Date: April 27, 2005

To: Hon. Louise Renne, President
    Members, San Francisco Police Commission

Re: In-custody death review board (DGO 8.12)

Dear President Renne and Commissioners:

Similar to officer-involved shootings, in-custody deaths\(^1\) are devastating events that often prompt strong community reaction. The San Francisco Police Department does not have a review process for in-custody deaths that includes investigative time-lines, civilian oversight representation and reporting requirements to the public and this Commission. Thus, when this Commission began discussing the role of the Firearm Discharge Review Board on February 16, 2005, the OCC requested that in-custody deaths be included in its purview. While this Commission declined to include in-custody deaths at that time, several members expressed interest in creating a review process for in-custody deaths.

On February 11, 2005, the Department provided the OCC Department General Order 8.12 which establishes a protocol for in-custody death investigations and review procedures. Given the need for transparency and accountability in the review of both officer-involved shootings and in-custody deaths, the OCC has revised DGO 8.12 in light of this Commission’s extensive discussions and actions concerning DGO 8.11 and 3.10.

This letter explains the need for an in-custody death review process that is similar to officer-involved shooting cases, outlines the essential components of DGO 8.12 and gives a history of the negotiations between the Department and the OCC. Attached to this letter is the OCC’s revised version of DGO 8.12.

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\(^1\) DGO 8.12 defines an in-custody death as “any death that occurs when a person is restrained by law enforcement personnel by means of physical restraints, detained or confined in a law enforcement vehicle, or detained or confined in a jail or detention facility.”
I. In-Custody Deaths Should Be Subjected to the Same Level of Scrutiny and Accountability As Officer-Involved Shootings.

Although in-custody deaths in San Francisco are thankfully infrequent (ranging on average from zero to five a year)\(^2\), the San Francisco community is strongly impacted when an individual dies in SFPD custody. Just as the Department states it is committed to reviewing its training, policy and procedures in light of the circumstances that lead to firearm discharges by members (see DGO 3.10), the Department needs to provide this same level of concern, review and accountability to in-custody deaths.

Several jurisdictions subject in-custody deaths to the same level of scrutiny as officer-involved shootings. For example, in Phoenix, a review board comprised of six members, three of whom are civilians, review both in-custody deaths as well as officer-involved shootings. In Dallas, no distinction is made in the review process between in-custody deaths and officer-involved shootings. In Portland, in-custody deaths and officer-involved shootings are covered under the Department’s “Deadly Force” directive. Additionally, Police Assessment Resource Center which assists city officials, oversight bodies and police executives in assessing and resolving police-community problems strongly recommends that protocols for the timely investigation and review of officer-involved shootings be accorded to in-custody deaths as well.

These jurisdictions recognize that communities want police accountability and transparency regardless of whether the loss of human life occurred because of the discharge of a weapon or by some other means while the individual was in the custody of the police. This Department should join these other forward-thinking jurisdictions that subject in-custody death cases to the same level of scrutiny that officer-involved shootings are.

II. DGO 8.12 Provides the Same Investigative Deadlines, Review Board Procedures and Reporting Requirements That Are Currently Contemplated Under DGOs 3.10 and 8.11

Because of the similarities between officer-involved shootings and in-custody deaths, the OCC revised DGO 8.12 in light of the extensive discussions this Commission has conducted concerning officer-involved shootings. Thus, the identical investigative timelines, administrative leave, reporting requirements and review board procedures have been included. While the Department’s original draft contemplated an In-Custody Death Review Board comprised of only law enforcement personnel (including a captain of training division and police department physician), similar to DGO 3.10, the OCC’s version includes the OCC director in an advisory role and a San Francisco Police Commissioner (with voting capacity) to be appointed by the San Francisco Police Commission President for a one-year term. Identical to officer-involved shooting cases, under OCC’s revised 8.12, officers involved in an in-custody death would receive assistance from the Crisis Incident Response Team and be given a minimum 10-day

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\(^2\) Given the low number of in-custody deaths, the OCC strongly recommends that the Police Commission reconsider whether it would be more efficient to expand the Firearm Discharge Review Board’s jurisdiction to include in-custody deaths.
administrative leave while the In-Custody Review Board and Behavioral Science Unit recommended to the Police Chief whether it is appropriate for the involved member to return to duty. Identical to DGO 3.10, OCC’s revised DGO 8.12 requires the Police Chief to write a written report to the Police Commission with a copy to the OCC of his/her decision of whether or not to return the member to field duty. Identical to DGOs 3.10 and 8.11, OCC’s revised DGO 8.12 requires the same investigative deadlines: completion of the Homicide Detail Investigation within forty-five days of the in-custody death, completion of the Management Control Division investigation within sixty days, and the Review Board’s issuance of findings within 120 days.

The Department’s original version of 8.12 includes more findings than permitted for officer-involved shootings. The Department suggests four findings: 1) proper conduct; 2) improper conduct; 3) policy failure; and 4) training failure. The OCC strongly agrees that findings concerning training and policy failure are critical to the review process.3

III. The OCC and the Department Have Reached An Impasse; The OCC Requests the Police Commission To Review the OCC’s Revised DGO 8.12 and Provide Guidance As to A Protocol For In-Custody Deaths.

From early January 2005 when the OCC approached the Department to include in-custody deaths in the contemplated Firearm Discharge Review Board, the OCC stated that civilian representation (through the OCC Director) was an essential component of any review process. Noting that no civilian representation was included in the Department’s In-Custody Death Review Board, the OCC again voiced this concern when it received the Department’s version of DGO 8.12 on February 11, 2005.

On March 23, 2005 the OCC provided the Department (and the POA) a line-edited revision of DGO 8.12 that was consistent with the Police Commission’s discussions and actions concerning officer-involved shootings. The OCC requested a meeting with the Department on April 6, 2005 to discuss among other policies, the Department’s response to the OCC’s revisions of DGO 8.12. At that meeting the Department declined to discuss any aspect of the Department’s response, stating that it wanted to see what action the Commission took on DGOs 8.11 and 3.10 at the April 6, 2005 hearing. The Department agreed to meet with the OCC on April 19 to discuss this policy and to provide the OCC a written response by April 15, 2005.

On April 8, 2005 the OCC provided the Department (and the POA) a revised version of DGO 8.12 that incorporated changes proposed or acted upon by the Police Commission on April 6, 2005. To facilitate a more expeditious process and because of the similarity in issues, the OCC also requested by letter that the Department present this revised version to the POA during its next meet and confer session scheduled to address DGOs 8.11 and 3.10. The Department declined to present it to the POA. The Department provided no written response to the OCC on April 15 or at any other time as to the OCC’s suggested revisions. Because the Department had declined to discuss DGO 8.12 at the April 6th meeting which had been specifically set up to

3 In its February 16, 2005 presentation to the Commission on officer-involved shootings, the OCC strongly advocated that the Firearm Discharge Review Board have the authority to make a policy failure finding. The Department opposed this recommendation.
discuss DGO 8.12 and because it declined to provide any written response to the OCC’s suggested revisions, the OCC cancelled the meeting on April 19, 2005 and informed the Department of its intention to bring DGO 8.12 before the Police Commission for the May 4th meeting.

IV. Conclusion

Currently the Department lacks a written protocol for the investigation and review of in-custody deaths. These cases are often highly charged and controversial and impact the community to the same extent that officer-involved shootings do. Our agency believes that in-custody deaths should be subject to the same degree of scrutiny as officer-involved shootings; the protocols of other police departments reflect this principle as well.

DGO 8.12 raises the identical issues such as composition of the Review Board, investigative deadlines, administrative leave and reporting requirements that this Commission, the Police Department, the Police Officer’s Association and our agency have spent several months debating in the context of officer-involved shootings. The OCC requests this Commission to review the OCC’s suggested revisions and take the necessary steps to adopt a written protocol concerning the investigation and review of in-custody deaths.

Sincerely,

Samara Marion
OCC Policy Analyst

cc: Police Chief Heather Fong, Deputy Chief Antonio Parra, Captain Charles Keohane, Steve Johnson (POA representative), Sgt. Riley (Police Commission Secretary), Mariam Morley (City Attorney), Doris Roberts (City Attorney).
This order outlines the rules and procedures to be followed in the investigation, review and reporting to the Police Commission and resolution of In-Custody Death Investigations. The definition of an In-Custody Death is any death that occurs when a person is restrained by law enforcement personnel by means of physical restraints, detained or confined in a law enforcement vehicle, or detained or confined in a jail or detention facility.

I. POLICY

It is the policy of the San Francisco Police Department to immediately respond to the scene of, and conduct a complete investigation of any death of person(s) who die while in the custody of the San Francisco Police Department, or, the San Francisco Sheriff’s Department.

The In-Custody Death Review Board shall review every in-custody death that occurs when a person is restrained by a SFPD member by means of physical restraints, detained or confined in a law enforcement vehicle, or detained or confined in a jail or detention facility.

The purpose of this review process is to ensure that the department is continually reviewing its training, policy and procedures in light of the circumstances that lead to the in-custody death and to determine if the SFPD member acted properly at the time of the in-custody death.

The San Francisco Police Department recognizes the public’s right to know about the circumstances involving an in-custody death. It is the policy of the San Francisco Police Department to provide as much information as possible through this public reporting process while complying with applicable civil and criminal laws and preserving the integrity of ongoing investigations.

II. PROCEDURES

A. IN-CUSTODY DEATHS OCCURRING IN SAN FRANCISCO POLICE DEPARTMENT FACILITIES, VEHICLES, OR CUSTODY. As soon as practical after a

1 Changes in red and underlined are OCC suggested revisions. These changes have been made in light of the Police Commission’s discussions and actions concerning officer-involved shootings. (DGOs 8.11 and 3.10)
person dies while in the custody of the San Francisco Police Department, the following notifications shall be made:

1. If practical, the member(s) involved shall notify Emergency Communications Division (ECD), and his/her immediate supervisor, or the platoon commander of the district in which the in custody death took place.

2. ECD shall immediately notify the Field Operations Bureau Headquarters (Operations Center after normal business hours.)

3. The Field Operations Bureau or the Operations Center shall make the following notifications:
   a. The on-call Homicide Inspectors
   b. The Crisis Incident Response Team (See DGO 8.04, Crisis Incident Response Team)
   c. Management Control Division
   d. District Attorney’s Office
   e. The Commanding Officer of the member(s) involved
   f. Chair of the In Custody Death Review Board
   g. Office of Citizen Complaints
   h. San Francisco Police Department Command Staff
   i. Legal Division
   j. Captain of Risk Management
   k. Secretary of the Police Commission

1. The officer involved in the incident or discovering the death shall immediately notify his/her supervisor.

2. The officer or supervisor notified shall immediately notify the Operations Center.

3. The Operations Center shall then notify:
   - The on-call Homicide Detail investigators,
   - The photo lab unit on duty or on-call,
   - The C.S.I. unit on duty or on-call,
   - The Management Control Division,
   - The Commanding Officer of the member(s) involved,
   - The on-call District Attorney and D.A. Investigator,
   - The on-call investigator for the O.C.C.
   - All other notifications as necessary.
B. INVESTIGATION PROTOCOL. The investigation into the in-custody deaths are investigated in shall be divided into two distinctly separate investigations.  

1. The Criminal Investigation.  Investigations to determine if there was criminal conduct on the part of the involved officer(s) are conducted separately by the Homicide Detail and the Office of the District Attorney.  
   The Criminal Investigation by the Homicide Detail shall be completed within forty-five days of the event.

2. The Administrative Investigation.  Investigations to determine if the member acted properly at the time of the in-custody death are conducted separately by the Management Control Division and (and the Office of Citizen Complaints if and when initiated by a C.C. when a citizen’s complaint is received regarding the incident.)  
   The Administrative Investigation by the Management Control Division shall be completed and forwarded to the Chief of Police within sixty days of the event. This report shall contain the findings and recommendations of the M.C.D.

3. The Homicide Detail and the Management Control Division shall respond immediately and conduct a timely investigation into every in-custody death. These investigations shall utilize the same numbering system, and be consistent with each other, e.g., 03-01 (first in-custody death of 2003), 03-02 (second in-custody death of 2003) etc.

C. SCENE.  The member who is involved in an in-custody death should limit his/her investigation and activity to the following:

1. As soon as practical, protect the crime scene and preserve all evidence. Prior to the arrival of the homicide detail investigators as provided under II.C.3., no person(s) should be permitted to enter the scene except to perform emergency medical assistance or assist in the preservation or assist in the preservation of the scene and evidence contained therein.

2. As soon as practical, attempt to obtain the name and address of any witness who may not remain at the scene.
3. When an in-custody death occurs within the City and County of San Francisco, the crime scene(s) shall be under that of the Homicide Detail upon the arrival of their investigators. No persons shall be permitted to enter the crime scene without the approval of the Homicide Inspector assigned the investigation or the Homicide OIC. Incident scenes shall be maintained and controlled until the arrival of the Homicide Detail investigators.

4. Units holding incident scenes shall ensure that all tools of medical intervention left at the scene by treating medical personnel remain at the scene for possible collection by C.S.I. personnel.

2.5. A crime scene log shall be maintained at the scene.

6. Nothing in this order shall prohibit a member from taking reasonable actions to ensure his/her safety or the safety of another person.

E. INVOLVED OFFICERS. The following actions will be taken in all cases of in-custody deaths:

1. All members shall be afforded all substantive and procedural rights and remedies as provided by applicable law, including without limitation thereto the Public Safety Officers’ Bill of Rights.

2. When a supervisor arrives on the scene, the supervisor shall have the involved member(s) escorted from the scene. If more than one member is involved in the in-custody death,
the members shall be separated and will be kept separate from one another, and shall not discuss the incident with each other prior to being interviewed by the Homicide Detail Inspectors. If possible, the supervisor shall contact the investigator from the Homicide Detail and ascertain if the involved member is to be taken to the Homicide Detail, the Investigations Bureau, or the involved member’s Station or Detail. In all circumstances the member shall be taken to a department facility.

3. Members of the department’s C.I.R.T. program may assist the member(s) involved prior to their interview with investigators. However, they shall not discuss the facts or details of the in-custody death with the member.

4. Officers who are involved in an in-custody death will be reassigned to his or her respective Bureau Headquarters. Officers shall not return to regular assignment for a minimum of ten days.

Within 10 days of an in-custody death, the Chair of the In-Custody Death Review Board shall convene the panel to discuss whether it is appropriate for the involved member(s) to return to duty.

Recommendations from this meeting, along with any recommendations made by the officers-in-charge of the Homicide and Behavioral Science Unit, shall be immediately forwarded to the Chief of Police for his/her consideration. Upon the Chief’s approval, a member may be returned to field duty, but only after completion of any mandatory debriefing (per DGO 8.04, Section 1.A), and any recommended retraining.

This reassignment is administrative only and in no way shall be considered punitive.

5. The officer shall receive a debriefing by the Crisis Incident Response Team and support as outlined in Section C, of Department General Order 8.04.
6. The Chief shall make a written report to the Police Commission, with a copy to the OCC, of his/her decision of whether or not to return the member to field duty.

F. REVIEW OF INVESTIGATIONS

1. Homicide Detail Investigation. The criminal investigation prepared by the Homicide Detail shall be completed and received by the Chair of the In-Custody Death Review Board within forty-five calendar days of the in-custody death event.

2. Management Control Division Investigation. The administrative investigation prepared by the Management Control Division shall be completed and submitted to the Chair of the In-Custody Death Review Board within sixty calendar days of the shooting event.

3. Within 30 days of the in-custody death, the Chair of the In-Custody Death Review Board shall convene the panel to determine whether the member acted properly at the time of the in-custody death. Within 60 days of the event, the Chair shall report the status of the matter to the Commission. Within 120 days the Board shall complete its investigation and issue its findings in accordance with this policy, unless evidence material to the investigation is not yet available.

The panel shall review the report from the Management Control Division, and may, if it deems necessary, call involved members to testify. The panel will review the incident to evaluate:

4. The In-Custody Death Review Board shall review written reports submitted by the Homicide Detail—Criminal Investigations, and the Management Control Division—Administrative Investigation. If the report of either unit is not completed, the investigator responsible for the investigation and his/her commanding officer shall appear before the In-Custody Death Review Board and explain, orally and in writing, the reason for not complying with the time limits of this order.

5. The In-Custody Death Review Board shall review the submitted reports and interview the involved investigators, as necessary.
6. The In-Custody Death Review Board can refer a case back to M.C.D. for further investigation or clarification, with a stated due date to the Review Board.

7. The In-Custody Death Review Board shall discuss the circumstances surrounding the in-custody death and the response of the officer(s). Within 15 days of completion of its investigation, the In-Custody Death Review Board will submit to the Chief of Police, for his/her concurrence, a written summary. This summary shall includes recommendations concerning the following:

1-a. Adherence to department policy by the member(s) involved.
2-b. The need to develop new policy where none existed at the time of the incident.
3-c. The need to develop new training and techniques to improve department performance.

Upon completion of their review, This summary shall also indicate one of the following findings: the In-Custody Death Review Panel shall return a finding to the Chief of Police. This finding will be:

1-a. Proper Conduct
2-b. Improper Conduct (with a recommendation for discipline)
3-c. Policy Failure (an identified need to develop or improve a policy for the type of incident encountered.)
4-d. Training Failure (the member never received, or, the department never developed a training program or technique to deal with the situation encountered by the member.)

8. The Chief shall review for concurrence and forward the In-Custody Death Review Board’s written summary to the Police Commission, with a copy to the OCC Director, within 15 days of receipt. In the event of disagreement between the Management Control Division and the In-Custody Death Review Board, the Chief of Police shall make the final decision. This summary report with the Chief’s decision shall be a public record. No report that is made public shall disclose any information deemed confidential by law.

The Director of the O.C.C. shall review the investigation and summary and recommend any further action (including an independent investigation) that the Director concludes is warranted. A summary of the O.C.C. Director’s recommendations shall be a public record.
The Police Commission shall review the In-Custody Death Review Board’s summary and the O.C.C. Director’s recommendations and take action as appropriate. No report that is made public shall disclose information deemed confidential by law.

G. POLICE COMMISSION YEARLY REPORT

The Chair of the In-Custody Death Review Board shall prepare a yearly report to the Police Commission, and a copy to the Director of the O.C.C. that contains a summary of each in-custody death occurring in San Francisco Police Department facilities, vehicles or custody, any disciplinary action or training recommended, and proposals for modifying department policy. This report shall be a public record. No report that is made public shall disclose any information deemed confidential by law.

H. IN-CUSTODY DEATHS INVOLVING SAN FRANCISCO SHERIFF’S DEPARTMENT PERSONNEL, VEHICLES, OR FACILITIES.

When an in-custody death occurs involving the San Francisco Sheriff’s Department, that agency shall notify the San Francisco Police Department Operations Center.

1. The Operations Center shall then notify:
   - The on-call Homicide Detail investigators,
   - The photo lab unit on duty or on-call,
   - The C.S.I. unit on duty or on-call,
   - The on-call District Attorney and D.A. Investigator,
   - All other notifications as necessary.

2. The Administrative Investigation will be conducted by the San Francisco Sheriff’s Department.