Santa Clara County Jail Grievance and Complaint Process:

Expert Consultant's Review and Recommendations for the Blue Ribbon Commission on Improving Custody Operations

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ACKNOWLEDGEMENTS

I wish to acknowledge Judge LaDoris Cordell, Chairperson of the Blue Ribbon Commission for Improving Custody Operations, as well as the other commissioners. Their serious attention to inmates' concerns and operations at the Jail is admirable and likely to spur important reforms. Judge Cordell facilitated my review by seeking full access to documents, personnel, and facilities. The Board of Supervisors is to be commended for convening the Commission, and President Cortese's recent State of the County address highlighted the Jail.

Jail staff and administrators also made themselves available for often-lengthy interviews on relatively short notice. Requested documentation was produced on an expedited timeline. I wish to thank all of the staff and administrators who were involved in my review. In particular, Captains Hoyt and Sepulveda were especially generous with their time and, along with Assistant Sheriff Beliveau, coordinated my visits and access to information and staff. Both the Sheriff and the Undersheriff were attentive and supportive. The Office of County Counsel, particularly Donald Larkin, and the Board of Supervisors, particularly Megan Doyle, both worked closely with me and the Jail to make the review go as smoothly as possible.

Attorneys Scott Emblidge and Jodie Smith and their outstanding team conducted interviews with 944 Jail inmates. The importance and breadth of this work simply cannot be overstated.

Most importantly, I want to acknowledge Michael Tyree and other human beings who have suffered or continue to suffer as a result of their confinement. I hope this report represents a small contribution in a larger effort to ensure Mr. Tyree's death was not in vain.

EXECUTIVE SUMMARY

This report addresses the process in place in the Santa Clara County Department of Correction ("DOC") and Santa Clara County Jail ("Jail") for addressing (1) uses of force that may be excessive or unnecessary and (2) allegations of serious staff misconduct. The report includes ten findings and 19 additional sub-findings. The report identifies ten corresponding recommendations and 20 sub-recommendations. The findings and recommendations are addressed under each relevant section of the report and are also listed together in Appendix 1 and Appendix 2, respectively.

FINDING 1 addresses the Jail's conflation of grievances and complaints, which results in Jail staff and administrators – at every stage of the grievance and complaint process – minimizing serious grievances that allege staff misconduct and treating such grievances as though they were any other run-of-the-mill grievance. This culture of disregard for serious inmate concerns finds a parallel in the Jail's handling of self-reported uses of force.

FINDINGS 2-7 address the flaws at each stage of the grievance and complaint process and, where relevant, the Jail's handling of use-of-force reports. The stages of the process – each infected with serious flaws – are as follows:

1. Inmate education
2. Filing methods
3. Review of and response to grievances
4. Referral for investigation
5. Investigation
6. Internal oversight

FINDING 8 addresses other related serious concerns, such as restrictive housing, staffing levels, the Jail's measures for preventing and responding to sexual misconduct, and crowding.

FINDING 9 addresses the lack of rigorous independent oversight.

FINDING 10 addresses the need for immediate implementation of the recommendations of the Blue Ribbon Commission.

A variety of acronyms are used throughout this report:

- ADA: Americans with Disabilities Act
- DOC: Santa Clara County Department of Correction
- DOJ: U.S. Department of Justice
- IAU: Internal Affairs Unit
- JOP: Jail Observer Program
- PREA: Prison Rape Elimination Act

QUALIFICATIONS

As an attorney with the U.S. Department of Justice ("DOJ"), Civil Rights Division (2009-2015), I led numerous system-reform investigations and compliance monitoring, including "pattern or practice" cases with the Special Litigation Section (2009-2013). These cases – of both individual facilities and statewide systems – involved conditions of confinement in correctional facilities and psychiatric hospitals and addressed a wide range of issues, including mental health treatment, restrictive housing, and use of force. As part of those investigations and compliance monitoring, I reviewed not only the pattern of conduct or treatment but also the underlying systems, including policies and procedures, grievance and complaint processes, training, internal investigations, and quality assurance and developed recommendations for remedial action. I led and conducted similar system-reform investigations and compliance monitoring, and developed detailed remedies, involving statewide disability services and mental health systems.

My work at DOJ and in other legal and advocacy positions has involved enforcement primarily of the U.S. Constitution and the Americans with Disabilities Act ("ADA"). I have specialized training to become a DOJ-certified auditor for jail and prison compliance with the comprehensive Prison Rape Elimination Act ("PREA") Standards.

I currently work as a consultant on systems reform and oversight. Appendix 3 to this report includes my complete C.V., and further information is available on my website, listed on the cover of this report.

METHODOLOGY AND SCOPE OF REVIEW

Methodology

My review, which began January 12, 2016, involved site visits, review of documents and records, and interviews. I spent a full day at Main Jail and a full day at Elmwood touring the facilities, speaking with officers and inmates, observing notices and postings, and reviewing documentation. I submitted detailed information requests and reviewed policies; inmate rule book; forms; a sample of grievances, use-of-force reports, and investigations; data; videos; training materials; external audits; and other materials. I also reviewed the testimony and materials presented to the Blue Ribbon Commission.

I conducted more than 20 formal interviews, almost all of them in person, of deputies; several grievance coordinators and other staff responsible for maintaining data; three PREA managers; the PREA coordinator, who also oversees the Internal Audit Unit; both facility commanders; three mental health supervisors; the head of the Internal Affairs Unit ("IAU"); the Captain who heads criminal investigations; the Assistant Sheriff; the Undersheriff; and the director of the Jail Observer Program ("JOP"). I also interviewed deputies and inmates during my site visits. I opted not to conduct formal interviews with inmates in light of the enormous undertaking by attorney Scott Emblidge and his team. I note that the information reported in those interviews find consistent support in my review.

To be clear, I always sought to corroborate, through interviews with staff and administrators and through review of policies, initial findings that resulted from my review of documentation.

Scope

I did not seek to – and I did not in fact – make determinations regarding the merit of any individual grievance, complaint, or use of force. This review instead addresses the Jail's policies and practices for receiving and responding to such allegations and incidents.

My review focused on the most serious types of grievances, those that essentially rise to the level of complaints, or allegations of staff misconduct. I also reviewed the Jail's response to uses of force, as these, like grievances and complaints, should be investigated for potential misconduct. I did not specifically review, but did make findings regarding, other serious issues that I came across in the course of my review. Some of these issues, such as staffing and cameras, relate somewhat to the focus of the review. Others, such as restrictive housing, were natural areas of inquiry – for example, to determine how inmates in such housing access the grievance system – but stood out for reasons unrelated to the focus of the review.

I devote a lengthy discussion to PREA because sexual misconduct is among the most serious types of misconduct that staff can perpetrate and because the PREA Standards are new and provide clear guidance regarding grievance and complaint procedures. If the Jail does not even take PREA seriously, that says something about how it approaches other types of misconduct.

BEST PRACTICES

I was asked to evaluate the Jail's policies and practices relative to best practices. I drew on written standards – the U.S. Constitution, American Bar Association standards, American Correctional Association standards, PREA Standards, and others – as well as research, DOJ settlement agreements, my own experience reviewing a variety of facilities, policies in other adult correctional facilities, and practices in place at Santa Clara County's juvenile detention facilities, which I visited for this review.

I reviewed research and examples of independent oversight and interviewed the inspector general for California's prisons and a former deputy inspector general for Los Angeles' Sheriff's Office, who now serves as the Independent Police Auditor for the San Jose Police Department. Of course, DOJ's compliance monitoring, and the monitoring conducted by others in DOJ cases, constitute a form of independent oversight.

COMMENDABLE PRACTICES

I observed a number of commendable practices that provide a reasonable basis for further refining the Jail's practices.

- The PREA video shown to inmates is very high quality and is comprehensive in its content.
- The Jail provides grievance forms in triplicate to ensure inmates have a receipt of their submission, and the Jail is now installing grievance boxes in various areas of the facilities.
- Despite a policy that permits the Jail to impose restrictions on inmates' access to the grievance process, the Jail does not impose such restrictions.
- The Jail responds to and seeks to resolve grievances, regardless of whether the grievances are submitted by the formal deadline.
- Many responses to grievances are respectful and transparent. Some go out of their way to reassure the inmate or provide substantial information.
- Staff take measures to track and ensure timely responses to grievances.
- IAU is thorough and comprehensive in many of its investigations.
- The Internal Audit Unit is now partially staffed and serves essential functions involving updating policies and measuring policy compliance.
- Administrative staff, at the direction of the facility commanders, take extraordinary initiative and exercise admirable creativity and dedication in making sense of otherwise

incomplete and inadequate data. These workarounds provide their bosses with meaningful data that aids in their ability to analyze patterns and trends.

- The primary PREA manager is committed and hard-working. Deputies seek opportunities to solve problems with inmates and take their jobs seriously. Nearly every individual I interviewed, at every level, was thoughtful and committed. There is a great deal of potential for collaborative reform.
- The Jail Observer Program is a critically important resource for inmates and families and benefits from creative, dedicated, and collaborative direction.

FINDING 1: Conflation of ordinary and serious grievances

The Jail permits inmates to file a "grievance" regarding any issue or concern. While the Jail's approach is appropriate in this regard, the Jail has failed to ensure that this breadth does not swallow or mask the most serious types of grievances. Instead, the Jail has in other ways perpetuated the conflation of ordinary grievances and grievances regarding staff misconduct, which the Jail calls "complaints" but seldom treats as such.

Background

Under policy, an inmate may use the grievance process to address "any conditions of confinement." (Policy 14.05, Sec. I.F.) A grievance is defined as "an inmate complaint arising from circumstances or conditions relating to his or her confinement." (Policy 14.05-1.)

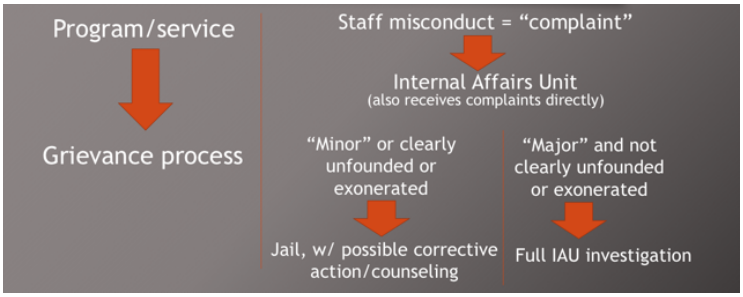
The use of the term "complaint" in the grievance policy is confusing in light of the fact that the Jail has a formal definition of "complaint." A "complaint" is an allegation of staff misconduct (Policy 1.19-1) and can be made to staff through the grievance process or other means or directly to IAU. (Policy 1.19, Sec. IV.)

In fact, it is the *grievance* process inmates use most often for addressing misconduct, and the Jail specifically encourages use of the grievance system. Yet, once the inmate resorts to this process to lodge a complaint – that is, allegations of misconduct – the complaint is almost never treated as a complaint and is instead handled like any other grievance.

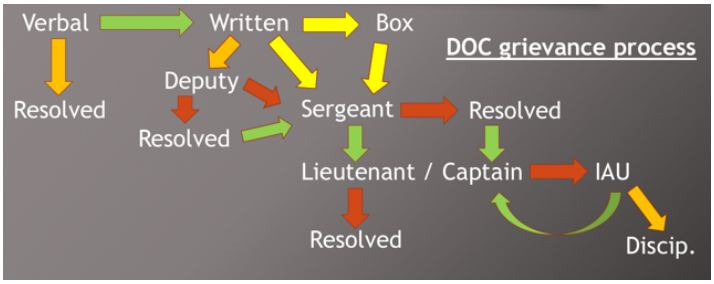
Best practice versus actual practice

The Jail has 23 categories of grievances. But in fact only two major categories of grievances exist, and it is this straightforward distinction that should guide the Jail's approach. The first of these two categories includes grievances that address concerns regarding programs, services, and general policies and conditions. The other category addresses allegations of staff misconduct. These two categories must be handled differently at each and every stage.

The Jail already treats different categories of grievances differently, routing grievances regarding medical and mental health to Custody Health for response. In the same manner, grievances that in reality constitute "complaints" should be routed to IAU. Policy also provides for "emergency" grievances, though in practice staff do not identify any grievances in this manner. (See, e.g., Policy 14.05, Sec. VI.B.)



Instead, the Jail's process for handling grievances is, to a large extent, a mess, as will become apparent in the discussion below regarding each stage of the grievance and complaint process and the equivalent stages of use-of-force review. All grievances are handled as grievances, even if they are in fact "complaints."[1]



Discussion

What explains this fundamental failure to properly distinguish between the two types of grievances and, in many cases, to identify some uses of force as serious enough for closer scrutiny? A number of explanations exist, including a policy that fails to clearly set out the fundamental distinctions between less serious and more serious incidents and allegations and that fails to list, among the purposes of the grievance system, identifying serious misconduct, as well as a culture of minimization that arises at least in part from a combination of understaffing, lack of guidance, and the enormous number of grievances that bury the most serious ones.

Policy: The policy on grievances identifies several purposes or goals of the grievance system (Policy 14.05-1; 14.05, Sec. I.A):

- Internal problem-solving
- Due process and access to the administration
- Continuous review of policy and procedure / monitoring problem areas
- Written documentation of inmate concerns

Not specifically listed is the goal of identifying and prioritizing potential serious abuses, although it should be. The PREA standards, for example, specifically contemplate that inmates may submit allegations of serious misconduct through the grievance process and that such allegations should be handled differently than other less serious complaints. While this goal may

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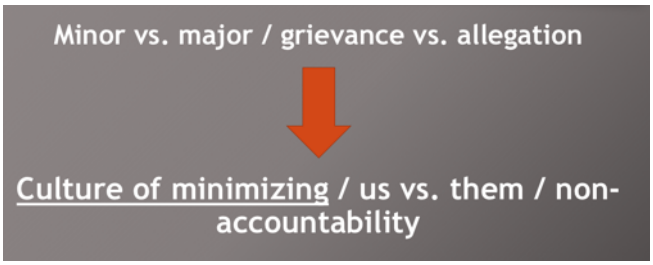
[1] Other grievances should also be considered urgent or serious, though they may not require referral for investigation because they do not constitute allegations regarding a specific staff member's misconduct. For example, grievances regarding personal safety, e.g., failure to protect an inmate from violence, should be addressed urgently. Similarly, grievances alleging that an inmate receives very little out-of-cell time should be handled with serious attention to the potential impact of such restrictions.

Additionally, grievances regarding programs or medical care or other issues may in fact be allegations against a particular staff member. For example, an inmate may allege that she has been denied access to programs or medical care out of retaliation or for some other inappropriate purpose. This would constitute a complaint regarding misconduct and should be handled as such.

be implied in the identified purposes, it does not come through clearly. Jail leadership therefore may not be attuned to actions that undermine this key function of the grievance process.

Similarly, the PREA policy and other PREA materials tend to minimize the less serious forms of PREA misconduct, namely, sexual harassment. That even very serious misconduct covered in the rigorous PREA standards is not taken seriously in policy is emblematic of the broader failure to handle serious allegations as such.

Culture: Inmates submit hundreds of grievances each year, and they complain about conditions through other means, as well, including verbally, request forms, and medical requests. It becomes a "boy who cries wolf" phenomenon, in which the Jail simply lumps all grievances together and does not always distinguish between run-of-the-mill grievances and serious complaints. Officers see inmates complaining about insignificant issues; feel, as the front-line staff, as though the grievances are largely directed at them; and react to nearly every complaint as though it is presumptively unjustified. Nor does the Jail have adequate staffing and other resources, such as data systems, to adequately ensure that serious complaints rise to the top. In short, there emerges an "us versus them" mentality, and serious concerns simply are not taken seriously.



This approach also reflects a culture of non-transparency or non-accountability, in which officers believe they are entitled to escape blame for what they perceive as minor complaints. This leads inevitably to a culture of impunity for even the more serious allegations. It cannot be up to the accused to determine the merit of the accusation. This is how the worst kinds of abuses can end up happening.

Culture takes hold only if leadership perpetuate it, and key personnel among the Jail's leadership held attitudes that undoubtedly promote this culture of minimization or disregard of inmate allegations. I have no reason whatsoever to believe that any malice underlies leadership's attitudes. Rather, they are products of the same culture. For example:

- A high-level Jail official repeatedly referred to the inmates as "offenders," despite the fact that the large majority of inmates are in the Jail for pre-trial detention and have not been convicted of their charges. As perceived offenders, inmates lack credibility and are simply trying to cause trouble for the staff by lodging complaints.

- Another high-level official did not understand that verbal comments referring to an inmate's perceived homosexuality or an inmate's sexual behavior should be considered sexual harassment and handled pursuant to PREA.

- A third high-level official specifically endorsed the practice of grievances accusing a specific officer of misconduct being handled by – including receiving a response from – that accused officer.

- As discussed in Findings 2-7, this mentality pervades through the entire process, appearing at each stage, including decision points at which the Jail leadership are the decision makers, such as whether to refer a grievance for investigation and whether to concur with a deputy's response to a grievance. The approach parallels the approach to the handling of uses of force – leadership minimize serious incidents by not referring them for investigation.

To be clear, none of this is to say that the leadership fail in all ways to identify serious issues. As discussed above, the facility commanders have made efforts to cobble together data to identify trends in serious incidents, have identified and addressed inappropriate staff responses to grievances, and of course have referred a number of serious incidents for investigation. One facility commander acknowledged the failure to properly distinguish between ordinary and serious grievances. The Undersheriff acknowledged the need for clearer guidance regarding what types of incidents or complaints should be automatically referred for investigation. The Jail is currently undertaking efforts to enhance the confidentiality of inmate grievances.

FINDING 1: The Jail fails to properly distinguish between the two categories of grievances – ordinary grievances regarding conditions and grievances alleging staff misconduct, or "complaints."

Finding 1a: A culture of disregard of, or minimization of, serious complaints and serious incidents, perpetuated by the Jail leadership and supported by ambiguous policies, has taken hold in the Jail.

Finding 1b: The culture of conflation pervades through the entire grievance and complaint process, creating serious flaws at each stage. The entire process for addressing potential uses of excessive force and allegations of serious misconduct therefore requires revision and ongoing internal and independent oversight.

Recommendation 1: The critical distinction between the two basic types of grievances should guide the Jail's approach at every stage, as well as the scope of independent oversight.

Recommendation 1a: Staff and inmates should be trained on the distinction, and policy should clarify the distinction, though inmates should be able to submit complaints through the grievance process.

Recommendation 1b: Grievance procedures must be viewed as a means of oversight of inmates' rights and of Jail and staff accountability.

FINDING 2: Inmate education

Inmates must receive information regarding the avenues available to them for lodging complaints. Generally speaking, inmates are aware of the grievance process, and inmates file many grievances. However, providing accurate information and providing information in a manner that makes inmates more likely to access it accomplishes several additional aims:

1. Conveying to inmates that the Jail welcomes grievances and takes them seriously
2. Pointing inmates to other available avenues, such as reporting misconduct directly to IAU
3. Ensuring due process by, for example, providing information about deadlines and the requirement to exhaust administrative remedies
4. Clarifying the scope of topics that a grievance may include

Discussion

While the Jail makes a gesture to provide information in a variety of ways, each method suffers from significant problems. The Jail provides inmates with an "orientation," but the orientation is composed of a disorganized, incomplete, and outdated rulebook and other incomplete materials; and two videos, both of which are screened for inmates in a manner and setting that make it unlikely that the inmates will view the videos in their entirety or absorb the information, neither of which is accompanied by an opportunity for inmates to ask questions, and one of which is outdated and incomplete. The Jail also posts various notices in the housing units and other areas of the facilities, but the notices often are incomplete, outdated, missing altogether, or placed in inconvenient locations. The grievance form itself provides another opportunity for information regarding the grievance process and other means of submitting complaints, but the grievance form contains no such information.

Materials	Provided?	Adequate?	Content	Format
Orientation video	Y/N	No	Minimal re grievance	Outdated, distractions
PREA video	Y/N	Yes	Complete	Distractions
Orientation Q & A	No	N/A	N/A	N/A
Inmate rulebook	Yes	No	Numerous omissions	No ToC
Postings / notices	Y/N	No	Incomplete, outdated	Torn, small, misplaced

Videos: The Jail shows inmates two videos: a general orientation video and a video on PREA. The PREA video is produced by the PREA Resource Center, which oversees PREA implementation nationally on behalf of DOJ. The video is therefore of very high quality and complete in its content. The orientation video appears to be quite old, is very slow, has outdated music, and lacks any production value. It is unlikely to inspire focus or attention from its viewers. The content is cursory regarding grievance procedures and does not discuss other methods of lodging complaints.

Both videos are shown under circumstances in which the inmates are likely to be distracted and are unlikely to view the videos in their entirety. Specifically, the Jail screens the video in the intake areas, where there is often a great deal of activity. Inmates are not taken to a specific area to view the video, and staff do not ensure that inmates watch the video from beginning to end.

The orientation does not include an opportunity for inmates to ask questions of staff based on the video presentation or other information. This opportunity for a Q and A is a best practice and is employed in Santa Clara County's juvenile detention facilities. Different inmates have different paces of learning and education levels, different familiarity with the rules and resources, and different language skills. An opportunity to ask questions allows inmates to fill in the gaps and address these varying skill levels. The videos are also screened on the housing units one day each week, but the screens are small and difficult to see from some of the cells and there is no way to ensure inmates are watching or understanding the information.

Rule books: During my site visits, in some housing units staff could not quickly locate copies of the rule books. More crucially, the rule books omit a lot of important information. Among the omissions are the following:

1. Information regarding PREA. While the rule book explains what type of staff conduct is prohibited and describes various reporting methods, it has not been updated to identify or explain the PREA Standards or include a crisis hotline, though a pamphlet and speed dial lists posted in housing units provide the hotline information.

2. Jail Observer Program. The rule book does not identify or describe the JOP, an important outside resource for inmates to report concerns.

3. A complete and updated speed dial list. The Jail posts "speed dial" lists, that is, lists of two-digit numbers inmates can dial from the phones in the housing units to reach various outside agencies or organizations. While the list refers to Human Relations, it does not specifically identify the JOP and does not indicate which calls are monitored.

4. "Complaint" procedure / IAU. While the rule book identifies IAU, it does not explain its purpose or scope.

5. Deadlines. The rule book does not advise inmates of the deadline for submitting a grievance, the consequences for a late submission (e.g., failure to exhaust administrative remedies), or the deadline for the Jail to provide a response to the grievance.

6. Table of contents. Without a table of contents, the rule book may be difficult for some inmates to navigate. The JOP has created a table of contents and made its existence public, yet the Jail has not incorporated it into the rule book or otherwise distributed it.

The rule book also provides confusing information. It indicates that an inmate "should first direct your complaint to the Officer in charge of your housing unit" and subsequently turn a grievance form in to any officer. This language risks being interpreted to require verbal submission before resorting to a written grievance form.

Other materials: A pamphlet provides information about sexual assault, the crisis hotline, and other ways to report sexual assault, but it does not cover sexual harassment. Yet another handout, which is also posted in some of the housing units, also contains information about how to report sexual abuse or sexual assault, but once again it does not cover harassment.

Postings: The postings in the housing units and other areas are a mess. They are not posted with any discernable organization in mind and instead create a cluttered and haphazard array of various types of information. Some of the notices, such as some of the PREA information and the ADA notices, are posted in some but not all the units (Policy 13.11, Sec. I.A.1 requires ADA postings in every housing unit). The grievance procedure is posted in only a small fraction of the units. Information about IAU and JOP is not posted in the housing units.

When information is posted, it is often outdated and/or incomplete. The ADA notices often included the name of a contact person who has been deceased for several years. The PREA information is contained in several different postings. The main posting, which has some design elements that make it more likely for inmates to review it and includes information in three languages, addresses sexual abuse but not harassment, even though PREA covers both types of misconduct – an omission that repeats itself throughout the Jail's PREA policies and procedures, as discussed in more detail below. The Jail could improve the design of the posting with color and images or symbols – the County's juvenile detention facilities employ very effective designs that make the posters easy to spot and highlight their importance. The U.S. Marshals Service requested that its PREA notice be posted, but the contact information provided is that of the federal government. While it does address sexual harassment, it is not clear whether such conduct is punished. Unfortunately, the policy does not help matters, as it requires only that "[e]ach housing unit has posted signs containing information for inmates to report sexual abuse," but not harassment. (Policy 14.15, Sec. XV.B.)

In some units, PREA information was posted in locations or in a format that made it unlikely for inmates to view it. In some areas of Main Jail-South, the information was posted in a hallway, but the inmates at either end of the hallway would only view it as they passed it on their way in or out of the unit. In such cases, the activity involved in moving inmates or the fact that the inmates are in motion make it unlikely the inmates would have enough time or focus to view or understand the material. In other cases, the print was so small and the posting placed so far away from the cell that the inmates simply could not read the information.

I observed that speed dial lists were often torn, outdated, or placed somewhere other than next to the phones.

Other random postings contribute to the disorganization and may distract inmates from more important information. For example, contact information for the 2014 PREA audit was still posted in a number of areas, and a 1993 inmate rule book was posted in one of the units.

POSTINGS / NOTICES			
Posting	Displayed consistently?	Complete?	Specific issues
PREA	No	No	Disjointed; policy
Grievance procedures	No	No	Almost never posted
IAU and JOP	No	N/A	Almost never posted
ADA	No	Y/N	Contact has died
Speed dial lists	Y/N	Y/N	Not near phones, torn, outdated

FINDING 2: The Jail provides grossly inadequate information to inmates regarding the options they have for addressing staff misconduct and other serious concerns, such as sexual misconduct by other inmates. Information is disjointed, haphazard, and incomplete.

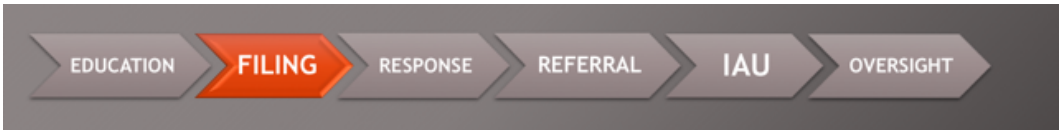
Recommendation 2: The Jail should make complete and accurate information readily available and should routinely update such information.

Recommendation 2a: The Jail should revise and update the orientation video, rule book, and many of the postings to ensure accuracy and completeness. The rule book should address information in a number of areas that is currently omitted.

Recommendation 2b: Postings should be complete, accurate, organized, properly located, and difficult to tear or remove. PREA information should address both abuse and harassment and should be contained in easy-to-identify and attractively designed posters. The Jail should post information regarding IAU and JOP.

Recommendation 2c: The Jail should screen the orientation and PREA videos free from distraction and should provide an opportunity for inmates to direct questions to staff.

FINDING 3: Filing methods



Inmates have a number of ways to file a grievance or complaint, including verbally, with a grievance form, through a call or a letter to IAU, and other methods. The Jail does not reject grievances for technical reasons or because they are outside of the deadline for filing. While policy inappropriately permits the Jail to place restrictions on access to the grievance process, including even emergency grievances, under some circumstances (Policy 14.05, Sec. VI), the Jail, commendably, has not enforced its policy since at least a couple years ago.

The Jail already acknowledges the need for confidential grievance procedures – it has confidential letters in its policies, and it is installing grievance boxes. But many staff seem resistant to the use of grievance boxes and believe instead that grievances should be resolved at their level. This belief represents a fundamental failure to appreciate the distinction between grievances and complaints and the inappropriateness of a subject officer handling the grievance that is filed against him or her. Moreover, inmates should continue to be encouraged to submit grievances verbally or in writing to an officer where the grievance can properly be resolved through those methods.

Other reasons exist for the need for confidentiality. In at least one unit, I encountered a situation in which inmates' grievances reportedly encountered vetting by other inmates before reaching staff.

Grievance boxes: In particular, the Jail has been without grievance boxes that provide the best option to ensure confidentiality. While "confidential letters" to the facility commander are another means, this method is seldom utilized – grievance forms are the default mechanism in the Jail – and, under policy, may in fact be referred back down the chain of command for response. It is remarkable that the Jail has lacked grievance boxes until now – the Jail began installing them this month. The County's juvenile detention facilities employ boxes, and this is standard practice in many facilities around the country – indeed, it is probably among the most obvious best practices. The Jail reports that it is likely to distribute computer tablets to inmates and that one of the functions may be to facilitate the filing of grievances. While that is a promising approach, I received no documentation or plans regarding the tablets, and it appears that their use as a means of filing grievances is a recent proposal.

I received conflicting reports regarding specific procedures the Jail contemplates for the boxes.

- Different personnel reported different impressions regarding whether the Jail will require inmates to use the grievance boxes or will also continue to permit inmates to submit grievances to staff. The best practice is to maintain all available filing methods and to use the grievance boxes as an *additional* option, not as a substitution.

- I also received conflicting reports about how often staff would collect the contents of the grievance boxes. Some understood that inmates may use the boxes for urgent grievances, thus necessitating collection every shift. Other staff indicated that a sergeant would collect the grievances from the boxes once each day.

- I received conflicting reports about where the Jail planned to place boxes. Some reports indicated the boxes would be placed only in the housing units, while others indicated inmates would have access to grievance boxes in other areas of the facility, as well. It is critical that the Jail place boxes in both housing units and other areas, as inmates seeking confidentiality may feel reluctant to submit a grievance in front of the housing unit staff, even if the staff cannot see the grievance itself. (Supervisors should not open on the housing unit the grievances that inmates have placed in the boxes. This would defeat the purpose of preserving confidentiality.)

Consistent with a theme I observed, the lack of a written plan for placement of and procedure for the grievances boxes indicates the reactive nature of their use. A plan helps to avoid confusion on the part of inmates and staff, which would diminish the confidence inmates have in what should be a confidential and reliable method for submitting grievances.

Other submission methods: In addition to bringing in boxes, the Jail should firm up its existing mechanisms. Many staff and inmates currently believe that inmates should submit grievances to housing unit staff. As discussed above, some of the materials provided to inmates may contribute to this confusion. Some even believe that inmates are supposed to submit their grievance to the shift that is the subject of the grievance. Policies indicate this is not the case, as do various other materials, but the Jail has not effectively communicated this message and some of the policies are ambiguous. Indeed, grievance forms were not uniformly readily available in some areas of the facilities. This belief may also deter inmates from filing grievances, particularly given the harsh nature of some of the responses by officers who are the subject of the grievance, as discussed below.

The Jail should provide inmates with better information regarding their option to report complaints directly to IAU. As discussed above, the Jail should cover this topic in orientation materials and postings. But inmates will only use this option if they have confidence that IAU will take their complaints seriously. As discussed below, that is currently not the case.

FINDING 3: The Jail has not made readily available to inmates a sufficiently confidential means of submitting grievances. No clear plan exists for the grievance boxes' proper placement or use, and many staff are unclear on the procedure and purpose. It remains to be seen whether computer tablets will facilitate the filing of grievances or complaints.

Finding 3a: Confidential letters are not really confidential and are not as convenient as other methods.

Finding 3b: There exists at the Jail, among both inmates and staff, the belief that grievances must be submitted to officers. Ambiguous policies reinforce this belief. Grievance forms are not available in some key areas.

Finding 3c: Confidentiality is essential in light of the widespread practice of subject officers responding to grievances regarding misconduct, the inappropriate and intimidating nature of some such responses, and the screening in some cases of grievances by other inmates.

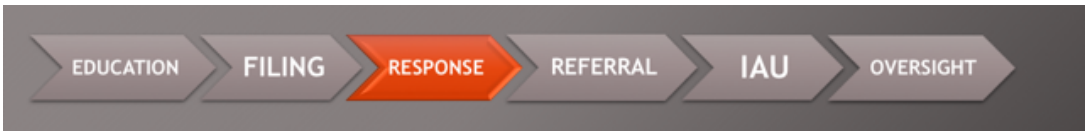
Recommendation 3: Inmates should have ready access to confidential means of submitting grievances and complaints.

Recommendation 3a: The Jail should develop clear plans for the placement of boxes and other filing methods; inmates should participate in the planning process.

Recommendation 3b: The Jail should clarify – in staff training, inmate education, and policy – that inmates may submit grievances to any staff member.

Recommendation 3c: The Jail should make grievance forms available in medical units and any other areas where inmates may be.

FINDING 4: Review and response



The Jail's failure to provide guidance to staff on the critical distinction between ordinary grievances and complaints that should end up with IAU is that staff whom an inmate accuses of misconduct in a grievance often respond to the grievance and, unsurprisingly, do so in a manner that risks creating the perception of retaliation or intimidation. Another less serious but still important concern is timeliness of responses to inmate grievances,

Staff responses: It is the most serious grievances that are rifest with potential for retaliation. That is because accused staff understandably feel the urge to respond and defend themselves. Staff may not realize, however, that it is precisely for these reasons that the accused staff member must not address this type of grievance herself. Nor may staff realize that an inmate may perceive a well-intentioned and genuine response as containing implicit retaliatory messages or an intimidating tone. By responding to such grievances, staff risk deterring further complaints.

Unfortunately, not only is it rather common for accused staff to respond to the grievance making the allegation; it is a sanctioned response. Jail leadership endorse this approach because of the conflation of ordinary and serious grievances: all grievances should be handled in the same manner. Officers receive only limited training regarding the grievance process, and it does not include instruction on proper handling of grievances that in fact constitute complaints, or allegations of misconduct. Because policy and practice encourage officers to seek to resolve grievances, officers assume that even grievances alleging misconduct should be addressed and resolved at the lowest level possible. Of course, it is not possible to resolve such a grievance without an investigation. Standard principles of due process simply do not permit the accused to adjudicate – or resolve – the accusation an inmate has made against him or her. There must be independent review. Accordingly, there is absolutely no need for the grievance to even pass through the officer; indeed, allowing that to happen compromises confidentiality and confidence in the process and creates risk of actual or perceived retaliation.

Issue	Best Practice	Jail's Practice
Can accused officer review, respond, "resolve"?	No	Yes
Written guidance?	Yes	No
Training for officers?	Yes	No
Timely response?	Yes	Yes/No
Inmates notified of delay?	Yes	No

In addition to many examples of an officer personally addressing grievances directed at that officer, I saw in the sample documentation I received examples of responses that, not

surprisingly, came off as intimidating or accusatory. Documentation indicated that the chain of command either actively or tacitly approved of the response.[2] A number of examples from Main Jail are illustrative:

- In one example from July 2015, an officer indicates on the grievance form – in the space made available for the officer's response – "Attitudes and slamming door are not grievable offense." The supervisor indicates that he or she "concurs" with the officer's response. Of course, all conditions or conduct is grievable, and the officer and supervisor's indication to the contrary is likely to discourage the inmate – and potentially other inmates whom the inmate shares the information with – from submitting grievances.

- In September 2015, an inmate submitted a grievance in which the inmate alleged: "I … was placed into a holding cell and strapped inside of a chair … . The sergeant … came into the cell choked me, and grabbed my penis (he was alone). … He stated, 'who's going to believe you over me?' He laughed at me and left." The officer's response was**,** "You are falsifying information for personal gain." This accusatory and unsupported response to a very serious allegation risks deterring the inmate from further recourse to the grievance process. Investigative procedures are in place to address such accusations.

- Though not pertaining to alleged misconduct, in October 2015, an officer indicated a classification issue was "not grievable." The supervisor concurred. This is especially troubling, given that classification is among the examples given in policy of grievable issues.

- In December 2015, an inmate at Main Jail submitted a grievance alleging that a deputy twice called him "faggot/maggot." The deputy's response on the grievance form included the following: "The above false accusations did not occur." As a PREA-covered allegation, this grievance should go directly to investigators. The tone of the response risks coming off to the inmate as aggressive.

If inappropriate responses to grievances risk discouraging inmates from continuing to use the grievance process, supervisors' mishandling of use-of-force reports can create a sense of impunity on the part of staff, who may feel less inclined to properly report uses of force (or to refrain from improper uses of force in the first place, though I do not evaluate whether there exists a pattern of excessive or unnecessary use of force). I saw numerous examples of use-of-force reports that did not entail interviews by the supervisor

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[2] Inmates reported to Mr. Emblidge's team that Custody Input forms can be used as retaliation for filing grievances. The Jail confirmed that, in these forms, officers make observations about inmates' behavior, and officers submit the forms to Classification, which can then refer to such forms when making decisions about classification level. However, because this information came to me very late in the review process, I did not have an opportunity to review samples of these forms or speak with Classification about whether the forms are in fact sometimes used by officers as a way to retaliate. But the format of the form lends itself to very subjective determinations. The lack of process or input from the inmate makes use of the forms a convenient way for officers to retaliate. Best practice clearly counsels against the use of such forms and instead encourages objective re-classification determinations.

Timeliness: Timeliness of responses tended to be an issue at Elmwood for grievances that were routed to mental health staff. Instead of the 30 days permitted in the Jail's policy (Policy 14.05, Sec. IV.A.3), responses took as many as 60 or 90 days. Custody Health's own policy does not provide a deadline and instead unhelpfully requires that responses be provided "within a reasonable time." (Policy 4130-AD25, Sec. IV.G.) Nor is the Jail empowered to enforce timely responses by Custody Health. The primary concerns regarding delayed responses is that inmates are left wondering what happened to their grievance and may submit additional grievances. It does not even occur to Jail staff or administrators to notify inmates of an anticipated delay in the response to a grievance, though such notification is a best practice and would demonstrate to inmates that the Jail has a thoughtful and attentive process in place.

The deadline for responses to PREA grievances is 90 days, per the PREA policy (Policy 14.15, Sec. XIV.E.3), even though the deadline for other grievances is 30 days, (Policy 14.05, Sec. IV.A.3). As some of the most serious grievances, PREA grievances should receive at least the same urgency as other grievances. The inclusion of this longer deadline in the PREA policy is emblematic of a generally hasty and sloppy approach to drafting the PREA policy – the Jail simply lifted language from the PREA Standards without considering how the language implicates other Jail policies. The PREA Standards allow facilities to allow up to 90 days for a response, but facilities are of course permitted to provide a shorter deadline. While the PREA Standards permit this lengthy response time and are generally a very strong set of standards, 90 days is far too long. If an investigation is occurring, the response can simply indicate as much. The Jail should not extend its 30-day deadline and should make the PREA policy match the broader policy on grievances.

FINDING 4: Grievances frequently yield inappropriate, incomplete, and delayed responses. Staff respond to grievances alleging misconduct by that staff – with leadership generally encouraging such an approach – and such responses often are inappropriate and even intimidating.

Finding 4a: Deadlines for responses are inconsistent, not always followed, not binding on Custody Health, and, for PREA, far too long.

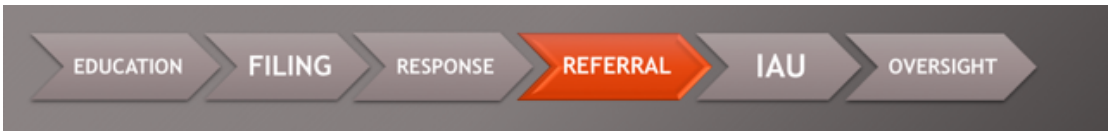
Finding 4b: Inmates do not receive notification or explanation of delays.

Recommendation 4: Responses to grievances should be appropriate, complete, and timely. Accused staff should not handle the grievance, and staff should receive training on handling misconduct grievances as complaints that should be directed, through supervisors, to IAU.

Recommendation 4a: Custody Health should be held accountable for late responses, the Jail should notify inmates if the response is going to be delayed beyond the deadline, and the Jail should shorten the deadline for responses to PREA grievances.

Recommendation 4b: When officers make inappropriate responses to grievances, supervisors should address this error on the grievance form so that the inmate understands that the Jail does not tolerate such responses. The Jail should discipline officers for intimidating or accusatory responses and should consider referring such responses for investigation of possible retaliation.

FINDING 5: Referral for investigation



The Jail's single most egregious failure regarding the grievance and complaint process arguably is the under-referral for investigation.

I encountered numerous examples of serious incidents or allegations that Jail officials should have referred for investigation but did not in fact refer:

- In December 2013, a use of force occurred in the unit for inmates with acute mental health needs. IAU summarized the supervisor's report: "IM [X] was laying face down in a pool of blood … from a two inch laceration to IM right eye area." IAU's summary of the employee report elaborated on what happened: "Deputies . . . threw two to three punches with a closed fist striking IM [X] on the face," resulting in stitches and hospitalization. Troublingly, IAU learned of this incident not as a result of a referral of the incident by Jail command but rather via a complaint that a mental health advocate filed on the inmate's behalf directly with IAU.

- In July 2015, at the Elmwood facility, an employee report indicated a use of force: "I grabbed the back of [inmate's] top shirt with both hands … and pinned him up against the break room door." Yet this employee report almost did not happen at all, as the supervisor noted a formal report: "[Deputy], who is a training officer, was trying to get out of writing a report. He mentioned that he did not take the guy down to the ground, and therefore, no report was needed. … I am going to be very careful with him regarding any incidents, and his reporting of them." Despite the supervisor's concerns regarding the failure to report a serious incident, the supervisor merely issued verbal counseling and did not seek referral for investigation of the failure to report. This practice is consistent with what administrators told me in interviews: that the Jail generally does not refer to IAU staff's failures to report a use of force and provides no guidance or criteria for referral.

- In November 2015 at Main Jail, a deputy performed a strip search, saw an object in an inmate's rectum, and pulled the object out of the inmate. The supervisor's summary noted, "I told [Deputy] he must review and follow" policy on cavity searches. The supervisor further "explained …: 'If the inmate refuses to remove the item, staff shall NOT attempt to remove the item. This would constitute an unauthorized Physical Body Cavity Search.'" Yet there was no documentation indicating that the deputy received any discipline or that anyone referred the issue to IAU, despite the PREA implications and other serious implications arising from the incident.

- In December 2015, an inmate at Main Jail submitted a grievance alleging that a deputy twice called him "faggot/maggot." The deputy's response on the grievance form included the following: "The above false accusations did not occur." A lieutenant noted:

"Supervisor conducted investigation – unfounded." Again, due to the PREA implications of the allegation, this grievance should have been flagged for investigation.

Policy suggests that all complaints should be referred to IAU. Yet nothing close to this standard occurs in practice, and the routing process has not accounted for this important distinction. That said, policy does not provide unambiguous guidance. Policy requires "IAU … to conduct thorough and impartial investigations or directly assist other Divisions in the investigation of … [a]ny allegation or complaint of conduct …. [and] [a]ny situation in which a person has been seriously injured or killed by any member of the department." (Policy 1.19, Sec. I.D.) The policy's requirement that IAU at least "directly assist" in investigations suggests that IAU must be made aware of all such allegations. (See also Policy 1.19, Sec. I.G (requiring assignment of IAU number to any allegation of a variety of staff misconduct).) General Order 14.01 (Sec. B.2.b) provides that allegations of sexual harassment and use of force must not be investigated at the divisional level and seems to suggest that all such allegations should be referred to IAU. The PREA policy requires that all abuse and harassment allegations be referred to IAU and Jail Crimes. (Policy 14.15, Sec. X.C.) Unfortunately, the requirement that IAU be notified is found in the section on staff reporting, and it is not clear that this same requirement applies to reports from other sources.

Several reasons – in addition to the general lack of prioritization or distinction between ordinary grievances and serious incidents or allegations and unclear policies – seem to underlie the Jail's frequent failure to refer incidents or allegations for investigation of some sort, i.e., either by IAU or by detectives tasked with investigating criminal conduct:

1. Failure to identify PREA-prohibited conduct or PREA allegation. As discussed above, the Jail defines PREA misconduct too narrowly. Harassment is serious, and the Jail officials should refer every harassment allegation. Moreover, leadership and staff need to be clear on what kinds of conduct qualify as harassment; they are not clear on this important concept. A high-level official indicated that staff commenting on an inmate's buttocks or remarking about an inmate's sexual behavior, or even an allegation that a staff member grabbed an inmate's genitals during a pat-down, would normally be handled at the Division level rather than by IAU.

2. Screening by leadership. I learned of a practice in which the Jail first refers incidents to the Sheriff's Office leadership before such incidents make their way to the Jail Crimes Unit. The captain who heads criminal investigations was troubled when he learned that the leadership was weighing in on whether the Jail ought to make the referral to his detectives. I reviewed several incidents with the captain that the Jail had not referred to his detectives, and he indicated that each one I reviewed should have been referred. The practice is problematic because of the perception of leadership potentially protecting against bad publicity and because the Jail command staff are closer to the situation and should be trusted, once clear guidance is in place, to make decisions about referrals. Of course, it is completely appropriate for leadership to then review those referrals and data on referrals to ensure that the Jail is making all necessary referrals.

3. Lack of clear policy for referral from Jail Crimes to IAU. The Jail's PREA policy provides for direct referral of PREA allegations to the Jail Crimes Unit rather than to IAU. While this is an appropriate approach and is permitted under the PREA Standards, it

is critical that any such allegations also find their way to IAU. After all, Jail Crimes may opt not to investigate for a variety of reasons, including that the conduct may constitute only harassment and not criminal abuse. The Jail has no mechanism in place to ensure that IAU receives word of such referrals, though, as discussed above, policy actually requires that the Jail refer all PREA allegations (and all allegations of misconduct) to IAU. Leadership acknowledged that such a gap may exist and indicated this may have been an oversight. Once the Jail remedies this gap, the Jail must also ensure that IAU investigators receive proper training to investigate sexual misconduct.

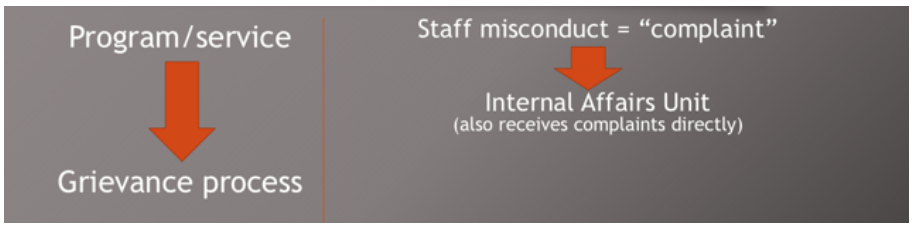
4. Deference to command staff experience. Jail commanders have full discretion regarding whether to refer uses of force or grievances for investigation. Leadership explicitly indicated this to me, noting that Jail commanders are paid to draw on their experience to make these kinds of decisions. One of the Jail commanders noted that, even in the case of criminal conduct, they are equipped to screen incidents for referral. The Jail commander noted that captains and lieutenants are peace officers, i.e., equivalent to law enforcement officers, and can therefore make determinations about whether conduct is appropriate for referral for investigation. The captain who heads Jail Crimes, on the other hand, made the critical distinction: his investigators are trained *detectives*, not simply patrol officers. Peace officers should gather and write up the preliminary facts and then refer the incident for a decision by trained detectives. For both IAU and criminal referrals, another principle is at stake: independence, or at least the perception of independence. Captains and lieutenants worked side-by-side with their subordinates and continue to work in a tight-knit culture. They must be able to be objective in their assessment regarding potential misconduct by their own staff. Clear guidance regarding the types of conduct or allegation that the Jail must refer, and a more independent assessment by investigators outside of the direct chain of command, aid in protecting against inappropriate bias or the perception thereof. The undersheriff reported to me that a process is currently in place to define which types of "significant" allegations or incidents the Jail should refer for investigation.

FINDING 5: The Jail routinely fails to refer for IAU investigation allegations of serious misconduct and incidents involving serious uses of force, other serious misconduct, and failure to report a use of force.

Finding 5a: No clear criteria exists regarding which types of use of force and other misconduct staff should automatically refer to IAU or the Jail Crimes Unit for investigation.

Finding 5b: The Jail lacks a process that ensures IAU receives notification of alleged staff sexual misconduct.

Finding 5c: Jail leadership and staff do not always understand what type of conduct falls under PREA and therefore require referral for investigation.



Recommendation 5: The Jail should automatically refer to IAU and the Jail Crimes Unit (i) every allegation of unnecessary or excessive use of force, sexual harassment (defined broadly), or sexual abuse, (ii) every use of force that qualifies under strict criteria, and (iii) failures to report a use of force. A Grievance Coordinator with appropriate seniority and training can play a role in this review process.

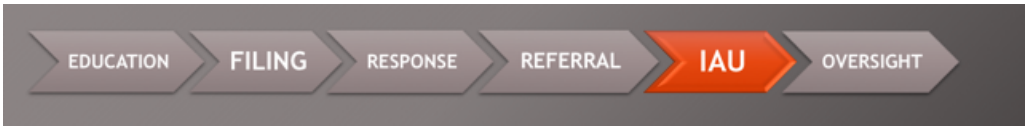
Recommendation 5a: Jail staff and leadership should receive training on what types of conduct constitute prohibited conduct under PREA.

Recommendation 5b: IAU should be notified of every referral to Jail Crimes where the referral involves potential staff misconduct. IAU investigators should receive training on conducting investigations of alleged sexual misconduct.

Uses of force that the Jail could ensure receive automatic referral for IAU/criminal investigation include incidents involving the following:

- Serious injury or hospitalization
- Injuries to the face or the genitals
- OC spray or OC spray delivered via certain methods
- Level 4 / Level 5 (Less lethal / lethal), e.g., "personal body weapons," other weapons

FINDING 6: Investigation



To be clear, it appears that the Jail almost never refers inmate grievances for investigation. However, inmates do report complaints directly to IAU, and the Jail sometimes refers staff misconduct to IAU.

These two avenues by which IAU receives allegations of staff misconduct – complaints made directly to IAU and Jail referrals of incidents – receive vastly different treatment, however. IAU conducts full investigations of referrals sent to it by Jail command staff. In contrast to this thorough review, when an inmate or someone on the inmate's behalf files a complaint with IAU, IAU almost always conducts a "preliminary investigation" rather than a full investigation. These preliminary investigations can hardly be called investigations, however, as they entail almost no interviews or other investigative activity and are written up in reports that range from two to four pages in length.

Source of complaint	Type of investigation	Adequate?
JAIL COMMAND	Full / formal investigation	Generally, YES
INMATES (or on inmate's behalf)	"Preliminary inquiry"	NO

A number of examples illustrate the inattention that IAU devotes to inmate complaints handled as "preliminary inquiries":

1. Following an October 2014 inmate complaint regarding a use of force at Main Jail, IAU requested employee reports. The inmate indicated in an interview with IAU that deputies punched him several times and "when the deputies secured him to the interview room chair, they smashed his head into the table and wall." The inmate reported that he believed deputies broke one of his fingers. In March 2015, IAU sent a follow-up email requesting the ERs but does not appear to have conducted any other investigation in the interim. Two months later, in May, IAU spoke with a lieutenant, again seeking the ERs. The ERs finally were submitted as a result of the IAU inquiry. Upon review of these reports, IAU questioned the inmate's credibility based on some conflicting statements and the lack of visible injuries nine days after the incident, but it conducted no interviews with staff or witnesses and no check on prior complaints. IAU closed the investigation in July 2015, nine months after IAU received the complaint.

2. IAU received a complaint in March 2014. Two supervisors had identified numerous issues with the incident, and the inmate was hospitalized after staff punched him in the face. IAU completed its interviews in March 2014 but did not close the matter until the following March, six days shy of a year after receiving the complaint.

3. In an example cited above, IAU received a complaint from a mental health advocate in December 2013 regarding a use of force at Main Jail's acute mental health unit. Despite the staff reports noting that the inmate "was laying face down in a pool of blood … from a two inch laceration" and required stitches and hospitalization as a result of the use of force, and despite the lack of any video evidence, IAU conducted no interviews. Even the victim was not interviewed. Nor did IAU check any prior complaints against the involved officers. IAU closed the investigation in June 2014, six months after the complaint was filed, even though IAU completed its investigative activities months earlier.

4. In response to an inmate complaint regarding a use of force in December 2013 at Main Jail, IAU noted, "IM [Z] has distorted and fabricated details of the incident …, possibly for the intent to gain some sort of benefit." IAU provided no explanation as to why it suspected the inmate sought to gain a benefit and conducted no interviews with other witnesses or officers. Nor did IAU check on any prior complaints against the involved officers. I note as an aside that IAU determined the complaint to be "Unfounded" even though the facts alleged did in fact occur, though the inmate got the date wrong and may have misidentified the staff involved. The proper finding would be "exonerated." IAU closed the investigation in September 2014 – an investigation that involved almost no investigative activity took nine months for IAU to complete.

Full investigations tend to be quite thorough, with numerous interviews, lengthy write-ups, and findings that frequently sustain the allegations. I received a couple investigations that proved recent exceptions to this rule, however, in which no inmates were identified as witnesses or interviewed. And the guidance provided in policy regarding investigative activities does not include review of past complaints against the accused staff member. (See Policy 1.19, Sec. V.G.1.)

Investigators receive no guidance regarding what information to review as part of a preliminary inquiry. General Order 14.01, Sec. B.1.a, seems to indicate that all serious allegations should receive a full investigation, but the policies are not entirely clear regarding when a full investigation is warranted, and no other guidance is provided. The PREA policy requires an investigation only of sexual abuse and similar sexual misconduct, but not harassment. (Policy 14.15-2 (defining the zero-tolerance policy).) The PREA policy is remarkably unclear regarding what types of allegations must receive an investigation and who is tasked with PREA allegations that do not rise to the level of "abuse." General Order 14.01 (Sec. B.2.b) provides that allegations of sexual harassment and use of force must not be investigated at the divisional level.

Like the preliminary inquiries, the full investigations take too long. Policy provides for "prompt resolution to complaints or allegations." (Policy 1.19, Sec. VII.A.1.) Most of the investigations I received do not align with this standard. The investigations bump up against the one-year deadline (Policy 1.19, Sec. VII.A.3), and IAU investigators often forego interviews until several months into the investigation. As a result, witness recollection may be compromised.

The head of IAU indicated to me that, as a result of the death of Mr. Tyree, IAU is conducting more investigations and its investigations are more thorough. However, staffing levels appear inadequate to ensure prompt and thorough investigations of all credible complaints.

FINDING 6: IAU investigations into serious inmate allegations are often inadequate and unduly slow. IAU reviews nearly all inmate excessive-force allegations through "preliminary inquiries," which almost always halt prematurely without full fact-finding. In contrast, referrals from Jail command staff receive full investigations.

Finding 6a: Preliminary and full investigations, including interviews, often take too long for IAU to complete.

Finding 6b: IAU is unfamiliar with PREA.

Finding 6c: No formal process exists for avoiding conflict of interest resulting from an IAU investigator investigating former colleagues.

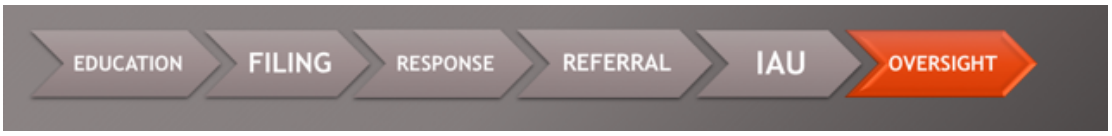
Recommendation 6: Inmate allegations of serious misconduct, including excessive or unnecessary use of force, sexual harassment, and sexual abuse, should receive full investigations. Investigations should include identifying and promptly interviewing all witnesses and reviewing prior complaints or incidents, and investigators should be provided with written guidance regarding these expectations.

Recommendation 6a: DOC should review and enhance IAU's staffing levels.

Recommendation 6b: IAU should become familiar with PREA.

Recommendation 6c: DOC should develop and implement a conflict-of-interest policy to prevent IAU investigators from inappropriately investigating former colleagues.

FINDING 7: Internal oversight



A number of the items discussed above address internal oversight. Jail command have been derelict in their responsibilities regarding inmate education, officer responses to and handling of inmate grievances, and referrals for investigation. There does not appear to be quality assurance conducted on the IAU preliminary inquiries.

This section addresses other formal mechanisms for quality assurance and internal oversight, specifically, the Internal Audit Unit and procedures for data collection and review. Quality assurance consists of three essential elements: data collection, including quantitative and qualitative data; data review and analysis; and corrective action, including policy revision.

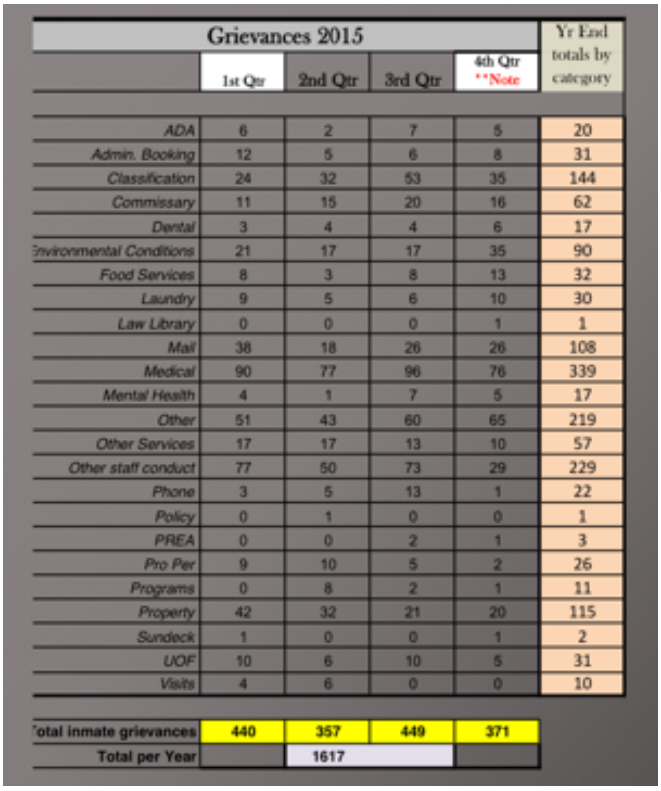
Internal Audit Unit: The Internal Audit Unit, which is written into policy, was essentially defunct for several years until approximately six months ago. Until that time, the unit lacked any staff. The unit has two essential functions: (1) monitor compliance with policies (data collection) and (2) review and update policies (corrective action). The gutting of the unit, I believe, has done enormous damage to Jail operations and represents not only a wasted opportunity but fundamental neglect. The unit is still seriously under-staffed, especially in light of the fact that the unit has to play catch-up following years of no action to update policies. The unit has yet to set a clear schedule for its review of policies or its compliance monitoring. The captain who oversees the unit acknowledged that the unit will not be able to review every policy annually, as contemplated in policy.

Data collection: The unit's own work is further compromised by the Jail's outdated and inadequate data systems. The Jail commanders expressed enormous frustration with the data systems and have taken admirable measures to make as much use of the available data as possible. This has required substantial investments of staff hours in manually refining and extracting data. For example, the incident data system categorizes incidents based on a very preliminary report from staff on the scene of the incident but does not re-categorize incidents once more information clarifies the nature of the incident. Far too many incidents are categorized as "informational," even where they involved a use of force.

Recognizing this flaw, the Jail commanders have tasked staff with reviewing all of the incidents and re-categorizing and aggregating them for the Jail commanders' quarterly reports. At one of the facilities, the staff responsible for this review – admirable in their creativity and effort – nonetheless are administrative staff and lack the necessary experience and training to properly categorize incidents, such as PREA incidents.

Similar problems affect the grievance data. The Jail has 23 categories of grievances. Some of these categories are unnecessary and see only one or two grievances a year. Other categories are too broad – "other staff conduct," for example – and conflate grievances of varying severity. As discussed below, one of the "other" categories – three such categories exist – included a large

number of grievances that could easily have been placed into other more specific categories that deal with serious issues. Especially problematic is that, once again, inexpert staff have been tasked as the Grievance Coordinators – though it appears that title has not been formally applied to any individual – and with assigning grievances to their respective categories. At least one of these staff did not understand the scope of PREA – which is one of the categories – to include nonphysical conduct.



Grievances 2015	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr **Note	Yr End totals by category
ADA	6	2	7	5	20
Admin. Booking	12	5	6	8	31
Classification	24	32	53	35	144
Commissary	11	15	20	16	62
Dental	3	4	4	6	17
Environmental Conditions	21	17	17	35	90
Food Services	8	3	8	13	32
Laundry	9	5	6	10	30
Law Library	0	0	0	1	1
Mail	38	18	26	26	108
Medical	90	77	96	76	339
Mental Health	4	1	7	5	17
Other	51	43	60	65	219
Other Services	17	17	13	10	57
Other staff conduct	77	50	73	29	229
Phone	3	5	13	1	22
Policy	0	1	0	0	1
PREA	0	0	2	1	3
Pro Per	9	10	5	2	26
Programs	0	8	2	1	11
Property	42	32	21	20	115
Sundeck	1	0	0	1	2
UOF	10	6	10	5	31
Visits	4	6	0	0	10
Total inmate grievances	440	357	449	371	
Total per Year		1617			

Custody Health has its own database for grievances, but it is employed at only one of the facilities. At the other facility, staff track a substantial amount of information, but the database cannot generate reports, undermining the ability to analyze the data.

Data review: The Jail violates policies regarding data collection and reporting, and it does so in ways that undermine its ability to analyze data for trends and patterns. For example, the policy on the grievance procedure requires that, among other things, the Jail track the housing unit and race of the inmate. (Policy 14.05, Sec. VIII ("Audit and Statistical Analysis").) The Jail does not collect such data. The same policy requires quarterly review and reporting "based on [the Division Commander's] findings." No such analysis is reported.

Similarly, I requested but did not receive the annual statistical reports required of IAU regarding the type and nature of complaints, disposition, and patterns. (Policy 1.19, Sec. IX.) IAU had to manually assemble the data it provided to the Blue Ribbon Commission because the database does not generate useful reports. An early warning system required under policy (General Order 14.01, Sec. A.3.f) is only now being rolled out.

FINDING 7: Outdated data systems hinder data collection and reporting, and policies are sorely outdated.

Finding 7a: DOC has only partially revived the Internal Audit Unit, which lacks adequate staffing.

Finding 7b: The Jail dos not collect or report required grievance and complaint data; Jail officials do not routinely review grievance data.

Finding 7c: Staff inaccurately input incident and grievance data.

Recommendation 7: The Jail should significantly strengthen its internal oversight system. The Internal Audit Unit should receive significant additional staffing. The Jail must update its data systems with 21st-century technology.

Recommendation 7a: The Jail should track and report on the timeliness and outcomes of grievances, as well as other required information; the Jail should ensure that staff input incident data accurately. Grievance Coordinators should have appropriate seniority and expertise to properly categorize and route grievances. The Jail should consider consolidation of some of the grievance categories and adding more specific categories.

Recommendation 7b: The Internal Audit Unit should create a clear schedule for review of policies and compliance and should prioritize policies regarding review and investigation of serious incidents and allegations.

FINDING 8: Other serious issues

During my review, I came across a number of other serious issues that bear attention. Undoubtedly, at least some of these issues are the focus of other external reviews. I would be remiss, however, to simply assume that and omit from this report at least my initial impressions. In some cases, the issue relates directly to the grievance and complaint procedures, but I have not specifically addressed them above because their connection to the grievance and complaint procedures is ancillary and because their impact on these procedures would not, on its own, justify redress.

Staffing levels

Staffing levels are inadequate, and this deficiency is well-known to leadership. The Jail operates primarily a direct supervision model, yet there are times when no officer is on the floor because the sole officer assigned to the floor takes his or her break or has to attend to other responsibilities. Due to a lack of cameras (discussed below), during these times, no staff is observing the housing area. One officer may be responsible for as many as 90 inmates on a floor. Due to a lack of cameras, other officers assigned to a central security area in the unit cannot observe any issues the assigned officer may be dealing with. Similarly, mental health staffing is deficient, something all three mental health supervisors reported to me.

In addition to having safety implications, the inadequate staffing complement results in the Jail's enormous reliance on restrictive housing, discussed below.

Finally, the staffing deficiencies impact staff's ability to respond to grievances. When staff are expected to handle on their own all sorts of issues that may arise, staff are unlikely to prioritize grievances, may become impatient, or may respond in a way that the inmates view as discouraging them from submitting grievances.

Restrictive housing

The Jail employs an unusual amount of restrictive housing, often in the form of "lockdown" resulting from a lack of staffing – staff either have to step away to attend to other issues or cannot have all the inmates out at once and must instead rotate successive groups out. Many inmates receive only a few hours a week of out-of-cell time. Access to programs and out-of-cell time account for a large number of inmate grievances. Of course, it is well known that restrictive housing is especially damaging for inmates with serious mental health needs, and the Jail employs restrictive housing in the case of these inmates, as well. Housing in the women's unit is particularly restrictive because of the small number of inmates and the range of security classification levels – as with some of the men's units, the inmates cannot all be out of their cells at once. The Jail does not seem to find it odd – though I did find it odd, as I discuss in more depth below – that inmates are placed on lockdown when civilians are in the housing unit. As a DOJ attorney, I never once experienced this.

Restrictive housing is a topic I focused a great deal on as an attorney with DOJ, and the Jail should refer to DOJ's settlements[3] and new guidance[4] regarding restrictive housing. Among the DOJ recommendations is that "[c]orrectional systems should establish standing committees, consisting of high-level correctional officials, to regularly evaluate existing restrictive housing policies and develop safe and effective alternatives to restrictive housing."

Sloppy categorization of grievances, described above, compromise oversight – staff often categorize grievances relating to access to programs, that is, lack of out-of-cell time, in vague catch-all categories.

Conditions / crowding

Conditions in Main Jail-South are, in a word, deplorable. They are an assault on basic human dignity and have no place in this country, let alone Silicon Valley. I was shocked at the level of crowding in both the cells used for multiple inmates and the dorm areas. The state's 2014 audit likewise cited crowding in these areas, and Main Jail-South is notorious. The facility is ancient and deteriorating, with entire areas no longer usable due to sanitation issues. It was in Main Jail-South that inmates most often called out to me, complaining to me that the conditions are disgusting. I understand a new facility is planned, but these inmates should not have to wait until completion of that construction, and the Jail should find other accommodations, for example by paying other counties to house them or conveying to the state that it can no longer accommodate some of the state prison inmates the state sends it. I challenge any observer to tour Main Jail-South and come out believing it is appropriate for housing human beings. Some areas are extraordinarily isolated and lack natural light.

During my visit, I nearly skipped an area of the facility because the entrance to a housing area appeared to be a closet or storage area from the outside. It opened directly from the elevator lobby area, which was packed with stacked meal trays. The door to the housing area was closed and locked. No officer was on the other side of the door, and no cameras provided supervision. My escort had to ask several officers where the assigned officer was – the assigned officer was not even in the small office across the elevator lobby area from the entrance to the housing area (though the line of sight was blocked due to the food trays stacked outside the office). He was somewhere else either drafting a report or taking a break, and his temporary replacement was not accounted for either. While this staffing issue is not necessarily directly related to the poor conditions and crowding in the building, it symbolized for me the rut of neglect and disregard that the Jail has fallen into regarding the inmates in Main Jail-South.

Cameras

I have already mentioned cameras several times. The Jail has not placed cameras in the housing units, creating security challenges and leaving officers on their own. The absence of cameras undermines the Jail's ability to adequately investigate allegations of misconduct or uses of force.

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[3] http://www.justice.gov/crt/special-litigation-section-cases-and-matters0

[4] http://www.justice.gov/restrictivehousing#principles

Prison Rape Elimination Act

This report has discussed in detail the Jail's approach to the PREA Standards as they relate to grievances and complaints. But PREA covers many other things, and the Jail has taken a reactive and uncoordinated approach to the PREA Standards as a whole. The Jail's first-ever PREA audit addressed the women's facility. The initial review found the Jail out of compliance with 35 out of 43 standards. As discussed below, I do not have confidence that the Jail has now met compliance with the Standards, the audit's final report notwithstanding. For example, the Jail's PREA policy does not define "harassment"; includes only "rape or sexual assaults" (Policy 14.15-1) and "nonconsensual sex, abusive sexual contact," and "staff sexual misconduct" (undefined) (Policy 14.15-2) in its definitions of "zero tolerance"; and sets a higher threshold than contemplated in the PREA Standards for protective housing – the policy provides, "If the results from the screening indicate a probability of victimization or sexually aggressive behavior, and an overall high level of risk, appropriate housing … implemented" (Policy 14.15, Sec. IV.1.a), while the Standards (115.42(a)-(b)) require that the Jail "shall use information from the risk screening . . . with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive" and "make individualized determinations." The Jail's facility-specific PREA managers each have other responsibilities, including as training officers, and devote very little time to PREA, despite the PREA Standards' requirement (115.11(c)) that PREA managers have "sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards."

FINDING 8: Other serious concerns exist and make it essential that the Jail improve its grievance and complaint procedures and internal oversight. The Jail relies far too heavily on restrictive housing, subjects inmates housed in Main Jail-South to deplorable conditions and severe crowding, grossly understaffs in both security and mental health, undermines security and investigations by lacking cameras in the housing units, and has taken a reactive approach to PREA compliance.

Recommendation 8: The Jail should prioritize addressing other areas of serious concern, including the overreliance on restrictive housing, crowding and conditions in Main Jail South, under-staffing, and PREA compliance.

Recommendation 8a: Internal and external oversight should specifically prioritize these issues, in addition to serious incidents and allegations of staff misconduct.

FINDING 9: Independent oversight

The Jail has not been subject to rigorous external oversight, and it seems to struggle with how to efficiently and comprehensively engage in an outside oversight process. This became evident during the Jail's engagement with my review, as the response was disjointed and required me to repeat or clarify the same requests multiple times. My interviews were – accidentally, I believe – characterized to staff as "interrogations." Omissions were not explained. Clearly responsive information was an after-thought in some cases. The primary person assigned to PREA implementation was not identified until I was already on-site for my interviews, even though I had requested to speak with staff responsible for PREA compliance. At one of the facilities, documentation was not produced for my review while on-site, even though I requested it well ahead of time and followed up with reminders.

I am firm in my belief that none of these problems arose from obstructionism. Rather, the Jail is addressing a number of separate inquiries, my timeline was very brief, and this type of rigorous inquiry is relatively foreign to the Jail.

The practice, mentioned above, of locking down inmates when civilians are on the housing unit is also problematic from the perspective of outside oversight. An auditor needs to be able to observe where inmates congregate to assess whether postings or boxes are properly placed, inter-group and staff-inmate dynamics to inform a determination regarding safety and staff conduct, and what activities are available to inmates. If a number of inmates remain in their cells during an opportunity to access programs, that may be helpful information. If an officer is interacting a certain way or unable to attend to other issues, these are observations that may inform an evaluator's analysis. As I mentioned above, I had never encountered another facility that insisted on locking inmates down while I was on the housing unit. The Jail does not seem to understand the concept of full and unfettered access.

This lack of independent oversight is a gap and another way that Jail staff and leadership are at risk of not being held accountable. Encouragingly, both the Sheriff and the Undersheriff have indicated they are open to the idea of independent oversight, and Board President Cortese indicated support for such oversight in his recent State of the County address.

Existing Oversight

There do exist entities that provide outside oversight, of course. And Jail officials pointed to these reviews in response to my asking them whether an independent oversight entity is needed. But these reviews occur infrequently and/or have been superficial.

State of California: The state provides biennial audits of the Jail. The 2014 review resulted in a five-page report. The report included three sentences under the heading "System-Wide Discussion," including the following: "Some concern was raised over access to out-of-cell time and exercise, a situation that staff is addressing. Inmates assured us that medical staff was responsive to their requests and expressed no complaints about the grievance or disciplinary processes." Given the discussion above, it is evident that the state's review does not include the type or level of review – or guidance – required to address issues affecting inmates' rights and

security. The review assesses compliance with Title 15, which imposes minimal standards. But the review does not appear to delve very deeply even into Title 15 issues.

Civil Grand Jury: The Civil Grand Jury addresses a very wide range of issues affecting the County, including jail operations. It is not required to address any particular issues. A lengthy report issued in June 2015 addressed educational and vocational opportunities for women confined at Elmwood. The report addressed classification and restrictive housing. The Civil Grand Jury has produced at least two other reports in the last decade or so related to women held at the Jail. It has little or no enforcement authority; its scope includes, in addition to the Jail, issues such as sea level rise, water treatment, child abuse; and members of the Civil Grand Jury are not professional investigators.[5]

Jail Observer Program: The JOP operates in a neutral manner to facilitate communication between inmates/families and the Jail. In my discussion with the JOP's staff, it was made clear that the JOP is not meant to function as an investigative body or enforcement body. The JOP puts out detailed reports on data it collects and analyzes, and the Jail should take this information seriously and establish a formal routine for meeting with JOP staff and addressing its questions and recommendations. The Jail should provide the JOP with data and other information on an ongoing basis, not only in response to ad hoc requests, and the County should ensure the JOP has adequate resources.

PREA audit: Each facility is subject to a PREA audit every three years. While the PREA auditor found the women's facility at Elmwood in compliance with all the standards by May 2015, the end of the compliance period, the auditor appears to have let them off easy. With respect to a number of Standards, the audit addresses only whether the Jail developed an appropriate policy and appears to ignore actual practice. In other cases, the audit simply does not address a portion of a particular Standard or simply gets the information wrong. At a minimum, the audit does not explain how it arrived at its conclusions, which undermines transparency.

Moreover, the PREA Standards require that the Jail make the PREA review public as a means of oversight and accountability. How a jail treats that responsibility is indicative of its tolerance for public scrutiny.

1. **PREA Standard 115.11: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

Subsection (a) of PREA Standard 115.11 provides: "An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct." As discussed above, the Zero Tolerance Policy at the Jail does not explicitly include harassment. The PREA auditor does not mention the Zero Tolerance Policy requirement in his final report.

Subsection (c) of the Standard provides: "Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards." As discussed above, the facility-specific PREA managers devote very little time to their PREA responsibilities. It does

[5] http://www.scscourt.org/court_divisions/civil/cgj/grand_jury.shtml#reports2014.

not appear the auditor assessed whether each facility has a separate PREA manager.

2. PREA Standard 115.22: Policy to ensure referrals of allegations for investigations

The auditor's report devotes only two sentences to the Standard on referring allegations for investigation, though this Standard is critically important and has numerous subsections. One of those sections pertains to whether a policy is in place. Subsection (a), however, addresses practice: "The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment." The auditor noted: "Agency ensures all criminal & administrative investigations are completed for sex abuse/harassment cases." It is unclear how the auditor arrived at this conclusion, though the auditor indicates he reviewed investigations but does not indicate he reviewed allegations that are not referred or investigated. As discussed above, my review revealed that many allegations are not properly referred or reviewed.[6]

3. PREA Standard 115.71: Criminal and administrative agency investigations

The auditor required corrective action regarding the requirement in subsection (b) for specialized training. But the auditor ultimately found compliance based only on revision of policy, not on whether training was actually provided. The same is true for the requirements regarding content of investigations (subsections (f) and (g)).

Subsection (a) – "When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports" – is not addressed in the auditor's report.

4. PREA Standard 115.73: Reporting to residents[7]

Again, the audit finds compliance based on the development of policies rather than proven practice.

5. PREA Standard 115.86: Sexual abuse incident reviews

Again, the audit finds compliance based on the development of policies rather than proven practice.

6. PREA Standards regarding transparency

PREA Standard 115.88 requires the Jail to make public, via its website, its annual reporting of PREA-related data, and the Jail's own policy (Policy 14.15, Sec, XXI.D.4, XXIII.C) mirrors this

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[6] The auditor may have been unable to determine whether policy is adequately implemented due to the lack of actual reports of abuse by female inmates at the Jail. He does not note this, however, and the Standards regarding investigations apply to the larger "agency," not just the women's facility.

[7] Throughout the PREA audit report, the auditor used the term "residents" rather than "inmates." He appears to have pulled language from audits of community corrections facilities rather than audits of jails and prisons, though it appears he applied the correct Standards.

requirement. The Jail has not made this data public. Standard 115.403 requires the Jail to make the auditor's report public, i.e., via the Jail's website. The Jail has not posted the report to the website. This lack of transparency – even in a case, as with PREA, in which transparency is mandated – reflects a lack of respect for the public's role in holding the Jail accountable.

Benefits of independent oversight

Jail administrators do not seem to appreciate the benefits of a permanent independent oversight entity that provides ongoing and routine oversight. The benefits are many. Such oversight allows the Jail to prevent crises, so that it does not have to take a reactive approach that entails inquiries from multiple entities and pressure to act quickly at the expense of thoroughness. When a crisis does occur, other entities are more likely to rely on the oversight entity and to hold off until they can determine whether the oversight entity is adequately addressing the concerns. Thus, the existence of such oversight results in a kind of consolidation of oversight and prevents the kind of redundancies and intensity of inquiries the Jail is currently experiencing in the wake of Mr. Tyree's death. Finally, embracing independent oversight is an important means of establishing trust. Clearly, inmates and families do not have a high level of trust that the Jail respects and protects inmates' rights. Establishing independent oversight is a means of remediation, undoing the damage – or perceived damage – that has been done. Where greater trust exists, greater safety results for staff and inmates.

Best Practices

Few models exist for independent oversight of jails. But independent oversight exists in many other contexts, including law enforcement agencies.

Substantive focus and activities: Rigorous oversight should focus on inmate safety and rights, addressing serious staff misconduct, use of force, and other physical harm. Its activities should focus on reviewing the Jail's own reviews, not reinvestigating specific incidents, unless a strong reason exists for doing so. Activities may also include reviewing policies and procedures related to particular issues affecting inmate safety and rights, including use of force, handling and investigations of misconduct complaints, and restrictive housing. Both the inspector general overseeing California's prisons[8] and the inspector general for the Los Angeles Sheriff's Office[9] provide clear information regarding their scope and activities and are strong examples of robust oversight mechanisms.

Standard: The oversight entity should review compliance with best practices, policy, and constitutional standards.

Access and independence: The entity should have full access and full independence, which requires its placement outside of the Sheriff's Office. This placement admittedly complicates the question of full access, but the Office of the Inspector General for the Los Angeles Sheriff's

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[8] Responsibilities of the Office of the Inspector General, http://www.oig.ca.gov/pages/about-us/responsibilities.php.

[9] Ordinance, https://oig.lacounty.gov/Portals/OIG/Reports/Certified%20OIG%20Ordinance.pdf.

Office, in addition to serving as a model for substantive responsibilities, provides an example of a process for working out such access while ensuring full independence.

Transparency: The oversight entity should provide periodic reports to the Board of Supervisors and should make those reports public. It should also serve as a resource for, and should act as the eyes and ears of, the public.

FINDING 9: Meaningful independent oversight of the Jail does not exist, and the Jail culture does not fully embrace transparency. In light of systemic deficiencies related to safety, and rights, and distrust by inmates, their families, and the community, independent oversight is essential.

Finding 9a: The Jail Observer Program serves an important function but is not positioned to provide rigorous oversight.

Finding 9b: The state, PREA, and civil grand jury provide sporadic oversight. Independent reviews often are not fulsome.

Recommendation 9: The County should establish an independent oversight entity that has (i) broad scope of authority regarding inmates' rights; (ii) with the cooperation of the Sheriff, full access to Jail facilities, data, records, staff, and administrators; and (iii) full independence, reporting directly to the Board of Supervisors and engaging in outreach to the public.

Recommendation 9a: JOP should receive additional resources, and the Jail should have in place a schedule for regular meetings with JOP.

FINDING 10: Implementation

Numerous problems with policies and procedures pervade throughout the grievance and complaint process and similar processes for identifying and addressing potential misconduct, as detailed above. The Jail will need to prioritize and develop a schedule. It will have to act with urgency but not at the expense of thoroughness and thoughtfulness. The PREA policy is an example of a policy that was recently slapped together quickly as a reaction to an external review. It suffers from numerous flaws. In short, the Jail must see to it that it implements the recommendations in this report, to the extent the Blue Ribbon Commission adopts them, and other Blue Ribbon Commission recommendations, and it should do so in a timely and comprehensive manner. This will require outside assistance. The recommendation regarding the development of a permanent independent oversight entity is especially involved and, by definition, cannot be implemented by the Jail alone.

FINDING 10: Many of the identified issues are nuanced and require urgent attention.

Finding 10a: The Jail tends to take a reactive approach to recommended changes.

Recommendation 10: The Jail and the County should immediately, urgently, and thoughtfully work to implement the Blue Ribbon Commission's recommendations.

Recommendation 10a: The Jail should work with outside assistance to ensure proper planning and prioritization for implementation of the Commission's recommendations.

CONCLUSION

The Jail has a great deal of work to do to implement an effective grievance and complaint process, as well as an effective process for addressing uses of force. Inmates understandably lack confidence in those procedures as they currently exist. The Jail must make unambiguously clear that it takes seriously inmates' allegations of staff misconduct and that it provides a fair and genuine review of uses of force. To do this, it must address every stage of the process, provide accurate and updated information to inmates and clear guidance to staff, exercise meaningful internal oversight, and embrace transparency, public engagement, and independent oversight.

The Jail must understand that each stage of the process provides another opportunity to get it right. But, each time the process fails because every stage fails, the Jail sends a message to inmates and staff that misconduct is tolerated, that staff are not accountable for their behavior, and that inmates have no recourse. As staff believe they can get away with minor misconduct, it is human nature to seek to get away with more. While the overwhelming majority of staff are responsible and act ethically and respectfully, a culture of impunity inevitably leads to some staff undertaking the worst kinds of abuses. Where there is smoke, there is fire. Where no checks and balances exist, misconduct will snowball from minor to major.

While this review did not undertake to decipher a link between this broader culture and Mr. Tyree's death, and while it may be impossible for any review to find a direct link, the kind of abuse he endured simply does not occur in a vacuum. Where the accountability system is broken, some will act in ways that reflect their belief that they will not be held accountable. The Jail has an opportunity to prevent this kind of abuse from repeating itself. Indeed, it has an obligation – under the law and under principles of basic human decency – to do so. The inmates housed in the Jail are members of the community, and they are human beings. I remain seized of this opportunity and willing to support the Blue Ribbon Commission and the Jail in their efforts to improve the Jail's practices and ensure every individual in the Jail is treated with dignity.

Appendix 1: Findings

FINDING 1: The Jail fails to properly distinguish between the two categories of grievances – ordinary grievances regarding conditions and grievances alleging staff misconduct, or "complaints."

Finding 1a: A culture of disregard of, or minimization of, serious complaints and serious incidents, perpetuated by the Jail leadership and supported by ambiguous policies, has taken hold in the Jail.

Finding 1b: The culture of conflation pervades through the entire grievance and complaint process, creating serious flaws at each stage. The entire process for addressing potential uses of excessive force and allegations of serious misconduct therefore requires revision and ongoing internal and independent oversight.

FINDING 2: The Jail provides grossly inadequate information to inmates regarding the options they have for addressing staff misconduct and other serious concerns, such as sexual misconduct by other inmates. Information is disjointed, haphazard, and incomplete.

FINDING 3: The Jail has not made readily available to inmates a sufficiently confidential means of submitting grievances. No clear plan exists for the grievance boxes' proper placement or use, and many staff are unclear on the procedure and purpose. It remains to be seen whether computer tablets will facilitate the filing of grievances or complaints.

Finding 3a: Confidential letters are not really confidential and are not as convenient as other methods.

Finding 3b: There exists at the Jail, among both inmates and staff, the belief that grievances must be submitted to officers. Ambiguous policies reinforce this belief. Grievance forms are not available in some key areas.

Finding 3c: Confidentiality is essential in light of the widespread practice of subject officers responding to grievances regarding misconduct, the inappropriate and intimidating nature of some such responses, and the screening in some cases of grievances by other inmates.

FINDING 4: Grievances frequently yield inappropriate, incomplete, and delayed responses. Staff respond to grievances alleging misconduct by that staff – with leadership generally encouraging such an approach – and such responses often are inappropriate and even intimidating.

Finding 4a: Deadlines for responses are inconsistent, not always followed, not binding on Custody Health, and, for PREA, far too long.

Finding 4b: Inmates do not receive notification or explanation of delays.

FINDING 5: The Jail routinely fails to refer for IAU investigation allegations of serious misconduct and incidents involving serious uses of force, other serious misconduct, and failure to report a use of force.

Finding 5a: No clear criteria exists regarding which types of use of force and other misconduct staff should automatically refer to IAU or the Jail Crimes Unit for investigation.

Finding 5b: The Jail lacks a process that ensures IAU receives notification of alleged staff sexual misconduct.

Finding 5c: Jail leadership and staff do not always understand what type of conduct falls under PREA and therefore require referral for investigation.

FINDING 6: IAU investigations into serious inmate allegations are often inadequate and unduly slow. IAU reviews nearly all inmate excessive-force allegations through "preliminary inquiries," which almost always halt prematurely without full fact-finding. In contrast, referrals from Jail command staff receive full investigations.

Finding 6a: Preliminary and full investigations, including interviews, often take too long for IAU to complete.

Finding 6b: IAU is unfamiliar with PREA.

Finding 6c: No formal process exists for avoiding conflict of interest resulting from an IAU investigator investigating former colleagues.

FINDING 7: Outdated data systems hinder data collection and reporting, and policies are sorely outdated.

Finding 7a: DOC has only partially revived the Internal Audit Unit, which lacks adequate staffing.

Finding 7b: The Jail dos not collect or report required grievance and complaint data; Jail officials do not routinely review grievance data.

Finding 7c: Staff inaccurately input incident and grievance data.

FINDING 8: Other serious concerns exist and make it essential that the Jail improve its grievance and complaint procedures and internal oversight. The Jail relies far too heavily on restrictive housing, subjects inmates housed in Main Jail-South to deplorable conditions and severe crowding, grossly understaffs in both security and mental health, undermines security and investigations by lacking cameras in the housing units, and has taken a reactive approach to PREA compliance.

FINDING 9: Meaningful independent oversight of the Jail does not exist, and the Jail culture does not fully embrace transparency. In light of systemic deficiencies related to safety, and rights, and distrust by inmates, their families, and the community, independent oversight is essential.

Finding 9a: The Jail Observer Program serves an important function but is not positioned to provide rigorous oversight.

Finding 9b: The state, PREA, and civil grand jury provide sporadic oversight. Independent reviews often are not fulsome.

FINDING 10: Many of the identified issues are nuanced and require urgent attention.

Finding 10a: The Jail tends to take a reactive approach to recommended changes.

Appendix 2: Recommendations

Recommendation 1: The critical distinction between the two basic types of grievances should guide the Jail's approach at every stage, as well as the scope of independent oversight.

Recommendation 1a: Staff and inmates should be trained on the distinction, and policy should clarify the distinction, though inmates should be able to submit complaints through the grievance process.

Recommendation 1b: Grievance procedures must be viewed as a means of oversight of inmates' rights and of Jail and staff accountability.

Recommendation 2: The Jail should make complete and accurate information readily available and should routinely update such information.

Recommendation 2a: The Jail should revise and update the orientation video, rule book, and many of the postings to ensure accuracy and completeness. The rule book should address information in a number of areas that is currently omitted.

Recommendation 2b: Postings should be complete, accurate, organized, properly located, and difficult to tear or remove. PREA information should address both abuse and harassment and should be contained in easy-to-identify and attractively designed posters. The Jail should post information regarding IAU and JOP.

Recommendation 2c: The Jail should screen the orientation and PREA videos free from distraction and should provide an opportunity for inmates to direct questions to staff.

Recommendation 3: Inmates should have ready access to confidential means of submitting grievances and complaints.

Recommendation 3a: The Jail should develop clear plans for the placement of boxes and other filing methods; inmates should participate in the planning process.

Recommendation 3b: The Jail should clarify – in staff training, inmate education, and policy – that inmates may submit grievances to any staff member.

Recommendation 3c: The Jail should make grievance forms available in medical units and any other areas where inmates may be.

Recommendation 4: Responses to grievances should be appropriate, complete, and timely. Accused staff should not handle the grievance, and staff should receive training on handling misconduct grievances as complaints that should be directed, through supervisors, to IAU.

Recommendation 4a: Custody Health should be held accountable for late responses, the Jail should notify inmates if the response is going to be delayed beyond the deadline, and the Jail should shorten the deadline for responses to PREA grievances.

Recommendation 4b: When officers make inappropriate responses to grievances, supervisors should address this error on the grievance form so that the inmate understands that the Jail does not tolerate such responses. The Jail should discipline officers for intimidating or accusatory responses and should consider referring such responses for investigation of possible retaliation.

Recommendation 5: The Jail should automatically refer to IAU and the Jail Crimes Unit (i) every allegation of unnecessary or excessive use of force, sexual harassment (defined broadly), or sexual abuse, (ii) every use of force that qualifies under strict criteria, and (iii) failures to report a use of force. A Grievance Coordinator with appropriate seniority and training can play a role in this review process.

Recommendation 5a: Jail staff and leadership should receive training on what types of conduct constitute prohibited conduct under PREA.

Recommendation 5b: IAU should be notified of every referral to Jail Crimes where the referral involves potential staff misconduct. IAU investigators should receive training on conducting investigations of alleged sexual misconduct.

Recommendation 6: Inmate allegations of serious misconduct, including excessive or unnecessary use of force, sexual harassment, and sexual abuse, should receive full investigations. Investigations should include identifying and promptly interviewing all witnesses and reviewing prior complaints or incidents, and investigators should be provided with written guidance regarding these expectations.

Recommendation 6a: DOC should review and enhance IAU's staffing levels.

Recommendation 6b: IAU should become familiar with PREA.

Recommendation 6c: DOC should develop and implement a conflict-of-interest policy to prevent IAU investigators from inappropriately investigating former colleagues.

Recommendation 7: The Jail should significantly strengthen its internal oversight system. The Internal Audit Unit should receive significant additional staffing. The Jail must update its data systems with 21st-century technology.

Recommendation 7a: The Jail should track and report on the timeliness and outcomes of grievances, as well as other required information; the Jail should ensure that staff input incident data accurately. Grievance Coordinators should have appropriate seniority and expertise to properly categorize and route grievances. The Jail should consider consolidation of some of the grievance categories and adding more specific categories.

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Recommendation 8: The Jail should prioritize addressing other areas of serious concern, including the overreliance on restrictive housing, crowding and conditions in Main Jail South, under-staffing, and PREA compliance.

Recommendation 8a: Internal and external oversight should specifically prioritize these issues, in addition to serious incidents and allegations of staff misconduct.

Recommendation 9: The County should establish an independent oversight entity that has (i) broad scope of authority regarding inmates' rights; (ii) with the cooperation of the Sheriff, full

access to Jail facilities, data, records, staff, and administrators; and (iii) full independence, reporting directly to the Board of Supervisors and engaging in outreach to the public.

Recommendation 9a: JOP should receive additional resources, and the Jail should have in place a schedule for regular meetings with JOP.

Recommendation 10: The Jail and the County should immediately, urgently, and thoughtfully work to implement the Blue Ribbon Commission's recommendations.

Recommendation 10a: The Jail should work with outside assistance to ensure proper planning and prioritization for implementation of the Commission's recommendations.

Appendix 3: Curriculum Vitae

Aaron B. Zisser

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SUMMARY OF QUALIFICATIONS

- More than five years as a Trial Attorney with the Civil Rights Division of the U.S. Department of Justice, developing and leading complex, cutting-edge systems-reform investigations and compliance monitoring, including extensive interviewing; review of policies, records, and data; and evaluation of internal investigation procedures and incident reports.
- Strong focus on addressing correctional policies and practices, including restrictive housing, use of force, mental health services, and sexual abuse; community mental health and disability services systems; and sex-based and race-based discrimination in education.
- Expert consultant on systems reform investigations and implementation / enforcement.
- Commissioner on Oakland Mayor's Commission on Persons with Disabilities.
- Demonstrated leadership and commitment to collaboration, creativity, and strategic community outreach.
- J.D., cum laude, from Georgetown University Law Center; B.A., with honors, from U.C. Berkeley.

PROFESSIONAL EXPERIENCE

Consulting, Oakland, CA, *May 2015 – present*

- Expert consultant to independent Blue Ribbon Commission, providing assessment and policy recommendations regarding policies and procedures in Santa Clara County Jails.
- Developed and presented webinar for school districts on federal enforcement regarding discrimination in student discipline and other practices through the State Performance Plan Technical Assistance Project.
- Completed training to become Department of Justice-certified auditor Prison Rape Elimination Act.
- Presented research on and developed policies for reducing incarceration and out-of-home commitments.

Disability Rights Advocates, Berkeley, CA, *Jan. 2015 – May 2015*

Senior Staff Attorney: Litigated and investigated disability rights matters, including use of solitary confinement in jail and juvenile detention, unnecessary institutionalization, and education.

- Prepared for and participated in settlement negotiations in jail case; interviewed inmates.
- Coordinated media strategy and multiple firms' initial discovery and negotiations in high-profile litigation.
- Requested and reviewed policies and data from dozens of juvenile detention facilities and related agencies.

U.S. Dept. of Justice, Civil Rights Division, Washington, DC, *July 2009 – Jan. 2015*

Trial Attorney, Attorney General's Honors Program: Lead attorney on complex and cutting-edge systems-reform cases on prisoners' rights, disability rights (*Olmstead*), and education and led high-profile strategic initiatives.

- Managed and directed teams of attorneys, investigators, paralegals, interns, and subject matter experts.
- Drafted findings letters, compliance letters, complaints, discovery requests, briefs, and settlements.
- Conducted comprehensive site visits, interviews, and reviews of policies, records, and data.

Educational Opportunities Section, *Aug. 2013 – Jan. 2015*

Led complex investigations and compliance monitoring on student discipline, harassment, and segregation.

- Conducted discovery, depositions, and hearing and initiated negotiations on student discipline.
- Co-led statewide investigation of race and disability discrimination in alternative disciplinary programs.
- Conducted site visits to dozens of schools and numerous alternative education programs.
- Interviewed state officials, district and school administrators, staff, students, parents, and advocates.
- Served on hiring committee for Attorney General's Honors Program attorneys.

Aaron B. Zisser

(628) 400 1203 ● aaronzisser@civilrightsconsulting.com ● Oakland, CA 94610

Special Litigation Section, *July 2009 – Aug. 2013*
Led "pattern or practice" cases regarding conditions in correctional and psychiatric facilities and unnecessary institutionalization; litigation on access to reproductive health services; and initiatives on solitary confinement.

- Developed and led first-of-its-kind investigation and findings letter focused on solitary confinement.
- Led investigation of prison and compliance monitoring of jail on mental health treatment, solitary confinement, and use of force and led and conducted compliance monitoring in psychiatric facilities.
- Co-founded solitary confinement working group; coordinated research; hosted experts and advocates.
- Led investigation of prison on sexual abuse and protection from harm.
- Developed and led statewide investigations and compliance monitoring of disability/mental health services systems (*Olmstead*); negotiated comprehensive settlement; coordinated statewide outreach.
- Conducted numerous site visits to correctional, psychiatric, and disability facilities in five states.
- Interviewed hundreds of prisoners, patients, residents, staff, administrators, and service providers.
- Conducted extensive reviews of policies, procedures, forms, inmate and patient records, incident reports, internal investigations and reviews, data, and other documentation.

American University Washington College of Law, *Aug. 2013 – Dec. 2013*
Adjunct Professorial Lecturer of Law: Co-taught seminar on multi-disciplinary public interest advocacy.

Public Interest Law Center of Philadelphia, *Sept. 2008 – June 2009*
Staff Attorney: Conducted litigation and advocacy on disability rights and special education.

- Conducted on-site investigations; reviewed data; drafted complaints, briefs, and discovery documents.
- Lobbied local and state officials and drafted op-eds and press releases.

Human Rights First, Washington, DC, *Aug. 2007 – Aug. 2008*
Human Rights Fellow: Lobbied and conducted other advocacy on international human rights issues.

- Observed Guantanamo Military Commission trial; was interviewed by national media; published blogs.
- Conducted government, UN, and media advocacy on protection of human rights defenders.

U.S. District Court for the Western District of Tennessee, Memphis, TN, *Aug. 2006 – Aug. 2007*
Law Clerk: Researched and drafted substantive orders, including numerous civil rights cases.

EDUCATION

Georgetown University Law Center, J.D., *cum laude, May 2006*

Honors: Moran Family Endowed Scholarship in Law, *2005-2006*; Witkin, CALI Awards, *Fall 2003*

Clinics: International Women's Human Rights Clinic, *Jan.-May 2006*
General Assistance Advocacy Project, *2003-2004*

Internships: Orleans Parish Indigent Defender Board, *Summer 2006*; Israeli anti-trafficking nonprofit, *Summer 2006*; U.S. Dept. of State, Office of the Legal Advisor, *Fall 2005*; Southern Center for Human Rights, *Summer 2005*; ACLU of the Nation's Capital, *2004-2005*; U.S. Dept. of Justice, Civil Rights Division, Criminal Section, *Summer 2004*

Certificate: Certificate in Refugees and Humanitarian Emergencies, *May 2006*

Journal: *Hastings Int'l and Comparative Law Review* (invitation extended – transferred to Georgetown)

Univ. of California, Berkeley, B.A., with distinction, Comparative Literature (Spanish and English), *May 2003*

Minors: Creative Writing; Spanish Language and Literatures

Study abroad: University of Salamanca, Spain, *2001-2002*

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Honors: Matrícula de Honor for term paper; Benjamin A. Gilman International Scholarship, *Fall 2001*

Volunteer: Mentored high school student, *Spring 2001 and 2002-2003;* Tutored in the public middle and high schools, *2000-2003*; American Jewish World Service, Development work in Honduras and Ukraine, *Summer 2003;* Interned at Santa Clara County Office of the Public Defender, *Summer 2002;* Tutored at local orphanage, *Fall 2001*

PUBLICATIONS

- "Spoiled voters or spoiled election?" in *The Philadelphia Sunday Sun*, Oct. 12-18, 2008
- "Report from Guantánamo: Hamdan trial is a false and unnecessary experiment," in *Jurist* online, July 2008
- "Fig Newtons and Fundamental Rights," and three subsequent blog posts, in *ACS Blog*, July 21-24, 2008
- *Pakistan's Courts and Constitution under Attack*, a Human Rights First report (co-author), Feb. 2008

BAR MEMBERSHIP, OTHER ACTIVITIES, AND LANGUAGE SKILLS

- **Bar memberships:** Admitted to practice law in California and New York State.
- **Mayor's Commission on Persons with Disabilities,** Oakland, CA, *Sept. 2015 – present*
  Commissioner: Advise the Mayor and City Council and other City boards and commissions. Review and comment on City policies, programs, and actions.
- **Training:** Selected for and completed week-long training to become DOJ-certified auditor for prison and jail compliance with Prison Rape Elimination Act standards; passed exam (awaiting certification).
- **Awards and honors:** As individual and as DOJ team from DOJ Arc of Virginia, for *Olmstead* case.
- **Guest-lecturer:** Comparative rights of women, at University of Memphis, Intro to Philosophy, *Spring 2007*. Invited to various panels and as guest lecturer at several DC law schools.
- **Other activities:** Alumni interviewer for Georgetown Law; DOJ Honors Program hiring committee (2014).
- **Language:** Highly proficient / near fluent in Spanish.

PRESENTATIONS, TESTIMONY, AND TRAININGS

- **San Francisco Board of Supervisors, Rules Committee,** *Jan. 2016*
  Invited to provide testimony to San Francisco Board of Supervisors regarding San Francisco Police Department's policies on use of force and encounters with individuals with psychiatric disabilities, the elements of and approaches to systems reform, and multi-system reform (police reform and community mental health reform).
- **State Performance Plan Technical Assistance Project (SPP-TAP),** *Dec. 2015*
  Provided webinar training to California school districts identified as having significant racial disproportionality in their special education programs. Training addressed the Department of Justice's approach to investigations and compliance monitoring in cases of discrimination in student discipline and segregation of students with disabilities, structure and content of DOJ consent decrees, examples of policies and procedures that can give rise to violations, and legal framework and trends in litigation and advocacy on *Olmstead* and student discipline.

- **American University Washington College of Law,** *Aug. 2013 – Dec. 2013:* Co-taught seminar on multi-disciplinary public interest advocacy. Developed and presented curriculum that included sessions on approaches to system reform through litigation, organizing, investigations, and advocacy and discussions of DOJ investigations and compliance monitoring.
- **U.S. Dep't of Justice, Civil Rights Division, Solitary Confinement Working Group,** *2011-2013:* As founding co-chair, curated, coordinated, and moderated numerous presentations and trainings with guest speakers, including Texas death row exoneree Anthony Graves; Southern Center for Human Rights; attorney Michael Bien (Rosen, Bien, Galvan, and Grunfeld); social psychologist Craig Haney; and others.
- **U.S. Dep't of Justice, Civil Rights Division,** *2011-2013*
  Trial Attorney: Led training of Special Litigation Section interns on DOJ's approach to investigations, compliance monitoring, and community outreach.

REPRESENTATIVE CASES AND PROJECTS

Corrections / conditions of confinement and law enforcement

- **Pennsylvania Department of Corrections,** *2013:* Lead attorney in first stage of statewide investigation of more than two dozen prisons that ultimately resulted in a findings letter identifying a pattern or practice of violations of the U.S. Constitution and Americans with Disabilities Act and resulted in sweeping changes to Pennsylvania's policies and practices. Investigation addressed solitary confinement and abuse of inmates with serious mental illness and intellectual disabilities, mental health services, suicide prevention, and other policies and practices.
- **Pennsylvania State Correctional Institution at Cresson,** *2011-2013:* Developed and served as lead attorney in groundbreaking pattern or practice investigation on solitary confinement that resulted in expanded statewide investigation (see above). Lead attorney during preliminary inquiry, investigation, and drafting and issuance of findings letter identifying a pattern or practice of violations of the U.S. Constitution and Americans with Disabilities Act, the first time the Special Litigation Section made findings in a correctional facility under the ADA. The case represented the Justice Department's most direct attack on the practice of solitary confinement and was the first Special Litigation corrections case to highlight the rights of inmates with intellectual disabilities. The investigation also addressed use of force, mental health treatment, suicide prevention, and other policies and practices.
- **Pennsylvania State Correctional Institution at Pittsburgh,** *2011-2013:* Lead attorney in pattern or practice investigation of allegations of widespread sexual abuse by staff and inmates and excessive use of force in a state prison.
- **United States v. Consolidated Government of Columbus, Georgia,** *2009-2012:* Lead attorney in compliance monitoring of settlement agreement in pattern or practice case involving Muscogee County Jail. Led compliance monitoring on mental health treatment, solitary confinement, and use of force, which resulted in a revised settlement agreement that marked the first DOJ settlement focused specifically on solitary confinement. Compliance monitoring also addressed protection from harm, medical treatment, sanitation, suicide prevention, and other policies and practices.
- **Oregon State Hospital,** *2009-2011:* Participated in pattern or practice investigation of two state psychiatric hospitals regarding mental health services, protection from harm, discharge planning, and other issues.
- **Connecticut Valley Hospital,** *2009-2011:* Participated in compliance monitoring of settlement agreement in pattern or practice case involving state psychiatric hospital. Compliance monitoring addressed mental health services, protection from harm, discharge planning, and other issues.

- **Preliminary inquiries,** *2009-2013:* Conducted in-depth preliminary inquiries of law enforcement agencies, state and local correctional facilities, and state corrections systems. Preliminary inquiries, which were not public, involved extensive fact-finding, community outreach, and report-writing.

Community mental health and disability services and unnecessary institutionalization (*Olmstead*)

- **United States v. Commonwealth of Virginia,** *2009-2013:* Developed and served as lead attorney in statewide investigation, including findings letter, pursuant to the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision; year-long settlement negotiations; and compliance monitoring regarding Virginia's system for serving individuals with intellectual and developmental disabilities. Comprehensive statewide settlement agreement reportedly required the state to invest more than two billion dollars to implement over ten years and marked a sea change in the state's approach to providing services, expanding services in the community rather than relying on large state-run institutions.
- **Oregon Services for People with Serious and Persistent Mental Illness,** *2009-2011:* Developed and participated in statewide investigation of Oregon's system for serving individuals with serious mental illness, pursuant to the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision. Investigation addressed the state's reliance on its state-run psychiatric hospitals and the lack of community-based services.

Education

- **Pennsylvania Alternative Education for Disruptive Youth Program,** *2014-2015:* Co-lead attorney in statewide investigation of alleged race and disability discrimination in alternative disciplinary programs, pursuant to the Americans with Disabilities Act and Title IV of the Civil Rights Act.
- **United States v. Avoyelles Parish School Board,** *2013-2015:* Lead attorney in consent decree compliance monitoring, litigation, and negotiations that resulted in modifications to existing desegregation consent decree with Louisiana school district regarding discrimination based on race in student discipline.
- **Junior Doe, et al. and United States v. Allentown School District,** *2013-2015:* Lead attorney in compliance monitoring of consent decree regarding policies, procedures, and practices on sex-based harassment of students, pursuant to Title IX.
- **Northeastern Local School District,** *2013-2015:* Lead attorney in compliance monitoring of settlement agreement regarding policies, procedures, and practices on race-based harassment of students.
- **California Department of Education,** *2013-2014:* Lead attorney in investigation of state agency's policies and procedures on ensuring school districts address the needs of English Language Learners.