



201 W. Colfax Ave., Dept. 1201
Denver, CO 80202
p: 720.913.3306
f: 720.913-3305
www.denvergov.org/oim

September 10, 2014

The Honorable Paul D. Lopez
Safety & Wellbeing Committee Chairman
District Three Council Office
4200 Morrison Road # 7
Denver, Colorado 80219

Re: Critical Issues to be Addressed in the Reform of the Denver Sheriff Department

Dear Chairman Lopez:

I write this letter in response to your verbal and written requests that the Office of the Independent Monitor (“OIM”) provide the City Council Safety and Wellbeing Committee with “input and findings” into the “possible causes” of the misconduct issues that have recently surfaced in the Denver Sheriff Department (“DSD”), and recommendations to address them. I also write pursuant to my obligations under Denver Municipal Ordinance to “make recommendations regarding policy issues” in the Denver Police Department (“DPD”) and the DSD, and to “address any other issues of concern to the community.”¹

As you know, the past eight months have been a time of upheaval and transition for the DSD. In its December 2013 Semiannual Report, the OIM discussed its investigation of the inmate grievance process in Denver’s jails, finding four systemic issues that compromised accountability, and making eleven actionable recommendations to address them. In the weeks that followed, the DSD commendably responded by significantly improving the accessibility of the complaint process for inmates. Yet, recent months have brought additional public scrutiny and critique of the DSD in other forums. The news media obtained and broadcast several videos documenting deputies using extremely troubling inappropriate force against inmates, prompting a public outcry. In July 2014, the City of Denver agreed to pay \$3.25 million to settle a high-profile civil rights lawsuit arising from incidents at the Downtown Detention Center (“DDC”). In addition, DSD leadership has been in flux, with Sheriff Gary Wilson stepping down in July, while the Administration has now initiated a national search for Denver’s next Sheriff.

These developments have prompted a collective call for answers from the community, faith leaders, City officials, and the DSD staff itself. Why has this happened? More importantly, are these developments the result of systemic problems in the DSD and, if so, what can be done to fix them? Mayor Michael B. Hancock has announced a series of steps to find answers, make changes and ultimately reform the DSD. This includes creating various taskforces to review DSD policies and procedures, soliciting community feedback, and hiring an independent consultant (“Independent Consultant”) to conduct a “top to bottom” organizational assessment of the DSD and suggest changes.

¹ See D.R.M.C. Art. XVIII § 2-371(b).

As you know, the OIM provides oversight of the DPD and the DSD through the review of internal investigations, disciplinary proceedings, and policies in those departments. The OIM staff includes former federal and local prosecutors, a criminologist, and a community relations liaison. To provide policy oversight, the OIM analyzes DPD and DSD procedures, examines best practices in jails and police departments around the country, and consults with officers, deputies, community members, inmates, and national experts on policing and corrections.² This work, and our independence from the departments that we oversee, provide the OIM with a unique opportunity to identify systemic issues that may foster or contribute to potential patterns of misconduct.

From this vantage point, and in the pages that follow, I identify several areas of DSD organizational policy and practice that I believe have contributed to the misconduct issues discussed above, and that require particular attention in the reform of the DSD.³ These include: 1) current significant supervisory gaps at the Downtown Detention Center, 2) deficiencies in DSD use of force reports and the use of force database, 3) inadequate retention of video documenting uses of force, 4) problems with the deputy rounds tracker system, and 5) weaknesses in the DSD's early intervention system. This letter also includes suggestions for a deeper examination of two policy areas recently implicated in disciplinary cases involving the use of inappropriate force: the authority granted to DSD deputies as peace officers to stop or arrest individuals, and the role of mental illness in Denver's jails.

In this letter, I do not comment in detail on the four areas that will be reviewed by the Independent Consultant as a condition of the settlement agreement between Jamal Hunter and the City and County of Denver: 1) inmate classification, 2) screening and recruitment of deputies, 3) disciplinary best practices, and 4) best practices related to Internal Affairs, although I agree that they merit examination, and make several limited observations about them below.⁴

Before discussing specifics, I want to make clear that DSD deputies perform a critical public safety function under extremely challenging circumstances, and most do so with talent and commitment to public service. A number of deputies have expressed to me that they are as troubled by the recently-revealed conduct of some of their fellow deputies as is the public itself. The goal of the current reform process must be to fix the systemic deficiencies that have compromised accountability in the DSD, without unfairly impugning the entire DSD staff with the misdeeds of what is only a small percentage of deputies. I look forward to working with the community, the Administration, City Council, the Citizen Oversight Board ("COB"), the DSD Reform Executive Steering Committee, the Independent Consultant, the Sheriff, and the DSD staff on this important effort.

² I thank the following individuals for sharing their time and expertise in our recent examination of jail and prison policies and practices: Professor Joseph Sandoval (Metropolitan State University), Rick Raemisch (Colorado Executive Director of Corrections), Steve Hager (Colorado Director of Prisons), Dr. Thomas W. White (Federal Bureau of Prisons, retired), Donald Leach (American Jail Association, retired), Mike Gennaco (Office of Independent Review), Julie Ruhlin (Office of Independent Review), Dr. Mary West (Colorado Department of Corrections, retired), and Rick Lichten (Los Angeles Sheriff Department, retired). The views expressed in this letter are those of the OIM, not the individuals with whom we have consulted.

³ Your requests sought OIM recommendations related to policy or ordinance. While this letter focuses on policy rather than ordinance change, the Citizen Oversight Board is sending you a letter dated September 10, 2014, in which one important ordinance change is proposed.

⁴ See Jamal Hunter v. City and County of Denver, 12-CV-02682-JLK (D. Colo.).

I. Supervisory Gaps at the Downtown Detention Center

Effective and frequent supervision of deputies by sergeants is one of the core principles of good jail management, and is necessary to ensure effective jail operations, to promote accountability, and to deter deputy misconduct. In many direct supervision jails (like our jails in Denver), most deputies are stationed alone inside inmate housing areas, frequently for long periods of time, and deputy isolation can become problematic.⁵ Contact between sergeants and deputies is one of the primary ways that a jail is able to set, convey and reinforce its performance expectations to deputies.⁶ In addition, because of their opportunities for frequent interaction with deputies, sergeants are uniquely positioned to identify deputies who are engaging in misconduct, and to take corrective action.⁷ To be effective at deterring misconduct and addressing deputy misbehavior, sergeants must frequently visit and be highly visible in inmate housing areas.⁸

National correctional organizations emphasize the importance of frequent supervision. According to the National Institute of Corrections:

Frequent Supervision by Management

[Jail] management must take an active role in ensuring that staff are successful in supervising inmates. Supervisors and administrators must maintain a high profile on [inmate housing] units to assure that staff are performing their duties correctly and according to established policy.⁹

The importance of frequent supervision to successful jail operations has been echoed in other jail practice guides.¹⁰ Frequent supervision of deputies is “essential to the supervisor’s knowledge of what is taking place throughout the jail, managing the shift, assessing staff performance, and providing coaching and support to individual staff.”¹¹ Indeed, the National Institute of Corrections has noted that “[w]ithout effective supervision, staff may begin to perform their duties in a way that is contrary to [principles of good jail management]—unbeknownst to either the supervisors or the administrator.”¹²

Frequent supervision is also critical to deterring deputy misconduct, and identifying problematic deputy behavior before it escalates into serious impropriety.¹³ As one analysis of patterns of jail misconduct noted, “a well-qualified deputy may fail if given poor support, training and supervision.”¹⁴ Effective and frequent supervision of deputies also helps to shield a city from the risk of potential civil rights lawsuits filed by inmates.¹⁵

⁵ Nat’l Inst. of Corrections, Direct Supervision Jails, the Role of the Administrator at 37.

⁶ Id. at 23.

⁷ See, e.g., Id. at 23; Police Executive Research Forum, Supervision and Intervention Within Early Intervention Systems at 9.

⁸ See, e.g., Nat’l Inst. of Corrections, Direct Supervision Jails, the Role of the Administrator at 57.

⁹ Id. at 57.

¹⁰ See, e.g., Nat’l Inst. of Corrections, Sheriff’s Guide to Effective Jail Operations, 31 (“It is incumbent on the jail administration to provide active, ongoing supervision to staff to ensure that the knowledge and skills developed in training are used in the jail and to ensure that staff are following the jail’s policies and procedures.”).

¹¹ Nat’l Inst. of Corrections, Direct Supervision Jails, the Role of the Administrator at 39.

¹² Id. at 23.

¹³ See, e.g., Police Executive Research Forum, Supervision and Intervention Within Early Intervention Systems at 9.

¹⁴ Report of the Los Angeles Citizens’ Commission on Jail Violence at 123.

¹⁵ Gerard J. Horgan, The Main Areas of Inmate Litigation in the 21st Century (“Strong supervision of deputies and frequent visits by supervisors to oversee the officers under their command is an important tool for reducing a jail’s exposure to costly litigation”).

The Role of Sergeants at the DDC

Sergeants are the front-line supervisors in the DSD, and many of their official duties involve supervising deputies.¹⁶ Specifically, DSD sergeants are required to:

“monitor[], guide[], correct[] employee performance, instruct[] and resolve[] problems encountered in new or unusual assignments . . . review[] and evaluate[] work performed by deputy sheriffs for effectiveness, resolve[] problems associated with security [and] . . . conduct[] briefings and staff meetings.”¹⁷

Despite this official policy, a number of supervisors and deputies have stated that DDC sergeants are often absent from the inmate housing pods for entire shifts, and sometimes multiple shifts at a time.¹⁸ Instead, many DDC sergeants spend the bulk of their shifts completing paperwork and managing each jail floor’s staffing roster, instead of supervising deputies. For example:

- *One sergeant told the OIM that official policy requires sergeants to circulate to all inmate housing areas under their command at least once every shift to supervise the deputies staffing those units. Yet, this sergeant also reported that on some shifts, approximately 90% of his time is spent on “filling rosters,” rather than supervising deputies. According to this sergeant, the DSD is currently having difficulty filling shifts, and the sergeant must spend most of his work day calling off-duty officers to try to get them to cover overtime shifts for other officers who are sick or on vacation (i.e., “filling the roster”). This sergeant also indicated that when he was promoted to sergeant, he was given only a short training course, but was otherwise basically “expected to know the job already.” He did not feel that he was adequately trained to be a supervisor in Denver’s jails.*
- *A captain reported that, at present, the sergeants under his command generally spend 80%-90% of their time “filling rosters.” Instead of being on the floor supervising deputies, his sergeants are “stuck” in an office making phone calls and doing paperwork. He described this as a “significant” problem in the DDC, noting that one of his sergeants has begun taking the roster home in order to make phone calls to deputies in the evenings and weekends, so that he can attempt to supervise deputies during the work day.*
- *Another sergeant reported that he often spends 70%-90% of his shifts filling the roster and completing other routine paperwork. He is concerned that he has little time to supervise or interact with the deputies under his command.*

¹⁶ See DSD Employee Manual at 22 (May 2014).

¹⁷ DSD Sergeants also have administrative responsibilities that include “establish[ing] priorities and assign[ing] work activities, [and] preparing written work schedules.” *Id.* Preparing written work schedules and finding officers to work each shift is colloquially known as “doing” or “filling” “the roster.”

¹⁸ In 2014, the OIM began a review of disciplinary cases involving deputies failing to perform rounds through inmate housing areas. In the course of this review, OIM staff interviewed deputies, supervisors and commanders in Denver’s jails to examine the mechanisms by which the DSD ensures that rounds are conducted. Interviewees were chosen by DSD supervisors on duty, and represent a small percentage of the deputies working in Denver’s jails, rather than a broad survey of the entire DSD staff.

These sergeants, and others, expressed frustration with these limitations, noting that they would be actively supervising deputies if not for the burden of managing the shift roster and completing associated paperwork.¹⁹ DDC deputies with whom we spoke corroborated that supervision is often absent in the DDC, and that they largely spend their time alone in the housing pods, with little interaction with their assigned sergeants. For example:

- *One veteran DDC deputy reported that the DSD’s “biggest problem” is a lack of first-line supervision. A sergeant visits his pod probably once every other shift, and usually “pops in” for thirty seconds, then leaves. He indicated that in nearly a decade as a deputy, he can only think of one instance in which he got either positive or negative feedback from a sergeant (other than in his annual personnel evaluation). The deputy indicated that he believes that the lack of supervision is not unique to his housing area or sergeant. He is routinely asked to relieve deputies in other pods. On more than a few occasions, he has found the pods to be in disarray, with inmates having hung sheets and towels up that obstruct the view from the deputy’s desk, in violation of policy. He noted that when deputies are not keeping order in the pods, sergeants should be addressing it immediately. He also noted that in his opinion, many sergeants appear to be “afraid to make waves” with deputies, and instead many of them try to make friends with the deputies under their command.*
- *Another veteran DDC deputy stated that he is visited briefly by his assigned sergeant on approximately every other shift. He noted that some sergeants are “old school” and spend more time being hands-on with deputies. He said that once a new deputy graduates from the Training Academy, the deputy is assigned to shadow an experienced FTO (Field Training Officer) for a number of weeks. After that time, the new deputy is assigned to a housing area and from then on, “no one supervises” the deputy, who is on his or her own in a housing pod.*
- *Another DDC deputy reported that a captain usually stops into his pod briefly once or twice a month. He stated that the amount of interaction between deputies and sergeants depends on the sergeant. With some sergeants, the only time a deputy will see them is when the deputy is walking by the sergeant’s office, he said. Other sergeants may stop into the housing area every other shift or so. This deputy also noted that after a new officer has completed the FTO program, they are “kind of on their own” in the inmate housing areas.*

These supervisory gaps at the DDC, and the perception by deputies that they are not being supervised, reduce mentoring of deputies, diminish opportunities for the early identification of deputy performance problems, and create conditions that could foster misconduct. Indeed, other jurisdictions across the United States that have wrestled with patterns of deputy misconduct and inappropriate use of force in jails have found inadequate supervision to be a key element of the problem. For example, in Los Angeles, deficient or absent supervision was identified as key to having fostered a jail culture that permitted deputy misconduct to flourish.²⁰

I believe that the current staffing model and work allocation that has many DDC sergeants prioritizing paperwork over actively supervising deputies should be changed. The National Institute of Corrections has noted that tasks that distract jail “supervisors from [their] essential duties should be reviewed to

¹⁹ I understand that the City of Denver’s Peak Performance Team is currently examining issues related to DSD staffing and workload.

²⁰ See generally, Report of the Los Angeles Citizens’ Commission on Jail Violence.

determine if they are necessary, if they can be performed overnight while the inmates are sleeping, if they can be performed by staff other than the housing officers and supervisors, or if they can be performed in a different way that decreases the time required.”²¹ I suggest that the DSD heed this advice, and I make four specific recommendations in this area:

1. The OIM recommends that the current work assigned to DSD sergeants be reviewed to identify and implement strategies to free sergeants from the administrative burdens that hinder their frequent and engaged supervision of deputies, including but not limited to the preparation and management of the daily shift roster, a task that may be better handled by administrative staff instead of sergeants;
2. The OIM recommends that there be an assessment of whether there are other causes of the supervisory gaps discussed above. This should include a systematic staffing assessment to examine the overall jail staffing and supervision model, the number of deputies supervised by each sergeant (their “span of control”) and the number of staff available to cover each shift at the DDC;
3. The OIM recommends that the DSD review and enhance the training provided to new sergeants to ensure that it thoroughly prepares them to supervise deputies, and make available additional resources that will enable sergeants to be more effective at providing supervision; and
4. The OIM recommends that the DSD evaluate the training provided to deputies, including but not limited to Academy Training and the training provided by Field Training Officers, to ensure that it adequately prepares deputies for the work of supervising inmates.

II. Deficiencies in Use of Force Reports and the Use of Force Database

Thoroughly investigating uses of force and making reliable determinations about whether they complied with law and policy is essential to creating a culture of accountability in a jail. National standards for law enforcement departments emphasize the importance of accurate and complete reporting on uses of force, which enables the identification of trends and patterns that may call for action by supervisors.²² I believe that the DSD framework for reporting and tracking uses of force has significant flaws that compromise the investigation and review of uses of force in Denver’s jails at present.

DSD policy requires deputies to prepare written reports documenting all physical force that they use or witness, ranging from “hands on” physical force to lethal force.²³ The policy requires that these reports (“use of force reports” or “OIC Reports”) must contain: “a detailed chronological description of the incident to include who, what, where, when, how, why (if possible), any injuries and medical treatment provided.”²⁴ They must also “be accurate and limited to factual events free from opinion or prejudice and detail all of the necessary information to provide a complete depiction of the incident, to include actions both taken and observed.”²⁵

²¹ Nat’l Inst. of Corrections, Direct Supervision Jails, the Role of the Administrator at 24.

²² *See generally*, Letter from U.S. Attorney Preet Bharara to Mayor Bill DeBlasio, CRIPA Investigation of the New York City Department of Correction Jails on Riker’s Island (August 4, 2014).

²³ *See* DSD Department Order 5011.1M(7).

²⁴ DSD Department Order 1115.1A (5)(C).

²⁵ DSD Department Order 1115.1A (5)(C).

After deputies complete use of force reports, the reports are entered into the DSD’s electronic Jail Management System (“JMS”). In addition to a narrative description of the use of force, the following information must also be included in JMS about each incident: incident type, the jail where it occurred, the location of occurrence inside the jail, the names of the involved deputies and inmates, and the level of force and equipment used during the incident.²⁶ DSD supervisors are required to review all use of force reports to determine whether the uses of force that they document complied with DSD policy and state law.²⁷ Specifically, supervisors are required to “review the use of force report[s] and indicate in writing whether DSD policies and Colorado Revised Statutes . . . have been followed and the force used was appropriate.”²⁸

Despite these requirements, the OIM has observed that the information often recorded in DSD use of force reports is sparse, with little of the necessary detail required to reliably assess the propriety of the force used. Indeed, many deputy use of force reports that have been reviewed by the OIM, even on serious uses of force resulting in injury, are a paragraph or two long, contain vague descriptions of the incident, and draw conclusions without sufficient supporting evidence. For example, use of force reports sometimes assert that an inmate was “resisting,” or state a conclusion about an inmate’s level of resistance (e.g., “active aggression”) without articulating the inmate’s specific actions. The conclusory nature of this kind of narrative description, without sufficient detail, may in many instances prevent even diligent supervisors from conducting meaningful assessments of whether the force used was appropriate or not. This observation is borne out by several recent disciplinary cases in which the responding supervisors judged serious uses of force to be appropriate, but later Internal Affairs investigations and disciplinary review determined that the force was inappropriate and merited serious disciplinary action for the involved deputies.

Even if DSD use of force report narratives were more comprehensive, DSD policy is still inadequate in that it permits sergeants to make a determination about the propriety of the force used by merely “review[ing] the use of force report and indicat[ing] in writing whether DSD policies” and state law were followed.²⁹ The policy does not require supervisors to speak with the involved inmate(s), or witness inmate(s) before making their assessment about the lawfulness of the force, nor does the policy require supervisors to review medical records, video footage, or any other evidence. In some cases that the OIM has reviewed, DSD supervisors have gone beyond relying on the report narrative alone, and have conducted more comprehensive evaluations of the available evidence. But doing a comprehensive review of the evidence on uses of force should not be a matter of discretion; it should be a requirement.³⁰

Similarly, capturing narrative descriptions in use of force reports while recording only minimal quantifiable use of force information inhibits meaningful analysis of patterns and trends in uses of force in Denver’s jails. Many law enforcement agencies require officers to record a wide variety of variables

²⁶ See DSD Department Order 1115.1A.

²⁷ See DSD Department Order 5011.1M(7)(A)(1); Colorado law requires law enforcement officers to report uses of excessive force to their immediate supervisor (CRS §18-8-802).

²⁸ See DSD Department Order 5011.1M(7)(A)(1).

²⁹ See DSD Department Order 5011.1M(7)(A)(1).

³⁰ See, e.g., DPD Operations Manual § 105.02(1)(c)(requiring supervisors responding to a use of force to “personally contact the officer immediately after the incident. The supervisor will interview witnesses and suspects, collect evidence and take photographs when appropriate. The supervisor will assist in preparing the Use of Force/Injury Report, paying particular attention to the facts of the incident.”). I believe that this is a sound policy, as it enables a more comprehensive review by the responding supervisor, as well as later evaluation by Internal Affairs, command staff, and the OIM.

about uses of force in order to make a use of force database more readily searchable. The DPD, for example, tracks specific information about the level of resistance, the apparent role of mental illness or intoxicants in the incident, any weapons used, specific description of type of force, the manner in which the force was used, the nature of the call that prompted the force, and the identities of all involved officers and supervisors.³¹ The relative depth of this searchable data permits the identification of particular shifts, areas, officers, supervisors, or kinds of calls that result in the use of force, which enables proactive action to address any concerning trends.

In addition, a number of law enforcement departments, including the DPD, send completed use of force packets to their Internal Affairs Bureaus for review after the responding supervisor has made his/her determination about whether the force was appropriate or not. This enables the Internal Affairs Bureaus in those departments to determine whether each use of force requires a more comprehensive investigation than the one conducted by the responding supervisor—a sound policy. While such a system would not be feasible under the current structure and level of staffing of the DSD Internal Affairs Bureau, once changes are made to DSD Internal Affairs, I believe that the DSD should evaluate whether they could emulate those other departments in this respect. Therefore:

5. The OIM recommends that the DSD revise its use of force reporting standards to require deputies and supervisors to submit comprehensive narrative descriptions of the circumstances surrounding any use of force, including specific detail about the particular actions of the involved deputies and inmates, rather than conclusory assertions;
6. The OIM recommends that DSD revise its use of force reporting framework to capture more specific variables about uses of force that can be quantified in order to enable more robust pattern and trend analysis of uses of force inside Denver's jails;
7. The OIM recommends that the DSD revise its policy to require supervisors responding to any use of force to interview involved deputies and inmates, and deputy and inmate witnesses, on video, and to collect and review other available evidence prior to making a determination about the propriety or lawfulness of any use of force;
8. The OIM recommends that the DSD evaluate the feasibility of sending all use of force packets (which include deputy use of force reports, any evidence gathered by the responding supervisor, and the responding supervisor's cover sheet) to the DSD Internal Affairs Bureau for an evaluation of whether a more comprehensive investigation should be conducted of the use of force than the one conducted by the responding supervisor; and
9. The OIM recommends that the DSD provide comprehensive training to all DSD deputies and supervisors about the new use of force standards outlined above.

³¹ See DPD Use of Force Reports.

III. Retention Period for Use of Force Video Should be Enlarged

Each year, inmates file complaints of inappropriate force with the OIM or DSD Internal Affairs. In many of the resulting Internal Affairs investigations, the involved deputies and inmates describe the incidents very differently. Without video footage to resolve these discrepancies, it can be difficult to prove or disprove whether the force used was appropriate or not.

Video from the cameras inside Denver's jails is generally retained for a period of thirty days and then erased, unless a supervisor specifically decides to preserve that footage.³² For various reasons, including a fear of potential retaliation, inmates often wait until after their release from custody before filing complaints alleging inappropriate force. Because there is currently no requirement that video of all uses of force be preserved beyond thirty days, video is sometimes deleted by the time the inmate actually files his/her complaint. In at least one case recently reviewed by the OIM, this compromised the investigation of a serious alleged use of inappropriate force that an inmate complained of after his release.³³ To prevent this from recurring:

10. The OIM recommends that DSD revise its policy to require that all available video footage of all uses of force be automatically preserved indefinitely; and
11. The OIM recommends that an assessment be conducted of the estimated costs for lengthening the retention period for all footage from cameras in DSD jails to a period that is longer than 30 days.

IV. Deputy Rounds Tracker System can be Improved

Inmate and community safety are integral to the core mission of the DSD.³⁴ The DSD has implemented many policies to promote inmate safety, perhaps none more important than the policy requiring deputies to routinely perform "rounds" through inmate housing areas. Doing rounds involves deputies walking through inmate pods at regular (but unpredictable) intervals and looking inside all cells to make sure that there are no safety issues or emergencies.³⁵ When supervising inmates in the general population, DSD

³² One of the reasons commonly cited for a short video retention period is that storing video for a lengthy period of time can become cost prohibitive.

³³ In 2014, an inmate complained about two incidents involving the alleged use of inappropriate force by deputies in the DDC Intake Area. The inmate complained that both of his wrists were fractured, which was corroborated by his medical records. Evidence obtained during the investigation suggested that the inmate's wrists may have been broken before he interacted with the deputies. In both incidents, DSD deputies completed incident reports stating that minor force had been used against the inmate. The inmate ultimately filed his complaint after his release from jail, and because more than thirty days had elapsed, no video was preserved to prove or disprove his claims.

³⁴ The DSD defines its mission as providing "safety and security for the community by ensuring care, custody, transportation and reentry services for detainees by operating safe, secure, efficient and humane facilities that adhere to federal, state, and local laws." See Denver Sheriff Department 2013 Annual Report at 4.

³⁵ DSD policy imposes various requirements on deputies performing rounds, including checking all doors, the condition of cells and housing areas, and looking for any potential safety hazards. DDC Procedures Manual § 802.00 ("A round is a visual and physical inspection by an officer of their assigned area which includes, but is not limited to focusing on unusual occurrences, security issues, welfare of inmates, staff, and the public."). DSD policy also instructs deputies doing rounds to "be especially alert to the health and wellbeing of all prisoners and the security of the area." See Downtown Division Procedures § 2004.00.

deputies are required to do rounds once every thirty minutes,³⁶ while more frequent rounds are required of high risk inmates, such as inmates on suicide watch or in special management populations.

Proper performance of rounds is critical to ensuring inmate welfare, deputy safety, and jail security, and rounds are required in prisons and jails throughout the United States. Rounds have been identified as key to correctional suicide prevention,³⁷ as well as to reducing the risk of sexual abuse and assault in prisons and jails.³⁸ Rounds can also help to minimize a city's exposure to potential liability where inmates are harmed and later sue.

The DSD has taken a number of steps towards ensuring that deputies consistently do their rounds, including imposing strong disciplinary penalties on deputies who fail to perform rounds.³⁹ The DSD has also trained deputies on the importance of rounds, and has installed "rounds tracker" technologies (described below) to automate the tracking of deputy rounds.⁴⁰ Notwithstanding these steps, in 2014, several disciplinary cases were handled that involved deputies failing to do rounds at the DDC. For example:

- *A deputy failed to conduct multiple rounds through his inmate housing area during a several hour period. At the end of this period, an inmate was found attempting suicide by hanging himself from his cell bunk bed. The inmate's cellmate found him and informed the deputy, who failed to take timely action to cut the inmate down. The inmate was ultimately cut down by a sergeant, and then revived. The deputy was terminated for failing to do rounds, and neglect of other duties.*
- *An inmate accused a deputy of bringing alcohol, marijuana, and crack cocaine into the jail, and allowing inmates to fight. An internal investigation did not substantiate these allegations. However, video footage demonstrated that the deputy repeatedly failed to perform rounds in the inmate housing area over a several hour period. The deputy also left the lights off in violation of policy, and allowed inmates to watch music videos on a DSD computer. The deputy admitted to each of these violations, and also admitted to routinely choosing not to use the rounds tracker provided by the DSD. The deputy further indicated a belief that deputies were allowed to "run our pod[s] any way we want." The deputy was terminated for this misconduct.*
- *A deputy repeatedly failed to conduct rounds during a shift and logged false or misleading information indicating that those rounds were completed. Video revealed that instead of conducting rounds, the deputy used an unauthorized cell phone and read a newspaper. During this period of inattention, an inmate had a medical emergency, and was later transported to Denver Health Medical Center. The deputy also brought a large unauthorized knife into the inmate housing area, and used it to cut food during the shift supervising inmates. The deputy also permitted lights to remain off in the housing pod, in violation of policy. The deputy was facing*

³⁶ See Downtown Division Procedures § 2004.00.

³⁷ See generally U.S. Dept. of Justice, Letter Regarding Mental Health and Suicide Prevention at Los Angeles County Jails (June 4, 2014).

³⁸ See U.S. Dept. of Justice, Findings Letter Regarding Investigation of Jail Annex, Oklahoma City, OK (July 31, 2008) at 3-5.

³⁹ See generally DSD Discipline Handbook, Appendix E.

⁴⁰ I generally support the use of this technology, however, note that "[t]echnologies are not replacements for skilled and committed security officers . . ." See National Prison Rape Commission Report at 6. See also Urban Institute Justice Policy Center, Preventing Violence and Sexual Assault in Jails: A Situational Crime Prevention Approach.

three disciplinary cases related to three separate misconduct investigations, and ultimately resigned.

These cases were not minor deviations from policy, but rather reflected blatant neglect of duty, and are not typical of the performance of DSD deputies in general. These deputies were appropriately held accountable by the Office of the Executive Director of Safety. Yet, in addition to addressing the individual acts of misconduct, the cases raise concerns about why these deputies felt free to so flagrantly neglect one of their core duties without fear of discovery. The supervisory gaps discussed above are one likely cause. Another is problems with the DDC rounds tracker system.

The DDC rounds tracker system automates the tracking of deputy rounds by requiring deputies to scan bar codes that are affixed to various locations throughout an inmate housing pod with an electronic device when they are conducting a round. The time and location of each one of these scans is then transmitted to an electronic tracking system, where it can be reviewed to ensure that deputies were actually walking through the inmate housing areas at the required intervals.⁴¹

The rounds tracker system does not measure whether or not the rounds were comprehensive and actually involved checking on inmates, merely whether or not deputies actually walked through their assigned inmate housing areas at the appointed times. Yet, to be effective at achieving this goal, the system must provide jail supervisors and administrators with easily accessible information about whether any deputies have failed to perform required rounds, and when. This could take the form of a regularly generated missed rounds report, or an alert to supervisors when a deputy under their command has missed rounds. Unfortunately, the OIM has been told that the DDC rounds tracker system does not currently have this functionality. Instead, supervisors who wish to check the rounds tracker system for compliance must engage in a laborious and time-consuming process of looking at individual inmate housing areas, individual shifts and deputies one-by-one. This inefficiency compromises the effectiveness of the rounds tracker technology now in use at the DDC.

In addition, some sergeants have also relayed that checking on deputy rounds in the rounds tracker system is largely considered to be a captain's responsibility, and that many sergeants do not generally check the rounds tracker system for rounds compliance. As sergeants are supposed to be providing front-line supervision of deputies, sergeants should play a significant role in verifying deputy compliance with the rounds requirement. Therefore:

12. The OIM recommends that the DSD determine whether the DDC rounds tracker software system now in place can be altered to enable routine reporting of missed rounds, such as the generation of a missed rounds report at regular intervals, and if not, explore whether a different rounds tracker system that has such functionality can be acquired; and
13. The OIM recommends that sergeants be given greater responsibility and accountability for monitoring whether the deputies under their supervision are performing rounds.

⁴¹ Some research suggests that rounds tracker technologies may be effective at decreasing inmate and staff misconduct, and may decrease inmates' perceptions of threats of physical violence and the likelihood and ease of acquiring contraband. *See, e.g.,* Nancy G. LaVigne et al, Evaluation of a Situational Crime Prevention Approach in Three Jails: The Jail Sexual Assault Prevention Project, (2011).

V. Early Intervention System can be Strengthened

Cities are increasingly recognizing the importance of early intervention systems for enhancing accountability in law enforcement departments.⁴² Early intervention systems electronically track information about deputy performance, including complaints, uses of force, and other variables, to help identify problematic behavior early in a deputy's career. When such behavior is identified, interventions such as additional training, mentoring, or reassignment may be implemented. Early intervention systems are widely considered to be a best practice in law enforcement, and evidence suggests that such systems may increase deputy accountability and strengthen relationships between supervisors and the staff they oversee.⁴³ In addition, research has found that the use of such systems has a direct impact on deputy behavior, and may reduce complaints and uses of force over time.⁴⁴

Model early intervention systems typically track an exhaustive set of performance indicators, including internal and citizen complaints, uses of force, civil suits, performance evaluations, failure to fulfill training requirements, and use/misuse of sick leave, among others.⁴⁵ When a deputy exceeds the threshold on a particular indicator, an evaluation is conducted to determine whether that employee requires intervention and if so, what steps would be most likely to help the deputy meet performance standards in the future.

The DSD recently began implementing a version of an early intervention system, which it has called the Employee Progression and Recognition Tracking System ("EPARTS"). EPARTS is a non-disciplinary program designed to help supervisors identify patterns of potentially problematic behavior and provide appropriate interventions (and to identify employees who are performing exceptionally well).⁴⁶ Under DSD policy, deputies will be flagged for EPARTS review and possible intervention (or commendation) when they exceed thresholds on three variables: use of force (three or more within a quarter), response to a duty-related death (one), and awards or commendations (one). I commend the DSD for moving to adopt an early intervention system. Yet, the current EPARTS framework excludes several performance indicators that are very important for ascertaining the risk of potential deputy misconduct. In particular, early intervention systems customarily track civilian/inmate complaints, and civil lawsuits that allege deputy misconduct, as both are strong indicators of potential misconduct risk. I believe that the exclusion of these variables from EPARTS compromises its effectiveness as an early intervention system for the DSD. Therefore:

14. The OIM recommends that additional performance indicators be added to EPARTS, including but not limited to inmate complaints and grievances, as well as civil lawsuits alleging deputy misconduct, and that the DSD consult with experts and/or peer agencies to determine whether other performance indicators should be tracked in EPARTS.

⁴² U.S. Dept. of Justice Office of Community Oriented Policing Services, Early Intervention Systems for Law Enforcement Agencies: A Planning and Management Guide at 53.

⁴³ U.S. Dept. of Justice, Principles for Promoting Police Integrity at 10 ; U.S. Dept. of Justice Office of Community Oriented Policing Services, Early Intervention Systems for Law Enforcement Agencies: A Planning and Management Guide at 54; The Commission on Accreditation for Law Enforcement Agencies (CALEA), Standards for Law Enforcement Agencies, Standard 35.1.15.

⁴⁴ Nat'l Inst. of Justice, Early Warning Systems: Responding to the Problem Police Officer at 3.

⁴⁵ U.S. Dept. of Justice Office of Community Oriented Policing Services, Early Intervention Systems for Law Enforcement Agencies: A Planning and Management Guide at 27.

⁴⁶ See DSD Department Order 2505.1A

VI. Deputy Peace Officer Authority Requires Reexamination

The DSD has a range of important public safety responsibilities, including running Denver's jails, securing its courts, serving civil process, and managing the City's vehicle impound facility. To carry out these responsibilities, DSD deputies are non-POST certified peace officers under the laws of the State of Colorado.⁴⁷ While DSD deputies are not patrol officers and do not police Denver's streets, Denver's Office of the Executive Director of Safety has authorized DSD deputies to exercise peace officer authority to stop or arrest suspects under certain limited circumstances. This includes rendering aid to DPD officers, and in situations involving exigent circumstances (such as when a criminal offense has been committed that involves a substantial risk of death or serious bodily injury and immediate action is necessary to stop or apprehend the person responsible).⁴⁸

Many DSD deputies may understand the scope of their limited authority to stop or arrest suspects. Yet, I believe that the 20-page policy that grants them this authority, which is infused with legalese, is confusing and requires reexamination.⁴⁹ In addition, several disciplinary cases have recently been handled that involved DSD deputies exercising quasi-police powers to improperly stop or arrest suspects. This includes a deputy who stopped a vehicle and eventually fired at its driver when the deputy felt threatened, and a deputy who approached a vehicle at gunpoint in a convenience store parking lot when he erroneously believed that its driver had an unauthorized firearm or was about to commit a crime. These cases emphasize the need for further examination of this policy, including determining the circumstances, if any, under which DSD deputies should have the authority to stop or arrest suspects, clarifying and simplifying the policy, and providing additional training to deputies on the scope of their authority under the policy. Therefore:

15. The OIM recommends that the DSD reexamine Department Order 2001.11 ("Exercise of Authority as a Peace Officer to Stop or Arrest Suspects") in order to: 1) determine the circumstances, if any, under which DSD deputies should have the authority to stop or arrest suspects; 2) clarify and simplify the policy; and 3) provide additional training to deputies on the scope of their authority under the policy.

VII. The Role of Mental Illness in Denver's Jails Requires Examination

Over the past half-century, the United States has experienced significant changes to its infrastructure for treating those suffering from mental illness. In 1959, almost 559,000 mentally ill patients were housed in state mental hospitals.⁵⁰ By the late 1990s, a shift to "deinstitutionalize" mentally ill persons had dropped the number of persons housed in public psychiatric hospitals to approximately 70,000.⁵¹ Many of those "deinstitutionalized" persons now live in the community and routinely come into contact with the criminal justice system.⁵²

⁴⁷ See C.R.S. § 16-2.5-103.

⁴⁸ See DSD Department Order 2000.11.

⁴⁹ As one example of the need for a comprehensive review, this policy authorized "bias based profiling" by DSD deputies "when authorized by the Sheriff or Executive Director of Safety for safety of staff and the public" until May 2014 when the OIM raised a written objection to this provision. Bias based profiling, which is generally unconstitutional, has now been removed from a more recent iteration of the policy.

⁵⁰ See Nat'l Inst. of Corrections, Mentally Ill Persons in Corrections (available at <http://nicic.gov/mentalillness>).

⁵¹ Id.

⁵² See generally The Office of the Independent Monitor's 2013 Annual Report (noting that over half of the officer-involved shootings in Denver in 2013 involved persons who appeared to be in mental health crisis at the time of their police contact).

Estimates of the percentage of municipal jail inmates who have mental illness vary. Some research suggests that approximately 1 in 7 male jail inmates and 1 in 3 female jail inmates have a serious mental illness (or 17% overall), a rate 6 times higher than for the general population.⁵³ In addition, inmates with mental illnesses are likely to stay in jail for twice as long as inmates with no mental health issues but similar charges and risk of re-arrest.⁵⁴ DSD staff have anecdotally reported that a relatively high percentage of inmates in Denver's jails suffer from, and are being treated for, mental illness.

A number of DSD deputies have received Crisis Intervention Training ("CIT"), which can be an important tool for learning how to successfully deal with persons with mental illness, who may not always be able to understand and properly respond to law enforcement commands, and may put deputies at greater safety risk.⁵⁵ Yet, several recent inappropriate force disciplinary cases involved inmates who either reported hallucinations, or were obviously in the midst of a mental health crisis at the time that inappropriate force was used against them. As the City undertakes its top-to-bottom review, one area of examination should be how to successfully manage and care for the high number of inmates with mental illness who are in Denver's jails, with a specific focus on training deputies and sergeants on issues around use of force with mentally ill inmates, in addition to other issues that are critical with this population. Therefore:

16. The OIM recommends that the DSD examine the current management and treatment of mentally ill inmates, the training provided to deputies and sergeants on mental illness, particularly related to the use of force, and other issues associated with having a relatively high percentage of persons with mental illness detained in Denver's jails.

VIII. Changes Must be Made to the Internal Affairs Bureau and the Disciplinary Matrix

An effective Internal Affairs Bureau with sufficient investigative resources is a key element of accountability in any law enforcement department.⁵⁶ For several years, the OIM has registered its concern that it has taken too long for investigations into alleged deputy misconduct to be completed.⁵⁷ As has recently been reported in the print media, the caseload and backlog in DSD Internal Affairs is growing, which is cause for additional concern.⁵⁸ The lengthy timeline for investigating and resolving jail misconduct complaints at present is unacceptable for accused deputies, for the public, and for the investigators in DSD Internal Affairs who are working hard under challenging conditions. The OIM staff looks forward to working with the Administration and the Independent Consultant on a long-term solution to this problem, which will likely involve dedicating additional resources to DSD Internal Affairs, taking steps to restructure the unit, and making significant investments in investigator training.

⁵³ Steadman, H.J., Osher, F.C., et al., Prevalence of Serious Mental Illness Among Jail Inmates, Psychiatric Services, November 2007; 58: 1472-1478, (2009).

⁵⁴ Council of State Governments Justice Center, Improving Outcomes for People with Mental Illness Involved in New York City's Criminal Court and Corrections System, 2013.

⁵⁵ Center for Problem Oriented Policing, The Problem of People With Mental Illness (2006).

⁵⁶ See, e.g., U.S. Dept. of Justice, Principles for Promoting Police Integrity ("Misconduct investigations should be thorough and impartial, and conducted in a reasonable, timely and consistent manner.").

⁵⁷ See, e.g., The Office of the Independent Monitor's 2012 Annual Report at 64 (noting that the expanding timelines for conducting internal affairs investigations "may prevent [the] department from acting quickly to correct or deter deputy misconduct, may lower morale, and tend[] to undermine public and department trust in the complaint process.").

⁵⁸ See http://www.denverpost.com/news/ci_26223276/denver-jail-inmate-internal-affairs-probes-swell-by

In addition, because providing a safe and secure environment for inmates is part of the core mission of the DSD,⁵⁹ disciplinary penalties for inappropriate force must be strong enough to deter potential misconduct, while also being fair to deputies. I believe that the DSD Disciplinary Matrix provisions on inappropriate force need to be restructured to ensure that they achieve both goals. I understand that the DSD's Discipline Taskforce is planning to recommend significant and necessary revisions to the disciplinary penalties associated with the use of inappropriate force, and I look forward to seeing these changes enacted.

Thank you for the opportunity to share my thoughts and views with you. This letter is not an exhaustive list of all "possible causes" of the recent misconduct issues in the DSD, but it does include a number of significant recommendations that I believe are critical to the reform of the DSD. If I can be of further assistance to you, other members of the City Council, or to the Safety & Wellbeing Committee, please let me know.

Sincerely,



Nicholas E. Mitchell
Independent Monitor

cc: Michael B. Hancock, Mayor
Christopher Herndon, City Council President
Dennis J. Gallagher, Auditor
Denver City Council members
Stephanie Y. O'Malley, Executive Director of Safety
Elias Diggins, Sheriff
DSD Reform Executive Steering Committee Members
Citizen Oversight Board Members

⁵⁹ See Denver Sheriff Department 2013 Annual Report at 4; 13.