

## INTRADEPARTMENTAL CORRESPONDENCE

June 15, 2018  
1.0

**BPC# 18-0224**

**TO:** The Honorable Board of Police Commissioners

**FROM:** Inspector General, Police Commission

**SUBJECT:** REVIEW OF THE LOS ANGELES POLICE DEPARTMENT JAIL AND  
HOLDING TANK STRUCTURES AND PROCEDURES

### **RECOMMENDED ACTION**

REVIEW and APPROVE the Office of the Inspector General's Review of the Los Angeles Police Department (LAPD) Jail and Holding Tank Structures and Procedures.

### **DISCUSSION**

At the direction of the Police Commission, the Office of the Inspector General (OIG) analyzed five years of in-custody deaths and attempted suicides within the LAPD jail facilities and police station holding tanks. The OIG identified anchor points used in attempted suicides that must be eliminated and, while evaluating procedures related to the documentation and review of suicides and suicide attempts, the OIG determined that some measures of reform were needed. The Department's jail intake and housing classification processes can be improved to address a lack of communication, documentation, consistency, and accuracy that is essential to ensure the health and safety of arrestees, inmates, and Department personnel. Finally, the OIG established a proposed adjudication protocol for in-custody deaths occurring within jails and police station holding tanks which seeks to resolve ongoing issues with the present adjudication system that is designed to investigate and analyze deaths occurring in the field. The new adjudication will avoid conclusions of "Does Not Apply" and will establish greater accountability, lessons learned, and preventative measures for these specific incidents.

### **E-Copy – Original Signature on File with the Police Commission**

MARK P. SMITH  
Inspector General  
Police Commission

Attachment

# LOS ANGELES POLICE COMMISSION

## REVIEW OF THE LOS ANGELES POLICE DEPARTMENT JAIL AND HOLDING TANK STRUCTURES AND PROCEDURES



Conducted by the

OFFICE OF THE INSPECTOR GENERAL

MARK P. SMITH

Inspector General

June 15, 2018

OFFICE OF THE INSPECTOR GENERAL  
REVIEW OF THE LOS ANGELES POLICE DEPARTMENT  
JAIL AND HOLDING TANK STRUCTURES AND PROCEDURES

I.	INTRODUCTION .....	1
II.	ORGANIZATIONAL BACKGROUND.....	2
III.	JAIL CELL AND POLICE STATION HOLDING TANK INSPECTIONS.....	2
IV.	JAIL INTAKE PROCESS AND MENTAL ILLNESS.....	4
	A. Los Angeles County Unified Arrestee Medical Screening Form .....	4
	B. Department-Initiated Intake Modifications.....	5
	1. Inmate Classification Questionnaire .....	5
	2. Records Management System.....	6
	C. Housing Classification Process.....	7
	1. Arresting Officer Communications.....	7
	2. Arrestee Privacy Concerns.....	8
	3. City Medical Personnel Communications .....	8
	4. Housing Classification Assessment .....	9
	D. Classification and Housing Officer Pilot Program .....	11
	E. Mental Health Training.....	11
	F. Post-Housing Mental Health Awareness .....	12
	G. Jail Operations Manual Concerns .....	13
V.	SUICIDE AND ATTEMPTED SUICIDE DOCUMENTATION AND REVIEW ..	14
VI.	JAIL AND HOLDING TANK IN-CUSTODY DEATH ADJUDICATION.....	16
	A. Reclassification of In-Custody Death Investigations.....	17
VII.	CONCLUSION.....	18
VIII.	RECOMMENDATIONS .....	19
IX.	ADDENDA.....	23

**OFFICE OF THE INSPECTOR GENERAL  
REVIEW OF THE LOS ANGELES POLICE DEPARTMENT  
JAIL AND HOLDING TANK STRUCTURES AND PROCEDURES**

**I. INTRODUCTION**

At the direction of the Los Angeles Board of Police Commissioners (Commission), the Office of the Inspector General (OIG) analyzed five years of in-custody deaths and attempted suicides within the jail facilities and police station holding tanks operated by the Los Angeles Police Department (LAPD or Department).<sup>1</sup> The data compiled from these incidents formed the basis for the OIG's comprehensive and multi-faceted review of the LAPD jails and station holding tanks with a primary objective of suicide and suicide attempt prevention.

The OIG identified the prevalence of anchor points and other structures used in suicide attempts by inspecting each of the Department's jail cells and holding tanks. The OIG then evaluated the Department's procedures for the documentation of, and review following, suicides and suicide attempts to ensure compliance with law and policy, as well as to confirm that current procedures are designed to minimize the incidence of suicide and suicide attempts with recurring circumstances.

A significant factor in suicide prevention is ensuring that an inmate is placed in an appropriate cell during confinement. To this end, the OIG examined the Department's intake and housing classification processes with specific attention to the identification, classification, and treatment of arrestees and inmates with mental health issues. This involved a detailed review of all required documents; analysis of related law and policy; a review of the pertinent training provided; discussions with the medical dispensary staff; and direct observation of arrestee booking and classification, from the point that an arrestee is brought to the jail to placement in a cell.

The final component of the Commission's directive was to review and modify the Department's policy for the adjudication of in-custody deaths that occur within LAPD jails and station holding tanks. Currently, all in-custody deaths are adjudicated as categorical uses of force, with evaluation focused on the involved officer's tactics, drawing or exhibiting of a weapon, and decision to use force. This standard does not apply consistently to deaths that occur in LAPD facilities because they rarely involve drawing of weapons or uses of force and, in some cases, do not include tactics that directly lead to the in-custody death. The OIG developed a proposed adjudication protocol for in-custody deaths occurring in LAPD jails and station holding tanks that will elicit findings necessary for continued improvement.

---

<sup>1</sup> For the purposes of this Report, "Police station holding tank" or "holding tank" refers to the temporary holding cells inside the geographical Area police stations, which are separate and distinct from the jail facility cells.

## **II. ORGANIZATIONAL BACKGROUND**

Custody Services Division (CSD) oversees the Department's ten jail facilities, which includes three regional jails and seven satellite jails located at various police stations. The larger, regional jails are Metropolitan Detention Center, Valley Jail Section, and 77<sup>th</sup> Regional Jail Section. Of the seven satellite jails, only Hollywood and Pacific are currently in use. The satellite jails located at Devonshire, Foothill, Harbor, Southwest, and Wilshire are all closed.<sup>2</sup>

Several police stations have adjoining LAPD jail facilities; however, each police station maintains holding tanks that are separate and distinct from the jails. The number and design of holding tanks vary from station to station. More importantly, the Office of Special Operations and CSD, which operate the LAPD jails, have no authority over the police station holding tanks. All police stations, and corresponding holding tanks, are under the control of the Office of Operations (OO).

## **III. JAIL CELL AND POLICE STATION HOLDING TANK INSPECTIONS**

From 2012 to 2016, the OIG determined that a total of 19 in-custody deaths and at least 102 suicide attempts occurred within the LAPD jails or station holding tanks.<sup>3,4</sup> The OIG performed a detailed analysis of these incidents, which provided valuable insight as to recurring issues as well as guidance for the OIG's inspection criteria (Addenda A-B). One of the most common means of self-inflicted harm in the OIG's review was suicide or attempted suicide by hanging. Suicide by hanging accounted for 21% (4 of 19) of the in-custody deaths reviewed by the OIG, and attempted suicides by hanging accounted for 39% (40 of 102) of all such reported incidents.

Two of the four suicides by hanging involved a corded telephone mounted to the wall of the cell. In a third suicide by hanging, the inmate tied the arms of a sweater around his neck and anchored it to a wall-mounted bunk bed frame. The fourth suicide by hanging incident involved an arrestee detained in a holding tank who tied a sweater around her neck and used a wall mounted "O-ring" as an anchor point.<sup>5</sup> Attempted suicides by hanging involved a larger variety of anchor points, with the most commonly used cell features being the bunk beds (used in 11 attempts), corded telephones (used in 10 attempts), and cell doors (used in 7 attempts). As a result, the OIG

---

<sup>2</sup> Per the Department, all satellite jails, open or closed, are annually certified by the Board of State and Community Corrections (BSCC) to be operationally ready for use at any given time.

<sup>3</sup> In-Custody Death investigations take up to 11 months to complete for adjudication by the Commission. The OIG's review included all jail and holding tank in-custody deaths that either occurred, were adjudicated, or were reclassified from 2012 through 2016.

<sup>4</sup> The OIG received and reviewed 102 reports confirming suicide attempts from 2012 through 2016; however, CompStat reflected a total of 147 suicide attempts during this period. The discrepancy results both from a presumed error in the 2013 suicide attempt statistics, noted in Addendum F, in addition to the unavailability of all reports with suicide attempt descriptions.

<sup>5</sup> The "O-ring" is a circular, metal ring mounted to the wall of the holding tank and was traditionally utilized to handcuff an arrestee to the wall in an effort to restrain movement.

inspection prioritized the identification of all anchor points with potential to be utilized in a hanging.

In order to directly observe the reported anchor points and to evaluate the extent of all other potential issues, the OIG performed onsite inspections of 435 jail cells and 113 police station holding tanks. In addition to anchor points, the OIG documented the presence of operational cameras, intercoms, and the adequacy of lighting in each cell and tank. The results found no significant or systemic issues with structural lighting and confirmed that intercom systems functioned properly, when they were present.<sup>6</sup> As to the issues emphasized in the OIG's suicide and suicide attempt review, the inspection determined 32% (140 of 435) of all jail cells had at least one corded telephone, whereas there were no telephones inside any of the holding tanks. The inspection further determined that 111 of the beds or bed frames in the jails and holding tanks were potential anchor points, and a total of 80 jail cell doors had metal bars that were accessible to inmates as potential anchor points.

The Department acknowledged that anchor points within the jail cells and holding tanks were a problem and expressed a willingness to continue making improvements to these facilities in addition to changes already in progress. Following a March 2015 hanging with a wall-mounted bunk bed frame at 77<sup>th</sup> Regional Jail, the Department eliminated the tie-off point by installing metal stripping to cover the gap between the frame and the wall. A total of 178 beds were safely modified by the end of April 2017. After ten attempts and two suicides by hanging using the corded telephone, MDC began researching cordless telephones, with installation expected to begin in mid-2018. Finally, the O-ring restraining devices, formerly used in the Foothill holding tanks, were removed immediately after the 2015 suicide by hanging utilizing that unique anchor.

The OIG inspections further underscored the need for improved supervision of inmates through video cameras and implementation of inmate safety checks for station holding tanks. The OIG found that 53% (229 of 435) of the LAPD jail cells and 40% (45 of 113) of the holding tanks were not equipped with video cameras and could not be monitored by video cameras positioned in the adjacent hallways. Many of these cells and tanks were designed for single or double occupancy, where inmates are typically left alone and unsupervised for relatively long periods of time.

The need for consistent monitoring with video cameras is especially important for the station holding tanks which, according to the Department, have no requirement for safety checks on confined arrestees. The LAPD jail cells, in comparison, are subject to law and policy that mandate inmate safety checks twice an hour.<sup>7</sup> Although the OIG was assured by the Department that arrestees in station holding tanks were under constant supervision, the OIG observed that the location and design of holding tanks varied from station to station, and arrestees were not always

---

<sup>6</sup> During the inspections, the OIG was informed that it was a common practice at MDC to temporarily deactivate intercom systems in specific cells due to repetitive and unwarranted use by inmates. The OIG expressed concern to command staff at CSD, who advised that this unauthorized practice would be addressed immediately.

<sup>7</sup> Cal. Code Regs. Tit. 15, §§1027, 1027.5; JOM Section 1/150-Safety Checks.

visible from the position of the nearest officers. Department and CSD personnel must have the ability to observe the activity of those in confinement at all times.

Custody Services Division recognized the need for improved monitoring, and it completed video camera installation in all single and double occupancy cells at MDC in December 2017. The OIG encouraged CSD to install video cameras in all such cells at each of the jail facilities. At the time of this report, 77<sup>th</sup> Regional Jail, Valley Jail, Hollywood, Pacific, and Foothill jails have cameras in all cells. The Harbor jail has cameras in 10 of its 32 cells. Devonshire, Wilshire, and Southwest jails have no video camera systems at all.<sup>8</sup>

Going forward, the OIG encouraged the Department to eliminate the anchor points cited in the inspections in order to decrease the number of deaths and attempts. Removal of these hazards do not appear to present a substantial detriment to the facility structures or operations and, in most cases, involve much needed replacement of antiquated equipment. The OIG also discussed with CSD that positive changes being made to MDC with video camera and cordless telephone installations should be performed at the remaining LAPD jail facilities as well.

#### **IV. JAIL INTAKE PROCESS AND MENTAL ILLNESS**

The OIG spent considerable time at each of the three regional LAPD jails, walking through the intake process with command staff, supervisors, and jail personnel. Several points of concern were noted by the OIG, including the limited and inconsistent information provided to CSD personnel about an incoming arrestee's perceived or actual mental health status; the consistency and accuracy of the housing classification determination; and the training provided to CSD personnel regarding identification and treatment of individuals with mental health issues. The Department estimated that approximately 60 to 70 percent of inmates suffer from some type of mental illness, making communication amongst Department personnel about an arrestee's mental stability paramount for the safety of CSD personnel and inmates.

##### **A. Los Angeles County Unified Arrestee Medical Screening Form**

The Los Angeles County Sheriff's Department requires the LAPD and CSD personnel to complete the Los Angeles County Unified Arrestee Medical Screening Form (County Medical Form) for each arrestee booked at an LAPD jail, even if the arrestee will not be sent to a County jail facility (Addendum C).<sup>9</sup> The County Medical Form is a two-page document with three sections including, "Arrestee Questionnaire," "Arresting Deputy/Officer Observation," and "Jailer Observations." The Arrestee Questionnaire section contains ten questions, many of which focus on the arrestee's mental health. This includes inquiries regarding suicidal feelings,

---

<sup>8</sup> Despite the fact that these jails are temporarily closed, Foothill and Southwest Areas have utilized the closed jails for ad hoc operational needs, such as DUI Task Forces. Furthermore, the closed Devonshire jail is utilized daily by the police station personnel for strip and visual body cavity searches and exclusively for arrestee bathroom accommodations.

<sup>9</sup> Form SH-R-422 (REV 09/16/2014)

any history of attempted suicide or other mental health issues, any treatment received from a mental health professional, and any required medications.

The two observation sections present both the arresting officer and the “jailer” with a series of questions to assess the arrestee’s mental, emotional, and physical stability. More specifically, the arresting officer is asked to report any use of force in the arrest, and whether the arrestee threatened suicide or “suicide by cop.” Similarly, the “jailer” is asked to report the presence of any behaviors indicative of suicide risk, as well as behaviors such as hallucinations, incoherent rambling, or unprovoked combative behavior. The detail obtained in completing the County Medical Form is to be considered by CSD personnel when determining an arrestee’s housing classification.

## B. Department-Initiated Intake Modifications

Two essential components of the intake and housing classification process were in transition during the course of the OIG’s investigation. The Department was reformatting and editing the Inmate Classification Questionnaire and Record of Medical Screening, which is used to capture information that may require an arrestee to be placed in segregated housing and provides instructions from the medical staff as to the conditions by which the arrestee should be housed. The Department was also testing implementation of the Records Management System (RMS), a software program designed to provide a centralized, electronic platform for data entry and database integration.<sup>10</sup>

### 1. Inmate Classification Questionnaire

Currently, the Department uses two versions of the Inmate Classification Questionnaire to capture preliminary housing information about the arrestee. The Inmate Classification Questionnaire and Record of Medical Screening (LAPD Form 05.36.00) is only used when the arrestee is seen by medical dispensary personnel (Addendum D). This form contains a section of eight questions determining the possible need for segregation; a section indicating that the arrestee will be placed in either general, segregated, or detoxification housing; and a third section, comprised largely of check boxes, which is filled out by medical dispensary personnel following the examination. Alternatively, the Inmate Classification Questionnaire (LAPD Form 05.37.00) is used for arrestees who do not initially require treatment by medical dispensary personnel (Addendum E).<sup>11</sup> It only contains the first two sections presented in the medical version of the form and does not have the third medical instruction section.

The OIG observed that use of these nearly identical forms during the intake process was inefficient and unnecessarily confusing. It was not uncommon for both versions of the form to be used for a single arrestee where a need for medical treatment did not arise until after the non-

---

<sup>10</sup> NicheRMS™ is a police records management system that is a trademarked product of Niche Technology Incorporated.

<sup>11</sup> This LAPD form is not available on the LAPD Forms online database.

medical form was already filled out. Furthermore, the forms lacked clarity as to whether the arresting officer or the CSD processing officer at the booking window should be asking specific questions. The Department's new form will only have one version, and it is expected to include revised questions with improved organization mandating specific personnel to ask certain questions to the arrestee. The City of Los Angeles Medical Services Division (MSD) will provide all content in the Record of Medical Screening section of the new form, which will continue to rely on a series of check boxes to indicate preferred housing conditions. The Department expects the revised arrestee classification form to supplement, and interact with, the County Medical Form, eliminating repetitive questions and allowing for the revised form to include questions more specific to LAPD jail operations. This interaction will further encourage CSD personnel to incorporate information from both forms into the housing classification determination.

## 2. Records Management System

A much larger transition to further the goal of overall efficiency and jail facility safety is the Department's implementation of the Records Management System. The RMS is a computer-based software system being tested by CSD that will eliminate hardcopy versions of documents related to the arrest and booking processes. If the RMS is successfully implemented at CSD, hard copy reports and forms will be replaced by the ability to populate the same information directly into RMS, which will then be accessible to all authorized LAPD personnel in real-time. Arresting officers will be able to enter any behavioral observation notes about the arrestee, or about the circumstances of the arrest, from the Mobile Data Computer.<sup>12</sup> For repeat offenders, this electronic documentation of criminal and mental health history can be used to notify arresting officers and CSD personnel of any behavioral and mental health issues exhibited during previous arrests. With the availability of this information through RMS, excessive wait times during the booking process will be eliminated for both arrestees and arresting officers, as CSD personnel will be able to initiate the booking process and housing classification evaluation before the officers and arrestees arrive to the jail.

In addition, the RMS is expected to serve as a central mainframe for City, County, Statewide, and National databases, providing the entire Department a single access point for all existing arrestee or inmate information. This may include State and County booking systems, and access to portions of the Los Angeles County Department of Mental Health database. At the time of this review, the RMS was in the beta-testing phase at MDC and was not currently linked to any outside databases. Until RMS is fully implemented, the MDC personnel are utilizing the original booking procedure in addition to populating the RMS with the same information. The OIG was informed that a complete installation of the RMS at CSD is expected to take at least one to two years.<sup>13</sup> Although there is obvious long-term potential, the success of this system is largely

---

<sup>12</sup> The Mobile Data Computer, formerly referred to as the Mobile Data Terminal, is the computer provided in each of the Department patrol vehicles.

<sup>13</sup> The Department's Information Technology Division (ITD) assigned a Project Manager to oversee implementation of the RMS, who provided the OIG with the timeline for potential Department-wide implementation.

dependent on a Department-wide agreement to invest in the technology, as well as the willingness of outside entities to provide access to their databases.

### C. Housing Classification Process

Upon arriving to an LAPD jail with a new arrestee, the arresting officer must complete several forms, including the County Medical Form and Inmate Classification Questionnaire, in order to initiate the intake process. Custodial Services Division personnel review the forms and, if medical treatment is necessary, the arrestee is sent to the medical dispensary. Following the medical examination, the arrestee is presented to the CSD processing officer at the booking window, and the arrestee's information is entered into the Decentralized Arrest Booking Information System (DABIS).<sup>14</sup> After review of the arrestee's documentation, the processing officer determines the appropriate housing classification. Housing classification involves an evaluation of all relevant factors about an arrestee that are known at the time in order to determine the most suitable cell placement during confinement.<sup>15</sup>

#### 1. Arresting Officer Communications

After carefully observing the process and reviewing the corresponding policies, the OIG had concerns about the consistency and accuracy of the housing classification evaluations, beginning with the information provided to CSD personnel about incoming arrestees. It is imperative that arresting officers communicate to CSD personnel the circumstances of the arrest, verbal and non-verbal behaviors exhibited by the arrestee, and any known history of mental health issues. Notwithstanding the CSD policy requiring processing officers to ask arresting officers about an arrestee's behavior, the OIG was informed that this conversation did not always occur.<sup>16</sup> Furthermore, arresting officers must state in the County Medical Form if the arrest involved physical resistance or the use of force, or if the arrestee threatened suicide or "suicide by cop," but these are the only questions relating to the arresting officer's observations in the field, and they are answered without any detailed explanation by checking 'Yes' or 'No.' The current version of the Inmate Classification Questionnaire contains no specific questions relating to the arresting officer's observations in the field.

The difference in the behavior of arrestees from when they are in the field to their arrival at the jail booking window can be profound. Knowledge and proper documentation of aggression or mental instability witnessed during the arrest will affect the housing classification and subsequent care of the inmate. The County Medical Form information must be supplemented with details from the arresting officer about an arrestee's behavior during the incident, in addition to a description of any physical resistance, use of force, or suicidal statements. Not only should the answers be documented by CSD personnel for consideration in the housing

---

<sup>14</sup> The DABIS is the Department's database that generates a booking number after the arrestee's personal information is entered.

<sup>15</sup> JOM 2/204.01-Inmate Classification – Defined.

<sup>16</sup> JOM 2/204.09-Responsibility For Classification.

classification, but also a set of written questions for arresting officers and CSD personnel to discuss should be employed to ensure the communication takes place in a uniform and consistently reliable manner.

## 2. Arrestee Privacy Concerns

Information acquired through the County and CSD questionnaires that must be completed for each arrestee are only helpful for housing classification if they are accurate. The OIG was informed that arrestees are asked personal questions without the guarantee of privacy. This is especially problematic regarding the County Medical Form, which contains sensitive questions about suicidal tendencies, current and past mental illness, prescription medications, and other health-related inquiries. Arrestees are less likely to be forthcoming with this type of information if they are in the presence of other arrestees, inmates, or even non-essential Department personnel. The Department acknowledged potential issues with this practice and informed the OIG that privacy protections are currently being discussed for future implementation.

## 3. City Medical Personnel Communications

The OIG observed a significant lack of communication between CSD and the medical dispensary personnel when incoming arrestees require medical treatment. The three regional jails each contain medical dispensaries, which are staffed and operated by MSD. The information provided to CSD personnel following an arrestee's medical examination is limited to the series of check boxes at the bottom of the Inmate Classification Questionnaire and Record of Medical Screening. There are no explanations justifying or explaining the boxes checked, and details about an arrestee's observed behavior during the medical examination are not relayed to CSD personnel. Medical exam results are recorded by MSD personnel on a multipage, City medical form, but it is purposely not shared with CSD personnel.<sup>17</sup>

According to CSD and MSD, the lack of communication is a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which prohibits unauthorized disclosure of medical information.<sup>18</sup> Although HIPAA does prohibit disclosure of medical records and information without the patient's informed consent, it also provides several exceptions to this rule.<sup>19</sup> Health providers may disclose protected health information to officers based on an administrative request if the information is relevant and material, specific and limited in scope, and "de-identified" information cannot be reasonably used. Additionally, protected health information of an inmate can be disclosed to officers for an inmate in lawful custody if it is necessary for any of the following reasons: (1) provision of healthcare to inmates; (2) the general health and safety of inmates; (3) the health and safety of law enforcement working at, or on the premises of, a correctional facility; (4) the health and safety of officers and staff

---

<sup>17</sup> Medical Record for Person In-Custody (Rev. 9/14) (Disk 2).

<sup>18</sup> Code of Federal Regulations (CFR), Title 45, Chapter A, Subchapter C, Part 164.

<sup>19</sup> 45 C.F.R. §164.512(f)(1)(ii)(C)(2017).

responsible for transferring inmates; or (5) the administration and maintenance of the safety, security, and good order of a correctional facility.<sup>20</sup>

The OIG believes these exceptions give clear authority for medical dispensary staff to legally share information derived from the medical examination of arrestees and inmates with CSD personnel for the purposes of housing classification. The information at issue is essential for the health and safety of both inmates and CSD personnel, as well as for the security and good order of the jail facilities. A proper evaluation for housing classification must be able to account for the answers and observations that are provided during an arrestee's medical examination.

#### 4. Housing Classification Assessment

Determining housing classification, per the Jail Operations Manual (JOM), requires the processing officer to review the Booking Approval, the Los Angeles County Unified Arrestee Medical Screening Form, the Inmate Classification Questionnaire and Record of Medical Screening, and any other pre-booking documents.<sup>21</sup> Following this review, the processing officer must then decide if there is a need for segregation or if the arrestee can be placed in general housing.<sup>22</sup> All decisions must be reviewed and approved by a supervisor. There are several factors provided by statute and by the JOM, which mandate segregated housing.<sup>23</sup> Otherwise, placing an arrestee in segregation is administratively based on the processing officer's evaluation of all documents, observations, and verbal information.

There is presently no formal system to ensure that the same set of factors is being consistently received and evaluated with regard to the housing of each arrestee. The processing officer and the supervisor, who must approve the housing classification decision, rely on their experience and instincts in reviewing the information to decide the best placement. While there is no question that CSD personnel possess considerable experience dealing with arrestees and inmates, the amount of detail to evaluate for each arrestee presents great difficulty for processing officers attempting to assess the most appropriate housing classification in a timely and consistent manner.

Unfortunately, Department and CSD policies provide very little guidance for this decision, especially pertaining to the identification and evaluation of mentally ill arrestees. For example, there is no policy or practice to assist in deciding the best placement for arrestees with depression or suicidal tendencies. The OIG was informed that while some supervisors felt that segregation

---

<sup>20</sup> 45 C.F.R. §164.512(k)(5)(i)(2017).

<sup>21</sup> Pursuant to JOM 2/204.09- Responsibility for Classification.

<sup>22</sup> JOM 2/204.09-Responsibility for Classification.

<sup>23</sup> Segregated housing is mandatory, pursuant to JOM 2/204.03-Mandated Inmate Segregation, for the following: Gender, Juveniles, Material witnesses, Civil process detainment, Conviction status, Mentally disordered, and Communicable diseases. Other circumstances that require segregation by the JOM include: "Green Light" arrestees (JOM 2/105.05), Arrestees with head coverings (JOM 2/107.01), Transgender Male to Female Pre-operative and Transgender Female to Male Post-operative (JOM 2/123).

was the best option for these arrestees, others placed them in general housing assuming they would be less likely to harm themselves in front of others. Similarly, although there is a statutory requirement to segregate the “Mentally Disordered,” the JOM fails to define the term and refers only to Title 15, which also does not specifically define the term.<sup>24</sup>

Even the medical dispensary provides relatively limited assistance due to the fact that MSD personnel are not licensed to perform mental health evaluations of arrestees. The MSD stated that their staff can only “probe” an inmate’s suicidal tendencies and perform “examinations” to determine if inmates require transfer to other facilities for treatment. In the absence of certified mental health professionals, it becomes the responsibility of CSD personnel to assess the mental well-being of arrestees for the purposes of housing classification.<sup>25</sup>

An evaluation that includes the burden of a mental health assessment, with the required document review and analysis of personal observations, all within a limited amount of time, is an intense and monumental task. Such an evaluation necessitates a structured system that decreases the likelihood of human error and guarantees a thorough consideration of all factors in a uniform manner for each incoming arrestee. This includes clear documentation as to the information analyzed and written justification for the determined classification.

The OIG was additionally concerned that housing classification evaluations conflicted with Department objectives involving arresting officer wait times at LAPD jail facilities. Department statistics cite an average “elapsed booking time” for each arrestee of 13 minutes, which the OIG believes to be inadequate for both completion of booking and performance of a thorough evaluation.<sup>26</sup> The CSD personnel responsible for housing classification must have an organized system that facilitates a proper determination, and any Department objectives in opposition to a more thorough process must be reconciled in favor of consistently accurate housing classifications.

#### D. Classification and Housing Officer Pilot Program

The Department recently began implementing a Classification and Housing Officer (CHO) at the 77<sup>th</sup> Regional Jail to facilitate the housing classification of arrestees. This pilot program bifurcates the duties of the processing officer at the booking window by assigning all housing classification responsibilities to the CHO. The processing officer will solely focus on DABIS and other data entry for booking. The CHO is located at the jail entrance in order to begin a

---

<sup>24</sup> JOM 2/204.03-Mandated Inmate Segregation. Title 15 does clarify that if medical staff are not available, the inmate may be considered “mentally disordered” if “he or she appears to be a danger to himself/herself or others or if he/she appears gravely disabled.” Cal. Code Regs. Tit. 15 Section 1052.

<sup>25</sup> City of Los Angeles Medical Services Division Correctional Care Policy and Procedures Manual, Mental Illness Section states, “Based upon such screening and in consultation with designated mental health authorities, the officer in charge of the jail facility shall determine whether the arrestee shall be referred to an appropriate mental health facility for psychiatric diagnosis and/or treatment.”

<sup>26</sup> See, CompStat Custody Services Division Profile, 2017, SEP / DP9 2017. The average times are recorded in the Profile section entitled, “Conventional Booking without Medical Treatment Times.”

dialogue and evaluation with the arresting officer and the arrestee upon entering the facility, establishing factors that will ultimately assist in determining the appropriate housing of the arrestee. The CHO pilot program commendably ensures an exchange of important information, although the consistency of details relayed can be improved by implementing a set of written questions and answers, in addition to any spontaneous questions that the conversation elicits.

The CHO program recognized the danger of failing to secure valuable arrestee information and behavioral observations during the medical examination. If an examination by the medical dispensary is necessary, the CHO will accompany the arrestee to document behavioral issues or relevant statements. Allowing a CHO to observe the examination ensures an arrestee's behavior is appropriately factored into his or her housing classification. The CSD stated, however, that due to the limited staffing of the pilot program, a CHO is not always available to accompany each arrestee. This must be rectified when the program is fully implemented, and any essential observations must be recorded in writing and attached to the arrestee's file.

The ultimate housing classification is determined by the CHO based on all relevant observations and the details acquired from the booking documents and written health assessments. The OIG is in support of full implementation of this position in all of the LAPD regional jails. It provides the focused attention to the evaluation process that is required for such an important decision, and it will resolve timing issues involving officer wait times as the classification process can run concurrently with the intake and booking processes.

#### E. Mental Health Training

As a result of the demands on CSD personnel to properly identify and classify arrestees with mental illnesses, expert level training in these fields must be provided. Although CSD personnel receive some mental health training, the OIG believes these trainings need to be enhanced and conducted with more frequency throughout the year.

Custody Services Division personnel is comprised primarily of detention officers, supplemented by a smaller number of police officers who are temporarily assigned to CSD.<sup>27</sup> The distinction is noteworthy as the mental health training received by police officers, as compared to detention officers, is different. Detention officers receive a BSCC mandated introductory training course that includes 2.5 hours of mental illness instruction, as well as four hours of suicide training. These segments are one-time trainings. In addition, for Fiscal Year 2015/2016, detention officers received an eight-hour version of the Department's Mental Health Intervention Training

---

<sup>27</sup>Police Officers are assigned to CSD on a rotational basis at the rank of Police Officer II. At the end of their six-month rotations, officers may elect to do a second six-month rotation.

(MHIT) to satisfy State-mandated in-service training requirements.<sup>28</sup> Unfortunately, this eight-hour mental health training does not occur every year.<sup>29</sup>

Police Officers who are assigned to CSD for less than one year do not participate in the in-service trainings because they are not subject to the annual mandate. However, all police officers entering CSD receive a one-time, four-hour suicide prevention training. According to CSD, no part of this training is specifically dedicated to identifying or dealing with mental illness. Police Officers do receive Peace Officer Standards and Training (POST)-mandated mental health training as a part of their Regular Basic Course Academy. This training includes a minimum of 15 hours of instruction, with 4 hours specifically devoted to the identification and treatment of persons with developmental disabilities and mental illness.<sup>30</sup> Custody Services Division reported that some officers have additionally received the Department's full 40-hour MHIT before entering their CSD assignment, but this does not account for all the police officers currently working in CSD.

Custody Services Division is presently considering implementation of biannual mental illness/mental health training for all CSD personnel. Additionally, the CHO program intends to provide each designated officer with the Department's full, 40-hour MHIT, along with a more frequent curriculum of mental health training going forward. The OIG recognizes that the Department maintains compliance with the minimum required training, as prescribed by policy and rule of law. Given the Department's assessment that a broad majority of arrestees booked at LAPD jails suffer some form of mental illness, all CSD personnel should ideally receive training above and beyond the basic requirements.

#### F. Post-Housing Mental Health Awareness

The value of a thorough fact-gathering and analytical process leading to the most appropriate housing classification also extends to the treatment of the arrestee during their confinement. The CSD personnel must develop the practice of continual reference to this information when issues with inmates arise. The OIG was informed that general warnings concerning an inmate's aggressive behavior or suicidal tendencies, for example, are presently being listed on Microsoft Excel sheets created by CSD personnel and accessible to those monitoring inmates. If RMS becomes a viable replacement for the current system of documentation, warnings with specific detail, along with the inmate's arrest and booking documents, will be accessible electronically

---

<sup>28</sup> The Mental Health Intervention Training focuses on bi-polarity, schizophrenia, and depression. This includes definitions of each diagnosis, associated side effects, and behavioral patterns. The primary objective is to prepare the officers to approach, react to, and deal with mentally unstable subjects. Officers participate in role-playing activities that encourage continued use of the techniques with a clear emphasis on maintaining patience, communication, and safety in all such interactions.

<sup>29</sup> The State requires every officer who has worked in CSD for at least one year to complete a total of 24 hours of in-service training. Custody Services Division selects different training topics each year for completion of these hours.

<sup>30</sup> POST Learning Domain 37-Persons with Disabilities. Per California Penal Code 13519.2 (a), the basic training course for law enforcement officers shall include instruction in the handling of persons with developmental disabilities or mental illness.

for review. Unfortunately, the OIG determined there was no preferred practice or policy requiring CSD personnel to review the inmate Excel sheet, or RMS notes, for the existence of mental health issues when deciding how to handle an inmate following a complaint, or other issue, during confinement.

During the course of the investigation, the OIG appreciated the great difficulty in discerning between inmates who make complaints out of frustration and those who actually require medical attention. However, the OIG observed that unless there was an obvious medical need, inmates' complaints during confinement did not prompt a review of their files to see if the behavior might be a product of underlying mental instability. For example, the OIG was informed that it was common to hear inmates in segregation complain about feeling claustrophobic when they simply wanted to get out of their small cells. What concerned the OIG about the lack of review for an inmate's mental health was that feeling claustrophobic may indicate the onset of a mental health episode. Without an assessment, any decision made to involve medical personnel, or to ignore the complaint, is uninformed and potentially difficult to justify if a critical incident occurs thereafter.

From a risk management perspective, and for the safety of all involved, whenever an inmate complains of an ailment that may be associated with a mental health issue, and a review of his or her file indicates a history of any such issues, it would be prudent for CSD personnel to follow-up with the inmate in-person, send them to the medical dispensary for further examination, and consider a change to their housing classification. It is important that the information collected during the housing classification process be effectively utilized throughout the inmate's confinement.

#### G. Jail Operation Manual Concerns

The OIG's investigation required an in-depth reading of the JOM to assess compliance of observed practices. It was immediately apparent that the JOM impedes divisional progress by failing to clearly define or describe key procedures, documents, and duties. One of the more concerning policies mandated that each arrestee's housing classification comply with the CSD Housing Assignment Plan, which had not been previously mentioned by CSD.<sup>31</sup> After requesting clarification, the OIG was informed that it was unknown if the document still existed; CSD confirmed that it was not currently used for housing classification.

Furthermore, despite the practice of obtaining supervisor approval for all housing classifications, the JOM only requires such approval when assigning an arrestee to segregated housing, allowing processing officers to assign an arrestee to general housing without any review.<sup>32</sup> The practice of having all housing classification determinations reviewed by a supervisor is one that is encouraged by the OIG and one that should be reflected accordingly in the policy. Other issues

---

<sup>31</sup> JOM 2/204.12-Housing Assignments.

<sup>32</sup> JOM 2/204.09-Responsibility for Classification.

discovered by the OIG appear to result from past changes to specific sections of the JOM without reviewing the entire policy for internal consistency.

The Department is aware that existing deficiencies in the JOM must be resolved before moving forward with the OIG's recommended changes, so that the policy accurately reflects acceptable current practices. This is especially important in the context of adjudicating jail in-custody deaths, which will compare an employee's action with the expectations recorded in the policy. The CSD and Department employees must have a clear reference guide as to the positions, responsibilities, and performance expectations inside the LAPD jails. A thorough revision of the JOM will also ensure compliance with Title 15, which mandates a comprehensive review and update to the JOM every two years.<sup>33</sup>

## **V. SUICIDE AND ATTEMPTED SUICIDE DOCUMENTATION AND REVIEW**

The OIG had discussions with the OO and CSD leadership about procedures related to in-custody deaths and suicide attempts, including post-incident reporting, in LAPD jails and station holding tanks. The OIG concluded that the Department's approach to procedures involving both types of incidents require reformation.

In-custody death investigations are conducted by the Department's Force Investigation Division in accordance with Department policy. However, there was some question as to CSD's implementation of 30-day reviews for all deaths occurring within the jail facilities, per Title 15.<sup>34</sup> Under Section 1046 of Title 15, jail and health administrators, along with pertinent medical staff, are to convene for a discussion of the medical care provided in such an event, and to decide if changes to policy, practice, or procedures are necessary, or if any issues require further study. As of March 2018, the OIG was assured that 30-day reviews of all in-custody deaths occurring in the jails are being conducted, as required by law.

Custody Services Division also acknowledged that the suicide attempt documentation and subsequent review for the jails is currently an informal process. The OIG had several issues with the documentation of attempted suicides in the jails. Following a suicide attempt at an LAPD jail facility, CSD supervisors most commonly generate a Morning Report to document the incident.<sup>35</sup> The Morning Report is not specific to suicide attempts but is used to document any significant actions or circumstances that may occur in the course of a day. The OIG observed that details regarding suicide attempts in the Morning Reports varied, but they typically provided a limited summary of the event, including the inmate's name, a description of the event, and actions taken by the involved CSD personnel. Some suicide attempt incidents provided to the OIG for review were recorded on informal Microsoft Word document tables entitled, "Watch Supervisor Log," and they contained minimal, bullet-point details. The OIG was informed that

---

<sup>33</sup> Cal. Code Regs. Tit. 15, §1029.

<sup>34</sup> Cal. Code Regs. Tit. 15, §1046

<sup>35</sup> JOM 1/200.01-Completion of Morning Report.

any available video footage associated with a suicide attempt was often viewed but was not consistently downloaded and saved for an official review by supervisors and command staff.

The lack of a separate LAPD form for attempted suicide documentation caused CSD difficulty in obtaining all the requested Morning Reports and Logs for the OIG in a timely manner (Addendum F).<sup>36</sup> More importantly, because there were no clearly defined standards for the detail required in documenting an attempted suicide, descriptions were inconsistent and occasionally insufficient. At times, the OIG was unable to determine exactly how the suicide was attempted and what actions were taken in response, while a small number of reports failed to identify the officers and inmates involved. Although CSD stated that attempted suicides were discussed periodically in divisional meetings to identify and resolve specific issues, the OIG believes attempted suicides warrant more systematic and detailed reviews by CSD leadership. Without a standardized system that documents suicide attempts separately, and reviews them thoroughly, recurring trends and preventative measures are difficult to achieve.

Suicide attempts in station holding tanks also concerned the OIG as the OO advised that no policy existed to require specific documentation or review of suicide attempts there.<sup>37</sup> Per the Department, if a suicide is attempted in a holding tank, station personnel would immediately call for a rescue ambulance. The OIG was informed that in some cases a brief description of the attempted suicide is recorded in the Watch Commander's Daily Report. The Daily Report is then reviewed by an Area Captain, who may request a copy of any available video footage of the incident. The Department explained that the arresting officers are expected to inform CSD personnel of such an incident that occurred prior to booking the arrestee, but they admitted that this notification to CSD may not always occur.

The need for standardized protocols, reviews, and ensuing corrective actions for both types of facilities is evident in the recurring attempted suicides that led to the recent structural modifications in the LAPD jails, as discussed above. The March 2015 suicide at the 77<sup>th</sup> Regional Jail involving the anchor point between the two-inch gap of the bunk bed frame and the cell wall was one of four incidents involving this specific anchor point. Until it was eliminated, similar suicides were attempted on January 27, 2015, April 27, 2016, and December 17, 2016. Similarly, the use of corded telephones was involved with two suicides that occurred at MDC on December 5, 2011, and March 27, 2016.<sup>38</sup> Of the ten attempted suicides reviewed by the OIG involving the use of a telephone cord, nine pre-dated the March 2016 suicide at MDC, which has now prompted discussions of cordless telephone installation.<sup>39</sup>

---

<sup>36</sup> On April 6, 2017, the OIG submitted a data request to CSD for all suicide attempt reports from 2012 through 2016. Over the next several months, CSD provided 102 Morning Reports with attempted suicide descriptions. The last Morning Reports were provided on July 31, 2017.

<sup>37</sup> Office of Operations correspondence, dated August 11, 2017.

<sup>38</sup> Categorical Use of Force Report Nos. 108-11 and 019-16.

<sup>39</sup> These suicide attempts occurred on March 2, 2013; April 21, 2013; June 24, 2014; September 27, 2014; November 30, 2014; March 15, 2015; June 27, 2015; August 5, 2015; and February 5, 2016.

Custody Services Division is planning to implement a formal set of procedures to ensure consistent documentation and review of attempted suicides in the LAPD jails. These changes will bring CSD into compliance with Title 15 requirements for jail policies and practices to include a multi-disciplinary review of suicides and suicide attempts.<sup>40</sup> It will also assist the Department in developing lessons learned to prevent future incidents. Although the station holding tanks are not subject to regulation under Title 15, the OIG strongly encourages the OO to implement similar documentation and review standards there.

## **VI. JAIL AND HOLDING TANK IN-CUSTODY DEATH ADJUDICATION**

Currently, the LAPD categorizes an in-custody death as a Categorical Use of Force. This requires the investigation and adjudication to focus on all “substantially involved” officers in the incident and to examine the tactics they used, the appropriateness of any weapons drawn, and the compliance with policy of any force that was used.<sup>41</sup> For most Categorical Uses of Force, such as officer-involved shootings, this investigation and adjudication process is designed to identify and immediately correct all issues through mandated training or disciplinary action. Unfortunately, the process fails to perform this valuable function in the context of in-custody deaths that occur in jails or station holding tanks.

These specific in-custody deaths often do not include instances of weapons being drawn and commonly occur without the use of force by Department personnel. In fact, tactics are also not evaluated in cases of suicide if Department personnel were not actively involved in the death. When the circumstances of the incident do not align with these categories, investigators are left with nothing to evaluate. Not surprisingly, 8 of the 19 in-custody deaths reviewed by the OIG had no findings and were adjudicated as “Does Not Apply,” reflecting the fact that current adjudication standards are not applicable for a proper analysis of the circumstances involved in most in-custody deaths occurring within jails and holding tanks.<sup>42</sup> Without findings for these eight incidents, no “substantially involved” officers were identified, which precluded an assessment of employee work history and practices leading to the incident. This undoubtedly inhibits divisional efforts to review lessons learned for these in-custody deaths and to establish preventative measures going forward.

In response, the OIG developed an adjudication process specific to in-custody deaths that occur in jails and station holding tanks that more appropriately evaluates the circumstances of these incidents. The “Jail Cell and Holding Tank In-Custody Death Adjudication Protocol” will supplement the existing Categorical Use of Force process by requiring the assessment and adjudication of the following categories: “Inmate Intake Procedures,” “Inmate Welfare Procedures,” and “In-Custody Death Procedures” (Addendum G). The options for “Findings”

---

<sup>40</sup> Cal. Code Regs. Tit. 15, §1030.

<sup>41</sup> See LAPD Manual 1<sup>st</sup> Quarter 2017, Volume 3, Section 792.05.

<sup>42</sup> Of the nine remaining incidents, three involved a use of force, one had findings related to the tactics utilized by the arresting officers, and seven of the in-custody death investigations were reclassified to general death investigations, which are not adjudicated at all.

and “Outcome” employed in the current adjudication will remain the same. The new categories represent the most pivotal procedures involved in maintaining the health and safety of each arrestee and inmate. A failure to perform any of these procedures, as required by law and policy, can foreseeably increase the chance of an in-custody death, whether by self-inflicted harm or otherwise. The OIG’s proposed adjudication therefore compels investigators to thoroughly examine these procedures and practices in each incident.

Furthermore, the definition of “substantially involved” personnel for this new adjudication process will be modified to include field/arresting officers responsible for communicating any issues with their arrestee to CSD personnel for housing classification purposes; CSD personnel tasked with the booking and housing classification process; CSD personnel responsible for conducting safety checks; and CSD personnel involved in the portion of the incident where the inmate was discovered to be either in medical distress or deceased. This change in definition expands the total number of employees to be interviewed and evaluated after each in-custody death; however, the increased workload is necessary to ensure that questionable procedures or practices are consistently identified and addressed immediately.

#### A. Reclassification of In-Custody Death Investigations

For the OIG’s new adjudication protocol to be most effective in avoiding preventable deaths in-custody, all deaths that occur in the jails and holding tanks should be subject to the new standards – including those that would otherwise be eligible for reclassification to death investigations. In reviewing documents and performing related research, the OIG discovered a total of seven in-custody deaths that were reclassified to death investigations, pursuant to the Office of the Chief of Police, Special Order No. 10, dated May 10, 2011.<sup>43</sup> Reclassification expedites the investigation and reporting of certain deaths that are deemed low-risk, typically resulting from natural causes or accidental or undetermined means. Although Department personnel are directed to initiate a thorough investigation for in-custody deaths, the Special Order indicates that once the conditions necessary for reclassification are satisfied, the investigation can be closed out with a Death Investigation Report (LAPD Form 03.11.00), which amounts to an abbreviated review of the incident.

The corresponding reports for the reclassified deaths under review contained such limited detail that the OIG was prevented from properly analyzing the circumstances surrounding them. Some of the files had only a single-page document stating that no force was used, along with confirmed autopsy reports of accidental or natural deaths. The inability to properly evaluate reclassified cases was especially problematic because they are simply closed after receiving approval, instead of being adjudicated by the Commission. Alleged misconduct or other administrative violations are not prerequisites for opportunities to learn about potential areas for improvement. Even where in-custody deaths are the product of natural causes, or accidental or undetermined means, there may be a critical opportunity to learn from the circumstances surrounding the event and the

---

<sup>43</sup> On May 10, 2011, the BOPC approved Department Policy that allowed for the reclassification of a Categorical Use of Force in-custody death investigation to a less extensive death investigation. This was designed to alleviate the Department’s workload with regard to the reporting and adjudication of such incidents. If the incident was deemed low-risk and satisfied the criteria listed, it could be submitted for reclassification.

ensuing investigation. Without thorough documentation and reporting, any subsequent review of the incident will be unable to analyze the relevant circumstances in order to obtain this beneficial information and, possibly, minimize the risk of recurrence in the future.

## **VII. CONCLUSION**

Following several months of meetings and inspections with the Department, the OIG identified a number of improvements necessary for CSD to continue its efforts in minimizing the incidence of in-custody deaths and suicide attempts. Eliminating anchor points that structurally facilitate hangings is a vital first step, in addition to improved video monitoring and strategic placement of video cameras within all jail cells and station holding tanks. Repeated use of specific anchor points or recurring methods of self-inflicted harm can often be identified, quickly resolved, and prevented by continuing to implement 30-day reviews of all in-custody deaths and developing written procedures for the specific documentation and thorough review of attempted suicides in jails and holding tanks.

Valuable lessons learned and the establishment of preventative measures can also be realized with the implementation of the OIG's proposed adjudication for in-custody death incidents within jails and holding tanks. A tailored protocol for such adjudications will ensure an investigation that examines practices, policies, procedures, and personnel specific to these incidents. This adjudication will create a level of accountability to improve detention-related operations overall.

What CSD personnel know about each arrestee going into confinement, and what housing classification each arrestee receives, contributes heavily to inmate safety. Due to the increasing number of arrestees with mental illness and the responsibility to identify and treat these individuals, CSD personnel must receive professional mental health training on a more frequent basis. The OIG further determined that fact-gathering practices for housing classification require modifications that encourage arrestees to provide honest answers and that ensure more consistent communication with arresting officers and medical dispensary personnel about an arrestee's behavior. All such communications with CSD personnel must be documented in a manner that facilitates an efficient evaluation and that remains accessible for review during confinement.

The OIG expects the determination of housing classification for arrestees to involve a thorough evaluation of a considerable amount of information. The exclusive reliance upon the instincts and experience of processing officers is unnecessarily susceptible to human error and creates an unfair liability. As such, this determination necessitates a formal, structured system of evaluation that will guarantee analysis of the same information, in a uniform manner, for each arrestee. The OIG believes that significant revisions to the Inmate Classification Questionnaire, implementation of RMS, and creation of the CHO position are substantial improvements addressing many of the concerns raised by the OIG in this Report. The OIG encourages the Department and CSD to invest in these new developments, in addition to initiating the OIG's recommendations as soon as possible.

## VIII. RECOMMENDATIONS

Based on the investigation and findings detailed in this Report, the OIG has several recommendations for Department action in furtherance of an improved approach to suicide and suicide attempt prevention in the LAPD jails and station holding tanks. These recommendations are listed below by corresponding Report section.

### Jail Cell and Holding Tank Inspections

1. **The OIG recommends that the Department remove all potential anchor points identified in this Report.** Although it may not be possible to guarantee the complete elimination of suicides and suicide attempts, the OIG's review concluded that elimination of anchor points may help decrease the frequency of such incidents and allow CSD personnel to focus on protecting inmates from other means of self-inflicted harm.
2. **The OIG recommends that the Department install video cameras in all LAPD jail cells and holding tanks where inmates or arrestees are likely to be housed alone.** Despite legal mandates to perform safety checks on inmates in LAPD jails, and in light of the fact that no such requirement exists for station holding tanks, it is essential for Department personnel to monitor arrestees and inmates continuously throughout their confinement. Typically, it is the activity occurring between safety checks, or when personnel are not physically present, that is the most concerning.
3. **The OIG recommends that the Department develop written procedures for police station holding tanks to perform random, documented arrestee safety checks at least twice an hour.** Without any practice or policy requiring Department personnel to perform documented monitoring of arrestees in holding tanks, the risk of a suicide attempt there is unnecessarily high, especially considering that safety checks can be performed with relatively minimal effort and time.

### Arrestee Officer Communications

4. **The OIG recommends that the Department develop a set of written questions for CSD personnel and arresting officers to discuss and answer in writing for consistent reporting of an arrestee's observed behavior leading up to his or her housing classification.** The OIG was informed by CSD personnel that communication with the arresting officer about an arrestee's behavior is not a consistent practice, despite JOM policy mandating an exchange of this information. Even with enforcement of existing policy, details of the conversation are not documented, as must occur for appropriate inclusion in the housing classification determination and for reference during confinement.

#### Arrestee Privacy Concerns

5. **The OIG recommends that the Department require arresting officers and CSD personnel to ask arrestee health and classification questions in a private space and not in the presence of other arrestees or inmates.** The housing classification determination can only be as accurate as the information under review. The Department must be invested in eliciting honest answers from each arrestee by requiring privacy, especially for sensitive questions pertaining to mental health.

#### City Medical Personnel Communications

6. **The OIG recommends that the Department work together with the City of Los Angeles Medical Services Division to ensure that greater detail concerning each arrestee's behavior and mental health is provided to CSD personnel on a consistent basis, prior to housing classification.** Assessing the mental stability of incoming arrestees is integral to proper housing classification, which will not be accurate without the details revealed, and behaviors exhibited, in an arrestee's medical examination.

#### Housing Classification Assessment

7. **The OIG recommends that the Department develop and implement a system designed to formally analyze the same set of factors in a uniform manner for each arrestee, ensuring consistent evaluation and documentation in determining the housing classification.** The amount of information to be reviewed and analyzed in a relatively short period of time places an unnecessary burden on CSD personnel making decisions based solely on their experience and instincts. The risk for human error is too great, as are the potential consequences. A formal system of evaluation with documented justification for the classification ensures greater thoroughness and uniformity in such a consequential decision.

#### Classification and Housing Officer Program

8. **The OIG recommends that the Department establish the permanent position of Classification and Housing Officer at MDC, 77<sup>th</sup> Regional Jail, and Valley Jail.** Assigning all classification responsibilities to a single supervising officer permits the requisite focus to be applied to the determination of housing. This presents an appropriate solution to increased communication with medical personnel and alleviates concerns about booking process efficiency, as the classification evaluation can proceed concurrently with the remaining booking procedures.

### Mental Health Training

9. **The OIG recommends that the Department develop and mandate extensive mental health training for all CSD personnel throughout each year.** The number of arrestees and inmates with mental health issues who are booked and confined in LAPD jails and holding tanks is significant and increasing each year. Without support from licensed mental health experts, it is crucial that CSD personnel receive professional training on a recurring basis that reinforces appropriate conduct in identifying and managing individuals with mental illness.

### Post-Housing Mental Health Awareness

10. **The OIG recommends that the Department require CSD personnel to include a re-evaluation of inmate documentation for signs of present or past mental health issues before taking action to address inmate health complaints and behavioral issues.** The OIG recognizes that inmate complaints occur often and many times do not require medical attention or a change in housing type. However, when complaints or issues arise, a review of inmate documentation for the presence of any mental health issues will provide CSD personnel with proper justification to involve the medical dispensary if warranted or to more appropriately address the inmate otherwise.

### Jail Operations Manual Concerns

11. **The OIG recommends that the Department immediately revise and edit the JOM to accurately reflect best practices, to provide formal descriptions of personnel positions and operational procedures, and to apply formal references to existing CSD documents.** The JOM provides insufficient guidance to CSD personnel regarding the housing classification process. The OIG found the language to be both confusing and contradictory. Various forms are referred to interchangeably by formal and informal titles, documents that no longer exist are cited in procedural mandates, and several policies do not reflect current best practices. Going forward, it will be impossible to properly adjudicate jail and holding tank in-custody deaths if the JOM does not accurately reflect best practices. As a result, a thorough revision of the entire JOM is a priority.

### Suicide and Attempted Suicide Documentation and Review

12. **The OIG recommends that the Department maintain compliance with Title 15 requirements for a 30-day review of all in-custody deaths occurring within the jail to assess circumstances, initiate any need for immediate change, and address any further issues raised.** The OIG was informed that CSD is now conducting the mandatory 30-day reviews of all such incidents in accordance with Title 15 and will continue to do so to further improve operations.

- 13. The OIG recommends that the Department develop a formal set of written procedures that require separate and detailed documentation, analysis, and review of all suicide attempts in any LAPD jail or police station holding tank.** Current practices make it difficult to locate reports that include summaries of attempted suicides, and the OIG found many of the summaries to contain insufficient descriptions of the incidents. Preventative measures and appropriate actions following suicide attempts can only occur if they are sufficiently documented and reviewed on a consistent basis.

#### Jail and Holding Tank In-Custody Death Adjudication

- 14. The OIG recommends that the Department implement the Jail and Holding Tank In-Custody Death Adjudication Protocol.** All in-custody deaths are presently adjudicated pursuant to the same standards as other Categorical Uses of Force, which analyze an involved employee's actions regarding tactics, drawing or exhibiting of a weapon, and force used. Many of the in-custody deaths that occur in jail do not have fact patterns or findings applicable to these categories, and they are often adjudicated as "Does Not Apply." As a result, involved CSD personnel are not identified, and there is no meaningful assessment of practices or conduct exhibited during the incident. A detailed assessment and proper adjudication tailored to these particular in-custody deaths are essential for divisional improvement.

#### Reclassification of In-Custody Death Investigations

- 15. The OIG recommends that the Department prohibit reclassification of Categorical Use of Force investigations to death investigations for all jail and holding tank in-custody deaths.** Reclassified death investigation reports contain insufficient detail about these critical incidents and are not adjudicated by the Commission. An inmate death from natural causes, or accidental or undetermined means, does not preclude the possibility that the conduct of CSD personnel can be improved in important and consequential ways. Every in-custody death has the potential to provide insight for operational improvement, as lessons learned may be derived from all such incidents, whether or not any misconduct is alleged.

#### BOPC Progress Report

- 16. The OIG recommends that the Department present the Board of Police Commissioners with a Progress Report, no later than February 26, 2019, that must include, but is not limited to, JOM revisions, anchor point elimination, the effectiveness of the Records Management System, the Classification and Housing Officer Pilot Program, and the revised LAPD Form 05.36.00.**

**IX. ADDENDA**

**Addendum A**

**In-Custody Deaths Adjudicated by Commission (2012-2017)**

Location	Date of Occurrence	FID Case Number	Means of Death	Cause of Death as Determined by the Coroner	Findings
<b>JAIL FACILITIES</b>					
Metropolitan Detention Center	4/10/2011	034-11	Inmate was discovered unresponsive in his cell. Upon entry, personnel observed that the inmate had tied his long-sleeve shirt over his face.	Asphyxia.	Does Not Apply.
	10/30/2011	098-11 <sup>44</sup>	Inmate was found unresponsive on his bed.	Undetermined.	Not Adjudicated.
	12/5/2011	108-11	Inmate hanged himself by wrapping the phone cord around his neck and placing the receiver back on its cradle.	Hanging.	Does Not Apply.
	4/29/2013	037-13 <sup>45</sup>	Inmate was in a holding cell awaiting transfer to an LASD transport bus when he collapsed. Inmate later expired at the hospital.	Undetermined.	Not Adjudicated.
	7/8/2014	036-14	Inmate became involved in a struggle with jail personnel. He was taken to the dispensary for evaluation and was placed in medical scrubs. After observing no injuries, he was cleared by the dispensary. Inmate began breathing rapidly. Paramedics opined that the inmate was suffering from Agitated Delirium. As inmate was being taken to the ambulance, he went into cardiac arrest.	Restraining maneuvers and other undetermined factors.	Tactics – Tactical Debrief for seven officers.  Non-lethal Use of Force – In Policy.

<sup>44</sup> Case reclassified to a death investigation and was not adjudicated.

<sup>45</sup> Case reclassified to a death investigation and was not adjudicated.

	10/19/2014	059-14 <sup>46</sup>	During meal service, inmate was found lying unresponsive on his bunk bed.	Natural.	Not Adjudicated.
	3/27/2016	019-16	Inmate hanged herself by tying an article of clothing around her neck to the telephone cord.	Hanging.	Does Not Apply.
Van Nuys Jail Section	7/7/2011	060-11	Video evidence showed inmate snorting heroin that was smuggled in by another inmate.	Multiple drug intoxication.	Does Not Apply.
	8/15/2011	072-11 <sup>47</sup>	During the dispensation of medication, inmate was discovered unresponsive on her bed.	Accidental.	Not Adjudicated.
	6/28/2015	053-15	Video evidence showed inmate ingesting possible narcotics that were wrapped in a paper bundle.	Upper gastrointestinal bleeding due to, or as a consequence of, ruptured esophageal varices, cirrhosis of the liver, ethanol use, hepatitis C, drug use, and hypertension.	Does Not Apply.
77 <sup>th</sup> Regional Jail	9/13/2011	083-11 <sup>48</sup>	Inmate was found unresponsive on his bed.	Accidental.	Not Adjudicated.

<sup>46</sup> Case reclassified to a death investigation and was not adjudicated.

<sup>47</sup> Case reclassified to a death investigation and was not adjudicated.

<sup>48</sup> Case reclassified to a death investigation and was not adjudicated.

	6/4/2012	038-12	Inmate became combative as he was being fingerprinted and was involved in a struggle with several detention personnel.	Effects of neck compression, coronary atherosclerosis with thrombosis, and cocaine intoxication.	Tactics – Tactical Debrief for six officers.  Drawing/Exhibiting In Policy.  Non-lethal Use of Force – In policy.  Less-lethal Use of Force – In policy.  Lethal Use of Force – Out of Policy, Administrative Disapproval for one officer.
	12/4/2015	092-15	Inmate hanged himself by tying an article of clothing around his neck to a gap between the bunk bed and cell wall.	Hanging.	Does Not Apply.
	11/1/2016	069-16 <sup>49</sup>	As detention officers were preparing for the transportation of inmates to court, the inmate was discovered unresponsive on his bed.	Dilated cardiomyopathy due to, or as a consequence of methamphetamine abuse.	Not Adjudicated.
Pacific Jail	6/22/2015	051-15	Inmate wedged himself in the gap between his bunk bed and the cell wall. Inmate was unable to get himself out and had an epileptic seizure.	Mechanical asphyxia due to, or as a consequence of, idiopathic epilepsy.	Does Not Apply.
<b>POLICE STATION HOLDING TANKS</b>					
Southwest Police Station	9/7/2013	081-13	After having been handcuffed and placed in the back of a police vehicle, the arrestee had continually advised officers that he could not breathe. The arrestee was transported to the Police Station where he lost consciousness.	Probable asthma.	Does Not Apply.

<sup>49</sup> Case reclassified to a death investigation and was not adjudicated.

<p>Foothill Police Station</p>	<p>3/12/2015</p>	<p>021-15</p>	<p>Arrestee hanged herself by tying an article of clothing around her neck to a wall-mounted O-ring restraining device.</p>	<p>Hanging.</p>	<p>Tactics – Administrative Disapproval for two officers.  Tactics – Tactical Debrief for one officer.</p>
<p>Harbor Police Station</p>	<p>3/27/2016</p>	<p>034-16</p>	<p>During a search of the arrestee at the holding tank, the arrestee swallowed a bag of narcotics, which became lodged in his throat.</p>	<p>Asphyxia due to an obstructed airway by a foreign object with contributing combined effects of alcohol, Heroin, and methamphetamine intake.</p>	<p>Tactics – Tactical Debrief for two officers.  Non-lethal Use of Force – In policy. Occurred during arrest not in the facility.  Less-lethal Use of Force – Out of Policy, Administrative Disapproval for one officer. Occurred during arrest not in the facility.</p>
<p>Hollywood Police Station</p>	<p>12/26/2016</p>	<p>088-16<sup>50</sup></p>	<p>Arrestee apprehended for transporting a stolen motorcycle. While he was in the police station holding tank, an officer checked on the arrestee and observed him holding his stomach. The officer asked him if he needed medical attention, but the arrestee refused. The arrestee then fell on the floor and began to convulse. He was transported to a hospital where he expired six days later.</p>	<p>Atherosclerotic cardiovascular disease. Effects of cocaine and methamphetamine and cardiomegaly were listed as other contributing conditions.</p>	<p>Not Adjudicated.</p>

<sup>50</sup> Case reclassified to a death investigation and was not adjudicated.

**Addendum B**

**Attempted Suicides by Anchor Point and Ligature (2012-2017)**

<b>Anchor Point</b>	<b>MDC</b>	<b>77<sup>th</sup> Jail</b>	<b>Valley Jail</b>	<b>Hollywood Jail</b>	<b>Pacific Jail</b>	<b>Total</b>
Bunk Bed Frame	1 Bed sheet	1 Bed sheet 1 Shirt 1 Ligature	3 Shirt 1 Bed sheet 1 Blanket	-	2 Blanket	<b>11</b>
Phone	3 Phone cord 2 Bed sheet 1 Cloth 1 Jacket	1 Pants	1 Phone cord 1 Sweater	-	-	<b>10</b>
Door	2 Bed sheet 1 Sweater 1 Shirt	-	1 Pants 1 Blanket 1 Shirt	-	-	<b>7</b>
Toilet	1 Shirt 1 Bed sheet 1 Pants	-	1 Bra	-	-	<b>4</b>
Smoke Detector or Vent Grill	-	1 String 1 Shirt	-	1 Shirt	-	<b>3</b>
Drain	1 Shirt	1 Shirt	-	-	-	<b>2</b>
Shower Stall	1 Bed sheet	-	-	-	-	<b>1</b>
Sink	-	-	1 Underwear	-	-	<b>1</b>
Light Fixture	-	1 Shirt	-	-	-	<b>1</b>
<b>Total</b>	<b>17</b>	<b>8</b>	<b>12</b>	<b>1</b>	<b>2</b>	<b>40</b>

**Addendum C**

**Los Angeles County Unified Arrestee Medical Screening Form (SH-R-422 REV 09/16/14)  
Page 1 of 2**

LOS ANGELES COUNTY UNIFIED  
ARRESTEE MEDICAL SCREENING FORM

ARRESTING AGENCY	ARRESTEE NAME		BOOKING NUMBER	DATE			
ARRESTEE QUESTIONNAIRE				YES	NO	REFUSE	
1	Do you feel suicidal or feel like hurting yourself? If yes, complete a Behavioral Observation and Mental Health Referral (Form SH-J-407), Inmate Special Handling Request (Form SH-J-181 or Intranet), and place an "S" (Suicidal) code on the inmate's wristband.						
2	Do any of the following apply to you: (If yes, circle all that apply)						
	Attempted suicide	Mental health issues	Under the care of a mental health professional	Taking psychiatric medications	Hearing things that are not there		
3	Do you require any medical attention? If yes, why:						
4	Do you have any injuries? If yes, what:						
5	Are you currently taking any medications? If yes, complete the below:						
	1) Name:	Dosage:	How Often:				
	2) Name:	Dosage:	How Often:				
	3) Name:	Dosage:	How Often:				
6	Do you have any medical conditions such as: (circle all that apply)						
	HIV/AIDS	Tuberculosis	High Blood Pressure	Diabetes			
	Epilepsy	Dialysis	Open Wound/Abscess/Boil (MRSA)	Other:			
	If yes to "open wound/abscess/boil," describe:						
7	Do you regularly use any Alcohol or Drugs? If so:						
	1) Name:	Last Use:					
	How Often:	How Much:					
	2) Name:	Last Use:					
	How Often:	How Much:					
	3) Name:	Last Use:					
	How Often:	How Much:					
8	Have you ever been in a "special education" class for slow learners or for emotional problems, considered developmentally disabled or a client of a regional center?						
9	Are you receiving ongoing medical treatment from any medical facility and/or assisted living, board and care, rehabilitation center? If yes, name and contact information of the facility/provider.						
	Facility/Provider:	Phone Number:					
10	Females only – Do you have any of the following conditions? (If yes, circle all that apply)						
	Birth Control Medication:	Pregnant -- If yes, do you have: Vaginal bleeding and/or Abdominal pain					
	Lactating/Breastfeeding	Other:					
ARRESTEE SIGNATURE				DATE			
DEPUTY/OFFICER WITNESSING		EMPLOYEE/ID NUMBER	DATE	TIME			

This form has been reviewed and approved by the Chief Physician of Medical Services Bureau and the Director of Jail Mental Health Services for the Los Angeles County Sheriff's Department. Original signatures are on file with the Medical Services Administration.

**Addendum C**  
**Page 2 of 2**

ARRESTING DEPUTY/OFFICER OBSERVATION (REQUIRED FOR ALL LASD AND OUTSIDE AGENCY BOOKINGS AT IRC OR SHERIFF STATION JAILS)					YES	NO	
1	Does the arrestee appear to have any injuries or medical problems?						
	If yes, describe:  <i>ARRESTEES WHO HAVE, OR ARE SUSPECTED TO HAVE, AN ACTIVE COMMUNICABLE DISEASE ARE TO BE SEGREGATED AND TRANSFERRED TO AN APPROPRIATE MEDICAL FACILITY AS SOON AS POSSIBLE. (TITLE 15, ARTICLE 5, SECTION 1051)</i>						
2	Did the arrestee physically resist arrest and/or require the use of force during the arrest?						
	If so, enter Report #: _____ a) If so, did the arrestee receive medical treatment?						
3	Did the arrestee threaten suicide or attempt "suicide by cop" during their arrest?						
	<i>If yes, complete a Behavioral Observation and Mental Health Referral (Form SH-J-407), Inmate Special Handling Request (Form SH-J-181 or Intranet), and place an "S" (Suicidal) code on the inmate's wristband.</i>						
4	Was the arrestee medically treated and cleared? (OK to Book: attach diagnosis/treatment/recommendations paperwork)						
	Name of clearing medical facility: _____						
	Provider: _____	Phone: _____					
5	Does the arrestee appear to be under the influence of alcohol and/or drugs? <i>If yes, have jailer begin "Intoxication Observation Sheet."</i>						
6	Does the arrestee have any prescribed medications in their property? If yes, list:						
7	Did the arrestee require assistance walking at the time of their arrest? (circle all that apply)						
	Cane	Crutches	Walker	Wheelchair			Observed Walking
8	Are you aware if the arrestee is currently a mental patient, under the care of a mental health professional, has a history of mental illness or suicidal?						
	If yes, list reason(s) if known:						
9	Is the arrestee suspected of murdering or attempting to murder a family member?						
DEPUTY/OFFICER NAME					EMPLOYEE/ID NUMBER	DATE	TIME

JAILER OBSERVATIONS					YES	NO
1.	Is the arrestee's consciousness level impaired? Examples: difficult to arouse, difficulty breathing, increased lethargy, unaware of their location, name, and date. <i>IF YES, SUMMON PARAMEDICS</i>					
2.	Does the arrestee have obvious symptoms suggesting the need for emergency care? Examples: bleeding, difficulty breathing, cold clammy perspiration, violent shaking, convulsions. <i>IF YES, SUMMON PARAMEDICS</i>					
3.	Does the arrestee appear to have visible signs of alcohol/drug withdrawal? (Examples: profuse sweating, profuse vomiting, anxiety, visual hallucinations. <i>IF YES, SUMMON PARAMEDICS</i>					
4.	Does the arrestee require more than minimal assistance when walking? <i>If yes, obtain medical evaluation.</i>					
5.	Does the arrestee's behavior or statements suggest a risk of suicide? Examples: severe depression, crying, withdrawal, silence, history of previous suicide attempt such as self-inflicted injuries? <i>If yes, place under close supervision/suicide watch, complete a Behavioral Observation and Mental Health Referral form and transport to the appropriate Reception Center.</i>					
6.	Does the arrestee display any of the following behaviors? Examples: responding to something that is not there, withdrawn, bizarre beliefs, rambling nonsensically, overly suspicious, combative without apparent provocation. <i>If yes, complete a Behavioral Observation and Mental Health Referral form and segregate and/or transport to the appropriate Reception Center.</i>					
7.	Does the arrestee appear to be developmentally disabled? If needed, refer to the "Quick Reference Guide for Developmentally Disabled," provided in Station Jail Manual. <i>NOTIFY THE APPROPRIATE REGIONAL CENTER (BY ARRESTEE'S ZIP CODE OF RESIDENCE), IF ARRESTEE IS TO BE HELD MORE THAN 24 HOURS. (TITLE 15, ARTICLE 5, SECTION 1057)</i>					

*If the arrestee appears to be under the influence of alcohol and/or drugs, the Intoxication Observation Sheet shall be completed.*  
**\*\*ANY AFFIRMATIVE ANSWER TO THIS QUESTIONNAIRE SHALL BE BROUGHT TO THE ATTENTION OF THE JAIL SUPERVISOR.**

JAILER SIGNATURE	EMPLOYEE/ID NUMBER	DATE	TIME
JAIL SUPERVISOR SIGNATURE	EMPLOYEE/ID NUMBER	DATE	TIME

**Addendum D**

**Inmate Classification Questionnaire and Record of Medical Screening (Form 05.36.00)**

LOS ANGELES POLICE DEPARTMENT			
INMATE CLASSIFICATION QUESTIONNAIRE AND RECORD OF MEDICAL SCREENING			
<i>This form shall be completed only when the arrestee is seen by dispensary personnel.</i>			
ARRESTEE'S NAME (PRINT) _____	DOB _____		
BOOKING NUMBER _____	CHARGE _____	DATE _____	
SEGREGATION ASSESSMENT (CHECK EACH CORRESPONDING BOX)			
HAVE YOU EVER ESCAPED OR ATTEMPTED TO ESCAPE FROM CUSTODY? ¿HA ESCAPADO DE CUSTODIA?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
HAVE YOU EVER BEEN A POLICE INFORMANT OR WITNESS FOR THE STATE? ¿HA SIDO ESPÍA DE LA POLICIA O TESTIGO DEL ESTADO?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
HAVE YOU EVER BEEN AFFILIATED WITH A PRISON OR STREET GANG? ¿HA SIDO AFILIADO CON ALGUNA PANDILLA? GANG IDENTITY _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
HAVE YOU EVER ASSAULTED A POLICE OR CUSTODIAN OFFICER? ¿HA AGREDIDO A UN POLICIA O CARCELERO?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
DO YOU FEAR FOR YOUR SAFETY WHILE IN THIS FACILITY? WHY? ¿TEME POR SU SEGURIDAD ADENTRO DE ESTA CARCEL? ¿PORQUE? _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
WHAT IS YOUR SEXUAL ORIENTATION? ¿CUAL ES SU PREFERENCIA SEXUAL?	HETEROSEXUAL <input type="checkbox"/>	GAY <input type="checkbox"/>	BISEXUAL <input type="checkbox"/>
IF YOU IDENTIFY AS TRANSGENDER, WHAT GENDER DO YOU IDENTIFY WITH? ¿SI SE IDENTIFICA COMO TRANSGENERO, CON QUE IDENTIDAD GENERA SE IDENTIFICA?	TRANSMAN F TO M <input type="checkbox"/>	TRANSWOMAN M TO F <input type="checkbox"/>	
ARE YOU IN POSSESSION OF RELIGIOUS ARTICLES YOU WOULD LIKE TO RETAIN? ¿ESTA EN POSESION DE ARTICULO RELIGIOSOS QUE DESEA RETENER?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
ITEM RETAINED BY ARRESTEE? YES <input type="checkbox"/> NO <input type="checkbox"/> DESCRIPTION OF ITEM AND REASON: _____			
I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT. ARRESTEE'S SIGNATURE: X _____			
DOES ARRESTEE SHOW ANY BEHAVIOR OR CONDITION SUGGESTING NECESSITY TO SEGREGATE?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
BOOKING RECOMMENDATION REVIEWED:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
MEDICAL SCREENING OR MEDICAL TREATMENT FORMS REVIEWED FOR ANY PHYSICAL OR MENTAL CONDITIONS REQUIRING SEGREGATION.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
HOUSING CLASSIFICATION			
GENERAL <input type="checkbox"/>	SEGREGATION <input type="checkbox"/>	DETOXIFICATION <input type="checkbox"/>	
INMATE CLASSIFICATION FORM COMPLETED BY:			
DETENTION OFFICER SIGNATURE _____	SERIAL NO. _____	DATE _____	TIME _____
WATCH COMMANDER SIGNATURE _____	SERIAL NO. _____	DATE _____	TIME _____
MEDICAL INSTRUCTIONS FOR PERSONS IN CUSTODY			
1. UNDER THE INFLUENCE OF DRUGS/ALCOHOL: NO <input type="checkbox"/> IF YES <input type="checkbox"/> OR UNABLE TO DETERMINE <input type="checkbox"/>			
Perform a complete medical evaluation and document your assessment on the medical record form.			
2. SAFETY CRITERIA: <input type="checkbox"/> SAFETY CELL <input type="checkbox"/> SOBERING CELL <input type="checkbox"/> LOW BUNK <input type="checkbox"/> DISPENSARY RECHECK DUE AT _____			
3. <input type="checkbox"/> VISUAL AND VERBAL CHECKS (COMPLETE CUSTODY OBSERVATION FORM.) <input type="checkbox"/> IF NOT ALERT OR EASILY WOKEN UP BY _____ TRANSPORT TO DISPENSARY IMMEDIATELY.			
4. <input type="checkbox"/> SUICIDE PRECAUTIONS. TRANSFER TO TWIN TOWERS/CRDF.			
5. SPECIAL DIET: <input type="checkbox"/> PREGNANT/LACTATING (double portions of milk with meals) <input type="checkbox"/> DIABETIC <input type="checkbox"/> LACTOSE INTOLERANT <input type="checkbox"/> SOFT			
6. <input type="checkbox"/> DEVELOPMENTALLY DISABLED/MENTALLY CHALLENGED - PLACE IN SEGREGATION CELL.			
7. OTHER _____			
8. <input type="checkbox"/> NO MEDICAL TREATMENT NEEDED.			
DISPOSITION: O.K. TO BOOK <input type="checkbox"/> TRANSFER TO: <input type="checkbox"/> CONTRACT HOSPITAL <input type="checkbox"/> TWIN TOWERS <input type="checkbox"/> WOMEN'S HOSPITAL <input type="checkbox"/> LAC, USCMC <input type="checkbox"/> CRDF			
RN/MD SIGNATURE _____	PRINT NAME/TITLE _____		DATE & TIME _____
05.36.00 (09/13) CC: A copy is to be maintained with the individual's medical record for person in custody form.			

**Addendum E**  
**Inmate Classification Questionnaire (Form 05.37.00)**

<b>INMATE CLASSIFICATION QUESTIONNAIRE</b>			
<i>This form shall be completed only when the arrestee is not seen by dispensary personnel.</i>			
ARRESTEE'S NAME (PRINT) _____		DOB _____	
BOOKING NUMBER _____		CHARGE _____	
<b>SEGREGATION ASSESSMENT (CHECK EACH CORRESPONDING BOX)</b>			
HAVE YOU EVER ESCAPED OR ATTEMPTED TO ESCAPE FROM CUSTODY? ¿HA ESCAPADO DE CUSTODIA?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
HAVE YOU EVER BEEN A POLICE INFORMANT OR WITNESS FOR THE STATE? ¿HA SIDO ESPIA DE LA POLICIA O TESTIGO DEL ESTADO?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
HAVE YOU EVER BEEN AFFILIATED WITH A PRISON OR STREET GANG? ¿HA SIDO AFILLADO CON ALGUNA PANDILLA? GANG IDENTITY _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
HAVE YOU EVER ASSAULTED A POLICE OR CUSTODIAN OFFICER? ¿HA AGREDIDO A UN POLICIA O CARCELERO?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
DO YOU FEAR FOR YOUR SAFETY WHILE IN THIS FACILITY? WHY? ¿TEME POR SU SEGURIDAD A DENTRO DE ESTA CARCEL? ¿PORQUE?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
WHAT IS YOUR SEXUAL ORIENTATION? ¿CUAL ES SU PREFERENCIA SEXUAL?	HETEROSEXUAL <input type="checkbox"/>	GAY <input type="checkbox"/>	BISEXUAL <input type="checkbox"/>
IF YOU IDENTIFY AS TRANSGENDER, WHAT GENDER DO YOU IDENTIFY WITH? ¿SI SE IDENTIFICA COMO TRANSGENERO, CON QUE IDENTIDAD GENERA SE IDENTIFICA?	TRANSMAN F TO M <input type="checkbox"/>		TRANSWOMAN M TO F <input type="checkbox"/>
ARE YOU IN POSSESSION OF RELIGIOUS ARTICLES YOU WOULD LIKE TO RETAIN? ¿ESTA EN POSESION DE ARTICULO RELIGIOSOS QUE DESEA RETENER? ITEM RETAINED BY ARRESTEE? YES <input type="checkbox"/> NO <input type="checkbox"/> DESCRIPTION OF ITEM AND REASON: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
DO YOU HAVE BOILS/DRAINING SKIN LESIONS? ¿TIENE VEJIGAS/INFECCIONES DE LA PIEL?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<b>I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT.</b>			
ARRESTEE'S SIGNATURE: X _____			
DOES ARRESTEE SHOW ANY BEHAVIOR OR CONDITION SUGGESTING NECESSITY TO SEGREGATE? EXPLAIN: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
BOOKING RECOMMENDATION REVIEWED:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
MEDICAL SCREENING OR MEDICAL TREATMENT FORMS REVIEWED FOR ANY PHYSICAL OR MENTAL CONDITIONS REQUIRING SEGREGATION.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<b>HOUSING CLASSIFICATION</b>			
GENERAL <input type="checkbox"/>	SEGREGATION <input type="checkbox"/>	DETOXIFICATION <input type="checkbox"/>	
INMATE CLASSIFICATION FORM COMPLETED BY:			
DETENTION OFFICER _____	SERIAL NO. _____	DATE _____	
SEGREGATED FORM APPROVED BY _____		SERIAL NO. _____	
05.37.00 (09/13) <span style="float: right;">© 2013</span>			

**Addendum F**  
**Morning Reports Denoting Attempted Suicide (Provided by CSD)**

<u>Location</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>5-Year Total</u>
<b>MDC</b>	2	14	13	11	15	55
<b>77<sup>th</sup> Jail</b>	-	-	6	8	9	23
<b>Valley Jail</b>	-	4	3	4	5	16
<b>Hollywood Jail</b>	-	-	2	-	-	2
<b>Pacific Jail</b>	-	-	-	1	1	2
<b>Unable to Determine<sup>51</sup></b>	-	-	3	1	-	4
<b>Total Provided By CSD</b>	<b>2</b>	<b>18</b>	<b>27</b>	<b>25</b>	<b>30</b>	<b>102</b>
<b>CompStat Attempted Suicide Totals</b>	<b>24<sup>52</sup></b>	<b>47<sup>53</sup></b>	<b>29</b>	<b>25</b>	<b>22<sup>54</sup></b>	<b>147</b>

<sup>51</sup> The location of the incidents could not be determined because the OIG was provided with four “Watch Supervisor Logs” in lieu of Morning Reports, which did not identify the jail facility. It should be noted the “Watch Supervisor Log” is a stand-alone Microsoft Word document and is not assigned an LAPD Form number.

<sup>52</sup> Per CSD, most of the 2012 Morning Reports were transported to Iron Mountain for Records Retention. The OIG was informed that onsite storage limitations at CSD require monthly transfer of all documents that are at least three months old.

<sup>53</sup> The 2013 CompStat Report listed a total of 47 attempted suicides, which was significantly higher compared to a three-year average of 26 suicide attempts per year. Upon closer examination, it appeared that the 2013 CompStat suicide attempt data was incorrect. CSD advised that it was a calculation error. The approximate number of suicide attempts in 2013 is unknown.

<sup>54</sup> The 2016 CompStat Report only included data compiled from Deployment Periods 1-12.

**Addendum G**

**Proposed Jail and Holding Tank In-Custody Death Adjudication Protocol**

Adjudication Area	Finding	Outcome
<b>Inmate Intake Procedures</b> <ul style="list-style-type: none"> <li>• Custody Transfer Communication (between officers and CSD personnel).</li> <li>• Booking Process.</li> <li>• Classification/Segregation.</li> <li>• Medical Screening.</li> <li>• Suicide Prevention.</li> </ul>	In Policy/No Further Action	Tactical Debrief
	Administrative Disapproval/Out of Policy	Tactical Debrief and one or more of the following: <ul style="list-style-type: none"> <li>• Extensive Retraining</li> <li>• Notice to Correct Deficiencies</li> <li>• Personnel Complaint</li> </ul>
<b>Inmate Welfare Procedures<sup>55</sup></b> <ul style="list-style-type: none"> <li>• Safety Checks.</li> <li>• Pill/Sick Calls.</li> <li>• Dispensary Visits.</li> </ul>	In Policy/No Further Action	Tactical Debrief
	Administrative Disapproval/Out of Policy	Tactical Debrief and one or more of the following: <ul style="list-style-type: none"> <li>• Extensive Retraining</li> <li>• Notice to Correct Deficiencies</li> <li>• Personnel Complaint</li> </ul>
<b>In-Custody Death Procedures<sup>56</sup></b> <ul style="list-style-type: none"> <li>• Notifications.</li> <li>• Cell Entry.</li> <li>• Medical Assistance.</li> <li>• Rescue Ambulance Request.</li> <li>• Title 15, 30-Day Review.</li> </ul>	In Policy/No Further Action	Tactical Debrief
	Administrative Disapproval/Out of Policy	Tactical Debrief and one or more of the following: <ul style="list-style-type: none"> <li>• Extensive Retraining</li> <li>• Notice to Correct Deficiencies</li> <li>• Personnel Complaint</li> </ul>

<sup>55</sup> Refer to JOM Section 1/150.

<sup>56</sup> Refer to JOM Section 2/207.