

1 PETER J. ELIASBERG (SB# 189110)
peliasberg@aclusocal.org
2 MELISSA CAMACHO (SB# 264024)
mcamacho@acluscal.org
3 **ACLU FOUNDATION OF**
4 **SOUTHERN CALIFORNIA**
1313 W. 8th Street
5 Los Angeles, CA 90017
Phone: (213) 977-9500
6 Fax: (213) 977-5299
7

CORENE KENDRICK (SB# 226642)
ckendrick@aclu.org
MARISOL DOMINGUEZ-RUIZ
(SB# 345416)
mdominguez-ruiz@aclu.org
ACLU NATIONAL PRISON
PROJECT
39 Drumm St.
San Francisco, CA 94111
Phone: (202) 393-4930
Fax: (202) 393-4931

8 NICOLAS MORGAN (SB# 166441)
nicolasmorgan@paulhastings.com
9 STEPHEN TURANCHIK
(SB# 248548)
10 sturanchik@paulhastings.com
PAUL HASTINGS LLP
11 515 South Flower Street, 25th Floor
Los Angeles, CA 90071-2228
12 Phone: (213) 683-6000
13 Fax: (213) 627-0705

14 *Attorneys for Plaintiffs*

15
16 **UNITED STATES DISTRICT COURT**
CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

17 ALEX ROSAS and JONATHAN
18 GOODWIN on behalf of themselves
and of those similarly situated,

19
20 Plaintiffs,

21 vs.

22 Robert Luna, Sheriff of Los Angeles
County, in his official capacity,

23
24 Defendant.

Case No. CV 12-00428 DDP (MRW)

DECLARATION OF
STEPHEN SINCLAIR

1 I, Stephen Sinclair, declare as follows:

2 **I. ASSIGNMENT AND QUALIFICATIONS**

3 1. I have been retained by Plaintiffs' Counsel to provide expert opinions on
4 the implementation of the 2014 settlement agreement in *Rosas v. Scott*, now *Rosas v.*
5 *Luna*. Specifically, I was asked to evaluate the Los Angeles Sheriff's Department
6 (LASD) and its ongoing use of head strikes against detainees, de-escalation policies
7 and training to avoid unnecessary uses of force, and the use of the WRAP restraint
8 device.¹ I have been retained at \$250 an hour. The matters set forth are my
9 independent opinions, true and correct of my personal and professional knowledge. If
10 called as a witness to testify, I could and would testify competently thereto.

11 2. My experience in adult corrections includes the 32 years I spent as an
12 employee of the Washington State Department of Corrections ("WADOC"). I began
13 as a Correctional Officer at the Washington State Penitentiary in September 1988 and
14 concluded my career as the agency Secretary. I was appointed Secretary of WADOC
15 in April 2017, confirmed by the Washington State Senate in January 2018, and served
16 until May 2021.

17 3. During my career, I have led numerous significant changes within
18 WADOC, many, but not all, of which are highlighted in my Curriculum Vitae
19 (**Attachment A**). These experiences taught me that creating change and new policy
20 is rarely the most challenging part of a transformation. In my experience, the most
21 difficult part is implementing those changes and sustaining outcomes in the future.
22 Through these experiences, I possess substantial knowledge and experience in
23 implementing change in carceral settings.

24 4. In addition to my work experience, I possess a Master of Public
25 Administration degree from the University of Washington; I have attended thousands

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27 ¹ The WRAP Device includes a locking shoulder harness, a belt to handcuff a
28 person behind their back, and leg restraints so that the custody officers can carry the
person or put them in a cart for transport; see https://saferestrains.com/?page_id=107.

1 of hours of training sponsored by WADOC, the Washington State Criminal Justice
2 Training Commission, the Washington State Patrol Investigator Academy,
3 Washington State Tactical Officers Association, and the Walla Walla Police
4 Department. My experience includes training and hours worked as a Reserve Police
5 Officer for the Walla Walla Police Department.

6 5. Since my retirement in May 2021, I have remained involved in the
7 corrections field, researching, analyzing, and providing expert opinions in cases
8 related to confinement in city, county, and state-operated confinement facilities. In
9 summary, I have spent much of the past 34 years working with, thinking about, and
10 analyzing the field of adult corrections on topics to include, but not limited to: the use
11 of force, the use of administrative segregation and restrictive housing, prison
12 regulations, correctional operations and the policies required to operate a safe and
13 humane corrections systems / facilities.

14 6. Specific to my use of force experience, I spent 11 years of my WADOC
15 career with the Special Emergency Response Team (SERT) as a team member and
16 eventually as the leader of an emergency response team. The primary mission of the
17 SERT was to provide specialized responses to hostage takings, high-security escorts,
18 and the application of force when required. Having received use-of-force training well
19 beyond that of most other corrections staff, SERT members, including myself, were
20 often called to lead and participate in pre-planned uses of force or immediate
21 responses to significant emergencies in progress. Much of the training for SERT that
22 I received was oriented toward potentially using lethal force and when it is appropriate
23 and inappropriate to use potentially lethal force against an incarcerated person. The
24 cornerstone of the use of possibly deadly force is the requirement that all other
25 reasonable alternatives must be exhausted before using deadly force, time and
26 circumstances permitting. As such, SERT also received substantial training on all
27 levels of force, including verbal tactics or de-escalation techniques, defensive tactics
28 (a.k.a. hands on techniques), and less lethal techniques. Through these experiences, I

1 have learned that most potential incidents can be and are resolved by properly
2 applying the lowest levels of force, *e.g.*, presence (a.k.a., a show of force)² and de-
3 escalation techniques.

4 7. Throughout my correctional career as a Sergeant, Lieutenant, Captain,
5 Critical Incident Reviewer,³ Associate Superintendent (Warden), and Superintendent,
6 I have reviewed a substantial number of uses of force incidents to determine policy
7 compliance. These reviews sometimes resulted in retraining and discipline for the
8 involved staff. While staff discipline is the least desirable outcome of these situations,
9 it is an essential element of maintaining a professional workforce and the agency's
10 integrity. As Assistant Director of Prisons and Director of Prisons, I had responsibility
11 for reviewing and contributing to the use of force policies. As Secretary, I was
12 responsible for all agency policies, including policies governing use of force.

13 8. I have served four years as a Commissioner of the Washington State
14 Criminal Justice Training Commission (2012-2021),⁴ overseeing curriculum
15 development for basic academies for Law Enforcement and Corrections and
16 certification standards. I also spent four years as a member of the Washington State
17 Sentencing Guidelines Commission (2017-2022).⁵ I am an active member of the
18 Correctional Leaders Association (CLA) and the American Correctional Association
19 (ACA).⁶ I received the 2020 Tom Clements Award for Innovation from CLA, and
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22 ² “Presence,” also known as “show of force” is a tactic where the escalation of
23 an incident is avoided. At the same time, additional staff can respond on the scene and
24 demonstrate to the potential aggressor that aggression is futile based on the
25 disproportionate number of responders.

26 ³ A Critical Incident Reviewer is an outside investigator who reviews
27 significant situations *e.g.* use of lethal force, escape, disturbances, etc., by other staff.

28 ⁴ See Criminal Justice Training Commission - <https://cjtc.wa.gov>

⁵ See Sentencing Guidelines Commission - <https://sgc.wa.gov/sentencing-guidelines-commission/sgc-members>

⁶ See Correctional Leaders Association - <https://www.correctionalleaders.com>
& American Correction Association - <https://www.aca.org>

1 was recognized by Washington Governor Christine Gregoire in 2009 for excellence
2 in management.

3 9. Concerning the *Rosas* settlement agreement, I have reviewed documents
4 related to the implementation of the settlement agreement between LASD and the
5 Plaintiffs. I also reviewed recent videos of uses of force and use of force report
6 packets. A complete list of all materials that I have reviewed is at **Attachment B.**

7 **II. SETTLEMENT AGREEMENT / IMPLEMENTATION PLAN**

8 **OVERVIEW**

9 10. The settlement agreement has been in effect since September 2014. Now
10 almost nine years later, there appears to be ongoing failures in critical areas of the
11 agreement, that directly correlate to unnecessary and excessive uses of force. Based
12 on my experience with implementing significant change in an equally large
13 correctional agency, I am perplexed by this fact.⁷ The fact that these failures are
14 directly related to the health and safety of the detainees in the custody of LASD, which
15 has a duty to protect the detainees in their custody and care, and of LASD staff, makes
16 it all the more critical that LASD address them without further delays. Yet, after
17 reviewing relevant documents and watching multiple videos provided by Defendants,
18 it is my opinion that excessive, and unnecessary force is still being used far too often
19 by LASD deputies in the jail.

20 11. The settlement agreement is monitored by three court-appointed
21 monitors and has been since its inception. The court monitors developed an
22 implementation plan filed with the court in April 2015 that defined “mandatory” items

23
24 ⁷ The Washington State Department of Corrections (WADOC) is a large
25 organization with many employees and a complex system of facilities and programs.
26 As of 2021, the department employed over 8,500 people, including correctional
27 officers, administrators, and support staff. The WADOC operates 12 state prisons,
28 which house approximately 16,000 inmates, 12 work release facilities, and several
other facilities and programs. In addition to managing the state's prison system, the
DOC is also responsible for supervising released inmates and providing them with
access to reentry services and programs. See <https://www.doc.wa.gov/>

1 LASD must comply with, and that required policy and other changes necessary to
2 achieve compliance. Dkt. 133-2. Each item had an intended completion date of June
3 30, 2015, with some extending into 2016 to accommodate staff training. The monitors
4 provide the court with regular reports on compliance by LASD, the latest available
5 for my review was July 1, 2021, to June 30, 2022 (11th Panel Report, Dkt. 238).

6 12. The items from the implementation plan most relevant to my review
7 were those that correlated to unnecessary or excessive use of force incidents, and the
8 review process used by LASD to hold, or not, hold staff accountable for incidents of
9 unnecessary or excessive force. I quote the relevant sections as follows:

10 **1. Leadership, Administration and Management (expect to be**
11 **completed by June 30, 2015):**

12 1.3 Department managers should be held accountable should they
13 fail to address use of force problems at the Department's jail facilities.

14 **2. Use of Force Policies and Practices (expect to be completed by**
15 **June 30, 2015):**

16 2.2 The Department's Custody use of force policies should
17 provide that force used by Department members: (a) must be used as a
18 last resort; (b) must be the minimal amount of force that is necessary and
19 objectively reasonable to overcome the resistance; (c) must be
20 terminated as soon as possible consistent with maintaining control of the
21 situation; and (d) must be de-escalated if resistance decreases.

22 2.5 The Department's Custody use of force policies should
23 provide that a Department member may not strike an inmate or use
24 chemical agents or a taser on an inmate who is restrained unless the
25 inmate is assaultive and presents an immediate threat of injury to a
26 Department member or another person, and unless there are no other
27 more reasonable means to control the inmate.

28 2.6 The Department's Custody use of force policies should
provide that striking an inmate in the head or kicking an inmate who is
on the ground, or kicking an inmate who is not on the ground anywhere
above the knees is prohibited unless the inmate is assaultive and presents
an imminent danger of serious injury to a Department member or another

1 person and there are no other more reasonable means to avoid serious
2 physical injury. The Department's Custody use of force policies should
3 also provide that kicking an inmate who is not on the ground below the
4 knees is prohibited unless the inmate is physically assaultive, and the
5 kick is utilized to create distance between the member and the assaultive
6 inmate.

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5. Data Tracking and Reporting of Force Incidents (expect to be completed by June 30, 2015):

5.2 Evaluations of force incidents by Unit Commanders should be reviewed as follows:

All Category 1 Force cases and Category 2 cases that do not meet the criteria for a roll-out by the Custody Force Review Team should be reviewed by a least one Commander in Custody Operations;

All allegations of force should be reviewed by at least two Commanders in Custody Operations;

Category 2 Force cases that meet the criteria for a roll-out by the Custody Force Review Team should be reviewed by the Custody Force Review Committee; and

Category 3 Force cases should be reviewed by the Executive Force Review Committee.

5.3 The Department's Custody use of force policies should provide that any unexplained tactical decisions pertaining to uses of force or any discrepancies among witnesses and/or evidence should be referred by the reviewing Commander(s) or committee in writing back to the incident investigator for additional investigation and then reported back in writing to the reviewing Commander(s) or committee.

13. Disposition of Use of Force Reviews and Staff Discipline Issues (expect to be completed by June 30, 2015):

13.1 The Department should have a firm policy of zero tolerance for acts of dishonesty or failure to report uses of force. If the Department does not terminate a member who is found to have been dishonest, used

1 excessive force, or violated PREA, the Department should document the
2 reasons why the member was not terminated and, in addition to the
3 discipline that is imposed, the Department should place the member on
4 a formal and adequate performance review program and closely monitor
the member's performance.

5 Dkt. 133-2 at pp. 1-2, 5-6, 10-11.

6 **III. SUMMARY OF MY OPINIONS**

7 13. In reviewing the available monitor (Panel) reports, it was startling to see
8 that in eight years, LASD has never achieved compliance with implementation plan
9 items 2.2, 2.6, 2.7, & 5.2. LASD has only achieved compliance once for 5.3. For item
10 1.3, it appears there was compliance at an earlier stage, but it has since slipped out of
11 compliance for the most recent reports.

12 14. The LASD has full control over its employees when it comes to
13 performing their job duties. This includes enforcing agency policies, training
14 standards, and performance expectations, as well as providing proper supervision to
15 ensure employees adhere to these standards. They also have the power to discipline
16 or even fire employees who repeatedly fail to meet expectations or commit serious
17 offenses.

18 15. In my experience, writing expectations in policy is essential, as is
19 ensuring staff receive the necessary training on the policy expectations. However,
20 effectively delivering the previously mentioned steps doesn't guarantee that the policy
21 will become a practice. Ultimately, only adequate supervision and management of
22 those expectations once staff have been trained will ensure that policy becomes a
23 practice. This requires supervisors and managers to hold staff accountable to those
24 expectations; if not, the policy becomes moot, and staff will not follow it, knowing
25 there are no repercussions. Simply stated, having a policy doesn't ensure the practice
26 of those policy expectations. Effective staff training is essential, but ultimately it is
27 constant and effective supervision and management and holding staff accountable that
28 will cause those policy expectations to become practice. Based on the material I have

1 reviewed, it is my opinion that LASD has failed to hold employees accountable to
2 published use of force standards. Additional detail for this opinion is provided below
3 in Part VII.

4 16. Like all confinement facilities or agencies, LASD has an “affirmative
5 duty of care and custody” for individuals in its custody and control. People held in
6 custody or control of a law enforcement agency, such as the LASD, have a right to be
7 free from unreasonable risk of harm. Therefore, it is a basic requirement for law
8 enforcement agencies to take reasonable steps to protect the safety and well-being of
9 individuals in their custody or control. Based on the numerous Panel reports that I
10 reviewed, as well as my review of use-of-force packets and video, LASD has failed
11 to significantly reduce the inappropriate use of head strikes by staff against inmates,
12 is overusing the WRAP restraints device, and is engaging in unnecessary force when
13 it can be avoided.

14 **IV. OVERVIEW OF USE OF FORCE IN LAW ENFORCEMENT AND** 15 **CORRECTIONS, AND THE NEED FOR DE-ESCALATION**

16 17. The following general overview is provided to give some perspective
17 and background on the use of force and standard practices in law enforcement and
18 corrections related to the various levels of force and when they may be used. The
19 following gives a general description of the levels of force and highlights the
20 differences between their use in corrections and law enforcement in the community.
21 As an example, it is highly unlikely deputies working in a jail are going to encounter
22 an inmate armed with a firearm or need to stop a fleeing person from jumping into a
23 car, driving dangerously, and potentially hurting others.

24 18. As discussed below in Paragraph 25, there is some difference between
25 corrections and law enforcement, because corrections are in a controlled environment
26 where the detainee’s physical mobility and access to deadly weapons is more limited
27 than any subject in the community. It should be noted that the terminology used to
28 describe levels of force can vary significantly between agencies, but the general

1 approach is consistent and includes similar tactics, techniques, and weapons, all based
2 on the level of resistance being encountered.

3 18. The levels of force used in any given situation are based on a continuum
4 that escalates based on the level of resistance displayed by the subject who is trying
5 to be controlled (*e.g.* suspect, inmate, etc.) It is a universal goal in use-of-force
6 situations to use only the least amount of force necessary to control the subject and
7 situation in the safest possible manner for all involved. It is important to note that
8 even though I used the term “continuum,” this should not be interpreted to mean that
9 each level or step must be attempted before elevating to a higher level of force. The
10 immediacy and severity of the situation can dictate and even require rapid escalation
11 in the force necessary to resolve the situation. An example of a situation that can
12 require a rapid escalation is in life safety incidents where the officer, or someone else,
13 is at immediate risk of grievous bodily injury or even death, for example, a police
14 officer who is facing a person armed with a gun.

15 19. Critical considerations for any agency in use-of-force situations are: is
16 using physical/deadly force appropriate for the situation and do the totality of the
17 circumstances, including immediacy and severity of the threat as well as the
18 seriousness of the objective justify the force being used? Law enforcement and
19 corrections levels of force can generally be clustered into general categories. The
20 category of most significance is de-escalation tactics, depending on the agency, these
21 may or may not be included as a level of force because technically de-escalation
22 tactics do not require force and, when done effectively can preclude the need for force.

23 20. **De-escalation tactics** are actions a peace officer uses that are intended
24 to minimize the likelihood of the need to use force during an incident. Depending on
25 the circumstances, de-escalation tactics may include, but are not limited to: using clear
26 instructions and verbal persuasion; attempting to slow down or stabilize the situation
27 so that more time, options, and resources are available to resolve the incident; creating
28 physical distance by employing tactical repositioning to maintain the benefit of time,

1 distance, and cover; when there are multiple officers, designating one officer to
2 communicate to avoid competing commands; requesting and using available support
3 and resources, such as a crisis intervention team, a designated crisis responder or other
4 behavioral health professional, or back-up officers, and certainly a supervisor.

5 21. As an example of a failure to de-escalate, in one of the use of force
6 incidents I reviewed, (# MCJ-03103), it started because the deputy involved was
7 arguing with the inmate about soap. The inmate did not like the responses he was
8 getting from the deputy and asked to talk to the supervisor, who likely could have
9 resolved the situation without the use of force.⁸ Supervisors are helpful in these
10 situations because when there is a dispute between staff and inmates, the supervisor
11 is viewed as the final answer, even when the inmate doesn't get what they think they
12 should, they feel heard and can generally accept the answer. The deputy could have
13 simply said he would see if one was available and made the call on the radio
14 summoning a supervisor and probably others to the scene. He could have continued
15 dialogue or not, from a safe distance waiting for others to respond. If the deputy had
16 done this instead of pushing the confrontation with the inmate, it most probably would
17 have resolved the situation through de-escalation. Unfortunately, the deputy failed to
18 use de-escalation techniques or call for a supervisor, and it resulted in the use of force.

19 22. Another example of a failure to de-escalate a situation, which resulted in
20 excessive force, is MCJ-922-02082. Again, an inmate who is restrained at the wrist
21 behind his back is exiting a cell to be escorted somewhere. The video does not include
22 audio, so it is not possible to know what was being said. If there was an aggressive
23 dialogue between the deputies and the inmate, then the officers could and should have
24 paused before opening the cell, and directed the inmate to back out of the cell to gauge
25 the inmate's level of cooperation. Instead, deputies just opened the cell and the inmate
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27 ⁸ A key requirement of the Implementation Plan is that "Department members
28 confronted with a situation in which force may be required must call a supervisor to
the scene as soon as time and circumstances permit." *See* Dkt. 133-2 at ¶ 2.7.

1 walked out face forward. LASD’s Force Manual 7-01/050.05 Inmate Extraction
2 Procedures says, “[w]hen simple instructions and requests fail to cause and inmate to
3 exit a confined area, a supervisor, at the minimum rank of sergeant, shall be notified
4 in all but life-threatening or exigent circumstances.” Again, deputies failed to use de-
5 escalation or alternate procedures that could have prevented this use of force.

6 23. Because of this failure, the deputies allowed the inmate to exit the cell
7 and the inmate attempted to pull away. As a result, one deputy grabs the inmate by
8 the head and aggressively slams his head into a concrete wall, causing significant head
9 trauma with lacerations to the inmate’s head, as shown below:



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18 LASD policy 7-01/030.00 Prohibited Force specifically prohibits the excessive
19 force used by the deputies including, “[d]eliberately or recklessly striking an
20 individual’s head against a hard, fixed object (e.g. concrete floor, wall, jail bars, etc.).
21 In this incident, no use of force documentation was available for my review. However,
22 included with the videos I reviewed, was a separate video looking directly into a cell,
23 presumably after the incident, and I could see the involved deputies apparently
24 discussing the incident and acting out the events that just occurred, which is also
25 against LASD policy.

26 24. The following is a general categorization of levels of force used in law
27 enforcement and corrections.

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1 **Physical Force** – Techniques to direct movement (e.g., push back, escort, lift,
2 carry); control holds like joint manipulation, wrist/finger locks; open hand techniques,
3 takedowns and use of restraints.

4 **Intermediate/Less Lethal Force** – Use of Oleoresin Capsicum (OC or Pepper
5 Spray), punches, kicks, or other strikes to the body when not directed toward the head,
6 neck, throat or spine. Use of batons, tasers, impact weapons, or munitions when not
7 directed toward the head, neck, throat or spine.

8 **Deadly Force** – All uses of firearms directed at an individual and can include
9 using less lethal weapons and impact devices when directed to the subject's head,
10 neck, throat, or spine area. The inclusion of less lethal is because when directed to the
11 subject's head, neck, throat, or spine can result in death or grievous bodily injury. As
12 is commonly known, the use of lethal force is reserved for life-threatening situations
13 when no other reasonable alternative exists. I discuss head strikes further in Part V.

14 25. In corrections as compared to patrol, the significant difference is that
15 correctional officers are in a secure environment they are familiar with, which means
16 the “suspect” will not get away. Other corrections officers are assigned to control
17 rooms or booths, and they can give directives for non-involved inmates to return to
18 their cells and then secure their cell doors or isolate the incident and individuals by
19 securing doors only under the officers' control. The officer addressing an agitated
20 detainee is almost always under observation by other staff, who can immediately call
21 for the assistance of others. Response times in correctional settings are significantly
22 shorter than for law enforcement in the community, and generally should be measured
23 in seconds instead of minutes, based on the almost immediate availability of
24 additional staff who have radios, can hear the call for help, and can respond
25 immediately while those assigned to control booths secure the area.

26 26. In reviewing the multiple LASD use of force videos, I was struck by the
27 exceptional number of staff who responded immediately once the use of force ensued.
28 In some of these situations, there were more than twenty (20) responding staff, and in

1 all but one (1) situation there were a minimum of three (3) officers present at the time
2 of the use of force. The immediate availability of these staff is important because it
3 causes a significant power shift, in a one-on-one situation there is a significantly
4 greater risk to a singular responding deputy; when multiple staff are present using
5 their control tactics training, they can more easily control individual limbs reducing
6 the risk of significant injury to all involved. Additionally, with multiple staff, they can
7 use team tactics to overpower the subject.

8 27. Because of the controlled environment, the immediacy with which
9 additional staff can respond to an incident, and the number of staff that LASD has
10 responding, this should mitigate LASD's need for higher levels of force. Staff should
11 be trained to create distance between themselves and the aggressive inmate, call for
12 backup, and use team tactics to restrain an uncooperative inmate if necessary. Team
13 tactics are the most common practice when corrections staff are restraining an
14 uncooperative inmate. With team tactics, multiple staff, depending on their level of
15 training, are applying hands-on techniques, including: finger, wrist, and other counter
16 joint techniques, takedowns, and pressure points. In very extreme situations, staff may
17 use body strikes to get the inmate restrained. Once restrained, sometimes including in
18 leg restraints, the inmate is considered controlled. In the most extreme situations
19 where an inmate is resisting but restrained, a wheelchair, gurney, or wrap devices may
20 be used to safely transport the inmate to a more secure setting.

21 28. There is also a downside to team tactics because often, one officer will
22 be using a pain compliance technique like a wrist, finger or joint manipulation to get
23 control of their limb of responsibility. This causes the subject to reflexively react to
24 the pain and other involved officers then perceive the reaction as aggression or
25 resistance, increasing and escalating the level of force they are using. I believe this
26 was the case in at least five of the videos I reviewed, including MCJ-04485, TTCF-
27 00620, MCJ-02673, TTCF-00226, IRC-01256, and possibly others. In the case of
28 team tactics, this reflex-reaction can be mitigated through communication and an on-

1 scene supervisor directing the actions of the deputies, but even this isn't always
2 effective in confined spaces and or when the supervisors can't see all that is going on.
3 In instances when you are dealing with someone who is restrained or you are trying
4 to remove the restraints, the best course of action is to back off, talk to the person to
5 explain what you are trying to accomplish, and re-assess. Minimizing the number of
6 staff involved is also helpful in these situations.

7 **V. LASD'S USE OF FORCE POLICY & HEAD STRIKE PRACTICES**

8 29. In addition to reviewing the settlement agreement, the implementation
9 plan, and monitor reports, I have also reviewed the latest, available to me, LASD
10 Custody Division Manual: Volume 7 – Custody Operations Force Manual (Force
11 Manual), and 10 use of force incidents (video & reports) where head strikes were used
12 against a detainee (9 videos), or where deputies struck a class member's head against
13 a fixed object, namely, the wall (1 video). LASD has made changes over the last nine
14 years to its Force Manual; however, based on the ongoing failures of compliance, the
15 appearance is none of these changes have been effective. As stated in paragraph 15,
16 simply changing policy without accountability rarely results in behavior change.

17 30. In the Force Manual I reviewed, dated 3/23/21, it says.

18 The following uses of force are prohibited absent life-threatening or high
19 risk / assaultive situations:

- 20 • Any kicking above the knee
- 21 • Carotid restraints
- 22 • Head strikes

23 31. In my training and professional experience, head strikes are reserved for
24 self-defense when there is an immediate risk of grievous bodily injury or death to the
25 responding officer or someone the officer is trying to protect, this is because impact
26 weapons like fists and feet when used to strike to the head, neck, throat, and spine
27 have a significantly greater risk of serious bodily injury or death. The court monitors
28 have repeatedly reported that LASD's overuse of head strikes is dangerous. *See*

1 Panel’s Eighth Report, Jan. 4, 2021 (Dkt. 202 at p. 10)⁹ (“Medical science informs us
2 that head blows are the ‘hidden injuries’ that create or exacerbate mental illness.
3 Agencies have long moved away from acceptance of head strikes. We encourage the
4 Department to pay particular attention to this issue moving forward.”); Eleventh
5 Report, March 8, 2023 (Dkt. 238 at p. 3) (“In cases where some force may be
6 warranted, the Panel continues to see improper head strikes by Department
7 personnel.”) Some examples of jurisdictions that consider strikes with hands and feet
8 to the head, neck, throat, or spine as a deadly force option include New York City and
9 Washington State.¹⁰ There is some indication even LASD must view head strikes as
10 akin to using a deadly weapon, because in at least one of the incidents (#MCJ-04485)
11 LASD charged the involved inmate—who used head strikes against an officer—with
12 Assault with a Deadly Weapon.¹¹ In the case of law enforcement officers in the
13 community, this risk is significant when required to go hands-on with individuals
14 based on any unknowns and the lack of timely back-up. There is a life safety

15 ⁹ Citations are to the Panel’s Reports’ page numbers.

16 ¹⁰ See, e.g., Washington Department of Corrections, DOC 410.920, Use of
17 Force Outside of Prisons at Part II.A.3.a. (defining deadly force as “strikes to the head,
18 neck, or spine”) at [https://agportal-s3bucket.s3.amazonaws.com/useofforcepolicy/
19 UseOfForcePolicy256.pdf](https://agportal-s3bucket.s3.amazonaws.com/useofforcepolicy/UseOfForcePolicy256.pdf); Corrections Dep’t, City of New York, Directive 5006R-
20 D, Use of Force at Part II.G (“The Department strictly prohibits the use of high impact
21 force, including ... strikes or blows to the head, face, groin, neck, kidneys, and spinal
22 column” except where the staff person is “in imminent danger of serious bodily injury
23 or death, and where lesser means are impractical or ineffective”) at
24 [https://www.nyc.gov/assets/doc/downloads/directives/Directive_5006R-
25 D_Final.pdf](https://www.nyc.gov/assets/doc/downloads/directives/Directive_5006R-D_Final.pdf).

26 ¹¹ As Steve J. Martin, a use-of-force expert and former administrator and
27 general counsel with the Texas Department of Corrections has written, “[I]f a self-
28 defense tactic such as non-blunt force can effectively neutralize a disruptive prisoner,
it is not appropriate to strike the prisoner with blunt force to the head, especially when
such strikes often do not actually neutralize the aggressing inmate. In fact, such tactics
often create a purely retaliatory cycle of violence in which both the officer and
prisoner sustain injuries and the degree of injuries sustained is more serious.” Steve
J. Martin, *Staff Use of Force in United States Confinement Settings*, 22 Wash. U. J. L.
& Pol’y, 145, 152-53 (2006).

1 component to remaining conscious and maintaining possession of your firearm.

2 32. Three head strike incidents that I reviewed occurred after the revised
3 Force Manual was issued (3/23/21). In all of these incidents, there were two or more
4 deputies present when the head strikes occurred. All head strikes used by staff were
5 after any assaultive behavior from the inmate had ceased. In two instances, head
6 strikes were used on inmates in restraints. In one incident the inmate was restrained
7 at the time and spat on a deputy who then hit the inmate in the face with a closed fist,
8 which appeared to be out of anger or retribution. In my opinion, all three of these
9 incidents involving head strikes were unprofessional, unnecessary, and excessive. The
10 most severe administrative action taken in these three cases (#MCJ-00856, MCJ-
11 00999, IRC-00030) was re-training for one of the assaults carried out by a deputy, but
12 the use of head strikes was still determined to be “objectively reasonable” or
13 “reasonable” by the second-level supervisors in all three cases. All three of these
14 situations were not life-threatening to the involved staff, so the only criteria used to
15 justify these excessive force incidents must have been “high risk/assaultive
16 situations.” I believe this language is extremely lenient and a loophole used as
17 justification not to hold staff accountable.

18 33. LASD has recently issued a directive stating head strikes may only be
19 used in use of force if (1) the inmate is assaultive; (2) the inmate presents an imminent
20 danger of serious injury; and (3) there are no other more reasonable means to avoid
21 serious injury. In my opinion, this new language is as lenient as the previous language
22 because a head strike incident (MCJ-00856) that occurred after the directive was
23 issued, involved unnecessary head strikes (*e.g.*, excessive force) against a restrained
24 inmate and was nonetheless approved by supervisors. The inmate was in wrist
25 restraints with his arms behind his back, being escorted by two deputies, when he
26 horse kicks one of the deputies behind him in the leg. Deputies immediately head
27 strike the inmate and continue with body and head strikes while the inmate is on the
28 ground. In the Supervisor’s Report on Use of Force, the supervisors said,

1 Were other force options considered?

2 No. The incident was in defense and reactionary to an unprovoked attack.
3 Deputy personnel; acted accordingly in response to the attack.

4 I did discuss that head strikes are acceptable and within policy under
5 certain circumstances; however, when feasible, body strikes and/or other
6 force options are preferable. I reminded the deputies of Rosas Provision
7 2.6 which states that striking an inmate in the head is prohibited unless
8 the inmate is assaultive and presents an imminent danger of serious
9 injury to a department member or another person and there are no other
10 more reasonable means to avoid serious injury. Suspect (name redacted)
11 was physically assaultive, the deputies were in danger of being seriously
12 injured and due to the rapidly evolving situation their force options were
13 limited.

14 34. The Lieutenant who reviewed this head strike incident in the Watch
15 Commander's Use of Force Review and Incident Analysis concluded.

16 Based on the information provided in the Supervisor's Report on Use of
17 Force prepared by Sergeant (redacted) # (redacted) and after reviewing
18 the videos and written reports, I determined that the force used in this
19 incident by Deputies (redacted) and (redacted) was objectively
20 reasonable to overcome the suspect's assaultive behavior. The actions of
21 personnel involved in this force were within Department Policy.

22 35. In my opinion this is an example showing where the inmate could not
23 and did not inflict serious injury and posed no threat of causing serious injury while
24 the two deputies were on top of him and were inflicting head and body strikes.
25 Because of this the deputies should have been disciplined for their actions.

26 36. In total, I reviewed nine (9) videos and packets documenting use of head
27 strikes by LASD deputies against inmates in custody. In at least three, maybe more,
28 of these head strikes incidents the inmate was already restrained, and multiple staff
were present. Based on LASD Force Manual and my training and experience, the use
of head strikes with a restrained inmate is egregious, unnecessary, and excessive. In
a previously mentioned incident (#IRC-00030) three deputies were escorting a

1 restrained inmate who spat on a deputy, who the used a head strike. There was no
2 noted corrective or disciplinary action for the use of head strike. In one of the before-
3 mentioned situations of head strikes while in restraints, an inmate was biting the finger
4 of a deputy, this may be justification for a head strike, but it appeared there were other
5 reasonable options available to get the inmate to stop, including the use of OC spray,
6 which they did use. Because of the number of deputies covering the inmate in the
7 video I could not determine the effectiveness of the OC.

8 37. Also of note, was that in one of the head strike incidents, (#MCJ-04485)
9 the deputy wrote that the head strikes were used when he (the deputy) was actively
10 taking head strikes from an unrestrained inmate. There was no video to support the
11 written statement by staff, but as written this was the one and only that I reviewed
12 when the head strikes were justifiable, in my professional experience.

13 38. My overall impression from my review of the materials provided is that
14 the use of head strikes by LASD deputies against inmates in their care and control is
15 primarily unnecessary and is excessive. Even with the current limiting language used
16 by the LASD in their Force Manual, it is being abused and causing unnecessary harm
17 to the inmate population. LASD has been scrutinized on this topic for nine years and
18 still fails to achieve compliance tells me there is an established culture at all levels of
19 the organization that still believes it is okay to use head strikes as long as there is
20 justification in somebody's mind.

21 39. It is evident in all of the incidents of head strikes I reviewed, that all
22 could have been avoided and the situation could and should have been resolved using
23 options that were available at the time to the involved staff.

24 40. As mentioned above at Paragraph 31, some correctional agencies have
25 taken proactive steps to eliminate head strikes. They have done this by elevating them
26 to deadly force, which requires exceptional justification for the staff who use them.
27 Even if LASD does take the simple step of eliminating the words "high risk/assaultive
28 situation" from their Prohibited Force policy, they will have to increase accountability

1 as well dramatically. Staff that do use head strikes, absent exceptional justification,
2 must be held accountable with discipline that demonstrates the administration’s zero
3 tolerance for the use of head strikes. It appears that in the preceding nine years the
4 LASD has never placed this level of importance on this egregious act.

5 41. The Court monitors have chronicled this failure repeatedly, pointing to
6 the need for more accountability by supervisors and incident reviewers, yet the
7 problem persists. For example, in the Panel’s Eighth Report (Jan. 4, 2021), the
8 monitors wrote:

9 The Panel has expressed concern for several reporting periods that the
10 Department relies too heavily on remedial training rather than discipline
11 in situations where the Department agrees that use of force policies have
12 been violated. The Panel has also seen numerous cases involving
13 violations of policy, such as head punches for inmate control, that result
14 in outcomes that do not reflect the seriousness of the offense.

15 Dkt. 202 at p. 5. In the Panel’s Tenth Report (April 7, 2022), the monitors wrote:

16 More specifically, the use of “head shots” (punches to the head of an
17 inmate) where prohibited by policy, has been relatively unchanged in the
18 last two years or more, and may be increasing. No issue has been
19 discussed more with management over the last six years and especially
20 in the last two years, to little avail. That problem is compounded by two
21 other factors. *Use of force reviews by supervisors and managers in the
22 serious cases selected by the Monitors, almost always fail to note out-
23 of-policy head shots or – less frequently – attempts to justify them.
24 Then the supervisors and managers are not held accountable for those
25 failures and the Deputies using the improper for are “counseled” or
26 sent to remedial training and actual discipline is seldom imposed.*
27 While the Department has openly acknowledged this continuing issue in
28 discussions with the Monitors, and is now contemplating changes to the
way head shots are categorized and reported, there has been little real
change or progress in more than two years.

Dkt. 205 at pp. 1-2 (emphasis added).

42. And in March of 2023, in their Eleventh Report, the Panel wrote that it
“has yet to review a case where the supervisor concludes the use of head strikes was

1 inappropriate. In order for the Department to achieve compliance with Provision 2.6
2 (head strikes), staff must be held accountable [for] head strikes.” Dkt. 238 at p. 5. I
3 concur with the court monitors that these are problems that must be addressed.

4 **VI. LASD USE OF WRAP RESTRAINT DEVICE**

5 43. As requested by Plaintiffs’ counsel, I reviewed a number of LASD use-
6 of-force incidents involving head strikes by officers, almost all of which also included
7 the use of the WRAP restraint. I also reviewed additional uses of force incidents
8 specific to the use of the WRAP restraint.

9 44. I am familiar with the WRAP restraint device from its limited use in
10 WADOC. In my experience, it was a tool reserved for those extreme cases where
11 restrained inmates, who continued to thrash and react violently while in traditional
12 restraints, were further secured for transport. The primary reason for using the WRAP
13 was to prevent self-injury of the inmate during transport.

14 45. Of the sixteen total videos and use of force packets I reviewed for this
15 declaration, I could determine the WRAP restraint was used in at least ten (10)
16 incidents, and suspect it may have been used in more based on the apparent routine
17 use of the device by LASD. It was surprising to me how routinely the WRAP was
18 used, even when traditional approaches absent the WRAP would have been safer,
19 faster, and reduced inmate contact. Also of note was that when the WRAP was used,
20 deputies were required to lift the inmate onto the transport cart. Requiring this level
21 of physical exertion as a matter of course is surprising because a known top cause of
22 workplace injuries is overexertion, including non-impact injuries resulting from the
23 exertion of physical efforts such as lifting, lowering, pushing, holding, carrying,
24 turning or throwing. Routine use of the WRAP and the requirement for staff to lift
25 inmates may even contribute increased workplace injuries for the LASD deputies.

26 46. Traditional approaches can include the use of just wrist restraints behind
27 the back (not waist restraints), followed by leg restraints at the ankles for greater levels
28 of resistance. If transport or escort is required a wheelchair or gurney can be used.

1 When the inmate needs to be placed in the secure cell, staff can use a cuff retainer to
2 secure them in the cell.¹² If an inmate attempts to pull away at any time, staff can
3 maintain control by controlling the cuff retainer. In my professional experience, the
4 WRAP is an exceptional restraint reserved for only the most uncontrollable inmates.

5 47. Prior to the expanded knowledge of positional asphyxia, the most
6 uncontrollable inmates may have been restrained by a cord/rope secured to the wrist
7 restraints and the leg restraints placing them in an awkward position where they could
8 no longer thrash, bang their head or contort their bodies. This practice has not been
9 used in many decades because of the numerous in-custody deaths resulting from
10 positional asphyxia.¹³ In 2021, in response to the killing of George Floyd and other
11 people, California passed AB 490, which prohibits law enforcement agencies from
12 authorizing techniques or transport methods that involve a substantial risk of
13 positional asphyxia.¹⁴

14
15 ¹² A cuff retainer is a simple tool made from a 6-to-8 foot rope with a clasp at
16 one end that attaches to the cuffs. This allows staff to pass the rope through the cuff/
17 feeding port in the cell door. The inmate is instructed to kneel while the leg restraints
18 are removed, then the cell door is closed, and the inmate is instructed to stand up and
19 back up to the cuff port so the wrist restraints can be removed. The use of the cuff
20 retainer is a safe way to place inmates in a secure cell and remove restraints while at
21 the same time allowing staff to maintain control of the inmate and wrist restraints.

22 ¹³ Positional asphyxia, also known as postural asphyxia, is a form of asphyxia
23 that occurs when someone's position prevents the person from breathing adequately.
24 People may die from positional asphyxia accidentally, when the mouth and nose are
25 blocked, or where the chest may be unable to fully expand. U.S. Department of
26 Justice, Office of Justice Programs, National Institute of Justice, National Law
27 Enforcement Technology Center, *Positional Asphyxia—Sudden Death*, (June 1995)
28 at <https://www.ojp.gov/pdffiles/posasph.pdf>.

¹⁴ The bill took effect on Jan. 1, 2022, and amended Gov't Code Section 7286.5.
See https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB490. It defines positional asphyxia as "situating a person in a manner that compresses their airway and reduces the ability to sustain adequate breathing. This includes, without limitation, the use of any physical restraint that causes a person's respiratory airway to be compressed or impairs the person's breathing or

1 48. LASD’s routine use of the WRAP also has the effect of prolonging
2 incidents and requires deputies to have unnecessary contact with the inmates. With
3 the WRAP deputies are required to apply a leg harness and a back/chest harness, then
4 cinch the two together with a strap. This amount of restraint is unnecessary because
5 in my experience, once an inmate is restrained with wrist and leg restraints, they can
6 typically move under their own power, but their ability to inflict injury on others is
7 mitigated when escorting staff use appropriate escort techniques.

8 49. In the videos I viewed, there were incidents (TTCF-00620, IRC-01264,
9 IRC-001692), of deputies forcing the inmate’s head down and forward bending them
10 over their legs while exerting an extreme amount of force on the inmate’s back by
11 cinching the strap. While I am not purporting to be a medical expert, in my
12 professional opinion, this appeared to be an unsafe practice that could impact an
13 inmate's ability to breathe. In several videos, inmates could be heard saying they
14 couldn’t breathe, some before the WRAP was even applied, and some after.

15 50. The draft WRAP restraint document implies that WRAP is a restraint of
16 last resort when all other methods have failed. In the videos I reviewed, this did not
17 appear to be the case; often, inmates had already been restrained, were not allowed to
18 stand up, and then automatically placed in the WRAP before any assessment could be
19 completed. In most cases, deputies held down these inmates, so there was no
20 opportunity for all involved to have a cooling-off period.

21 51. A cooling-off period is a period of time that can last for several minutes
22 or even just a couple of minutes, depending on the situation, so everyone can take a
23 break and reassess the situation before moving forward. This cooling-off period will
24
25

26 _____
27 respiratory capacity, including any action in which pressure or body weight is
28 unreasonably applied against a restrained person’s neck, torso, or back, or positioning
a restrained person without reasonable monitoring for signs of asphyxia.” Gov. Code
§ 7286.5 (b)(4).

1 allow the on-scene supervisor to dialogue with the involved inmate to determine better
2 if there is a need for the WRAP.

3 52. The draft document indicates the on-duty watch commander shall
4 authorize the use of the WRAP; some videos I viewed did not have audio, making it
5 impossible to determine if authorization was requested. Still, my overall impression
6 was that no prior authorization was sought or given before using the WRAP. Even if
7 the new language is adopted in the draft WRAP Restraint document, based on the
8 LASD's track record, I am skeptical that their existing culture will be able to
9 implement these changes and hold staff accountable, based on my review of these
10 incidents and the reviews conducted on them.

11 53. There was an exceptional video provided, which made me question the
12 practicality of using the WRAP as routinely as LASD does. (# TTCF-00226) In the
13 video, the inmate was already in the WRAP and arrived at what appeared to be a
14 disciplinary cell. Four deputies lift the inmate out of the cart and carry him into the
15 cell. There are five deputies and the inmate in a small area between the metal bunk
16 and the wall, which appears to be a space approximately 7 feet long by 4 feet wide.
17 In this limited area, deputies attempt to remove the WRAP, and the inmate can be
18 heard grunting; it appears a deputy is applying body pressure to try and maintain
19 control, but it is also likely causing distress and pain for the inmate.¹⁵

20 54. The inmate complains about the pain repeatedly, and you can see
21 deputies shuffling around in the small area as the situation escalates. The inmate says
22 the cuff hurts and is getting agitated, continuing to cry out in pain. Deputies are telling
23 him to relax, but he is obviously in pain from the control techniques the deputies are
24 using. At this point, there are five deputies within the confined space in part of the
25 cell, and an additional deputy and sergeant also in the cell. The inmate continues
26 screaming in pain, and the deputies' movements are more aggressive.

27
28 ¹⁵ See Paragraph 28 (description of drawbacks of team tactics).

1 55. This continues for approximately 10 minutes; the inmate screams out
2 about his ankle hurting. There are 3-4 deputies on him at this time, most probably one
3 of them kneeling on his ankle. At about 12 minutes, all other restraints are off because
4 deputies are preparing to exit the cell but maintain body pressure on the inmate.
5 Another deputy comes into the cell with an unholstered Taser, but the other deputies'
6 bodies entirely cover the inmate. At 15:57 minutes into the video OC (Pepper Spray)
7 is used on the inmate.

8 56. At 17:53 minutes, someone screams out, and two deputies throw
9 multiple punches at the inmate. Because of the number of deputies present, it cannot
10 be determined from the video where they were punching the inmate. In the
11 documentation, one deputy states that he “punched him several times to the face area”
12 (p. 44). It appears more punches were delivered shortly after this, but again hard to
13 determine in the video. At 19:18, the wrist restraints were removed. This WRAP
14 removal lasted approximately 19 brutal minutes. The inmate was hurt throughout the
15 incident, and at least one deputy received a bite to his finger.

16 57. There were no other videos that showed the WRAP removal process, and
17 I hope they were not as brutal as this one was. Throughout this video, I questioned
18 how the WRAP was safer for everyone involved, staff and inmates. Granted, I could
19 not see the inmate’s actions or gauge his resistance level, but I could hear he was in
20 pain throughout this incident. I could not help but reflect on the countless uses of force
21 I have been involved in or reviewed during my career and speculate if using the
22 traditional approach with leg restraints, wrist restraints, and a cuff retainer would have
23 had a different outcome. I believe it would have been different and safer for everyone
24 involved.

25 58. Based on the videos I reviewed that involved using the WRAP restraint,
26 it is my opinion that LASD overuses this tool and should reserve its use for genuinely
27 exceptional circumstances, not for common application after fights and assaults.

28

1 **VII. DISHONEST REPORTING & LACK OF ACCOUNTABILITY**

2 59. In reviewing the use of force documents provided several incidents of
3 dishonest reporting and downplaying by reviewers were noted, which represent a
4 significant issue for LASD. In my opinion this is the root cause for the ongoing use
5 of unnecessary heads strikes (excessive force) and other negative behaviors. If LASD
6 continues not to hold deputies accountable for these incidents nothing will change,
7 just like in the preceding eight years they have been under the settlement agreement.

8 60. The LASD Guidelines for Discipline and Education-Based Alternatives
9 spell out what LASD considers to be discipline. Verbal counseling and retraining are
10 considered non-disciplinary, yet almost exclusively, in the use of force documents
11 provided with the incidents I reviewed, they were used to address incidents of obvious
12 excessive force and dishonesty. In the LASD Guidelines for Discipline and
13 Education-Based Alternatives, dishonesty is specifically cited as an example of a
14 situation that would warrant non-progressive discipline. In my opinion, LASD has the
15 ability and authority to discipline for these actions but routinely fails to do so. The
16 penalty ranges provided in the Guidelines are adequate; the problem is that LASD
17 routinely fails to impose the discipline within the range. Given LASD's long history
18 of noncompliance and the materials I have reviewed, those penalties should be
19 mandatory for the issues I have discussed above, *i.e.*, overuse of head strikes.

20 61. LASD deputies are POST (Peace Officer Standards and Training)
21 certified. In California, law enforcement and corrections officers (deputies) can lose
22 POST certification under certain circumstances. POST has the authority to revoke,
23 suspend, or deny certification to law enforcement officers who engage in certain
24 conduct or fail to meet certain standards.¹⁶

25
26 ¹⁶ See 11 CCR § 1202, Peace Officer Certificates;
27 [https://govt.westlaw.com/calregs/Document/IEB831B7058E011EDB4D7A6ED066E269F?viewType=FullText&originationContext=documenttoc&transitionType=Cat
egoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/IEB831B7058E011EDB4D7A6ED066E269F?viewType=FullText&originationContext=documenttoc&transitionType=Cat
28 egoryPageItem&contextData=(sc.Default))

1 62. California law provides for a range of disciplinary actions that can be
2 taken against law enforcement officers who engage in misconduct, including
3 revocation or suspension of POST certification. POST may revoke or suspend an
4 officer's certification for a variety of reasons, including:

- 5 • Conviction of a felony or certain misdemeanors
- 6 • Dishonesty or falsification of official reports
- 7 • Use of excessive force
- 8 • Discrimination or harassment¹⁷

9 63. In addition to the above reasons, POST may also revoke or suspend an
10 officer's certification for other conduct that reflects poorly on the officer's fitness to
11 serve as a law enforcement officer.

12 64. California law requires law enforcement agencies to report to POST any
13 officer who is terminated or resigns in lieu of termination due to a violation of POST
14 standards, including use of excessive force, dishonesty or falsification of official
15 reports, and discrimination or harassment.¹⁸ Reporting officers who violate POST
16 standards is important to ensure the integrity of the law enforcement profession, and
17 to maintain public trust in law enforcement. By reporting officers who violate POST
18 standards, law enforcement agencies help to ensure that these officers are held
19 accountable for their actions and that they do not continue to work as law enforcement
20 officer in California.

21 65. As noted above tolerance for excessive use of force and dishonesty has
22 significant impacts for LASD and the law enforcement professional overall. In Part V,
23 I chronicled incidents where I believe excessive force was used. In addition to this, I
24

25 ¹⁷ See 11 CA ADC § 1205 Serious Misconduct;
26 [https://govt.westlaw.com/calregs/Document/I415583F08DAF11ED85DFA03C23B7](https://govt.westlaw.com/calregs/Document/I415583F08DAF11ED85DFA03C23B73F24?viewType=FullText&originationContext=documenttoc&transitionType=Cate)
27 [3F24?viewType=FullText&originationContext=documenttoc&transitionType=Cate](https://govt.westlaw.com/calregs/Document/I415583F08DAF11ED85DFA03C23B73F24?viewType=FullText&originationContext=documenttoc&transitionType=Cate)
28 [goryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/I415583F08DAF11ED85DFA03C23B73F24?viewType=FullText&originationContext=documenttoc&transitionType=Cate)

28 ¹⁸ See Post Commission on Peace Officers Standards and Training,
<https://post.ca.gov/sb-2>

1 believe there were several incidents of dishonest reporting where deputies minimized
2 the level of force used or failed to report it at all.

3 66. In addition to dishonest reporting by the deputies themselves, there were
4 incidents where supervisors and incident reviewers downplayed incidents and failed
5 to hold deputies accountable. This justification is a classic example of why LASD is
6 failing to hold their staff accountable. This is indicative of a culture that needs to
7 change. I have experienced incidents where cronyism is pervasive in a correctional
8 culture, so I know the devastating impacts on the integrity of the organization and even
9 the morale of the work unit. Cronyism is created when staff who work together for
10 extended periods of time and then some are eventually promoted into positions of
11 greater responsibility, where they are required to hold their former peers accountable
12 but fail to do so. Based on my review of the mentioned incidents cronyism is pervasive
13 in LASD corrections. Some examples of what I have stated are listed here.

- 14 • Incident MCJ-04390: One deputy describes the detainee’s alleged seated
15 punch (see above) to the deputy’s leg as “I felt the great force of his punch.”
16 The deputy also describes the detainee’s injuries (he was bleeding profusely
17 from the head after a head strike) as “redness to cheek and small cut,” which
18 appears to be cut and pasted on more than one witness statement. But the
19 medical report has full litany of injuries including bloody and swollen nose
20 and cut lip. (pp. 45-46). One deputy stated, “I did observe swelling and
21 redness along with blood protruding from [the detainee’s] right facial area.”
22 (p. 36)
- 23 • Incident TTCF-01254: While being placed in a WRAP cart after a cell
24 extraction, the detainee is spitting a little because of OC spray during cell
25 extraction. At 12:22, deputy hits him in the side of the face. In the written
26 report, witnesses and watch commander downplay head strike (p. 21 –
27 deputy who hit him says he “struck.” Witness deputies say “tap” at p. 24,
28 “lightly struck” at p. 25, “lightly tapped” at p. 28, and watch commander
calls it a “gentle nudge” at p. 36). Not found out of policy until final level
of review at pp. 43-44. Nothing in that final review, however, notes the
problems with deliberately downplaying the force used.
- Incident MCJ-03103: The detainee is asking for soap, talking on the hall,
asks to speak to a supervisor, the deputy slams him against the wall and

1 punches him multiple times in the head. Witness statements (other
2 incarcerated people) at pp. 11-13, the detainee’s statement at p. 13, and the
3 video all contradict deputy’s justification (pp. 29-31) for using force. The
4 watch commander claims to be unable to evaluate veracity because of video
5 pixelation (p. 40).

- 6 • Incident MCJ-02673: The repeated statements by deputies in their reports
7 about how the head strike was to respond to the detainee having his hands
8 underneath him and their fear he had a weapon seem fabricated. (e.g., p. 38).
9 There is a lot of what seems to be copying among the reports – almost
10 verbatim discussion of inmates’ having shanks, inmates of the same race
11 initiating force to keep face among their peers, etc. (p. 38) “Due to the fact
12 of recent attacks on deputy personnel and several shanks (inmate jail made
13 weapons) being recovered from Module 2400, I immediately went towards
14 the deputies. . . “ “Due to previous events of inmates making threats and
15 staff assaults against deputy personnel at MCJ, coupled with the numerous
16 recovered jail house-made weapons (shanks) in Modules 2200/2400, I was
17 on heightened alert.” (p. 43) “Within the last week, there have been threats
18 and staff assaults within the facility. Also the 2000 Floor personnel have
19 recovered a numerous amount of jail made weapons ‘Shanks.’” (p. 53)
- 20 • Incident MCJ-00690: The video shows at 1:15 that one deputy puts his knee
21 on the detainee’s neck with what appears to be full weight and appears to
22 have his right fist pushed against the detainee’s face; at 1:39 the deputy takes
23 his knee off the detainee’s neck. Deputy writes that he “inadvertently put
24 his neck across [detainee’s] back and shoulders” (p. 14) – inconsistent with
25 video. LASD witnesses write that after they took the detainee’s cap off, “I
26 observed inmate [] turn his body while lifting both of his arms upward.”
27 (p. 15). This also is inconsistent with video. LASD witness does not mention
28 seeing the other deputy put his knee on the detainee’s neck. (p. 15) The
deputy who used his knee was disciplined, but not for dishonest reporting,
nor were the other witnesses flagged for dishonest reporting. IAB noted that
the video footage showed the knee on head/neck (p. 9).

67. In my 32 years directly working in the corrections profession I have
experienced use of force situations from all angles, as the one performing it,
documenting it as the on-scene supervisor, reviewing it, and even as an independent
Critical Incident Review member and team leader. I can recognize creative writing

1 intended to minimize or justify inappropriate actions by staff. I also recognize the
2 importance of honest reporting for the reasons previously expressed.

3 68. As an example, while I was a Correctional Captain at one facility, my
4 office window faced a courtyard where inmate movement took place. I spent a lot of
5 time there reviewing use-of-force reports. One day I heard a radio call for an incident
6 taking place in the courtyard outside my office. I witnessed a new corrections officer
7 confront an aggressive inmate, after attempting to de-escalate the situation the officer
8 essentially tackled the inmate to take him to the ground to apply wrist restraints. It
9 was not excessive and was practical given the situation. A couple of days later I was
10 reading the use of force package for this incident, in the officer's statement he had
11 written in his report, he had used a straight arm bar technique to place the inmate on
12 the ground. Obviously, this was not what happened, so I left my office to speak with
13 that same officer and ask why he had not reported what he did in the use of force. He
14 said he was afraid to write down the tackle because it wasn't a trained technique and
15 other staff had told him what to write. I explained to the new officer that the most
16 important thing he can do in corrections is to maintain his integrity and that of the
17 agency through honest reporting and instructed him to re-write his report to reflect
18 the true events.

19 69. In my example, the officer was justified in his actions, was new to the
20 profession, and conformed to the culture he was in. He was admonished for this but
21 also, he was educated on the expectations of the agency. Later in my monthly
22 Lieutenant's meeting with the Lieutenants who reported to me, I talked about this
23 situation to clarify my expectations for honest reporting and explained that if this goes
24 unchecked they are doing their staff a great disservice, which could have a negative
25 impact on a person's employment. I also pointed out the fact we never know when an
26 incident will become the subject of an external review and when that happens their
27 inactions will then be the problem. It was their responsibility to ensure all their staff
28 had a clear understanding of acceptable boundaries. Apparently, this had the desired

1 effect because I started seeing a change in the verbiage used in the use of force reports
2 I was reviewing.

3 70. I recognize the small number of LASD incidents I reviewed was likely a
4 small percentage of their overall use-of-force incidents and because of this, it may be
5 easy for LASD to try and overlook dishonesty. My experience says the opposite,
6 whenever these incidents of dishonesty are recognized, they must be appropriately
7 addressed in order to maintain to the integrity of the agency. Appropriately
8 addressing, with discipline, these situations with staff is equally important to those
9 same staff so they and all their peers clearly understand the professional boundaries
10 required by their profession.

11 71. In corrections, there will always be some incidents where staff use
12 excessive force and or are dishonest about their actions, my experience tells me every
13 one of these is a critical incident and must be addressed with discipline. Failure to
14 address these situations, by disciplining the responsible staff, will make it acceptable
15 making it a part of your culture and increasing the rate of occurrence. Based on the
16 level of acceptance demonstrated by LASD, through their lack of accountability, they
17 have created a culture of acceptance for excessive and unnecessary use of force.

18 72. This lack of accountability was noted many times in the Monitor reports,
19 I am in complete agreement with their observations. This includes the reports I quoted
20 above at Paragraph 41, and the following:

- 21 • Panel’s Fifth Report (May 31, 2019), Dkt. 198 at p. 6: “[T]he ‘sharp
22 increase’ in deactivated investigations coupled with the ‘marked
23 decrease’ in the number of these investigations, calls into question the
24 extent to which the Department will hold Deputies accountable for
25 misconduct, including in particular dishonesty and excessive use of
26 force, in the future. ...[T]he direction of the Department is of concern to
27 the Panel.”
- 28 • Panel’s Fifth Report at p. 17: “Commanders are reluctant to find a use of
force out of policy (and therefore subject to discipline) even when they
acknowledge that the force was problematic...”

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- Panel’s Eighth Report (Jan. 4, 2021), Dkt. 202 at p. 5: “The Panel has expressed concern for several reporting periods that the Department relies too heavily on remedial training rather than discipline in situations where the Department agrees that use of force policies have been violated. The Panel has also seen numerous cases involving violations of policy, such as head punches for inmate control, that result in outcomes that do not reflect the seriousness of the offense.”
- Panel’s Ninth Report (June 30, 2021), Dkt. 203 at p.6: “The Panel continues to see cases involving violations of policy, such as head punches for inmate control, that result in Departmental actions that do not reflect the seriousness of the offense. The Panel has highlighted this shortcoming in prior reports (see Eighth Report, p. 5) but has not seen any meaningful change in the extent to which Department staff (and managers) are held accountable for violation of force policies. The Panel is also concerned that in cases where the Panel has found a policy violation regarding use of force, and where the supervisors or mid-managers reviewing the incident have failed to identify a policy violation or even question the use of force, no action is ever taken against the supervisor and/or mid-manager.”
- Panel’s Tenth Report (April 7, 2022), Dkt. 205 at p.2: “From the use of force packages we have been reviewing, we are no longer seeing progression towards professional management of force situations. It is time for the jail culture to stop supporting behaviors that are forbidden by Policy.”
- Panel’s Tenth Report at p. 6: “Other issues raised by the Panel in prior reports persisted in the Tenth Reporting period, most notably, the failure of the Department to mete out discipline in cases where force policies are violated or Department personnel inaccurately described force incidents in their written reports.”
- Panel’s Eleventh Report (March 8, 2023), Dkt. 238 at p. 12: “The Panel continues to review cases involving violations of policy, such as head punches for inmate control, that result in Departmental actions that do not reflect the seriousness of the offenses. The Department must hold Deputies accountable for use of force violations and hold supervisory staff accountable when they fail to identify and/or appropriately address violations.”

- Panel’s Eleventh Report at p. 22: “In Case 4, Inmate E was being escorted back to his housing unit, cuffed behind his back. A Deputy put Inmate E’s back to the wall of the elevator. When Inmate E pushed forward and resisted being placed against the wall, he was taken to the floor and punched 15 times by at least two Deputies. One of the supervisory reviews of the incident concluded “...based on the facts surrounding this incident, it appears that the application of force was objectively reasonable.’ . . . The fourth case, however, illustrates how inappropriate force can be embraced by Supervisors. Leadership must hold Deputies accountable for unwarranted punches for Rosas compliance.”

73. In sum, the process currently used by LASD to review use of force incidents is not working. Because of this, I would recommend a review process to include more independent reviews conducted by individuals outside the work unit where the incident took place. These independent reviewers must hold the integrity of the organization above all else in order to prevent the continuation of cronyism. These independent reviewers must also be empowered to invoke mandatory discipline in all instances of dishonesty and excessive force.

VIII. CONCLUSION & RECOMMENDATIONS

74. LASD has been part of the *Rosas* settlement agreement and implementation plan for nine years and has made some effort to show improvement related to the use of force requirements of the implementation plan. However, they have never achieved compliance in the critical areas. Based on this, LASD must elevate what is required before head strikes can be used by staff and clarify that they are prohibited uses of force except in life-threatening situations. LASD should elevate the use of head strikes to deadly force like other agencies have done.

75. In addition, the administration must prioritize this change, and ensure that staff at all levels are held accountable to the policy expectations. This will take a cultural shift and require increased mandatory discipline for those who use this form of unnecessary and excessive force. This accountability must extend to those who review and endorse these actions by staff. Again, LASD has yet to achieve this based

1 on their current approach for the entirety of the settlement agreement, and
2 implementation plans existence. Because of the appearance of cronyism and lack of
3 accountability, the best approach for LASD to use for the review of use-of-force
4 reports is the use of independent reviewers with an interest in organizational integrity
5 who are empowered to invoke mandatory discipline.

6 76. The WRAP restraint is being overused and, as a result, likely, causing
7 more harm than good. An analysis of work-related injuries or secondary use-of-force
8 incidents as a result of using the WRAP should be conducted by LASD. In my
9 professional opinion, the WRAP should be reserved for those rare and unique
10 situations where other forms of restraint have failed.

11 77. Finally, I can't imagine any correctional administrator wanting to see
12 anybody hurt in their correctional system, least of all their staff. Staff and inmates are
13 most likely to be hurt during the use of force, which is why there is an emphasis on
14 only using the amount of force necessary to resolve the situation. It is also a reason to
15 avoid use-of-force whenever possible. The way to do this is to emphasize de-
16 escalation tactics, including creating distance, waiting for backup before taking
17 aggressive action, and slowing things down to allow everyone to evaluate their
18 options, including the inmates. When these incidents result in unnecessary or
19 excessive use of force the responsible staff should be disciplined to re-enforce the
20 expectation.

21 78. In the videos I reviewed, I noted several instances where deputies could
22 have used the before mentioned approaches and would have changed the situation.
23 This even applies when engaged in the use of force once the inmate has been
24 restrained; pausing and letting everyone evaluate the situation, stopping the pressure
25 on the inmate, may change the situation altogether. This is especially true when using
26 team tactics and having multiple staff apply control techniques that perpetuate the
27 incident. LASD would benefit from cooling-off periods to better measure the
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1 resistance level. This would be applicable in the use of force and the application of
2 the WRAP.

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I declare under penalty of perjury that the foregoing is true and correct.
Executed on May 30, 2023, in Olympia, Washington.



Stephen Sinclair

ATTACHMENT A

STEVE SINCLAIR

Justice & Liberty Group LLC

PO Box 13349
Olympia, WA 98508
(509) 386-1617 | ssinclair@JALG.org

Executive Summary

Over 30 years of progressive experience in adult male and female corrections from serving as a Correctional Officer to being appointed Secretary of the Washington State Department of Corrections by Gov. Jay Inslee in 2017. Accountable for over 19,000 supervised individuals and over 17,000 incarcerated individuals within 12 correctional facilities and 12 work release facilities.

Experience with all levels in corrections settings within a state correctional system including maximum custody (restrictive housing), work release, reentry and community corrections. Specialty areas include restrictive housing reform, violence reduction, use of force, programming, gender responsive/trauma informed services, correctional culture change and emergency response.

Developed and co-directed the highly successful Sustainable Practices Lab (SPL) at the Washington State Penitentiary resulting in thousands of incarcerated individuals receiving training and work experience in conservation, horticulture, aquaculture, carpentry and many other fields. The program has produced hundreds of thousands of pounds of produce for the facility as well as local residents in need of food. Additionally, SPL has significantly reduced landfill waste through repairs and recycling of goods and materials including reclamation of over 30,000 board feet of wood.

Delicately and successfully navigated and developed years-long productive relationships with numerous diverse stakeholders including the state legislature, victim advocates, Columbia Legal Services, Disability Rights Washington, NAACP, Teamsters Local 117 and the Washington Federation of State Employees.

Recipient of the 2020 Tom Clements Award for Innovation by the Correctional Leaders Association and recognized by Governor Christine Gregoire in 2009 For Excellence in Management.

In 2021, after retirement from 32 years with Washington State Department of Corrections, started the Justice & Liberty Group, LLC (JALG). As an expert I have produced several reports for clients and participated in depositions as well as provided trial testimony. In January of 2022 JALG was retained by the Kansas Department for Aging and Disability Services to conduct an extensive security review and cultural assessment of the Larned State Hospital, following two recent elopements of patients.

My experience as an expert witness has been informative and educational because it has given me the opportunity to conduct forensic reviews of situations that have not gone well. This is a unique opportunity because late in my career in corrections I was rarely able to delve into and do my own analysis of the incidents that went wrong in the agency. Doing this work now has informed my opinions a great deal and helps me see the common, but sometimes unique failures that result in negative outcomes for correctional agencies and facilities.

The work as an expert has also enabled me to view countless policies and practices of jails and correctional agencies from across the nation. I understand the commonalities of the correctional work as well as the risks these organizations take when they are not responsive to an evolving world.

Knowledge, Skills, and Abilities

Culture Change

Expert understanding of the value of creating a balance between security practices and incarcerated individual programs in order to create a safe and humane correctional environment for the incarcerated and the staff who work there. Significant experience through multiple levels of leadership in leading employees through change to enhance correctional culture, improve practices and deliver better outcomes.

Systems Change

Demonstrated ability to analyze complex situations to find systemic changes that enhance correctional environments, increasing defensibility of practice and reduced tort liability. Specialized expertise in creating agency policy to address emerging issues based on case law and being proactive to increase humanity in the correctional system.

Stakeholder Engagement and Policy Development

Extensive experience working with elected and non-elected members of the legislature and other stakeholder groups including victim advocates and families of incarcerated individuals to find policy solutions to complex social problems and build strategic efforts to move these initiatives forward to become law. Significant experience testifying at hearings and developing relationships with key elected officials with influence over the agency and its budget.

Guided many challenging and adversarial meetings to successful resolutions including collective bargaining agreements, agency policy and public policy. Key stakeholders included Columbia Legal Services, Disability Rights Washington, NAACP, Teamsters Local 117, and the Washington Federation of State Employees.

Labor Relations

Skilled negotiator when working with labor unions or special interest groups with a demonstrated ability to find solutions and achieve mutually beneficial outcomes. Led effort to create new Collective Bargaining Agreement (CBA) language to change an age-old practice impacting bid rights for staff assigned to restrictive housing. In subsequent CBA negotiations with the Teamsters local 117 successfully negotiated first time for Interest Arbitration in a state contract.

Crisis Management

Skilled crisis manager having successfully led various facilities and groups through numerous crisis situations in a complex authorizing environment. Implemented incident command structure to quickly established highly organized response to acute and on-going crises including 16 months of agency leadership during the COVID-19 pandemic.

Leadership Development

Extensive experience mentoring and developing leaders to be successful in their organizations. Significant role in redefining leadership teams to build trust amongst members and establish shared operating norms for teams.

Accomplishments

Secretary – WADOC Headquarters 2017-2021

- Led agency transformation to strengthen alignment between strategic goal to reduce recidivism and agency operations by establishing separate division responsible for successful reentry.
- Developed successful new strategic approach to funding agency budget resulting in the largest budget increase in the agency's history.
- Successfully competed for and was selected by the Vera Institute restrictive housing reform initiative "*Safe Prisons, Safe Communities: From Isolation to Dignity and Wellness Behind Bars*"
- Led delegation to Norway to engage in knowledge sharing and immersive learning experience about their world-renowned approach to corrections.
- Established foundation for significant culture change through extensive work with AMEND and the Norwegian correctional system to adapt best practices to the Washington corrections system as part of a broader effort to shift the culture of the agency.
- Successfully led and navigated numerous political dynamics to pass legislation to improve correctional outcomes (see legislative successes)
- Transformed executive management team from dysfunctional to highly cohesive and trusting that eliminated silos and increased collaboration. Prior to this transformation the team was evaluated and determined to be exceptionally dysfunctional based on the "*The Five Dysfunctions of a Team*" assessment. The post evaluation using the same tool showed a significantly improved culture. Post assessment by the [Coraggio Group](#) showed these improvements - Trust +93%, Conflict +53%, Commitment +68%, Accountability+50%, Results +72%
- Coalesced agency staff from bottom up to change agency mission statement and values to reflect the importance of delivering humane and people-centered corrections work.
- Ensured integration of agency values in daily work by changing the employee evaluation process to prioritize adherence to and demonstration of agency values as primary expectations.
- Drove implementation of the agency's first-ever Dynamic Risk tool to assess incarcerated individuals' risk to re-offend.
- Successfully developed and implemented first WADOC Transgender, Intersex, and/or Gender Non-conforming Housing and Supervision policy.

Prisons Director - WADOC Headquarters 2014-2017

- Implemented agency policy that eliminated punishment for self-harm by individuals with mental illness. Reduced length of segregation time for offenders in crisis and improved conditions of confinement.
- Effectively managed the division budget by ending the fiscal year under budget.

- Designed and implemented an outcomes-based management system for the Prisons Division that focuses on results through the use of performance metrics and quarterly performance reviews
- Created a headquarters outcome-based management system for statewide program managers to clarify roles and responsibilities as well as better align efforts to agency outcomes.
- Implemented incentives to decrease energy use and carbon production in prisons facilities.
- Partnered with colleagues to change internal audit process to monitor individual facility corrective action plans in the areas of Safety, Operations Inspections, Emergency Management, and Critical Incident Reviews. Facility operations became more efficient and agency policy compliance increased and agency risk reduced.
- Partnered with Chief Financial Officer to create a facility fiscal management system to better manage the division's budget. The use of this system has created a common language and process. This has resulted in increased performance and better trained emerging leaders with the skills necessary to effectively manage with limited resources.
- Facilitated the launch of bee keeping programs at all 12 correctional facilities following successful partnership with the Sustainability in Prisons Project to co-host a statewide Bee Summit to promote and expansion of bee keeping within the correctional system.
- Served as agency lead for Teamsters Collective Bargaining Agreement for the 2017-2019 biennium.

Deputy Director Prisons - WADOC HQ 2011-2012

- As Deputy Director partnered with the [Vera Institute](#) to evaluate the use of max custody in WADOC. This resulted in changes in practice that significantly reduced the use of max custody beds and operating costs.
- Initiated partnership with Disability Rights Washington to better serve offenders with disabilities who are housed in specialized units and max custody. The effectiveness of this relationship has prevented potential litigation and improved our service to individuals with disabilities.
- Agency lead for Teamster 117 Collective bargaining
- Initiated significant changes to agency Restrictive Housing policy resulting in 40% reduction of time spent in Restrictive Housing pending administrative action.

Superintendent – Washington State Penitentiary 2008-2014

- Reduced violence through the application of several strategies including Prisons [Cease Fire Model \(intervention of gang violence\)](#), Earned Incentive Program, Creation of Sustainable Practices Lab (Job Creation), and Max Custody Congregate Programming. Maintained 30% violence reduction at the Washington State Penitentiary. (<https://results.wa.gov/archived-decrease-rate-violent-infractions-prison>)
- Created the [Sustainable Practices Lab](#) to reduce idleness and give incarcerated individuals to contribute to our communities and local non-profits. Currently employees over 120 people.
- Partnered with facility Business Advisors to create a fiscal management system that increased ownership and accountability for facility budgets. Reduced facility expenditures by \$1,000,000 in first year in food service and plant maintenance.
- One of the first states in nation to create congregate programming in maximum custody so those with greatest need could be afforded opportunities for change. Significantly reduced rate of return to max custody. Engaged staff in shifting culture to reduce violence against staff and need for uses of force.

- Partnered with Washington State University to start a [Monarch butterfly](#) rearing program in a specialized living unit to improve the diminishing Monarch population.
- Instituted an Earned Incentive Program (incentive based level system) to expand incentives for well behaving individuals. This system allowed individuals who demonstrated good behavior to have expanded access to recreational activities, fund raising events and other incentives.
- Re-started facility gardening program to decrease food cost and provide more fresh vegetables for facility population. Reduced food costs and harvested over 175,000 pounds of fresh produce, which went to the facility kitchens and local non-profit organizations.

Associate Superintendent - Callam Bay Corrections Center & Washington State Penitentiary 2004-2008

- Led an effort to establish assigned seating in the dining hall that eliminated large scale fights and significantly reduced one on one altercations.
- Worked with office clerical staff to develop violence trends and data collection systems which was instrumental in violence reduction efforts.
- Created a work group of managers, supervisors and officers focused on reducing facility violence through data analysis.
- Created work group to review current practices in population management of the facility segregation unit.
- One of only two agency staff selected to participate in the Executive Excellence Program presented by the University of Washington.

Captain – Clallam Bay Corrections Center

- Worked with Roster Manager to create overtime trend analysis to better manage overtime spending. Significantly reduced overtime expenditures.
- Created local Emergency Response Committee to develop a group of subject matter experts to participate in local and statewide audits.
- Led a group of managers and supervisors through a successful audit that resulted in exceptional marks for the facility's security practices.
- Developed a partnership with regional law enforcement agencies for the sharing of resources in various mutual aid events.
- Selected to represent the department in contract negotiations for legislated civil service reform in 2005.
- Designed & implemented facility movement control system (system modeled by other facilities).
- Implemented roster management procedures that dramatically reduced employee grievances related to roster management.
- Received Governor's recognition for facilitating a process improvement team to streamline correctional officer hiring procedures. Greatly increased number of qualified correctional officer applicants which reduced overtime related to vacancies by 150%.
- Facility recognition for exceptional practices - developed, planned and led Correctional Lieutenants in process to prepare facility for departmental security management audits
- Implemented and coordinated Inmate Recovery Team (escape response team) at Clallam Bay Corrections Center and with sister facility.
- Coordinated participation of facility emergency response teams in regional border and narcotics enforcement effort involving local, state and federal law enforcement agencies.
- Planned and coordinated numerous facility wide searches.

- Developed facility violence trend analysis system to better determine where to deploy appropriate resources for targeted results. Reduced facility violence by over 50%.
- Acted as leader of the Security Management group for the development of the CBCC Strategic Plan.

Additional Positions Held

Shift Lieutenant Washington State Penitentiary	1997 - 2000
Correctional Sergeant Washington State Penitentiary	1995 - 1999
Correctional Investigator Washington State Penitentiary	1992 - 1995
Correctional Officer Washington State Penitentiary	1988 - 1992

Special Assignments

Special Emergency Response Team Washington State Penitentiary Squad Leader	1989 - 2000
Inmate Recovery Team Washington State Penitentiary Team Leader Department Coordinator	1995 - 2000
United States Army Honorably Discharged	1984 - 1988

Groups/Organizations

Washington Criminal Sentencing Taskforce (Legislative Body) Member	2020 - 2021
Washington Criminal Justice Training Academy Commissioner	2017 - 2021
Washington Sentencing Guidelines Commission Member	2017 - 2021
Sustainability in Prisons Project Co-Director	2016 - 2021

Correctional Leaders Association Program and Training Committee, Chair Restrictive Housing Committee, Member	2017 - Present
Correctional Peace Officer Foundation Member	2017 -2021
American Correctional Association Member	2014 - 2021
Walla Walla Valley Early Learning Coalition Member	2008 - 2011
Walla Walla Chamber of Commerce Member	2008 - 2014
Walla Walla Executive Alliance Member	2008 - 2014
Inmate Recovery Team Academy Lead Instructor; Agency Coordinator	2001 - 2008
Boy Scouts of America Scout Master	2003 - 2004
Statewide Emergency Response Committee Lead Instructor; Agency Coordinator	2000 - 2005
Departmental Emergency Response Auditor Lead Instructor; Agency Coordinator	2000 - 2008
Departmental Security Management Auditor Lead Instructor; Agency Coordinator	2003 - 2008

Education/Training

Master of Public Administration (MPA) University of Washington, Daniel J. Evans School of Public Affairs	2007 Graduate
Cascade School of Executive Excellence Dan Evans School of Public Affairs, University of Washington	2006
Law Enforcement Officer, Reserve Washington State Criminal Justice and Training Commission Reserve Law Enforcement Academy	March 1997 – October 1997

Washington State Patrol Investigator

Washington State Patrol Academy

September 1992**Correctional Officers Academy**

Washington State Criminal Justice and Training Commission

December 1988**Emergency Medical Technician**Pikes Peak Community College
Colorado Spring, CO**1987 - 1988****Other Training/Certifications**

• Mid-Management	November 2000
• First Level Supervision	March 1996
• Tracking Operations for Technical Teams	April 1994
• Drug Investigator	April 1993
• Audio Intelligence Devices (Montana CJTC)	May 1993
• Advanced SWAT	April 1991
• SWAT Basic	October 1989
• Emergency Response Instructor	April 1998
• Universal Tracking	September 1997
• Firearms Instructor Update	April 1997
• H&K MP5 Operator	January 1997
• Modified Tactical Team	November 1996
• Firearms Instructor	June 1996
• Electronic Restraint Devices	January 1996
• Polaroid Photography for Law Enforcement	October 1995
• Tactical Tracking Instructor	September 1995
• Instructor Development	September 1995
• The Reid Tech. of Interview & Interrogation	May 1995
• Washington State Patrol ACCESS/WACIC	1992 - 1998
• Inmate Tele-monitoring Operations	January 1993
• Explosive Entry Techniques	January 1991

Case Work

1. Deposition & Testimony - Darold R.J Stenson v. Eldon Vail, et al. No. 08-2-02080-8 (March 2009)
(Prevailed in trial)

NOTE: All of the following work has been accomplished since May 2021.

2. Report, Deposition & Testimony – December 14, 2021, Vincent Keith Bell v. Yvette Williams, Michele Fisher, City and County of San Francisco et al., Case No.: 3:18-cv-01245-SI, U.S. District Court, Northern District of California, San Francisco Division. (Prevailed at trial)

3. Report & Deposition - Jack Emmitt Williams v. Lawrence, et al., Case No. 3:19-cv-01369-CRB (PR), U.S. District Court, Northern District of California, San Francisco Division. (Settled)
4. Report & Deposition – Maurice L. Wallace, #R-10764 v. John Baldwin, et al., Case No. 17-cv-00576-DWD, U.S. District Court, Southern District of Illinois. (On-going)
5. Report – Odelvin Jacinto Martinez as Administrator of the Estate of Ferdy Isais Jacinto Martinez v. County of Rockland et.al., Case # 21-cv-1276, U.S. District Court Southern District of New York (Settled)
6. Report & Testimony - Dewayne Earl Bartholomew -Pierce County Superior Court No. 1 Case #. 81-1-00579-1 (Positive Result)
7. Report & Deposition – John Rapp (for Nicholas Winton Rapp) vs. NaphCare, Inc., et al., case # 3:21-cv-05800. Galanda Broadman, PLLC (On-going)
8. Reports (3) & Deposition (2) - Sidley Austin, LLP (All cases on-going) (Some cases information pending expert disclosure)
 - Report & Deposition - Wonder Williams vs Anthony J. Annucci, et al, Case No. 9:20-cv-0147-(BKS-TWD)
 - Report & Deposition – Troy Hendrix vs Anthony J. Annucci, et al, Case No. 9:20-cv-743 (GTS/TWD)
 - Report – Lee Woods vs Anthony J. Annucci, et al, Case No. 9:20-cv-570 (BKS/CFH)
9. Retained – Makyyla Holland vs Broome County; David E. Harder et al Case No 22-CV-00297-DNH-CFH, United States District Court for the Northern District of New York, Paul, Weiss, Rifkind, Wharton & Garrison LLP (On-going)
10. Testimony – State of Oregon vs James Samuel Defrank - Malheur County 9th Judicial District of Oregon Case #11094090C (Not Guilty)
11. Report – Kristi Goldstein vs City of Philadelphia case No. 2:21-CV-01433, United States District Court for the Eastern District of Pennsylvania, Pennsylvania Institutional Law Project (Settled)
12. Report – Gonzalez vs TDCJ Case no. DCCV21-2825-87, District Court of Anderson County, Texas & Gonzalez vs Lumpkin et al case No. 6:21-cv-351, United States District Court for the Eastern District of Texas. Edwards Law, Austin, Texas (On-going)
13. Retained – Oregon Public Defense Services Commission, Office of Public Defense Services resentencing Anthony Scott Garner Case No. 981296 Clatsop County, Oregon (On-going)
14. Retained – Michael T. Smith, (for Jeana Michelle Rogers) vs NaphCare, Inc., & Kitsap County case No. 3:22-cv-05069-DGE. Galanda Broadman, PLLC (On-going)
15. Report – Ethan Lofton, =by and through Veda Leary as Guardian of Ethan Lofton v. Franklin County Mississippi, Amite County, Mississippi Case No. 5:22-CV-0052-DCB-BWR, The Eichelberger Law Firm, PLLC, Mississippi (On-going)

16. Retained – David Derahn, Pierce County Public Defender's Office (On-going)

17. Retained – American Civil Liberties Union (ACLU) National Office (Case information withheld pending expert disclosure)

18. Retained – Bickerman Dispute Resolution, LLC Case information withheld pending expert disclosure)

Consulting

JALG Commissioned by the Kansas Department for Aging and Disability Services to conduct a Security Review and Cultural Assessment of the Larned State Hospital. January 2022 – April 2022

Collective Bargaining & Personnel Matters

Washington PERC # 128405-I-16 Arbitrator's R18

FMCS No. 161203-0576-6 DOC# 1082-3096 Arbitrator's R11

Publications

Politico, Opinion | Why Pell Grants Can Help Fight the Pandemic, December 4, 2020

ATTACHMENT B

Rosas v. Luna
Stephen Sinclair Corrections Expert Review Materials

Rosas Case Documents

Rosas Settlement Agreement (Dkt. 110)
Final Implementation Plan (Dkt. 133-1)

Rosas Monitor Panel Reports

Panel's 1st Report (Dkt. 141)
Panel's 2nd Report (Dkt. 148)
Panel's 3rd Report (Dkt. 181)
Panel's 4th Report (Dkt. 195)
Panel's 5th Report (Dkt. 198)
Panel's 6th Report (Dkt. 199)
Panel's 7th Report (Dkt. 201)
Panel's 8th Report (Dkt. 202)
Panel's 9th Report (Dkt. 203)
Panel's 10th Report (Dkt. 205)
Panel's 11th Report (Dkt. 238)

LASD Policies

Custody Division Manual _ Volume 7 - Custody Operations Force Manual.pdf
LASD Guidelines for Discipline.pdf
WRAP RESTRAINT Monitors and Plaintiffs Proposed Changes 03.07.2023.docx

Use of Force Packages / Videos

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]
5. [REDACTED]
6. [REDACTED]
7. [REDACTED]
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12. [REDACTED]
13. [REDACTED]
14. [REDACTED]
15. [REDACTED]
16. [REDACTED]

Miscellaneous Research / Articles / Other Jurisdictions' Policies

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1205.&lawCode=PEN

<https://post.ca.gov>

11 CCR § 1202, Peace Officer Certificates;

[https://govt.westlaw.com/calregs/Document/IEB831B7058E011EDB4D7A6ED066E269F?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/IEB831B7058E011EDB4D7A6ED066E269F?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

11 CA ADC § 1205 Serious Misconduct;

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