.
- F6. The District Attorney responded to last year's Grand Jury recommendation that "Each Critical Incident Report should describe the nature of participation by the District Attorney's Office in the investigation of the incident." The prior District Attorney stated that the office would maintain a log or "Critical Incident Participation Report" detailing their involvement in each critical incident case and that they would include the log in each Critical Incident Report. In the two reports written by that office, no log was included.
- F7. For the two incidents reported on by the District Attorney, the time to issued a report varied from three days less than one year to one and one-half years. The incomplete report has taken four and one-half months to date and a statement from the District Attorney's spokesperson indicated that he was not sure when it would be completed.

Conclusions

Each of the Critical Incident Reports reflects a thorough, detailed, and unbiased investigation by those assigned to the case to determine whether any criminal liability existed. The conclusion of the District Attorney's Office in each incident is clearly based on the evidence. In addition, for one incident, a Deputy District Attorney went to the scene of the incident, attended the autopsy and was also present during the questioning of a key witness.

The District Attorney's Office takes an inordinately long period of time to complete their reports. The process should be expedited so that no agency being investigated would have to wait such a lengthy time (one and a half years in one case) before learning whether an employee or employees were determined to have violated any criminal law.

The Jury concurs with the findings of the District Attorney's Office that there was no wrong-doing on the part of any officer involved in the incidents reviewed. There are, however, some jail computer software upgrades that would provide information to help jail personnel more accurately assess inmates during booking, and there are some procedures that could be improved. Because the computerized record management system at the main jail does not include past records of inmates in custody, the intake staff was not aware of past suicide attempts or mental health issues for two of the inmates involved in the incidents. The staff relied on the only information they had, the written answers by the inmates regarding suicide attempts and mental

health issues on the mandatory “Pre-Booking Medical/Mental Health Screen.” In both inmate deaths the information provided by the inmates was inaccurate or incomplete. Had past records been accessible, at least one death might have been prevented. Also, an inmate who had been booked two days earlier was assigned to a cell whose door was not visible from the control desk. Although he indicated no thoughts of suicide during the booking process, he committed suicide. While suicidal behavior is very difficult to predict when not acknowledged by the inmate, the Jury believes that if the newest prisoners could be housed in cells with doors visible to staff, the potential for problems could be reduced.

Finally, a male officer transported a female prisoner to the hospital for a medical exam. He could not be present for nor observe the actions of the prisoner who was disrobing for the exam. During that time, the prisoner hid drugs in a body cavity and was able to smuggle them into the jail. Later she gave them to another prisoner who overdosed.

The Jury stresses that all personnel involved in the incidents reviewed were highly competent professionals. Therefore, our recommendations for the agencies focus on process issues, not people issues.

Recommendations

R1. The Sheriff’s Office should integrate the Records Management System and the Jail Management System to allow inmates’ records of mental health issues to be readily available to jail staff.

R2. The Sheriff’s Office should provide for a female officer to be present during hospital medical exams of female inmates.

R3. Newly incarcerated inmates should be assigned to cells with doors that are visible from the control desk.

R4. The District Attorney’s Office should shorten the time the agency being investigated must wait for written notice of any criminal wrongdoing.

R5. The District Attorney should routinely provide the Grand Jury with a copy of each Critical Incident Report in a timely manner, including the “Critical Incident Participation Report” for that incident.

Required Responses to Findings

None

Required Responses to Recommendations

The Sheriff: R 1, R2, and R3

The Board of Supervisors: R1

The District Attorney: R4 and R5