Santa Cruz County Office of Inspector General

First Annual Report

October 29, 2024

OIR GROUP

Michael Gennaco | Julie Ruhlin | Samara Marion
Teresa Magula | Florence Finkle

6510 Spring Street #613 | Long Beach, CA 90815
310.906.0259 | OIRGroup.com

Table of Contents

Introduction

The move to create an independent oversight body for the Santa Cruz County Sheriff's Office ("Sheriff's Office" or "SCCSO") began in earnest in 2021, shortly after enactment of state law that specifically gives California counties the ability to establish Offices of Inspector General to play a role in the monitoring of local sheriff's offices. While the law did not require any County to adopt independent oversight, in Santa Cruz the Sheriff embraced the idea of outside oversight and publicly signaled his support of and willingness to work cooperatively with an Inspector General. Only a handful of the 58 Sheriff's Offices in California have adopted any form of oversight since the 2021 law passed, and few have done so with the level of commitment as Sheriff Hart. For those few counties who have oversight entities over their Sheriff's Offices, they often have been met with both resistance and legal challenges that have impeded and slowed their work. Other California counties are still struggling to develop any meaningful oversight of their Sheriff's Offices. Santa Cruz County stands in sharp contrast, and County leaders (and Sheriff Hart in particular) should be commended for their efforts in this arena.

This discussion about oversight in Santa Cruz County was taking place amidst a national reconsideration of policing and potential reforms that began in the wake of the murder of George Floyd in 2020 and called for a reimagining of the way law enforcement interacts with the community they serve. Also in 2021, a Grand Jury called for a new level of oversight into Sheriff's Office operations after its report highlighted a series of disturbing in-custody deaths and assaults on incarcerated persons.

By the end of 2022, the County had created an Office of Inspector General ("OIG") and in early 2023 selected OIR Group[1] to fill the role. We officially

---

[1] OIR Group is a team of police practices experts that has worked exclusively in the field of independent oversight of law enforcement since 2001. It is led by Michael Gennaco, a former federal prosecutor and a nationally recognized leader in the oversight profession. OIR Group has worked in jurisdictions throughout California

began work on July 1, 2023. This First Annual Report discusses our activities in our first full year as OIG for Santa Cruz County and is meant to provide a window into the Sheriff's Office from the perspective of its independent oversight entity.

OIR Group's years of experience across a number of jurisdictions have provided us with a valuable range of familiarity with best practices in law enforcement. We bring that experience, and an understanding of what makes an agency most effective, to each assignment. But we are also careful to recognize that each law enforcement agency operates in a unique context, and that understanding local history, priorities, institutions, and community dynamics is critical to our engagement.

We began our work in Santa Cruz County with a range of meetings – the Sheriff and his team, members of the Board of Supervisors and their staffs, other County stakeholders, the association representing deputies, and community members and groups who had been active in establishing the OIG and those who had direct interest in and knowledge of concerns surrounding the jails and Sheriff's Office operations. And we facilitated an open forum for any member of the public to share their views.

We continued our outreach efforts throughout the year, meeting with important community stakeholders. We also received formal complaints from members of the public, which we forwarded to the Sheriff's Office and monitored through completion. We heard frequently from incarcerated persons who had specific complaints or questions, as well as strongly-held views on potential jail reform efforts. We discuss these regularly with Corrections Bureau leaders. And we hold regular meetings with the Sheriff and his executive team, to maintain open lines of communication, receive updates on various Sheriff's Office initiatives, and discuss questions that arose during the course of the OIG's work.

We acknowledge the ongoing substantive concerns expressed by many members of the public around conditions in the County's jails and address many of these in this Report. When we discussed these issues with Sheriff's Office leaders, we were impressed by their sincerity in

---

and in several other states, and its members have reviewed hundreds of critical incidents and thousands of misconduct investigations involving the police.

understanding the community's frustrations and their desire to meet the public's expectations for the quality of care for incarcerated individuals.

We also acknowledge the significant challenges the Sheriff's Office confronts, many of which are beyond its immediate and direct control. A nationwide staffing crisis for law enforcement that in Santa Cruz County has required correctional officers to work mandatory overtime shifts for *over seven years*. The Sheriff is also challenged by an antiquated jail facility that is maintained by an entity outside the Sheriff's span of control.[2] And the Sheriff's Office has been required to rely on medical and mental health services provided (until very recently) by a contractor whose quality of care raised enough concerns that the County recently replaced it with a new provider.[3]

In addition to monitoring complaints and addressing the individual concerns of incarcerated persons, we also took a broader look at two key areas of operation for any law enforcement agency – administrative investigations into allegations of deputy misconduct, and the agency's response to uses of force by its deputies and officers. Our findings and recommendations in these two areas comprise the bulk of this report and include:

- Recommended improvements to the scope and format of administrative investigative reports to ensure they are consistently detailed and inclusive and thoroughly address all performance issues that emerge

- Revisions to the Body-Worn Camera policy to require personnel to activate their cameras at the outset of any response to a call for service or investigative or enforcement activity, prior to initiating the actual contact

---

[2] For example, we heard repeated questions about a controversial generator issue first raised following a widespread power outage that impacted the Main Jail. The Sheriff's Office purchased a $1 million generator in 2018 that has yet to be installed because of issues with various County contractors. In the meantime, the Sheriff's Office rents backup generators as a temporary fix to avoid the potentially catastrophic effects of another power outage.

[3] Beginning July 1, 2024, the County replaced the former contractor with a new provider of medical and mental health care services for its jail population, NaphCare.

- Regular documentation of all current use of force review processes, including supervisor reviews and holistic evaluations conducted by the Use of Force Review Committee to track issues concerning tactics, decision-making, planning and coordination, choice of force options, de-escalation efforts, equipment, or supervision

- Working with the OIG on a systematic review of Sheriff's Office use of force policies, to eliminate inconsistencies and align its policies with best practices.

We want to emphasize the extent to which the Sheriff has held true to his commitment to cooperate with the OIG and facilitate our work. From the very beginning of our tenure, the Sheriff's Office has been fully transparent, communicative, and receptive to our questions, ideas, and requests for information. We have enjoyed complete access to all Sheriff's Office records and the freedom to interact with any members of the command staff and others as needed. This access is pivotal to the transparency that the County prioritized in creating the OIG, and strengthens our ability to make informed assessments and offer our input from a persuasive foundation. Our regular meetings with the Sheriff, Undersheriff, and Chiefs provide an additional forum for sharing information and ideas of common interest.

We hope this Report will add to the public's understanding not only of our role but also of Sheriff's Office operations. We remain committed to being available to members of the public and incarcerated persons who contact us about their specific complaints or broader concerns, and we look forward to a continued collaborative approach with Sheriff's Office leadership in addressing the recommendations made in this report, as well as ongoing issues as they arise.

Community Complaints and Allegations of Misconduct

A law enforcement agency's ability to investigate its own personnel with objectivity and rigor, and to address violations of policy or other misconduct with appropriate remedial measures is critical to its effectiveness in at least two fundamental ways.

One is a matter of public legitimacy: A community's acceptance of law enforcement's authority depends on the trust that this authority is exercised fairly and in accordance with legal and administrative standards. There has long been skepticism among some segments of the public about agencies' expansive internal control over complaint investigation, the proper outcomes, and what, if any, disciplinary action is warranted. Concerns about conflict and bias – understandable questions about whether the police can fairly "police" themselves – are compounded by confidentiality provisions that restrict outside scrutiny.

The second is an internal matter impacting the agency's overall effectiveness. A department's own disciplinary process is how agency leadership maintains performance standards, reinforces priorities, and addresses violations of policy with objective accountability measures. Ideally, administrative investigations into misconduct also provide a window into operational needs, including, for example, adjustments to policy or training, and non-disciplinary forms of intervention for involved officers.

The Sheriff's Office conducts administrative investigations of allegations of misconduct received from two main sources: external parties, such as a community member who complains about a deputy's response or an

incident in the jail;[4] and internally by the Sheriff's Office itself based on information it receives in a variety of ways.

Overall, while we make suggestions for improving the process around investigations and reporting, we found that these complaints were resolved appropriately, with outcomes that align with general standards for administrative investigations.

Complaints Received by OIG

The external complaint category includes those received by the OIG and then forwarded to the SCCSO for review and investigation. During our first year as OIG, we received 11 contacts from members of the public who are not incarcerated (we address our interaction with incarcerated individuals and grievances arising in Corrections later in this report). Of these, three involved personnel from other agencies, not the Sheriff's Office, and we forwarded them to the appropriate agencies. We conducted an extended in-person meeting with one complainant, who ultimately decided to withdraw the complaint for personal reasons. One "complaint" was actually more of a request for information. We connected that individual to the Sheriff's Office to resolve his concern. One complaint regarding harassment by the Sheriff's Office was closed after extensive communications with the OIG indicated there was no actionable misconduct alleged. Two complaints have been fully investigated and are deemed completed. Three others are more recent and still in the investigative process.

For each of the two completed cases, we received and reviewed the complete investigative packet from the Sheriff's Office. We found the investigations to be thorough and fair, and both were appropriately concluded with "not sustained" findings. Following our review, however, we met with Sheriff's Office leadership to address a couple of issues we

[4] The Sheriff's Office receives complaints in a variety of ways – through its website, on paper forms submitted at a station, in person or over the phone, or via a complaint submitted to the OIG. The Sheriff's Office website has an obvious link for "Feedback" that takes the user to a "Comment Form" that can be used to submit a Comment, Complaint, Commendation, Suggestion, Question, or Request. We appreciate the universality of this form, and especially welcome the inclusion of the "Commendation" option, as we see formal positive feedback of this type as a crucial element of an effective accountability system.

had surrounding these cases. In one case, while we agreed with the Sheriff's Office that the involved deputies' conduct was within policy, we nonetheless thought that one of the deputies made an unnecessary comment that potentially escalated the situation. Leadership agreed with our assessment and indicated they would address this performance issue with the deputy.

The Sheriff's Office was similarly receptive to our feedback regarding letters to complainants informing them of the disposition of their complaints. We discuss this issue, below, as it likewise applied to all the complaints we reviewed as part of our overall audit.

Broader Audit of Complaint Investigations

Beyond the 11 complaints received by the OIG, we wanted to take a broader look at complaints, to see a larger number and a wider cross-section of allegations. We asked for and received a list of all 46 administrative investigations completed in 2023 – 38 based on allegations made by a member of the public, and eight generated internally. They represented a variety of allegations – ranging from complaints about cases not properly investigated, to the content of social media posts, unprofessionalism, rude or dismissive conduct, unnecessary use of force, and unlawful detention. Five of these cases resulted in sustained findings of policy violations by Sheriff's Office personnel.

We reviewed 20 of these cases, selected from across the range of allegations. We evaluated the Sheriff's Office approach to the complaint investigation process across several key components that contribute to its overall effectiveness, including:

- Complaint intake: whether the Sheriff's Office facilitates the acceptance of complaints from the public through clear communication and an inclusive intake system.
- Investigative process: that the Sheriff's Office investigates allegations of misconduct in thorough, fair, and appropriate ways.
- Internal accountability: that the Sheriff's Office upholds its own policy and procedural standards apart from external prompting from the OIG, community, or other external stakeholders.

- Holistic accountability: that the Sheriff's Office uses its administrative investigation process as a mechanism for providing useful feedback that extends beyond individual accountability determinations.

- Complaint notification and transparency: that the Sheriff's Office promotes trust through transparency and notification regarding its processes and the outcome of complaints.

We found the Sheriff's Office handling of outside complaints to satisfy many of these foundational markers of an effective complaint investigation system. Complaints were taken seriously, investigated objectively, and assessed fairly when the evidence-gathering was complete. We also found potential for improvement in some important aspects of the process. These include:

- The timing and source of complaints should be clearly documented. In some cases we reviewed, it was not always clear how and when the complaint arrived at the Sheriff's Office. This is important information for tracking complaints on a number of levels and should routinely be included in the investigative report. Most importantly, tracking the date of complaint intake is essential to ensure that cases are completed within a one-year statute of limitations and that the appropriate disciplinary measure(s) can be taken if necessary.

- Investigations were consistently completed in a timely way – generally within 120 days or fewer – with just one case we reviewed extending longer than we would have anticipated given the nature of the allegations and investigative work required. There could be any number of legitimate reasons for this, but no reasons were provided in the report. It would be a better practice for investigators to routinely document their progress on cases, providing in the investigative report any reasons for delay.

- Some investigative reports could have benefited from a clearly-developed timeline of events to more plainly lay out the facts and established the basis for the investigator's findings.

- Investigations consistently reference a review of body-worn camera footage, but often did not describe with any specificity what the

video showed. Effectively and accurately summarizing body-worn camera footage is an important component of the review process as a case travels through various levels of evaluation and reviewers, not all of whom will have the time (or be required) to review body-worn camera footage in detail.

- Investigators did not always record or contemporaneously document the date and time of telephone calls to complainants or witnesses.

- In some other cases, the investigative report's evidence section only detailed the complaint in broad strokes. Investigative reports should consistently delineate the alleged conduct underlying each alleged policy violation, analyze the evidence, and provide disposition recommendations for each allegation and for each subject officer.

- Investigators should regularly consult with Training personnel in cases where a complainant alleges excessive force. In the case we reviewed involving a deputy's use of a head lock (discussed more fully in the Use of Force section below), we believe the investigator's analysis could have benefited from additional expertise on defensive tactics in how the Sheriff's Office trains deputies to use various control holds. This collaboration may also identify areas that require re-training, either for an individual officer or Office-wide.

- In some cases, we saw missed opportunities to provide training, feedback or other remedial actions that would improve deputy performance. For example, we reviewed one case in which an individual complained various times that the on-scene sergeant did not possess the authority to demand that she provide identifying information. In that case, the sergeant's and other deputies' insistence that she provide identifying information escalated the encounter, and a formal investigation was initiated.

  But the investigative report assumed that the deputies and supervisors were correct in their insistence that the complainant was required to identify herself, when in fact this was an erroneous

understanding of California law.[5] This case suggests that all involved (officers and supervisors on scene as well as investigative personnel) need retraining on the legal standards around the rights of individuals detained based on reasonable suspicion.

However, this was not identified as an outcome of the complaint investigation. As we noted above, complaint investigations, irrespective of the ultimate policy determination, can serve to identify areas of concern that require remedial action. The Sheriff's Office should establish a mechanism to identify these areas, route the action to the appropriate unit (for example, to an officer's direct supervisor for informal counseling, or to the Training unit for directed training), and document the outcome.

- Finally, the Sheriff's Office should always view complaint responses as an opportunity to engage with the public in a positive, helpful way. For example, we reviewed a case where an individual submitted a complaint about fees imposed on an impounded car. Sheriff's Office personnel explained that this was not an issue the Sheriff's Office could address but instructed that the complainant could appeal the fees by submitting a form, and was directed to pick up a blank form at the Sheriff's Office Records division. This was a missed opportunity to provide "customer service" by either offering to email the complainant the blank form or, even better, including links to these forms on the Sheriff's Office website.

We have been gratified by the Sheriff's Office leadership's receptivity to our feedback on the cases we have discussed and look forward to working with them to address these issues identified in our broader review of investigations.

---

[5] See California Commission of Peace Officer Standards and Training, Basic Course Workbook Series, Student Materials, Learning Domain 15, Laws of Arrest, Version 4.16, Detention 3-9, at p. 3-12, https://post.ca.gov/portals/0/post_docs/basic_course_resources/workbooks/LD_15_V-4.16.pdf.

RECOMMENDATION 1: The Sheriff's Office should work with the OIG to improve the scope and format of administrative investigative reports to ensure they are consistently detailed and inclusive and thoroughly address all performance issues that emerge.

Body-Worn Camera Policy

In a number of cases we reviewed, both in the context of community complaints and use of force incidents, we noted that some officers or deputies had not activated their body-worn cameras. [6] Current SCCSO policy too narrowly defines the circumstances under which deputies are required to turn on their cameras by focusing on outcomes. It states that personnel shall activate their cameras, as soon as it is safe to do so, in situations including, for example: use of force, arrest, and detention or citation. But these outcomes are not always predictable. By the time a deputy realizes a seemingly routine contact is going to necessitate force, it is often too late to expect a deputy to be able to safely activate a camera.

A more effective policy requires personnel to activate their body-worn cameras at the outset of any investigative or enforcement activity, and before initiating contact specifically related to a call for service. Policy should instruct deputies to activate their body-worn cameras as they are traveling to a call rather than wait until they arrive at a location which may require a dynamic response. This guidance comports with progressive law enforcement standards nationwide and components of a model body-worn camera policy.[7]

---

[6] In a related body-worn camera issue, some of the case files we reviewed contained body-worn camera recordings not assigned to a particular officer. The Sheriff's Office should ensure that personnel appropriately identify body-worn camera recordings by tagging it.

[7] See, for example, the IACP's Body-Worn Camera Model Policy at /https://www.theiacp.org/sites/default/files/all/b/BodyWornCamerasPolicy.pdf

RECOMMENDATION 2: The Sheriff's Office should revise its Body-Worn Camera policy to require personnel to activate their cameras at the outset of any response to a call for service or investigative or enforcement activity, prior to initiating the actual contact.

Complaint Disposition

At the completion of any investigation and disposition of a public complaint, state law simultaneously obligates agencies to inform complainants of outcomes (in the interest of transparency) yet places limits on what kind of details can be shared (to protect the privacy rights of involved officers). In many agencies – SCCSO included – this tension has led to a reliance on boilerplate language that does little beyond the required minimum – and is unlikely to bring much in the way of satisfaction or reassurance to members of the public who have lodged their concerns. Submitting an earnest complaint, waiting for several months, and then receiving such a short notification that the allegations were "unfounded" (with no further explanation) is a recipe for dissatisfaction.

We have long taken the position that a middle ground is both possible and desirable. We encourage agencies to do all they can to assure complainants their concerns were understood and taken seriously. This could include a recounting of the allegation itself (which helps to personalize the response), generalized description of the investigative steps that provided the basis for the outcome (which helps to show due diligence) and some effort at conveying a recognition of the complainant's perspective (such as, "I understand how frustrating this situation must have been for you …"). There may be times when an apology is appropriate (such as, "I am sorry that the Sheriff's Office did not meet your expectations."). And gratitude for the complainant's willingness to come forward is always a welcome response, letting the complainant know that whatever the outcome of the individual investigation, complaints can help the agency spot areas for improvement, identify concerning patterns or trends, and lead to changes in policy and training.

While the complainant may not always agree with the investigation's outcome, a more personalized close-out letter helps convey recognition of the individual's concern, communicates the notion that the complaint was

given serious consideration, and ideally helps foster understanding and acceptance of the results.

We identified this issue in the first cases we reviewed and discussed it with the Sheriff and his team in one of our regular meetings. They understood our perspective, agreed with this recommendation, and committed to changing the Office's approach to disposition letters. We appreciate the willingness to adopt a new practice for letters to complainants, and include it as a formal recommendation here for purposes of tracking and subsequent reporting on the Sheriff's office progress and compliance.

> RECOMMENDATION 3: The Sheriff's Office should, to the extent permissible by law, personalize its notification letters to complainants by providing some details of the steps taken during the investigation and a generalized description of the investigation, along with making some effort to recognize the complainant's perspective.

Use of Force

Among the topics the OIG is intended to audit is Sheriff's Office investigations into the use of force. We used a review of specific use of force incidents from 2023 – both from Corrections and Operations, across a variety of force categories – to examine broader issues of policy and procedure, as well as to evaluate the Sheriff's Office's internal review mechanism.

In discussing uses of force, it is important to set context: the Sheriff's Office Operations deputies responded to over 75,000 calls for service from January to December of 2023[8] and reported 336 incidents that resulted in a use of force. Similarly, Corrections manages an average daily jail population of around 325 incarcerated persons, interacting with these individuals on a regular basis for various reasons. In 2023, Corrections reported 181 use of force incidents. None of the incidents we reviewed involved the use of deadly force, and none resulted in anything more than minor injury to the subject. In fact, the Sheriff's Office receives few complaints regarding use of force by its personnel.

Despite the small percentages of total encounters that result in a use of force, we view this topic as a priority: using force is an important (and often high-profile and high-risk) exercise of law enforcement authority that warrants careful scrutiny and review. As such, we requested and received force data for a one-year period. From a total of 517 use of force incidents, we reviewed a total of 34 cases, selected randomly from each category of force to ensure we saw the full spectrum of uses of force. For each incident, we requested and reviewed all written documentation of the force and the internal review process, all video (including body-worn camera footage), and any other evidence.

[8] We note that nearly 3,600 of these calls were categorized as mental health-related calls for service.

While we saw a number of incidents that were resolved using minimal force and excellent de-escalation skills, some incidents pointed to inconsistencies or inadequate guidance provided by specific SCCSO policies, including those around the use of electronic control devices (Tasers), projectile impact weapons, and the use of restraints involving individuals' necks. Almost all the cases we reviewed demonstrated a need for improved documentation around the internal evaluation of the use of force to address how deputies deployed force options and other tactical considerations. We highlight our key concerns regarding force reporting, investigation and review practices below, and then focus on some specific categories of force that require further consideration and policy refinement.

Consideration of De-Escalation

We observed several commendable efforts at de-escalating incidents, both in the field and the jail:

- In one case, deputies responded to a call for violation of a restraining order. When they arrived, a female was yelling and throwing items at a window. Deputies communicated with her calmly, resulting in her initial compliance and she was detained with minimal physical force. Later in the incident, when she again became agitated, deputies patiently answered her questions, explained their actions, moved down to her level (she was seated, and several deputies kneeled to engage with her) and took turns trying to persuade her to get in the police vehicle. One deputy even carefully wiped the female's nose.

- In another case, deputies and mental health professionals spent over two hours negotiating with a man in crisis who was armed with a knife (while also taking care to consider their tactical positions and have lethal and less-lethal options available should the subject become aggressive). After several hours, a deputy thought to offer the man a cigarette in exchange for his dropping the knife; this was effective, and the man was successfully detained.

These incidents suggest that the Sheriff's Office is effectively using de-escalation as part of their regular operations.[9] This is in large part due to its early adoption of the Integrating Communications, Assessment, and Tactics (ICAT) training program, which emphasizes de-escalation as a core component of critical decision making.[10] In fact, the Sheriff's Office effective use of the ICAT program was highlighted by the Police Executive Research Forum, a nationally known police research organization, in an April 2024 newsletter and training guide.[11]

We noted, however, that deputies are not regularly reporting use of de-escalation, and the Sheriff's Office policy does not expressly contemplate de-escalation as a critical component of a non-force option. De-escalation is only briefly cited in the use of force policies as a possibility for deputies (as distinct from retreat) and detailed in Policy 433: Crisis Intervention. De-escalation should not be siloed to crisis incidents: It is an essential component of a deputy's toolkit and a requirement of California state law.[12]

These are missed opportunities for formalization of the Sheriff's Office's existing focus on effective uses of de-escalation.

Agencies now regularly include de-escalation in their use of force policies, including requiring that deputies document de-escalation efforts made prior to using force and, if none were used, document why de-escalation tactics were not attempted. Requiring officers to fully document de-

---

[9] We reviewed some incidents where de-escalation was not used or was not effective. We highlight several in this report.

[10] ICAT was developed by the Police Executive Research Forum (PERF): https://www.policeforum.org/icat-training-guide

[11] https://www.policeforum.org/assets/SpotlightSantaCruz.pdf; https://www.policeforum.org/assets/ICATJails.pdf

[12] Senate Bill 230, enacted in response to concerns about use of force following the George Floyd murder, required agencies to adopt de-escalation guidance in policy and training. In response to state law requirements, agencies now expressly instructed officers to consider de-escalation techniques prior to using force when feasible. Example policy language may include the following:

> *When appropriate and as safety permits, officers should use de-escalation techniques in order to reduce the need for force and should de-escalate the use of force as resistance decreases, while staying in control.*

escalation efforts in their reports would give the Sheriff's Office the opportunity to gather reliable data around when de-escalation methods have been considered (at least in the use of force context), positively reinforce conflict resolution skills, and identify and affirm personnel who have the capability and temperament to handle difficult situations without resorting to force. In departments that do not encourage or require report-writing on force-avoidance efforts, those efforts often go unnoticed and personnel with the skill and mind-set to defuse situations go unrecognized.

With the understanding and acknowledgement that deputies frequently demonstrated effective de-escalation tactics, we recommend the Sheriff's Office policies include a requirement that personnel fully document their efforts to de-escalate a situation.

> RECOMMENDATION 4: The Sheriff's Office should amend policy to require that all deputies detail in writing the circumstances surrounding their use(s) of force to include any efforts to de-escalate prior to the use of force; and if no de-escalation techniques were deployed, an explanation for why none were deployed.

> RECOMMENDATION 5: The Sheriff's Office force review process should explicitly consider whether de-escalation techniques were attempted prior to moving to force options and if not, determine whether it would have been appropriate to consider them.

Use of Force Investigation and Review

We learned that the Sheriff's Office reviews uses of force at various levels, starting with a supervisor's response to the scene (which, as we detail later, showed room for improvement). These incidents are logged by the shift supervisor in the daily log, which is evaluated by the Watch Commander. All force incidents are also reviewed by the officers' supervisors, who flag any questionable uses of force for additional review

by the chain of command.[13] And use of force incidents are reviewed during a monthly Use of Force Review meeting, which involves various members of command staff discussing and evaluating the incident. These often result in directed training or other remedial actions for the involved deputies specifically, and, often, in training for all deputies through roll call briefings or during annual training blocks.

These processes, as described to us, are aligned with best practices for force review.[14] However, it was difficult to evaluate the effectiveness and outcomes of these processes because they are not formally documented. Only one of the 34 cases we reviewed concluded with a documented assessment of whether the use of force complied with Sheriff's Office policy, and we did not receive documentation for any chain of command review that identified issues with individual deputy performance, or addressed any deficiencies in training or policy.

The Sheriff's Office cited several concerns regarding documenting the administrative process, ranging from perceived limitations of the Peace Officers' Bill of Rights to the implications for potential future litigation. We view it differently: formally documenting administrative evaluations of force – both individually and holistically – do not violate deputies' rights, and the value of documenting proactive remedial actions benefits the Sheriff's Office in the long term in ways that far outweigh speculative concerns about future lawsuits. Documentation is an important component of a vigorous process for investigating and reviewing force, and a hallmark of an advanced law enforcement agency.

We recommend that the SCCSO create a mechanism for documenting their reviews of force incidents at all levels. Here, we outline what that reporting and documentation process might look like for the Sheriff's Office.

Currently, deputies document their force within an arrest report. We were generally impressed with the level of detail and quality of deputies' and

---

[13] Some uses of force are automatically reviewed, including any force that involved charges of battery on a peace officer and all that involve vehicle pursuits.

[14] Unfortunately, we did not have the opportunity to attend a Use of Force Review in person, but will include this in our work plan for the coming year.

correctional officers' written reports of their uses of force, while noting that they should also include information about de-escalation (or lack thereof).

Then, line supervisors sometimes (though inconsistently) document their investigation of the incident – including reference to any interview of the person on whom force was used – in a supplemental report that is attached to the general offense report. Because that document is sent to the District Attorney for potential prosecution of the subject, however, supervisors are constrained in the amount of critical detail they can provide in these reports. And supervisors do not currently make any formal determination or recommendation about whether the force used was in policy.

A more robust and discerning practice is for direct, but uninvolved supervisors to prepare a separate use of force report that includes a description of the force used and also documents the supervisors' investigation and review, along with an evaluation of the incident.[15] Specifically:

- After supervisors review all available video evidence, dispatch and computer-aided dispatch (CAD) reports (where relevant), and all other relevant evidence, they should collect and link it in one central file.
- Supervisors should prepare a use of force memo that provides a summary of the incident, documents the interviews of the subject of the force[16] and any deputy or civilian witnesses, and makes findings and recommendation about whether the force was in policy and whether any commendations or remedial measures are needed.
- These memos should be routed to command staff for review, approval, and any further action.

[15] Most agencies use software specifically designed for the purpose of collecting evidence in one file, documenting supervisor review(s), routing the incident through the chain of command, and tracking the findings for reporting purposes.

[16] Having a use of force memo separate from the incident report allows a supervisor to fully document subject interviews even where there is no *Miranda* waiver.

RECOMMENDATION 6: The Sheriff's Office should require uninvolved supervisors to thoroughly review and evaluate all uses of force and document their actions, findings, and conclusions in a stand-alone use of force report that is separate from the incident report.

RECOMMENDATION 7: Sergeants' use of force memos should be routed to command staff for review, approval, and any further action.

In addition to documenting the entire review process, we also found room for improvement in the way supervisors respond to the scene of a use of force in the cases we reviewed.[17] In most cases, if supervisors responded, they did not interview the subjects on whom force was used. When they did, they sometimes conducted the interview in the presence of the deputy who had used force, and often the interviews lacked the objectivity that is necessary in this context. Sometimes supervisors did not obtain important facts and did not identify witnesses or other involved parties. And in some cases, an involved supervisor conducted the review of the use of force; supervisors should not be assigned to review or evaluate incidents in which they either used or directed others to use force. In those cases where supervisors use or direct force, they should prepare supplemental reports documenting their actions.

The Sheriff's Office acknowledged that its supervisors could do better, and outlined its plan for more supervisor training in these on-scene investigations, including creating a checklist of supervisor requirements. We will continue to review supervisors' on-scene responses to ensure compliance with its policies and best practices. As the Sheriff's Office develops its supervisor training, we recommend that it provide line

[17] The Sheriff's Office policies (for both Corrections and Operations) require an uninvolved supervisor to respond to the scene and take some fundamental steps toward assessing the situation and investigating the incident, including: obtaining basic facts from those involved, ensuring that injuries are treated appropriately, interviewing the person on whom force was used, identifying witnesses and any additional evidence, such as surveillance footage, reviewing and approving reports, determining the likelihood of civil litigation, and evaluating the need for an administrative investigation. See the Santa Cruz County SO Corrections Policy Manual 509.7 (Use of Force, Supervisor Responsibility) and the Santa Cruz County SO Policy Manual 300.7 (Use of Force, Supervisor Responsibility).

supervisors additional training on the best practices for interviewing subjects, with emphasis on asking open-ended neutral questions and providing additional guidance on the intersection between individuals' *Miranda* rights[18] and the department's interest in obtaining and documenting statements from those upon whom force was used.

> RECOMMENDATION 8: The Sheriff's Office should ensure that supervisors reviewing the use of force interview the person on whom force was used or document the reason for not conducting an interview.
>
> RECOMMENDATION 9: The Sheriff's Office should provide supervisors additional training on best practices for interviewing subjects upon whom force is used.
>
> RECOMMENDATION 10: The Sheriff's Office should revise its policy to prohibit supervisors from interviewing subjects of uses of force in the presence of deputies or officers who used force.

Finally, we also recommend that the Sheriff's Office document the findings and outcomes of its regular use of force review meetings. While we do not doubt that these review sessions result in thorough scrutiny of these incidents, we did not see any related documentation of either the session or completion of remedial actions. We are strong proponents of the idea that these well-intentioned sessions be documented to ensure that the directed actions are memorialized and completed in a timely way.

As examples of the type of holistic response we expect, we highlight a few issues raised in cases from our audit – issues that did not necessarily render conduct "out of policy" but which nonetheless warranted the further discussion and analysis taken by the Sheriff's Office:

- In one incident that occurred in the jail's intake area, correctional officers took a handcuffed man who was suspected of being under the influence of methamphetamine or fentanyl down to the ground

[18] Policy 300.7(c) requires the supervisor to interview the subject of the use of force, even if the person has not voluntarily waived *Miranda* rights, but also provides that the content of the interview should not be included in the supplemental report if there is no waiver.

when he became uncooperative. The man did not sustain observable injuries, but takedowns involving restrained individuals involve an inherent risk of injury.

This issue was identified by the Corrections leaders reviewing the case, with swift remedial action taken in the form of department-wide training.

- Two deputies conducting a security check saw a vehicle with four passengers. One got out as the deputies drove up, and they recognized him as someone on active parole. He appeared to tuck something into his shorts/waistband and then ran. One deputy began to pursue on foot, through a wooded area. He lost sight of the subject at least once, but eventually caught him, pulled him to the ground, and secured him without further use of force.

  The subject was not carrying a gun at the time he was caught, but detectives later found one along the path of the pursuit, in the area where the deputy had lost visual contact.

  This incident raised numerous policy considerations and safety concerns, most notably the deputy's decision to pursue alone a subject he believed to be armed, while leaving his partner alone at the car with three unsearched and unsecured individuals, and his decision to continue the pursuit through difficult terrain even after losing sight of the suspect. The Sheriff's Office has a foot pursuit policy that addresses each of these factors and advises deputies to consider alternatives to pursuit when a number of safety concerns are present.

  We learned from the Sheriff's Office that they addressed these concerns, both with a debriefing of involved deputies and by using this scenario as part of a division-wide strategic communications training, to remind staff of the dangers of solo foot pursuits and encourage thinking about alternative tactics.

That these issues were identified and addressed as part of the Sheriff's Office review of force incidents is commendable, and indicative of its embrace of a more holistic review model, where the goal is not to undermine deputies or strain for ways to be critical, but to consistently

reinforce the Sheriff's Office's training and values and identify ways to improve deputy responses.

We identified issues in another incident – including a sergeant's decision to approach two individuals alone, one of whom reportedly possessed a gun, without waiting for back-up and/or broadcasting this information – that were not as thoroughly addressed as we believe they should have been. The incident concluded uneventfully, but raised officer safety concerns worthy of discussion. Following dialogue with the Sheriff's Office, they acknowledged our position and agreed that a more robust supervisor review and documentation process may effectively and consistently "catch" these kinds of concerns.

We appreciate the Sheriff's Office long-standing commitment to the thorough review of uses of force. We nonetheless reiterate the importance of documenting these outcomes in some format, for purposes of transparency and accountability, and to ensure that identified reform measures are completed in a timely way. Following our initial discussions around the findings and recommendations we present in this report, we understand that the Sheriff's Office is already moving forward with efforts to develop an enhanced force review documentation process. We look forward to working with the Sheriff's Office to achieve these goals.

> RECOMMENDATION 11: The Sheriff's Office should develop a formal mechanism for documentation of its internal use of force review process at all levels.

Conducted Electrical Devices (Tasers)

We reviewed seven cases involving use of the Conducted Electrical Device, commonly referred to as the Taser. Of these, three were by Corrections Bureau deputies in the jail setting; in all three, the Taser was merely "displayed" as a possible use of force should the incarcerated person fail to comply with deputy orders. Four were by Operations Bureau deputies in the patrol setting; of these, three were Taser displays and one involved three unique Taser deployments.

Our review of these cases suggests that the Sheriff's Office should take a closer look at the ways in which deputies are deploying the Taser, both in jails and in the field, and at the policies that guide use of this weapon.

First, and most importantly, the Sheriff's Office Taser policy does not effectively set out the contemporary legal standard for use of the Taser. The current policy allows for Taser use on a subject who displays "physical resistance," but does not define the level of resistance that warrants its use. It goes on to state that the Taser may be deployed on an individual who is "potentially violent" and that "has demonstrated, by words or action, an intention to be violent or to physically resist." It also allows use for subjects who only pose a threat of self-harm, stating that use is permissible when it "reasonably appears to present the potential to harm […] him/herself." This current policy language does not align with current case law regarding the use of Tasers.

We recommend that the Sheriff's Office consider limiting use of the Taser to subjects who are displaying assaultive resistance, defined as "subjects that are aggressive or combative; attempting to assault the officer or another person, or physically displays an intention to assault the officer or another person."

> RECOMMENDATION 12: The Sheriff's Office should update its policy to align with case law regarding use of the Taser, limiting the use of the Taser to subjects who are displaying assaultive resistance.

Second, we reviewed several cases where deputies used the Taser in drive-stun mode.[19] Currently, both Corrections and Operations policies permit the use of Taser in drive-stun mode, but we found that the

---

[19] The Taser is designed to create neuromuscular incapacitation (NMI) by delivering a shock to the body through electrical conduction. This is achieved in two ways: by deploying the two electrical probes that attach to the skin, or by deploying probe(s) and completing the electrical loop by placing the Taser device itself against the skin, which is referred to as "close/direct contact mode" or "three-point contact" mode. In either method, the probe(s) or points of contact must spread and attach to deliver the electrical current. This is less likely to occur in close contact mode; the officer's proximity to the subject can impede the probe spread and attachment.

The Taser model used by the Sheriff's Office can also be deployed in "drive-stun mode." This is when the Taser is placed directly against the skin and no probes are deployed; it does not result in NMI and only causes pain.

Operations policy does not sufficient restrict its use to the legal standard we noted above. As it is currently written, the Operations policy allows for use of drive-stun mode solely as a means of pain compliance, which does not meet the legal threshold for use of the device. We recommend that, at a minimum, the Operations policy align with the Corrections policy language regarding use of the Taser in drive-stun: the Corrections policy states that drive-stun mode can be used where there is an "immediate danger."[20]

> RECOMMENDATION 13: The Sheriff's Office should update its Operations policy to align with the Corrections policy, and to meet legal standards for use of the device generally and in drive-stun mode.

Second, we observed that deputies in both Corrections and Operations did not regularly follow Sheriff's Office policy that requires that warnings be provided prior to any Taser deployment.[21] The purpose of the warning is to provide the subject an opportunity to comply prior to deploying the device and to advise fellow deputies (and potential bystanders) that the device may be deployed. Merely unholstering the Taser and displaying it (as we observed in two cases) is not a substitute for the verbal warning; even if the subject him/herself sees the device, fellow deputies may not.

In the Operations cases, some deputies issued a broad use of force warning (something to the effect of: "force may be used against you if you do not comply"). While this warning is helpful, we recommend that deputies who have unholstered and may use their Taser device provide a specific warning regarding possible Taser use. We acknowledge that some cases unfold too quickly to allow for a warning. When those situations occur, deputies should expressly document the reasons why they did not give a warning.

---

[20] Some contemporary force experts have suggested that the use of drive-stun is ill-advised because of officers' reliance on this mode as pure pain compliance. Any use of the Taser, even if "only" in drive-stun, must meet the legal threshold for use of this device. See, e.g. PERF & COPS, 2011 Electronic Control Weapon Guidelines (March 2011), pages 14, 19.

[21] Operations Policy 303.4 and Corrections Policy 507.3.

RECOMMENDATION 14: The Sheriff's Office should reinforce its requirement to provide a warning regarding Taser use and ensure appropriate remediation when officers do not effectively document a reason for not giving a warning.

Finally, we reviewed one concerning case where two deputies, one of whom was a supervisor, targeted sensitive areas on a subject that are not advised per policy[22] and the manufacturer's warnings. More troubling is that the deputies did not document these target areas or provide any rationale as to why they selected them over other (suggested) target areas. Unfortunately, as we note in other sections of this report, the deputies did not activate their body-worn cameras, so there is no video record of what occurred.

In this case, a subject who had been armed with a machete and was hiding under a vehicle appeared to be reaching for the weapon as he was moving out from under the vehicle toward deputies. Without issuing a warning, the responding supervisor deployed one round from his Taser. One of the probes struck the baseball cap that the subject had been wearing and the other fell to the ground. The subject fell forward and deputies went hands-on to apprehend him.

A third deputy – who had activated his body-worn camera – arrived and observed deputies struggling to handcuff the prone, but still aggressive subject. Without any warning or communication, he placed the Taser on the subject's upper thigh and deployed one cartridge. Body-worn camera footage then showed the deputy place the device into the subject's groin area between the buttocks and deliver one cycle of drive-stun. The deputy then delivered a second round of drive-stun to the right upper hamstring area. Whether this was intentional or a result of the subject's movements was unclear. Regardless, we were concerned that the Taser was used in target areas that are listed as a "sensitive areas" to avoid.

---

[22] Operations Policy 303.5.3 states: "Reasonable efforts should be made to target lower center mass and avoid the head, neck, chest and groin. If the dynamics of a situation or officer safety do not permit the deputy to limit the application of the TASER device probes to a precise target area, deputies should monitor the condition of the subject if one or more probes strikes the head, neck, chest or groin until the subject is examined by paramedics or other medical personnel."

We were also concerned that the Taser deployment by the second deputy could have shocked his fellow deputies who were hands-on with the subject.

These incidents and the issues raised suggest that more training may be necessary, especially if the Sheriff's Office updates its policies as we recommend. The training should include the legal threshold for use of the Taser in all modes, providing specific warnings for use of the device, the challenges of using the device in drive-stun (for example, if used during a hands-on fight involving other deputies, drive-stun may also shock other deputies[23]), and the risks associated with Taser deployment, including when deployed to sensitive target areas.

Impact Weapons

The Sheriff's Office uses two types of kinetic impact weapons: a 12-gauge less-lethal shotgun, which deploys a projectile designed to temporarily incapacitate a person, and the Pepperball launcher, which fires small plastic balls filled with a derivative of OC[24] powder at sufficient velocity to cause the projectile to burst upon impact and disperse the chemical agent.

Our audit of these cases suggested that the Sheriff's Office should carefully review and reconsider the ways that deputies use these tools, both in the field and in custodial settings.

---

[23] For example, we reviewed one case in the jail where a subject had lunged at and taken down a deputy; both were grappling on the ground. A second deputy approached, unholstered his Taser and warned that he would use it. He decided not to due to the circumstances, which was commendable thinking: had he deployed, the Taser shock could have affected the other deputy.

[24] "OC" is short for oleoresin capsicum, the active ingredient in pepper spray and derived from the naturally occurring compound in chili peppers. OC is an inflammatory agent, which results in near-instant inflammation to the body's mucus membranes, often causing a runny nose, watery eyes, the need to close the eyes, difficulty breathing, upper respiratory pain and inflammation, and coughing. It can also cause a burning sensation on skin.

Sheriff's Office personnel have various methods to deploy OC spray, including the standard issue canister that all deputies and correctional officers carry on their duty belts. Unless otherwise specified, a reference to OC deployment refers to this standard issue OC.

First, we reviewed two cases involving deployment of the less-lethal shotgun by Operations deputies trained in their use.[25] Per the Operations Bureau's Policy 302: Control Devices, use of this tool is limited to "violent confrontations." The policy goes on to describe several possible use cases, while also stating that this tool is not limited to those cases only. The policy does not clearly define "violent" or provide clear guidance on the levels of resistance that warrant use of this (or any) kinetic impact weapon. While use of any force option requires deputies to make real-time choices about the reasonableness and necessity of using force, this policy's lack of guidance, does not align with current standards and leaves too much room for operator discretion.

And while we found one of the less-lethal shotgun deployments to be in response to an aggressive and armed individual, we reviewed another deployment that did not seem to initially meet this threshold. In that case, an intoxicated subject reportedly living on the side of the railroad tracks was refusing to comply with deputy commands. Several minutes into the encounter, he picked up a rake, turned away from deputies and began banging a fence with the rake while speaking incoherently. Deputies had time and distance on their side to communicate with this non-compliant subject.[26] But rather than reposition and continue to communicate, deputies seemed eager to end the encounter. A deputy fired one round from the less-lethal shotgun, striking the subject in the leg.[27] Instead of resolution, this deployment immediately escalated the incident. The subject, now angry at the deputies, turned toward the deputies and began slamming the rake on the ground. Rather than reposition, the deputies all

---

[25] We did not review uses of the less-lethal shotgun by Corrections deputies. While the use in jail is permitted, it is extremely restricted only to "de-escalate a potentially deadly situation," which is appropriate. There were no reported uses of this weapon during the period of our review.

[26] This incident involved a Field Training Officer and his trainee; the trainee seemed to have difficulty with effective communication, repeating generic phrases he likely learned in the academy, and the FTO took over communication at times, which included attempts to establish rapport. When the deputy with the less-lethal shotgun arrived, he, too, issued commands. While we appreciate that the tenured deputies were using this as a "teachable moment" for the trainee, having three deputies issue commands can be confusing and ineffective.

[27] As we noted in the Taser section, deputies here provided a generic use of force warning. It is preferrable for deputies to warn subjects of the specific force that might be used (here, a less-lethal projectile) and its potential to inflict pain and/or injury.

approached the now aggressive subject, and the deputy fired a second round from the less-lethal shotgun; it is unclear if this round struck the subject. The subject tossed the rake, complied with commands, and was detained.

Second, we reviewed several cases that involved use of the Pepperball launcher. This tool is generally used by law enforcement in two main ways:

- The first is as an *impact weapon*, where the projectile is targeted at and intended to strike a subject to deliver moderate pain (and, of course, chemical agent), directly at the subject. When used in this way, the deployment of Pepperball should be limited to actively aggressive or potentially aggressive subjects in the same way as any impact projectile.

- The second is for *dispersing chemical agents*, which is sometimes referred to as "area saturation." When used for this purpose, deputies deploy Pepperball into an area by aiming the projectiles at a surface above or behind a subject, causing the spheres to burst and the chemical agent to disperse. It is used in the same way a deputy might deploy OC from a handheld canister to gain compliance and control.

Our case review, however, showed that deputies in both Corrections and Operations used the Pepperball launcher in both ways interchangeably, often striking subjects with the projectiles when the level of resistance posed by the subject suggested that area saturation – not direct strikes – would have been appropriate. This was particularly notable when Pepperball was used in cell extractions on passively non-compliant subjects, as we detail below.

This confusion may stem from the fact that current Sheriff's Office policy does not differentiate the two types of use cases, and does not classify the Pepperball launcher as an impact weapon:

- In the Operations policy, uses of Pepperball are listed under "OC Guidelines" (see 302.7), and it is not listed as an impact projectile weapon.

- In the Corrections policy, Pepperball is listed as a "Projectile Chemical Agent" (see 509.4.4), as distinct from *impact projectile*, and does not explain how to use the tool for area saturation. Policy states that "personnel deploying the pepper projectile system should not intentionally target [the head, neck, spine or groin] except when the correctional officer reasonably believes the inmate may cause serious bodily injury or death to the correctional officer or others," but does not sufficiently limit use of the tool as an impact weapon in circumstances that only warrant area saturation.

We recommend that the Sheriff's Office carefully consider the uses of Pepperball, provide clear guidance in both policies that differentiates between use of the tool as an impact weapon versus chemical agent dispersal, and consider restricting use of the Pepperball in the jail to scenarios involving aggressive or assaultive subjects (as we discuss further below).

Chemical Agents in the Jails

In four of the cases we reviewed, jail personnel used chemical agents on incarcerated persons to facilitate the removal from their cells for reasons related to severe mental health issues. These complex scenarios have no ideal outcome. Once the decision is made that an individual needs to be removed from a cell for their own well-being, and the person is either unwilling or unable to voluntarily comply, the Sheriff's Office has few alternatives. Personnel can enter the cell and forcibly restrain the person, as we saw in one case we reviewed. This creates the risk of injury to both the incarcerated person and staff. The use of chemical agents creates pain and discomfort, and can create collateral contamination, but also can limit the need for additional force. Each of these scenarios requires thorough articulation and documentation of all relevant decisions and a holistic after-action review. As with the use of force in general, we found room for improvement in the Sheriff's Office documentation of its response to these challenging situations.

In two of the four cases we reviewed in this category, individuals had refused to voluntarily take court-ordered medication.[28]

- An individual housed in the unit of the Main Jail designated for those with the most severe mental illness refused to take his court-ordered medication. About an hour after a Supervising Correctional Officer (SCO) advised the individual that force would be used if he did not voluntarily take his medication, a different SCO directed a correctional officer to deploy OC spray into the cell. When the individual still refused to comply with orders to come to the cell door to be restrained, a correctional officer deployed 11 rounds of Pepperball. Some of these struck the individual in the hands and legs. Officers then entered the cell and secured the individual.

  He was removed from the cell, where mental health staff administered the medication. He was then decontaminated to remove the effects of the chemical agents and was cleared by medical staff.

- In another case, which unfolded over the course of several hours, an individual refused to voluntarily take his court-ordered medication. He eventually was confined alone in the dayroom patio area of the housing unit. Officers met under the direction of a supervisor and developed a plan to enter the patio and secure the individual. Following a verbal warning, one officer fired two rounds of Pepperball, striking the man in the back. Officers entered the patio and took the individual to the ground and secured him.

  A mental health professional administered the ordered medication, then officers secured the individual in a safety chair[29] and

---

[28] California Penal Code section 2603 allows for the involuntary treatment of an individual with a serious mental disorder, only when certain conditions are met, including that the individual is gravely disabled and does not have the capacity to refuse treatment with psychiatric medications, or is a danger to self or others. The process for obtaining a court order involves multiple steps and includes representation for the incarcerated person.

[29] A safety chair is a form of "clinical restraint" intended to be used when an individual is disruptive, assaultive, and/or self-injurious as a result of a medical issue or mental illness. The individual's hands and feet are secured to chair that resembles a wheelchair. It is often used to facilitate movement and to allow medical or mental health providers to safely approach and treat the individual. Sheriff's Office policy

decontaminated him with water. Medical staff examined him and found no injuries or health concerns.

In the two other incidents we reviewed, incarcerated persons needed to be removed from their cells for their own health and safety reasons.

- An individual had smeared feces on himself and cell surfaces, and the cell was littered with trash. He was shadow-boxing and talking incoherently while ignoring officers' and mental health professionals' attempts at communicating with him.

  At the direction of a sergeant, officers deployed OC spray, then entered the cell to secure the individual. He resisted officers' efforts and tried to bite them as they struggled to gain control of his arms and legs. He was ultimately restrained, then attended to by mental health and medical professionals.

- An individual who had been deemed an assault risk because of his past behavior toward officers and other incarcerated persons was determined by mental health staff to need a higher level of care due to his deteriorating mental state and was set to be rehoused into the acute mental health unit. He refused to leave his cell.

  At the direction of a sergeant, officers deployed OC spray, to little effect. An officer then deployed eight rounds of Pepperball, aimed at the individual's hands and legs. Officers then entered the cell to secure the individual, who continued to struggle. At one point, an officer unholstered and displayed a Taser, but did not fire it. The officers restrained the individual with handcuffs, then moved him to a separate area to be decontaminated and treated by medical and mental health staff.

Forcibly removing an individual from their cell should always be a last resort, after all other resources and efforts to gain the individual's cooperation have been exhausted. Based on our review of these

---

contains detailed guidelines for monitoring and documenting placement of individuals in safety chairs.

incidents, the decision to move individuals appeared to be necessary and legitimate, made with the guidance of mental health professionals.[30]

The “best practices” governing these situations requires consideration of a number of circumstances:

- Scrutiny of the reason for the cell extraction and evaluation of alternatives
- Timing and quality of supervisory involvement and control
- Involvement of mental health and medical teams in communicating with the incarcerated person and in overall decision-making
- Involvement of deputies with specialized mental health training, if available
- Consultation with medical staff regarding vulnerabilities of the person to be moved
- Video record of entire incident from various vantage points
- Decontamination and medical clearance after the use of chemical agents.

Sheriff’s Office officials indicated that these incidents are carefully planned and scrutinized, with consideration given to all these factors. As was true with other use of force incidents we reviewed, however, we did not see clear documentation relating to these issues. For example:

- Some written reports referenced efforts to talk with the individual and gain voluntary compliance, but these efforts were not included in the body-worn camera recordings tagged to the incident.

- There were no clear timelines provided, so it was often difficult to ascertain how long the incidents stretched out or how much time an individual was given to comply after various orders were given.

- In some cases, the warning that chemical agents would be used were not clearly given.

[30] Corrections appropriately does not question the judgment of medical professionals, nor include medical or mental health records in its use of force documentation.

- There was no documentation about any collateral effects of the chemicals on other incarcerated persons, potential evacuation of adjacent cells, or how any impacts on others would be addressed.

- Given that these are planned responses, corrections personnel should consult with medical staff to ensure the incarcerated person does not have any medical condition that would make them particularly vulnerable to chemical agents (such as asthma, for example). If this consultation occurred, it was not included in the documentation of these incidents.

> RECOMMENDATION 15: The Sheriff's Office should develop additional guidelines around planned uses of force to ensure that personnel document all relevant factors before deciding to deploy chemical agents to facilitate removing an individual from a cell for mental health-related reasons.

We also saw very little documentation of collaboration between medical, mental health, and corrections staff to address the situations presented. As the Sheriff's Office continues to establish relationships with its new medical provider, it should include those personnel in discussions about how these challenging scenarios are handled.

> RECOMMENDATION 16: Jail leadership should include its medical and mental health providers in an after-action review of incidents in which officers use chemical agents or other force to assist with administration of medication or facilitate a mental health-related housing move.

We noted during these incidents that correctional officers also were obviously impacted by the chemical agents that they deployed. We recommend that all personnel responding in these situations wear appropriate protective masks.

> RECOMMENDATION 17: The Sheriff's Office should make available appropriate protective gear so that officers who participate in planned uses of force are protected from the effects of chemical agents.

Finally, we recommend that the Sheriff's Office reconsider the use of Pepperball launchers as a means of introducing chemical agents into a

cell. Their use as an impact weapon in these scenarios – where the individual is passively non-compliant and does not currently pose an assault risk – should be prohibited. But even when used solely as a dispersal mechanism for chemical agents, we see a number of potential downsides of their use on severely mentally ill individuals. We encourage the Sheriff's Office to explore other more effective and potentially less harmful ways to accomplish the objective.

> RECOMMENDATION 18: The Sheriff's Office should reconsider its use of Pepperball launchers for cell extractions, particularly those involving individuals who are passively non-compliant.

Neck Restraints

In one use of force case that was also the subject of a written complaint, a patrol deputy used a "head lock" to control an assaultive subject. The deputy was attempting to detain the man for a probation violation when the man threatened him with a large heavy metal object. The deputy engaged the man, with the assistance of officers from a local police department, and ultimately grabbed the subject's head and pinned it against his body in what was described as a "head lock." The deputy took the subject to the ground while maintaining the head lock hold, and the other officers were able to move in and place handcuffs on the subject.

The deputy did not activate his body-worn camera until after this use of force. Neither the reviewing supervisor nor the IA investigator addressed this issue.[31]

Because this incident was the subject of a complaint, it was routed to and reviewed by Internal Affairs, which deemed the force to be "proper, lawful and justified to effect an arrest based on the level of resistance presented."

---

[31] While we recommend elsewhere that the Sheriff's Office revise its Body-Worn Camera policy to more broadly require personnel to activate their cameras, the circumstances here suggest the deputy should have activated his camera, even under current policy requirements.

California's Assembly Bill 1196[32] was enacted by the state legislature in 2020, following the murder of George Floyd. It prohibits any state or local law enforcement agency from authorizing the use of a "carotid restraint" or "choke hold" by a peace officer. Carotid restraint is defined by the statute to mean "a vascular neck restraint or any similar restraint, hold, or other defensive tactic in which pressure is applied to the sides of a person's neck that involves a substantial risk of restricting blood flow and may render the person unconscious in order to subdue or control the person." Choke hold is defined as "any defensive tactic or force option in which direct pressure is applied to a person's trachea or windpipe."

Despite the passage of this law and unlike many other law enforcement agencies, current Sheriff's Office policies do not explicitly prohibit the use of the carotid restraint control hold and chokeholds. This policy restriction should be added as soon as practicable.

Beyond the prohibition of these two particular neck restraints addressed in state law, we suggest that the Sheriff's Office prohibit all types of neck holds or any type of pressure applied to an individual's neck, including "head locks." The inherent dangers of any type of force applied to the neck outweigh the overall effectiveness of this type of restraint. And while we understand there is a distinction between different types of head and neck restraints, it is too easy for a deputy intending to apply a "head lock" to inadvertently apply a prohibited "choke hold" particularly in the volatile environment of a force encounter.

> RECOMMENDATION 19: The Sheriff's Office should prohibit the use of choke holds and carotid control holds, as required by California law, and should generally prohibit all restraints that involve applying pressure to an individual's neck, with an exception for those situations in which deadly force is justified.

[32] Codified at Government Code Section 7286.5.

Other Policy Issues

We limited our discussion of policy issues to those that were raised directly by the force incidents we reviewed. But the number of recommended revisions we identified in those policies we reviewed leads us to find that a broader review of the Sheriff's Office use of force policy may be beneficial. The goal would be to identify and remedy inconsistencies between policy and practice, as well as to ensure that policies comply with best practices and state laws across a range of subjects.

For example, in a number of cases we reviewed, the only use of force was the drawing of or pointing a firearm. These circumstances suggest that the Sheriff's Office practice is to report the pointing a firearm as a use of force. But existing policy does not make that clear (it defines force as the "application of … a weapon to another person" and later describes the display of a firearm as a "potential application of force"). These types of inconsistencies should be clarified and corrected.

We noted that the use of force policy also did not clearly define the types or levels of resistance that deputies may face. While use of force is based on a deputy's own, reasonable evaluation of the resistance facing him/her, it can be helpful to clarify the levels of resistance (and which force tools might be most appropriate or legal to overcome it) within its policy. We recommend that the Sheriff's Office add definitions of resistance types and clarify the legal thresholds for use of force tools (we also discussed these types of policy modifications in our Taser, impact weapon, and chemical agents sections above).

We noted several further refinements that would provide deputies additional guidance and bring the Sheriff's Office's policies into compliance with legal standards and best practices. We recommend that the Sheriff's Office work with the OIG on to identify and implement additional policy revisions.

> RECOMMENDATION 20: The Sheriff's Office should work with the OIG to review its use of force policies, and revise policies to eliminate inconsistencies and align with best practices.

Community Outreach Efforts

A critical part of the OIG's scope of work is to participate in community outreach efforts, to both educate the community about the work of oversight in Santa Cruz County and to hear from the community about current law enforcement concerns. In our first year, we engaged with the community in a variety of ways. We have appreciated community members' willingness to meet with us and share their concerns and have used these conversations to guide our interaction with the Sheriff's Office.

As part of its initial launch, the OIG held two community listening sessions: A virtual meeting on June 22, 2023, to explain the OIG's oversight role and to offer community members an opportunity to share their experiences and any concerns involving the Sheriff's Office, and an in-person session at the Santa Cruz County Building on June 28, 2023, to again introduce the OIG team members and to listen to community members who attended (there was also an option to attend virtually). That same day, the OIG team met with community members and representatives from organizations that had advocated for the adoption of the county ordinance to establish the OIG. The OIG team also met with the Sheriff, his command staff and representatives of the Deputy Sheriff's Association. Finally, the team met with members of the Board of Supervisors and other County stakeholders.

We also began working with graphic designers from the County's Information Services Department to develop a website that serves both to inform the public about the OIG's mission and role and to provide a means for individuals to reach out to us with their questions and concerns. The website is available in ten languages including Spanish, Chinese, and Arabic.

Throughout the year, we have connected with dozens of people who initially reached out to us via the website. Many of these individuals wanted assistance in filing their complaints or to learn more about the

Sheriff's internal investigation processes and our role in it. We talked frequently with these complainants by phone and on one occasion, met complainants in person.

During the year, the OIG team also did more targeted outreach with groups who have been active leaders in criminal justice reform efforts. We met with Santa Cruz chapter members of the ACLU, NAACP, and NAMI. The OIG team also met with staff from Motivating Individual Leadership for Public Advancement (MILPA) in Watsonville, the Santa Cruz County Public Defender's Office (its Santa Cruz and Watsonville satellite), Monarch Services, and the Santa Cruz County Justice and Gender Commission chairperson. The OIG team also talked with family members of inmates, a religious leader who provides faith services within the jail, and civil rights attorneys.

Throughout these conversations, the OIG team heard from community members on a range of topics. One organization spoke positively of its past collaborations with the Sheriff's Office that had lapsed due to changes in the organization's leadership. The organization expressed interest in resuming communication and pursuing partnership opportunities with the Sheriff's Office. We conveyed this to the Sheriff' and he welcomed that renewed engagement. Another organization that provides services inside the jail reported positively about its working relationship and communication with Sheriff's command staff.

In addition to concerns raised about a number of high-profile in-custody deaths that occurred in the several years preceding the establishment of the OIG,[33] the majority of issues raised by community members during our engagement and outreach efforts were related to conditions in the jails. Those include: concerns about an increase of double and triple bunking and bunk beds being placed in day rooms at the jail; the use of solitary confinement, particularly for those with mental illness; the status of jail maintenance projects such as the repair of emergency call buttons and non-functioning intercom systems; questions about the status of promised

[33]See e.g., Santa Cruz County Grand Jury Report, *Justice in the Jail (June 17, 2021)* which describes inmate deaths, violence, equipment failures, and criminal convictions of deputies that occurred in the Main Jail between 2017 and 2020 and recommends adoption of a Sheriffs Oversight Board or Inspector General. *https://www.santacruzcountyca.gov/Portals/0/County/GrandJury/GJ2021_final/3_JailJustice_Report.pdf*

updates to the classification system used in custody facilities; and the quality of medical and mental health care for those in the jail facilities.

They also addressed concerns about limitations on visiting, emphasized the desire that Blaine Street (the woman's facility) remain open permanently,[34] and advocated for contact visits between incarcerated inmates and their children at Blaine Street and Rountree.

We spoke with Sheriff's Office leadership about each of these concerns to better understand the history, from its perspective, and to get updates on the status of particular recommendations and reform efforts. Many of the concerns center on facilities issues. The Sheriff stressed to us that the jails are maintained by the General Services Division, which is outside his span of control. Complaints about plumbing and antiquated facilities naturally fall to the Sheriff's Office, and it is a source of regular frustration that there is little the Sheriff can directly do to make corrections.

That said, one big area of concern – emergency call buttons, intercoms, and door locks – are to be addressed by a $5 million upgrade to the jail control systems set to be completed by the time this report is published.

Another – the status of the jail's classification system – is likewise an issue the Sheriff's Office has addressed. An objective classification system is essential for daily management of a jail population, to keep both staff and incarcerated persons safe. The system relies on a set of well-defined characteristics (such as severity of charge, history of violence during prior incarcerations, and prior convictions) to assign each individual a security level that will guide decisions around where to house them and what types of programming are available.

In 2013, Santa Cruz County Jail implemented a validated objective classification system based on the National Institute of Corrections model jail classification system, though the circumstances surrounding the inmate assaults discussed below suggest the system was not always functioning optimally. Because a jail's population and needs change over time, a classification system needs to be closely monitored and periodically audited and re-validated.

---

[34] In 2021, the Sheriff's Office closed Blaine Street and a housing unit at Rountree due to an inability to staff the facility. It reopened Blaine Street on May 19, 2023.

Recognizing this, the Sheriff's Office commissioned the creators of the objective jail classification system to return to the County to perform an audit last year. The auditors evaluated the system overall by assessing existing policies, performing a statistical analysis, and conducting an onsite visit to observe the classification and reclassification processes. Their report concluded that the Sheriff's jail classification system meets industry standards, while also making several recommendations for potential improvements. The Sheriff's Office shared with us internal documentation demonstrating completion of each of these recommendations.

Responses to many other concerns – lack of out-of-cell time or use of "solitary" and limitations on visiting – ultimately circle back to the Sheriff's pernicious staffing challenges or issues about the aging Main Jail facility. These bigger issues are, to some extent, outside of the Sheriff's control or ability to quickly address. Working with those constraints, however, the expectation is that the Sheriff's Office do all it can to minimize the impact they have on the lives of incarcerated persons and their families.

On the visiting front, Corrections acquired a new body scanner that will soon be installed at Rountree to facilitate in-person visits at that jail. In September 2024, in-person visits resumed at the Blaine Street facility, and the Sheriff's Office has committed to keeping Blaine Street open, with the ability to provide more flexible visiting options for incarcerated women.

We heard from community that the use of "solitary confinement" is a significant concern. The Sheriff's Office does not use the term "solitary confinement." Rather, policy defines incarcerated persons who need to be separated from others as "Special Management Inmates." This term encompasses two other definitions – "Administrative Separation"[35] and "Protective Custody" – that are meant to describe different reasons for an individual's need to be kept apart from others. Administrative Separation is defined as:

[35] Current Corrections Policy still refers to "Administrative Segregation," though the term currently employed by all the relevant forms and written protocols refers to "Administrative Separation."

> *[N]on-punitive placement for people who have threatened or assaulted staff and/or incarcerated people, behavior not conducive to the least restrictive housing, potential escape threat, incarcerated people who have sex charges and refuse to sign protective custody paperwork, Prison Rape Elimination Act (PREA) violation or a gang member or former gang member who needs to be interviewed by Classification for proper housing.*

"Protective Custody" hinges not on the incarcerated person's conduct, but on the potential reaction of others and the need to keep the person safe from others who may target them.

With either status, the result is increased time spent alone in one's cell, not intended as a matter of punishment, but as a practical reality given the increased staffing demands of guarding these individuals and the limited space availability for having people out of their cells one at a time.

Given these realities, it becomes incumbent on Corrections staff to be thoughtful about who is placed on Administrative Separation ("AdSep") and how long they remain classified in this way. Both under-classifying and over-classifying carry obvious significant downsides, and we acknowledge that the balancing act is not a simple task.

To that end and in response to recommendations made in the 2023 audit of the classification system, Corrections has recently revised its processes surrounding Administrative Separation, to include new forms that clearly lay out the reason for assigning someone to AdSep and establish a more extensive review process to evaluate appropriate placement. Generally within 24 hours of being placed in Administrative Separation, jail management meets with representatives from Classification, Medical, and Mental Health to review the AdSep placement. The same group meets weekly to discuss the status of each individual designated as AdSep, with the goal of ensuring that the designation is being used appropriately and only for those who most warrant it. Importantly, after this meeting, the individual assigned to AdSep receives a document that describes what specific behavior is needed before the AdSep placement can be changed. We will continue to check in with Corrections leadership regarding the status of these weekly review meetings and their success at accomplishing this objective.

Review of In-Custody Deaths

One of the most prominent concerns we heard in meetings with some community members and organizations surrounded the status of several Sheriffs' investigations into in-custody assaults and deaths that preceded the establishment of the OIG. They talked about the in-custody deaths of Tamario Smith,[36] German Carrillo,[37] Mark Beckner[38], and the assault of

---

[36] On May 10, 2020, Santa Cruz County correctional officers found 21-year-old inmate Tamario Smith unresponsive inside his cell. According to the Sheriff Office's press release, Smith died of acute water intoxication, due to the over-consumption of water in a short period of time, a situation compounded by underlying mental health issues. https://shf.santacruzcountyca.gov/Portals/1/Tamario%20Smith%20Cause%20of%20Death.pdf; see also Santa Cruz County Grand Jury Report, page 10. June 17, 2021. *https://www.santacruzcountyca.gov/Portals/0/County/GrandJury/GJ2021_final/3_Jail Justice_Report.pdf; and Smith* v. *County of Santa Cruz et al*. US District Court for the Northern District of California Case No. 5:2021-cv-00421 https://dockets.justia.com/docket/california/candce/5:2021cv00421/372115

[37] On October 13, 2019, 24-year-old inmate German Carrillo was murdered by his two cellmates inside his Santa Cruz County jail cell, and correctional officers did not discover his body for at least 36 hours. See Santa Cruz County Grand Jury Report, pages 9-10. June 17, 2021. *Justice in the Jail. https://www.santacruzcountyca.gov/Portals/0/County/GrandJury/GJ2021_final/3_JailJustice_Report.pdf*; see also Lawsuit Over In-Custody Killing of German Carrillo Advances, March 16, 2021, *The Good Times* https://www.goodtimes.sc/lawsuit-over-in-custody-killing-german-carrillo-advances/; and *Carrillo v. County of Santa Cruz* US District Court for the Northern District of California Case No. 5: 2020cv06973. https://dockets.justia.com/docket/california/candce/5:2020cv06973/366933

[38] On November 1, 2022, Santa Cruz County correctional officers found inmate Mark Beckner unresponsive in an observation cell in the Santa Cruz County jail. The County Coroner determined during an autopsy that Mr. Beckner had died due to a splanchnic aneurysm. A federal district court lawsuit against the Santa Cruz Sheriff's Office and County alleges that after Mark Beckner was booked into the jail and alerted staff that he was withdrawing from opioids; correction officers and medical staff failed to properly monitor his deteriorating medical condition and transfer him to a hospital. See *Beckner* v. *County of Santa Cruz et al* US District Court for the Northern District of California Case No.23 cv-05032-BLE

Tyler Luttrell.[39] They raised concerns about the issues they saw as having played a role in those incidents. They pointed to the jail's classification system, non-functioning emergency on-call buttons and intercoms, and what appeared to be significant lapses in inmate protection and monitoring, and wondered about the role of correction officers and medical providers in contributing to these deaths. They sought an analysis of system failures that permitted two of German Carrillo's cellmates to kill him and prevented deputies from discovering his deceased body in his cell for over 36 hours. They questioned the appropriateness of placing individuals with mental illness such as Tamario Smith in solitary confinement. They complained about the quality of medical and mental health care that the then medical services contractor provided and pointed to the in-custody deaths of Tamario Smith and Mark Beckner as examples of inadequate care. They emphasized that mental health and medical staff are not sufficiently involved in monitoring suicidal or detoxing inmates who are placed in safety cells and wanted to know what changes in protocols had been implemented to address the past in-custody deaths.

Several community members expressed distrust in the Sheriff's ability to internally investigate these incidents and pointed out that the public had yet to learn about the results of any internal investigative review the Sheriff may have conducted about these incidents including whether these investigations resulted in officer discipline and any changes in jail policies or procedures.

---

https://dockets.justia.com/docket/california/candce/5:2023cv05032/418863; see also https://www.santacruzsentinel.com/2022/11/09/cause-released-in-santa-cruz-county-inmate-death/; https://lookout.co/santa-cruz-county-sheriffs-office-inmate-death-main-jail/.

[39]Tyler Lutrell alleged in a federal district court civil lawsuit against the Santa Cruz Sheriff's Office and County that he was placed in a cell with two known violent felons who sexually assaulted him after he notified deputies of his cellmates' escalating threats. See *Luttrell v. Hart et al.* US District Court for the Northern District of California Case No. 5:2019cv07300 https://law.justia.com/cases/federal/district-courts/california/candce/5:2019cv07300/351121/45/; see also Santa Cruz County Grand Jury Report, pages 8. June 17, 2021. *Justice in the Jail. https://www.santacruzcountyca.gov/Portals/0/County/GrandJury/GJ2021_final/3_Jail Justice_Report.pdf.*

Our scope of work did not include specifically reviewing or reporting on these cases, all of which pre-date the OIG's creation and have been or currently are the subject of lawsuits against the County and the Sheriff's Office. The refrain we heard from members of the public is that they want the "full story" of these incidents. The facts as reported publicly lead to understandable questions about how such events could occur and what the Sheriff's Office is doing to ensure they never happen again.

While the County has been focused on the litigation of these cases, the public has not forgotten about them. It will be difficult for the Sheriff's Office to move forward and establish trust with some segments of the community until there has been a fully transparent accounting of these cases and a comprehensive corrective action plan for how to address any systems deficiencies these incidents revealed.

We understand that the facts and causation issues surrounding these events are disputed and that the Sheriff's Office account of the assault and deaths would include evidence and details that would paint a picture of the events that is both more nuanced and more comprehensive than what has been publicly released to date. We recommend that once litigation is concluded on each case, the Sheriff's Office provide a public report detailing the critical facts, identifying performance, structural, or other issues that were not optimal, and setting out any remedial plan for addressing the deficiencies identified.[40] Alternatively, the County could specifically engage the OIG to report on these incidents.

> RECOMMENDATION 21: The Sheriff's Office should provide a fully transparent accounting of the three high-profile in-custody deaths and one sexual assault that occurred between 2018 and 2022, following the completion of litigation of each case, including factual details and a comprehensive corrective action plan to address the performance or systems deficiencies identified.

Going forward, we also are committed to in-depth review of all in-custody deaths that occur during our tenure as the OIG. In this past year, there

[40] We note that Senate Bill 519 (codified at Cal. Penal Code Section 832.10) provides for public access to investigative reports and certain other records related to in-custody deaths.

has been one in-custody death, a 42-year-old man who died by suicide in August 2023. A member of the OIG team was notified of this incident within a day of its occurrence. That notification included a detailed briefing on all of the facts known to the Sheriff's Office at the time. We had a follow-up conversation with Sheriff's Office leadership 10 days later, as more information had been gathered during the Sheriff's Office investigation.

The Sheriff's Office conducted an in-custody death review of this incident less than a month after the death. The OIG attended this meeting in person. We made the following observations of the process as it played out with respect to this suicide:

- All the necessary and appropriate individuals convened to review the incident: Sheriff's Office command staff, detectives who had investigated the circumstances, investigative detectives, and administrator and one of the nurses from the contractor who provided medical and mental health services at the jail at the time, a County Health administrator, the medical examiner who performed the autopsy, and a member of County Counsel's office.

- Sheriff's Office detectives who had investigated the in-custody suicide provided a detailed presentation about the incident. They were knowledgeable and able to respond to all questions presented. The incident was thoroughly investigated, including a timeline of the individual's housing assignments and moves, details of his interactions with Corrections personnel, and a documented review of all available video.

- The atmosphere of the meeting was open and collaborative. Participants freely asked questions and considered potential outcomes without finger-pointing or defensiveness. Discussion focused not only on the individual incident but looked more broadly at whether protocols or procedures could be enhanced to prevent a similar incident from happening in the future.

We appreciated the notification, briefing, and invitation to attend the in-custody death review. We saw this as a positive gesture by the Sheriff's Office to demonstrate its support of our work at the very outset of our engagement. As with any in-custody death, this was a tragic incident, but

the resulting straightforward investigation did not involve the complexities of those earlier in-custody deaths cited by community members during our engagement efforts.

We will continue to attend in-custody death reviews and, where appropriate, expand our role to include further review of reports and evidence, and make recommendations to ensure the Sheriff's Office conducts a robust investigation and review of all in-custody deaths.

OIG's Communications with Incarcerated Persons

Throughout the first year of our work, the OIG received hundreds of emails and phone calls from incarcerated persons or their family members[41] regarding specific complaints or requests. The majority of these were generated by a handful of individuals who contacted us repeatedly. Many of these contacts related to medical care – either questions about the quality of care or requests to expedite an individual's access to medical appointments. Others were complaints about visiting, the irregularities in out-of-cell time, concerns about the conditions of the jails or the quality of the water and food, specific complaints about disciplinary measures imposed on an incarcerated person, or changes made to the way legal mail is handled. One wrote about a specific use of force incident that had been investigated by the Sheriff's Office (an investigation we reviewed and found to have been concluded appropriately).

The OIG team reached out to the Sheriff's Office executive who oversees the Corrections Bureau to learn more about the circumstances behind each question, complaint, or grievance. He was unfailingly responsive. He often knew about the individual and his complaint before hearing from us. And in the unusual case where he did not, he quickly researched the situation and provided a substantive response to the concern. For those contacts that involved questions about access to or the quality of medical

[41] Family members most often reached out via the OIG website to convey concerns about their loved ones in custody. Often, family members would forward to us emails they received from the person in custody. Recently, those in custody have been able to reach out via the jail's email communication system, after we worked through a number of technical challenges we encountered with the technology at the outset of our engagement.

care, the Chief timely requested a medical visit for the individual and responded to us regarding the timing of the care provided.

Some of the cases we inquired about required some follow-up work by Corrections or led to further questions about the systems and processes employed. For example, we learned about the auditing capabilities for the video visiting technology, the revised process for reviewing individuals in administrative separation, and rules and regulations around visiting and the disciplinary system.

Where individuals had submitted grievances through the jail's internal grievance system,[42] the Chief provided copies of grievances so we could see the Sheriff's Office's documented response to the individual. This provided us a window into the grievance system. In general, the Sheriff's Office responses are timely, courteous, and appropriate. And we note that the electronic grievance system seems to be working well, in that many of the issues around grievances we have seen over our years working around various jail systems have often centered on access to paper forms and the ease with which these can get lost or mis-routed. The tablet system eliminates these concerns in many important ways: Individuals have easy access to the form via the tablet and can seamlessly submit their grievances. There can be no question about when a grievance is submitted, and issues with a lost form. The electronic form can quickly be routed to the appropriate responder (medical, for example). Supervisors are able to provide a response back to the grievant on the tablet system, and the individual can easily submit an appeal to that response.

While we were generally impressed by the grievance system, we also realize we had a limited window, viewing just those grievances involving individuals who also reached out to the OIG. In the coming year, we will continue to monitor the jail's grievance system and will consider a more thorough audit of the system.

As an outcome of our communications with incarcerated persons and their loved ones, we were gratified to be able to help some individuals in small

[42] Incarcerated persons can submit written grievances, either via a paper form or – more often – electronically via the tablet system. The Sheriff's Office is required to provide formal responses, and the grievant can appeal that response up to the level of Chief of Corrections.

but meaningful ways, often simply by providing a better understanding of the processes at work or through the simple reassurance that their husband or son had, since their call to us, seen a doctor or nurse. We also were appreciative of the communications, questions, and complaints we received from incarcerated persons. Many of these led us to ask questions and ultimately learn much about jail operations, including its challenges and leadership's efforts to address those. We found this to be an invaluable part of our introduction to the work of the Sheriff's Office this past year.

Moving Forward

As we begin our second year as the OIG for Santa Cruz County, we look forward to a continued relationship with engaged members of the community, and to further collaboration with the Sheriff's Office. Indeed, much of our work this first year has led us to a greater understanding of where there is room to grow and expand our role.

We heard from some community groups a desire for more frequent formal communications from the OIG. We acknowledge that we spent more time this past year *listening* and less time *talking*. We commit to providing more periodic reporting in the coming year, and intend to submit quarterly reports outlining our activities, findings, and any recommendations made.

We also look forward following up on recommendations we make in this report – working with the Sheriff's Office on revising its use of force policies and developing a more formal mechanism for reviewing force incidents. And we will further engage with the Sheriff's Office on its required reporting of any uses of weapons defined as "military equipment."[43]

We'll continue to look at administrative investigations into complaints that come through the OIG as well as those generated internally by the Sheriff's Office. And we will look at ways to expand our evaluation of the Grievance system for incarcerated persons.

Finally, we look forward to engaging with the Board of Supervisors and the public on issues addressed in this report, with an eye toward hearing their priorities for our future work.

---

[43] Assembly Bill 481 (California Government Code section 7072(a)) requires that law enforcement agencies report to the jurisdiction's governing body on their use of military equipment in an annual report.

Recommendations

1: The Sheriff's Office should work with the OIG to improve the scope and format of administrative investigative reports to ensure they are consistently detailed and inclusive and thoroughly address all performance issues that emerge.

2: The Sheriff's Office should revise its Body-Worn Camera policy to require personnel to activate their cameras at the outset of any response to a call for service or investigative or enforcement activity, prior to initiating the actual contact.

3: The Sheriff's Office should, to the extent permissible by law, personalize its notification letters to complainants by providing some details of the steps taken during the investigation and a generalized description of the investigation, along with making some effort to recognize the complainant's perspective.

4: The Sheriff's Office should amend policy to require that all deputies detail in writing the circumstances surrounding their use(s) of force to include any efforts to de-escalate prior to the use of force; and if no de-escalation techniques were deployed, an explanation for why none were deployed.

5: The Sheriff's Office force review process should explicitly consider whether de-escalation techniques were attempted prior to moving to force options and if not, determine whether it would have been appropriate to consider them.

6: The Sheriff's Office should require uninvolved supervisors to thoroughly review and evaluate all uses of force and document their actions, findings, and conclusions in a stand-alone use of force report that is separate from the incident report.

7: Sergeants' use of force memos should be routed to command staff for review, approval, and any further action.

8: The Sheriff's Office should ensure that supervisors reviewing the use of force interview the person on whom force was used or document the reason for not conducting an interview.

9: The Sheriff's Office should provide supervisors additional training on best practices for interviewing subjects upon whom force is used.

10: The Sheriff's Office should revise its policy to prohibit supervisors from interviewing subjects of uses of force in the presence of deputies or officers who used force.

11: The Sheriff's Office should develop a formal mechanism for documentation of its internal use of force review process at all levels.

12: The Sheriff's Office should update its policy to align with case law regarding use of the Taser, limiting the use of the Taser to subjects who are displaying assaultive resistance.

13: The Sheriff's Office should update its Operations policy to align with the Corrections policy, and to meet legal standards for use of the device generally and in drive-stun mode.

14: The Sheriff's Office should reinforce its requirement to provide a warning regarding Taser use and ensure appropriate remediation when officers do not effectively document a reason for not giving a warning.

15: The Sheriff's Office should develop additional guidelines around planned uses of force to ensure that personnel document all relevant factors before deciding to deploy chemical agents to facilitate removing an individual from a cell for mental health-related reasons.

16: Jail leadership should include its medical and mental health providers in an after-action review of incidents in which officers use chemical agents or other force to assist with administration of medication or facilitate a mental health-related housing move.

17: The Sheriff's Office should make available appropriate protective gear so that officers who participate in planned uses of force are protected from the effects of chemical agents.

18: The Sheriff's Office should reconsider its use of Pepperball launchers for cell extractions, particularly those involving individuals who are passively non-compliant.

19: The Sheriff's Office should prohibit the use of choke holds and carotid control holds, as required by California law, and should generally prohibit all restraints that involve applying pressure to an individual's neck, with an exception for those situations in which deadly force is justified.

20: The Sheriff's Office should work with the OIG to review its use of force policies, and revise policies to eliminate inconsistencies and align with best practices.

21: The Sheriff's Office should provide a fully transparent accounting of the three high-profile in-custody deaths and one sexual assault that occurred between 2018 and 2022, following the completion of litigation of each case, including factual details and a comprehensive corrective action plan to address the performance or systems deficiencies identified.