# IOLERO's Annual Report

2019-2020

## **Annual Report Roadmap**

Pages 1-2

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IOLERO's current ordinance, legal challenges and proposed changes.

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## **Annual Report Roadmap**

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Four Operational
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### **IOLERO's Four Operational Branches**

#### **COMMUNITY ADVISORY COUNCIL (CAC)**

The CAC makes community-driven policy recommendations, promotes large-scale, systemic reform and community partnership in law enforcement operations.

#### **AUDITS**

If IOLERO does not have sufficient resources to audit complaints against the Sheriff's Office, how do we know if the Sheriff's Office is following its policies?

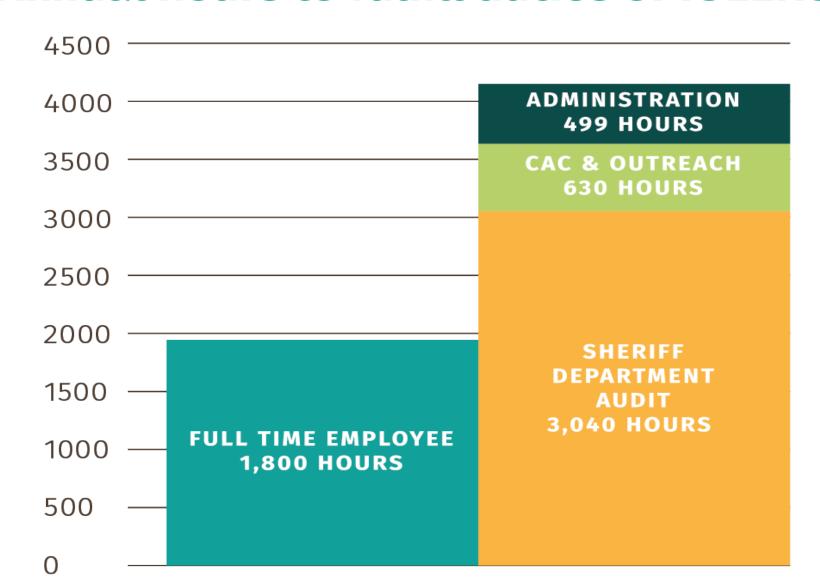
#### **COMMUNITY OUTREACH & INREACH**

For IOLERO to be effective, the whole community has to be aware of the department and its services.

#### **PROACTIVE WORK**

To truly create a change in culture, increase transparency and improve the relationship between the Sheriff's Office and the community, IOLERO must proactively "relationship-build" with both the community and the Sheriff's Office.

# Underfunded and Overtasked Annual hours to fulfill duties of IOLERO



### **IOLERO's Growth**

#### **Budget in March 2019**

- \$562,322
- One Director/Attorney
- One Admin. Asst.

#### **Budget Fiscal Year 2020-2021**

- \$1,391,174
- One Director/Attorney
- Two Attorneys
- One Programs Manager
- One Admin. Asst.

## Successes Despite the Challenges

- Partnership with SSU
- Internship Program through SSU
- CAC policy review (UOF, De-esc, community-oriented policing)
- Bi-lingual E-Newsletter: 450 to 7500 subscribers
- Social Media Campaign
- Re-designed brochures and website
- Brochures displayed in jails and across county
- Expanded allegations reviewed by IOLERO
- New policies

## Sharing Info with the Public is Limited by Law

Generally speaking, CA law provides protections for two categories of confidential peace officer records: (1) personnel records, and (2) **records of citizen complaints** about individual officers, and reports or findings relating to investigation of such complaints.

The law allows for discussion of the auditor's critiques and evaluation of the administrative investigation, the manner in which the SO's procedures and practices may have contributed to the basis of the complaint and IOLERO's recommendations for institutional improvement.

## **Audit Categories**

When a complaint is investigated, there are four general findings that are made by the SO:

**1. Sustained**: Means the SO found a violation of its policies based on

the evidence.

**2. Exonerated**: Means the SO found there was no violation of policy.

3. Inconclusive: Means there was not enough evidence to prove or

disprove the complaint.

**4. Unfounded**: Means the evidence does not support the complaint.

### **Summaries**

From January 1, 2019 to July 31, 2020:

IOLERO received 24 completed investigations from the SO between June 2019 and July 2020.

12 of those cases were audited including the David Ward case. Critical incidents where a death occurs, like Mr. Ward's case, take 4-6 months to audit.

### **Summaries**

#### **Sheriff's Office Decisions**

# • 4 cases were sustained (violation found)

• 5 cases were exonerated (no violation found)

• 3 cases were unfounded

#### **IOLERO's Conclusion**

- Agreed (3)
- Incomplete (1) (Review addl MH employee)

- Agreed (3) and made recommendations
- Incomplete (2) (Rev. dispatch and med. staff)
- Agreed (1)
- Disagreed (2)

### **David Ward**

Five recommendations stemmed from this audit.

- 1. Adopt **de-escalation policies** like the high-risk stop procedure and incorp. them into policy manual.
- 2. Modify the Vehicle Pursuit Policy (when to initiate/terminate)
- 3. Investigate conflicting information from **dispatch**
- 4. Increase training in biased policing (implicit bias) and crisis intervention.
- 5. Address training issues with IA investigators (leading questions)

### **David Ward**

- Two new policies, one new investigation:
  - 1. Overarching de-escalation policy that will apply to all p&p (in addition to the requirements of SB 230 and AB 392)
  - 2. Increased training: Implicit bias: 2hrs every 5yrs to 4 times per year + the min.

<u>Crisis Intervention</u>: 32 hours for life **to** 4 times per year + min.

3. Opened investigation of dispatch

### Complaint: Error in ICE Reporting

• Eight recommendations stemmed from this audit.

- 1. Revise **training program** (provide trainer and guide for employees interpreting the statute)
- 2. Provide **regular trainings** for employees (e.g.: bi-annual)
- **Two-person system** of review where every case is reviewed separately by two different employees before notifications are made to ICE
- 4. Assign the duty of ICE notification to a **specified team** who receives regular training
- 5. Do not notify ICE until there is a **conviction**
- 6. Authorize employees to run RAP sheets for sex-registrants
- 7. Training in **open-ended questions**
- 8. Allow auditor to **sit-in on interviews** of witnesses

# Complaint: Error in ICE Reporting

All of the recommendations were incorporated into a new Immigration Notification policy except for:

1. Waiting until a conviction before ICE notification

2. Allow the auditor to sit-in on IA interviews

# Complaint: Injury During Transportation of Combative Arrestee

• Two recommendations stemmed from this audit:

1. Adopt a policy for deputies transporting verbally aggressive or combative arrestees to minimize injuries.

2. IA investigators should not use email to interview witnesses.

# Complaint: Injury During Transportation of Combative Arrestee

• Adopted: Transportation of Arrestees Policy

When transporting a physically or verbally aggressive, violent or combative arrestee, deputies should notify Sheriff's dispatch while in route to the county jail and request dispatch notify jail staff. The transporting deputy should provide dispatch an estimated travel time to the jail and any safety considerations. Dispatch will notify the jail staff of the impending arrival and provide jail staff with the information.

Upon arrival at the jail, the transporting deputy waits for the assistance of jail staff which may include mental health staff, medical staff or additional deputies and a video recorder (in addition to BWC's) prior to removing the arrestee from the vehicle.

### **Trends**

- 1. Witness Interview Issues: Leading questions was the most common issue.
- 2. Incomplete Investigations: Two cases involved errors by jail MH/Medical staff where an inmate was placed in general population instead of the MH or medical. A third case involved the harassment/intimidation of an inmate.

3. **De-escalation**: Most significant issues arose in the David Ward case (p.31-40)

**4. Dispatch issues**: Two cases involved issues of dispatch providing inaccurate or incomplete information to the deputies. (p.31 and p.47)