County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

555 W BEECH STREET, SUITE 505, SAN DIEGO, CA 92101-2940
TELEPHONE: (619) 238-6776 FAX: (619) 238-6775
www.sdcounty.ca.gov/clerb

REGULAR MEETING AGENDA
TUESDAY, MARCH 14, 2017, 5:30 P.M.
San Diego County Administration Center
1600 Pacific Highway, Room 302/303, San Diego, 92101

(Free parking is available in the underground parking garage, on the south side of Ash Street, in the 3-hour public parking spaces.)

Pursuant to Government Code Section 54954.2 the Citizens' Law Enforcement Review Board will conduct a meeting at the above time and place for the purpose of transacting or discussing business as identified on this agenda. Complainants, subject officers, representatives or any member of the public wishing to address the Board on any of today's agenda items should submit a "Request to Speak" form to the Administrative Secretary prior to the commencement of the meeting.

DISABLED ACCESS TO MEETING

A request for a disability-related modification or accommodation, including auxiliary aids or services, may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting. Any such request must be made to Ana Becker at (619) 238-6776 at least 24 hours before the meeting.

WRITINGS DISTRIBUTED TO THE BOARD

Pursuant to Government Code 54957.5, written materials distributed to CLERB in connection with this agenda less than 72 hours before the meeting will be available to the public at the CLERB office located at 555 W Beech Street, Ste. 505, San Diego, CA.

1. ROLL CALL

2. MINUTES APPROVAL

a) Minutes of the February 2017 Regular Meeting *(Attachment A)*

3. CONTINUED ITEMS

a) Create Rules & Regulations Ad Hoc Subcommittee

b) Establish CLERB regular meeting schedule *(See Attachment C)*

4. PRESENTATION / TRAINING

a) Introduction of Probation Division Chief David Joralemon

-continued on next page-

5. EXECUTIVE OFFICER'S REPORT

a) Workload Report - Open Complaints/Investigations Report *(Attachment B)*

6. BOARD CHAIR REPORT

7. NEW BUSINESS

a) N/A

8. UNFINISHED BUSINESS

a) State Mandated Ethics Training (AB 1234)

b) 2016-2017 Statement of Economics Interests Form 700 Annual Disclosures

c) Executive Officer Search Committee

9. BOARD MEMBER COMMENTS

10. PUBLIC COMMENTS

a) This is an opportunity for members of the public to address the Board on any subject matter that is within the Board's jurisdiction. Each speaker should complete and submit a "Request to Speak" form to the Administrative Secretary. Each speaker will be limited to five minutes.

11. SHERIFF / PROBATION LIAISON QUERY

12. PUBLIC COMMUNICATION (*Attachment D*)

The following correspondence or news articles are attached to this agenda.

Article Title

The New, More Powerful Wave of Civilian's Oversight of Police

13. RECESS

14. CLOSED SESSION

a) PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE
Discussion & Consideration of Complaints & Reports: Pursuant to Government Code Section 54957 to hear complaints or charges brought against Sheriff or Probation employees by a citizen (unless the employee requests a public session). Notice pursuant to Government Code Section 54957 for deliberations regarding consideration of subject officer discipline recommendation (if applicable)

DEFINITION OF FINDINGS	
Sustained	The evidence supports the allegation and the act or conduct was not justified.
Not Sustained	There was insufficient evidence to either prove or disprove the allegation.
Action Justified	The evidence shows the alleged act or conduct did occur but was lawful, justified and proper.
Unfounded	The evidence shows that the alleged act or conduct did not occur.
Summary Dismissal	The Review Board lacks jurisdiction or the complaint clearly lacks merit.

CASES FOR SUMMARY HEARING (11)

ALLEGATIONS, RECOMMENDED FINDINGS & RATIONALE

13-007

1. Death Investigation/Inmate Suicide - Deputies were summoned and responded to the dayroom, where they found the decedent on the ground with blood near his head. Inmate Robert Lubsen had climbed upon the second Tier railing and dove head-first onto the concrete floor below.

   Recommended Finding: Not Sustained
   Rationale: There was no complaint of wrongdoing in this death investigation; a review was conducted in accordance with CLERB Rules & Regulations, 4.6 Citizen Complaint Not Required: Jurisdiction with Respect to Actions involving Death. Upon discovery of the decedent, detentions staff responded quickly to secure the unit and allow medical staff to begin resuscitative efforts. Lubsen was treated by medical staff and paramedics at the scene before being transported via ambulance and Life Flight to Palomar Hospital. He was diagnosed with nondisplaced skull fractures, sternal fractures, and vertebral fractures. Lubsen's condition did not improve, and on February 12, 2013, he was extubated and later pronounced dead. It is unknown if clarification of conflicting reports from the decedent would have averted this tragedy, and therefore insufficient evidence to determine if misconduct or negligence on the part of Sheriff's Department personnel factored into this inmate suicide.

2. Misconduct/Procedure – Deputy 1 allegedly failed to properly classify the decedent.

   Recommended Finding: Not Sustained
   Rationale: The decedent was arrested for burglary and related crimes and booked into a county detention facility. During medical intake, the decedent denied that he was suicidal, denied any suicidal ideation, and denied having any prior suicide attempts, despite the documentation of a previous suicide attempt (PSA) in the decedent's Jail Information Management System (JIMS) record. A PSA is an Administrative Alert entered into JIMS to more easily identify inmates who have special needs or considerations. According to a department information source, additional, more detailed information about the PSA was possibly available through a medical consultation, and given the conflicting information provided by the decedent, could have been sought by a classification deputy and utilized in the classification decision. A medical consult, with particular emphasis on the conflicting information provided by the decedent, could possibly have resulted in the temporary placement of the decedent in a Safety Cell, pending a psychological evaluation, where he would have been closely monitored, assessed within 24 hours, and placed in mainline housing only upon clearance by medical staff. Given, however, the ambiguity of the information provided by the decedent, his self-report of not being suicidal, coupled with the lack of observable indicators during the classification interview of a person with suicidal ideation or psychiatric issues, there was insufficient data to support a Safety Cell placement, and therefore insufficient evidence to either prove or disprove the allegation.

15-110

1. Death Investigation/Inmate Suicide – Deputy 1 housed Inmate Jason Nishimoto in Administrative Segregation, where he was later found in his cell hanged by the neck with a sheet attached to an overhead air vent.

Recommended Finding: Action Justified
Rationale: There was no complaint of wrongdoing in this death investigation; a review was conducted in accordance with CLERB Rules & Regulations. Jason Nishimoto was arrested on the charge of PC§ 245 (A)(l) Assault with a Deadly Weapon or Force Likely to Produce Great Bodily Injury, after he was involved in a domestic altercation. Family members reported, but it was never confirmed, that the decedent had ingested a large quantity of his psychiatric medication the day before his arrest. Per family members and the decedent, he took the medication as a sleep aid and not in a suicidal attempt; however, as a precautionary measure, the decedent was evaluated and cleared by a Psychiatric Emergency Response Team (PERT) before being transported to Tri-City Medical Center for further evaluation. The decedent was assessed and cleared for booking after denying any suicidal ideation, and Tri-City Medical Center's discharge summary documented that housing on a Medical Observation Unit, or in a Sobering Cell or Safety Cell would not be required. During medical intake at Vista Detention Facility, and again while being assessed by medical and psychiatric staff, the decedent denied that he was suicidal, while also denying any previous suicide attempts. The decedent was screened, assessed, and subsequently classified and housed in Administrative Segregation, pursuant to policies and procedures set forth by the Jail Population Management Unit guidelines, and pending a Regional Center assessment by psychiatric staff. Nishimoto was found hanged during an hourly security check, and was unresponsive to the resuscitative efforts of deputies and medical staff. He was later pronounced deceased at the scene. The Medical Examiner attributed the cause of death to hanging, and the manner to be suicide. Detentions staff classified, housed, monitored and supervised the decedent's activities according to Department policies and procedures, and the evidence showed that the actions of the deputies were lawful, justified and proper.

16-012

1. Death Investigation/Medical – Deputy 1 discovered Inmate Rojelio Torres unresponsive in his cell during a security check.

   Recommended Finding: Action Justified
   Rationale: During a security check on January 1, 2016, the decedent was discovered "down and unresponsive." Emergency medical procedures were initiated by deputies and medical staff in accordance with Sheriff's policy until the decedent was transported, via ambulance, to the hospital where he was diagnosed with a hypoxic brain injury, and his health declined until his death on January 16th. An autopsy was performed and the death was determined to be natural due to cardiac arrhythmia. The actions taken by all involved personnel were lawful, justified and proper.

16-014

1. Death Investigation/Medical – Deputies 1- 3 found inmate Ronald Wells in distress and transported him to the medical unit where he became unresponsive.

   Recommended Finding: Action Justified
   Rationale: The decedent was housed in a psychiatric module and records indicated he was mentally incapacitated and rapidly declining. He was psychologically evaluated, but did not meet Psychiatric Security Unit (PSU) admission criteria and was instead prescribed an antipsychotic medication. On January 16, 2016, the decedent fell down the stairs and was transported to a hospital for medical treatment. Medical tests revealed no acute findings and Wells was released back to jail. On January 19th, the decedent was again in distress and became unresponsive while at medical. Advanced cardiac life support measures were initiated and despite lifesaving efforts, he could not be revived. An autopsy concluded that the cause of death was atherosclerotic cardiovascular disease, and the manner of death was natural. The evidence showed the actions of the deputies were lawful, justified and proper.

16-029

1. Misconduct/Procedure – Deputy 2 allegedly failed to decontaminate the complainant after spraying him with OC spray.

   Recommended Finding: Action Justified
   Rationale: The complainant alleged that after being sprayed with Oleoresin Capsicum (OC spray), Deputy 2 failed to decontaminate him. While in a holding cell awaiting a psychological evaluation, the complainant – a Level 6, Green Band inmate - slipped out of his waist chains and began to violently swing the chains. Deputy 2 instructed the inmate to stop swinging the chains and to turn around to be re-handcuffed, but the complainant refused to comply. Deputy 1 contacted the complainant and after failing to gain his cooperation, informed him that force would be used if he did not comply. The complainant refused to comply, prompting the deployment of OC spray through the food flap of the cell door. The complainant succumbed to the chemical agent, backed up to the cell door, and was re-cuffed and removed from the cell. Surveillance video showed that the complainant was immediately taken down the corridor to medical staff, where he was decontaminated per Addendum F and policy guidelines. These guidelines require that the deputy deploying non-lethal chemical agents ensure that appropriate decontamination measures are undertaken as soon as practical after application. This act did occur and was lawful, justified and proper.

2. Misconduct/Procedure – Deputy 1 allegedly ordered deputies and/or medical staff not to decontaminate the complainant after he was sprayed with OC spray.

   Recommended Finding: Not Sustained
   Rationale: The complainant alleged that Deputy 1 ordered deputies and/or medical staff not to decontaminate him after he was sprayed with OC spray. Deputy 1 denied making this statement, and Deputy 2 denied that he heard Deputy 1 or any other deputy issue such an order. The complainant was immediately decontaminated by medical staff following OC deployment, but absent an audio recording of this entire incident, or an independent witness to this event, there was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – Deputy 1 allegedly left the complainant in a holding cell for 3 hours while “cross-cuffed” and covered in OC spray.

   Recommended Finding: Action Justified
   Rationale: The complainant alleged that Deputy 1 left him in a holding cell for 3 hours while “cross-cuffed” and covered in OC spray. Deputy 1 denied this allegation, stating that the complainant was placed in a holding cell to await his return to his originating facility, but he did not know the exact length of time he was in this cell. Deputy 1 further stated that the complainant was classified as a "Greenbander" due to his violence toward staff and other inmates. The complainant had just displayed "assaultive behavior" by swinging his waist restraints and refusing to cooperate, and being “crossed-chained” was not done out of maliciousness, but because of his overt violent behavior, and to protect the deputies transporting him. Additionally, surveillance video documented that the complainant’s eyes and face had been rinsed by medical staff prior to being placed back in a holding cell. The complainant stated that he slipped his waist chains because the lock had malfunctioned, and he was found to have lied about not being decontaminated. His statements then, regarding the length of time that he was crossed-cuffed in a holding cell, are questionable leaving a preponderance of evidence that Deputy 1’s actions were lawful, justified and proper.

4. Excessive Force/Handcuffs – Deputy 2 allegedly handcuffed the complainant excessively tight.

   Recommended Finding: Not Sustained
   Rationale: The complainant alleged that Deputy 2 handcuffed him excessively and unbearably tight in order to punish him. Deputy 2 stated that the complainant was cross-cuffed as a more restrictive, yet more effective way of securing combative inmates, as opposed to securing waist chains on an inmate with their hands hanging by their sides. This was done in order to prevent the complainant from slipping the waist chains again, which would pose a threat to deputies and staff members. He denied, however, that the complainant was handcuffed excessively tight. Medical records did not note any obvious injuries to the complainant, nor were pictures taken

of the complainant following this incident due to his assaultive behavior and continued threats. While the need to ensure that an inmate is properly secured is understood, it is unknown whether or not the line between "secured" and "excessive" was crossed, leaving insufficient evidence to either prove or disprove this allegation.

5. Misconduct/Discourtesy – Deputy 1 allegedly suggested that the complainant use toilet water to decontaminate himself after being sprayed with OC spray.

   Recommended Finding: Not Sustained
   Rationale: The complainant alleged that Deputy 1 suggested that he use toilet water to decontaminate himself after being sprayed with OC spray. This allegedly took place after medical staff had rinsed the complainant's eyes and face, and he was placed in another holding cell. Deputy 1 denied the allegation without explanation, and Deputy 2 denied that he heard Deputy 1 make this statement. Absent an audio recording or an independent witness to this statement, there was insufficient evidence to either prove or disprove the allegation.

6. Misconduct/Truthfulness – Deputy 1 allegedly "lied" when he documented that medical staff had decontaminated the complainant by "rinsing his eyes," when they allegedly hadn't.

   Recommended Finding: Action Justified
   Rationale: The complainant alleged that Deputy 1 "lied" in a report when he documented that medical staff had decontaminated him by "rinsing his eyes," when they reportedly hadn't. Following the deployment of OC spray on the complainant, surveillance video captured medical staff decontaminating the complainant by rinsing his eyes and wiping his face. Deputy 1's report of this decontamination process is corroborated by video evidence, Deputy 2's report and medical records, showed that his statements regarding this incident were truthful, justified and proper.

16-031

1. False Arrest – Deputy 4 arrested the complainant.

   Recommended Finding: Action Justified
   Rationale: The complainant said Deputy 4 arrested her, but then offered no further details pertaining to this allegation and was unavailable for explanation. Deputies 3 and 4 were dispatched to investigate a family disturbance, which was confirmed by the reporting party. Deputies gave the complainant several commands, which she ignored. The complainant then reportedly kicked and pushed a rolling chair into Deputy 4's legs before she swung an open hand, striking him in the face and causing an abrasion. After a struggle, deputies arrested the complainant for Resisting an Executive Officer. Deputies are authorized to use force that is reasonable and necessary to effect an arrest and overcome resistance. The evidence showed that the arrest, and the force used, was lawful, justified and proper.

2. Excessive Force – Deputy 1 "choked the complainant out."

   Recommended Finding: Action Justified
   Rationale: The complainant reported that while at the Courthouse, she suffered a PTSD induced panic attack and flinched when a deputy went to grab her arm. A use of force ensued, at which time the deputy "choked her out," and dangled her off the ground. The complainant said she suffered "TMJ" from the chokehold, and she could not even swallow until after she was released from custody. Inmates awaiting court proceedings informed deputies that the complainant was "going off." Deputy 2 gave the complainant commands, but she failed to comply, distanced herself from staff, and yelled, "Don't touch me!" Deputy 1 applied a carotid restraint with minimal pressure on the complainant's neck until she stopped resisting; he did not render her unconscious. The complainant was evaluated for injury, but said she did not require medical attention. The video evidence showed the complainant's resistance, and that the actions taken by deputies were lawful, justified and proper.

16-033

1. Misconduct/Procedure – Deputy 2 allegedly "stole" the complainant's legal paperwork, food and/or hygiene items.

   Recommended Finding: Summary Dismissal
   Rationale: The complainant failed to identify the involved members upon submittal of his signed complaint, and was unavailable for clarification upon receipt of departmental evidence. He left local custody on an unknown date and was not found to be in state custody or at his last reported known address. Correspondence was sent to an out-of-custody address which was not returned, but went unanswered. Efforts to contact the complainant via a telephone number listed in CLERB's data base, was also unsuccessful. Upon opening of all investigations, complainants are duly informed that they are obligated to cooperate fully with our investigation, and that failure to maintain current contact information with our office may result in their case being submitted to the Review Board for closure. The complainant's current whereabouts are unknown, preventing a thorough review and investigation of this complaint.

2. Misconduct/Procedure – Deputy 2 allegedly refused to sign and/or log the complainant's grievance.

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale #1

3. Misconduct/Retaliation – Deputy 2 allegedly threw the complainant in the "hole" for filing grievances.

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale #1

4. Excessive Force – Deputy 1 & Deputy 2 allegedly slammed the handcuffed complainant violently against a wall, causing bruising to his left shoulder and both wrists.

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale #1

5. Misconduct/Procedure – Deputy 1 allegedly denied the complainant his legal documents.

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale #1

6. Misconduct/Procedure – Deputy 1 allegedly denied the complainant medical care after a use of force.

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale #1

16-039

1. Misconduct/Procedure – Deputy 1 allegedly failed to provide the complainant a requested report.

   Recommended Finding: Summary Dismissal
   Rationale: The complainant reported that after filing a report of alleged crimes against her, Deputy 1"denied" her a complete report. This allegation as filed by the complainant did not show a prima facie showing of wrong doing. Attempts were made to contact the complainant to clarify her complaint issues, but were unsuccessful; the complainant had failed to maintain contact with the CLERB office following the filing of her complaint. Correspondence was sent to the complainant's P.O. Box address listed in CLERB's data base, but was neither returned nor answered. A telephone call was made to the complainant's listed number and a message was left. To date, there has been no response. Upon opening of all investigations, complainants are duly informed that

they are obligated to cooperate fully with our investigations, and that failure to maintain current contact information with our office, may result in their case being submitted to the Review Board for closure. The complainant's current whereabouts are unknown, preventing a thorough review and investigation of this complaint.

2. Misconduct/Procedure – Deputy 2 allegedly referred the complainant to the Psychiatric Emergency Response Team (PERT) without "indicating a reason (s) for doing so."

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale #1

16-041

1. Illegal Seizure – Deputy 1 had the complainant's vehicle improperly towed.

   Recommended Finding: Action Justified
   Rationale: The complainant said her car was towed from an area with signage that had incorrect times listed. She said, "I am alleging financial motivation, predatory towing practices, and that the construction company is liable for providing/posting incorrect and unclear signs, as well as the tow company, Road One Towing, for towing my car outside of the posted times." Deputy 1 was flagged down by an engineering employee that was responsible for posting tow away signage in their construction zone. They had looked for the vehicle owner without success and the vehicle was impeding their project. Deputy 1 documented the signage, had the vehicle towed, and entered it into the system as a stored vehicle. Deputy 1 was authorized by VC§ 22651, Circumstances Permitting Removal of Vehicle, to have the vehicle towed and the alleged act was lawful, justified and proper. Sheriff's policy dictates that if an owner disputes their findings, they may file a claim with the County for fees associated with the towing and storage and the complainant was referred to County Claims.

2. Misconduct/Procedure – Deputy 1 allegedly entered inaccurate evidence into the complainant's case.

   Recommended Finding: Action Justified
   Rationale: The complainant alleged that incorrect evidence was entered into her case when Deputy 1 used a different sign to establish "proof" of a legal tow. According to Deputy 2, the towing of a vehicle does not require the collection of evidence per se; however deputies will often photograph any observed violations or signs in the area prior to towing a vehicle. The photographs that Deputy 1 took were properly placed into the Uniform Resource Locator (URL) folder for the case number related to the incident and also transferred to a non-rewritable CD and logged into evidence at a Sheriff's station. The evidence showed that the items logged by Deputy 1 were lawful, justified and proper.

16-051

1. Death Investigation/Medical – Inmate Adrian Sanchez experienced two medical emergencies during the booking process, and subsequently died of methamphetamine intoxication.

   Recommended Finding: Action Justified
   Rationale: Deputy 3 arrested the decedent for an outstanding warrant and possession of methamphetamine. During processing, Sanchez was acting sluggish and said he was hypoglycemic. He cleared medical screening, but prior to being screened by x-ray, Sanchez fell forward and began to convulse. Deputy 3 advised paramedics and hospital personnel of the possibility that Sanchez had ingested narcotics, but Sanchez denied it. Hospital staff treated Sanchez for his epileptic seizure and held him for observation for approximately 7 hours until he was released and cleared to be booked into custody. Sanchez was then x-rayed and cleared for booking by detentions medical staff who marked his booking paperwork with an "expedite to medical" request, and placed him into a holding cell. Less than two hours later, inmates alerted Deputy 2 that Sanchez was having another medical emergency. Deputies 1 and 4 entered the cell and found Sanchez lying on the floor in the middle of the

cell. Nurses rendered first aid and moved Sanchez to a medical area for additional medical resources. As paramedics were transporting Sanchez, he went into cardiac arrest and died approximately 4 hours after deputies found him in distress. Based on the autopsy findings, the cause of death was listed as acute methamphetamine intoxication, with epilepsy as a contributing factor. The medical examiner concluded that the elevated level of methamphetamine was similar to levels noted in other cases where individuals either swallowed or inserted illicit drugs for concealment or transport. Detention staff did not know how or when the decedent obtained methamphetamine. The x-ray findings were negative, and no foreign material was found in his gastrointestinal tract. There was no complaint of wrongdoing and the death investigation review showed that the deputies' actions were lawful, justified and proper.

17-005

1. Misconduct/Medical – The complainant submitted a signed complaint alleging violations related to confinement, medical neglect and abuse.

   Recommended Finding: Summary Dismissal
   Rationale: The complainant's submitted statement did not specify any deputy misconduct. The complainant was contacted and clarified that his complaint revolves around medical staff over whom CLERB has no authority.

Continued

EXECUTIVE OFFICER
(VACANT)

County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

555 W BEECH STREET, SUITE 505, SAN DIEGO, CA 92101-2940
TELEPHONE: (619) 238-6776 FAX: (619) 238-6775
www.sdcounty.ca.gov/clerb

February 27, 2017 **Attachment C**

TO: Review Board

FROM: Sandra I. Arkin, Board Chair

PROPOSAL: CHANGE MEETING TIME TO 3:00 PM

This item, to change the monthly meeting time from 5:30 to 3:00 p.m., was continued from the February 2017 agenda so that all Board members could contemplate.

RATIONALE:

- Having a public meeting in the County Administration Building (CAC) after normal business hours requires Sheriff's staffing for security. The cost is $132/hour for two deputies; a new expense that has not been budgeted for and would require authorization.
  - Traffic is lighter at that time of day.
  - The air conditioning goes off at 5:00 p.m., and there is no exception to keep it on.
  - Historically, there have been ten - eleven annual meetings to provide for a summer and/or winter break.
  - Meeting elsewhere in the County would put an undue burden on staff.
  - The current location/room is available and/or there is meeting space available in the same building.

http://www.governing.com/topics/public-justice-safety/gov-police-civilian-oversight-oakland-seattle.html

The New, More Powerful Wave of Civilian Oversight of Police

Cities are strengthening civilians' authority over law enforcement officers. But just how far should their power extend?

BY J.B. WOGAN | FEBRUARY 27, 2017

In Oakland, Calif., police will soon answer to civilians newly entrusted with the power to discipline officers and fire the chief. Last November, the city's residents voted to create a civilian-run commission with a level of authority over law enforcement that is rare in this country.

“This was a no-brainer given Oakland’s history,” says Rashidah Grinage, coordinator of the Coalition for Police Accountability, a group that helped write the ballot measure, which faced no formal opposition and passed with 83 percent of the vote. “Most people realized that it would be futile to try to argue against instituting a police commission of this nature.”

The Oakland Police Department has been under federal oversight since it settled a lawsuit in 2003 for $10.5 million. More than 115 plaintiffs alleged in the suit that four rogue officers had beat and planted evidence on them.

The reforms in Oakland parallel similar changes in large cities around the country. In the last election alone, voters strengthened civilian oversight of police in Denver, Honolulu, Miami, New Orleans and San Francisco.

“We’re in the middle of a national police crisis, and that’s created a lot of public support for a stronger form of citizen oversight,” says Samuel Walker, author of the book *Police Accountability: The Role of Citizen Oversight.*

In the 1980s, when Walker began studying the issue, he found only 13 civilian oversight agencies in America. Today, there are more than 200.

The notion that a civilian-led organization should police the police has received a spike in attention since the fatal 2014 shooting of Michael Brown, an unarmed black teenager, in Ferguson, Mo. In the wake of Brown's shooting, former President Obama's Task Force on 21st Century Policing recommended that localities adopt some form of civilian oversight “to strengthen trust with the community.” Similarly, the Ferguson Commission -- an independent study group appointed by the Missouri governor -- and Campaign Zero, a national group associated with Black Lives Matter, have also called for more civilian oversight.

Historically, police unions have opposed greater oversight by civilians, says Walker. In some places, that was still true in the last election. The Oakland Police Officers Association, for example, spent money on negative

campaign mail in an effort to unseat two city councilmen who cosponsored the oversight ballot measure. (Both won re-election.)

In its present form, civilian oversight usually doesn't guarantee a meaningful check on police. Some places only have a passive agency that receives and reviews citizen complaints but has little independence or authority over the police department. Others have an auditor that can proactively investigate and make public recommendations about systemic issues. But regardless of their structure, most commissions can't force the department to adopt their advice.

The coming changes in Honolulu and Oakland, however, represent a new wave of civilian oversight. Both civilian commissions will be able to fire the police chief, and in Oakland's case, also to discipline officers.

"The [new] commission will not recommend. It will impose," says Grinage, in reference to Oakland.

Not all proponents of strong civilian oversight, however, think civilians should have the right to discipline law enforcement. Walker, the author, says it could backfire.

"We want to heighten the accountability of the chief. We want to turn the spotlight on the chief and say, 'You are the head of this agency and it's your responsibility to fix these problems. The last thing we want to do," he says, "is create a situation where the chief can say, 'Hey, it's not my problem. You took that power away from me.'"

Walker argues that civilian oversight can have a greater impact if it focuses less on punishing individual officers and more on fixing systemic problems.

"To really improve policing, it requires organizational reform, as opposed to investigating individual citizen complaints," he says. "Let's assume the agency succeeds in disciplining an officer. That doesn't change the organization. Even if it results in the officer being fired or quitting, that officer will be replaced by another officer subject to the same culture, the same inadequate policies, inadequate training [and] poor supervision that the previous officer was."

Despite the fact that civilian oversight has existed in some form since the early 20th century, it's still not clear that it's effective. Academics have not yet studied the impacts of different civilian oversight models.

But clarity may be on its way.

In the past two years, the National Association for Civilian Oversight of Law Enforcement published reports that shed light on the relative strengths and weaknesses of various approaches to civilian oversight. For example, complaint-and-review-based models tend to be less expensive because they rely on citizen volunteers, but they also may lack resources, expertise and independence. Agencies that conduct audits, however, can affect long-term, systemic change, but they may not address specific, high-profile incidents of

concern to local civil rights activists. To expand upon those recent reports, the Obama administration in its last year awarded the group with a grant to study nine oversight agencies and develop best practices.

Even places known nationally for forward-thinking approaches to civilian oversight have some of the same problems plaguing police departments around the country.

Take Seattle: In the 1990s, it was one of the first places to have a civilian-led unit focused on investigating complaints and making recommendations. Decades later, it ended up under federal oversight after the U.S. Department of Justice found "a pattern or practice of excessive force that violates the U.S. Constitution and federal law."

The city has since identified issues with its civilian oversight and is working to improve them. One such problem is that the office lacked credibility both inside and outside the police department.

"In some parts of the community, the Office of Professional Accountability (OPA) was viewed with hostility and seen as nothing more than a rubber stamp used by the police to justify misconduct under the guise of independent investigations," OPA Director Pierce Murphy wrote in a retrospective report last year.

The problems with OPA are illustrative of how the operational details of citizen oversight matter. In many ways, the office appeared to be part of the police department, not an autonomous unit. The director's office was located inside the Seattle Police Department headquarters. Its media relations, community outreach and public website were coordinated by the police department's public affairs office. Letters from the office were printed on police department letterhead.

OPA also used to share its recommendations with the police department before publishing a public report. If the police chief chose not to adopt some of them, he or she didn't have to explain why.

Under Murphy, OPA has moved into its own office building and gotten its own website. His team now publishes investigative findings without waiting for a response from the police chief, and the chief has to respond in writing when she disagrees with a recommendation. In a move that would satisfy Walker, the group also now issues "management action recommendations" that try to examine and improve systemic issues.

Even with all the recent tweaks under Murphy, civilian oversight in Seattle is likely about to undergo further change. After months of negotiation with a federal monitor, Seattle Mayor Ed Murray sent legislation to the city council in early February that would create an independent civilian inspector general.

J.B. Wogan | Staff Writer jwogan@governing.com | @jbwogan