PASADENA POLICE DEPARTMENT

Performance Audit of Detective Operations

Executive Summary (edited for Public Release)

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# TABLE OF CONTENTS

I. Introduction ................................................................................. 1
II. Acknowledgements .................................................................. 3
III. Engagement Staff Qualifications ............................................. 5
IV. Engagement Work Plan ............................................................... 7
   - Audit Scope and Methodology .............................................. 7
   - Audit Sampling ..................................................................... 7
   - Report Submission and Exit Conference .......................... 8
   - Audit Impairments ............................................................... 8
V. Training ..................................................................................... 10
   - Training Programs for Follow-up Investigators ................. 11
   - Objective No. 1: Training Management System ............... 12
   - Objective No. 2: Training for Detectives ............................ 13
   - Objective No. 3: Training for Professional Standards ....... 15
VI. Detective Policies and Procedures ............................................ 16
   - Detective Organization ...................................................... 16
   - Investigative Procedures .................................................... 18
   - Sample of Investigative Cases ........................................... 19
   - Corporals as Homicide Investigators ................................. 21
VII. Homicide Investigations ............................................................ 23
   - Audit Sample ...................................................................... 23
   - Audit Methodology ............................................................ 25
   - Audit Impairments .............................................................. 25
   - Objective No. 1: Response to Crime Scenes .................. 26
   - Objective No. 2: Evidence Collection & Analysis ............ 27
   - Objective No. 3: Interview & Interrogation ....................... 31
   - Objective No. 4: Investigative Documentation .................. 38
   - Objective No. 5: Organization of Case Book ................. 43
   - Objective No. 6: Supervisory Oversight of Homicide Investigations 44
   - Use of Informants .............................................................. 46
VIII. Non-Homicide Investigations .................................................. 48
   - Audit Sample & Impairments ............................................ 48
   - Audit Methodology ............................................................ 49
   - Objective No. 1: Follow-up Investigation ........................ 50
As you approach the Pasadena Police Department, you can’t help but notice the magnificent old buildings that comprise Pasadena’s Civic Center. To the left is City Hall, to the right lies the old Pasadena Library and directly ahead is the Police Building. As you walk up the stairs and approach the front door to the Police Station, there is a large brass plate embedded in the middle of the floor. The Pasadena Police Department badge is etched in the center of that plate and it is surrounded by three of the Department’s mottos, one of which is:

“How we get the job done is as important as getting the job done”

In writing this report, we strove to achieve a balance between the actions a police officer is allowed to take under the law, behavior we believe constitutes sound public policy and the law enforcement community’s “best practices.” So, in keeping with the Department’s motto so eloquently expressed on that brass plate, the focus of this engagement goes beyond simply evaluating the Department’s compliance with minimum legal standards. Instead, it provides a road map for the Department to “get the job done” in a manner that is effective, while remaining respectful of its citizens and consistent with this great nation’s Constitutional principles.

Ronald C. Sanchez, CLEA, CGAP
President and COO
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CHAPTER I: INTRODUCTION

For several years now, the Pasadena Police Department has been the subject of increasing public scrutiny. This has been punctuated by several key incidents most notably the officer-involved shootings of Le Roy Barnes in 2009, Sherwin Williams in 2010 and Kendrec McDade in 2012. These incidents were all investigated by detectives assigned to the Department’s Homicide/Major Assault Unit.\(^1\) In response to community concerns, the Department entered into a contract with the Los Angeles County Office of Independent Review (OIR).\(^2\) Under that contract, the OIR reviewed the Department’s investigation into the Barnes and McDade officer-involved shootings. The OIR review of the Barnes case has been released and, while identifying some areas for improvement, found no significant deficiency in the investigation.

Meanwhile, at least according to the Pasadena Star News, the FBI has “opened a probe” into some of these cases and the District Attorney’s office is “reviewing the material” it received regarding complaints about the actions of some detectives.\(^3\) In addition, an unusually acerbic relationship has developed between the homicide detectives and some members of the (defense) bar. This has spawned several newspaper articles and televised interviews airing the attorneys’ negative view of the manner in which the detectives have conducted investigations. Those allegations have included perjury, bribery and hiding exculpatory evidence. One lawyer sent the Department a declaration from an alternate juror stating that she believed one of the detectives “invented evidence” against a murder defendant. There was also an allegation that a detective kicked down the door of a lawyer’s home to serve a search warrant in retaliation for the lawyer insisting that he be present when the detective interviewed his client. It is not surprising that several of these incidents have become the subject of lawsuits, some of which are currently pending in court.

The community itself has expressed its concern. Mr. Joe Brown, former President of the NAACP’s Pasadena Branch, has been quoted in several newspaper articles expressing his concern that, “The residents’ patience with the police department is running thin.” He also expressed concern about several specific homicide detectives describing them as, “…names you keep hearing when our young men bring up the cops they are having issues with on the streets.” But Mr. Brown was also quick to commend Chief

\(^1\) The unit’s name has changed somewhat over the years, but its area of responsibility has remained fairly consistent.
\(^2\) The County has deactivated the Office of Independent Review in lieu of the Office of Inspector General.
\(^3\) Citations include various Pasadena Star News articles including one on February 13, 2013.
of Police Phillip Sanchez saying, “Under Chief Sanchez, there has been a change. Officers cannot do what they used to do without facing disciplinary action.”

In 2012, Chief Sanchez asked the Los Angeles County Sheriff’s Department to investigate several of these complaints. On August 20, 2013, the Department announced that the Sheriff’s Department had completed its investigation and that six of the eight allegations that officers beat suspects, threatened witnesses and hid evidence were deemed unfounded, not sustained due to lack of evidence or exonerated the officers.

In February 2013, Judge Larry Fidler, a highly respected member of the Los Angeles judiciary, dismissed a 2007 homicide case after ruling that the detectives had committed misconduct by failing to produce potentially exculpatory evidence. In the hearing leading up to that ruling, a detective testified that he had never heard of the Brady rule and was unaware that he was required to turn over evidence that might be exculpatory. In his ruling, Judge Fiedler summarized the officer’s testimony by asking rhetorically, “Does he think I’m a turnip farmer and I fell off my truck on the way to the market?”

Within days of that ruling, Pasadena Mayor Bill Bogaard and Chief Sanchez announced they were initiating a comprehensive independent audit of cases handled by the Detective Bureau. Specifically, they asked Veritas Assurance Group to examine the Department’s homicide investigations dating back to 2005 as well as a cross-section of other investigations and criminal case filings to ensure consistency in reporting and evaluate procedural adherence. Shortly after the engagement commenced the review was expanded to include a review of personnel complaints alleging Unconstitutional Policing by detective personnel.

Veritas’ team of subject-matter experts (SMEs) spent the next six months conducting a rigorous review of homicide cases, non-homicide cases, personnel complaints, detective practices and training programs. The Institute of Internal Auditors (IIA) provides the following definition for internal auditing:

“Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organization’s operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.”

Consistent with the IIA’s definition of internal auditing, we conducted independent and objective assessments to evaluate the Department’s organizational operations and risk management procedures. Audit assessments tend to concentrate on risk exposures and make recommendations to improve and thereby minimize those exposures while maintaining operational efficiency. While we have recognized that a great deal of the work performed by the Department was performed correctly we also identified many things that were problematic and identified the causal factors which included, but were not limited to: human error; policy and control weaknesses; and, supervisory and managerial failures.
The findings of our audit revealed that the Department has a group of extremely hard-working detectives who frequently brought violent criminals to justice. However, we also found a serious lack of formal training for those detectives, weak policies regulating the way in which criminal investigations are conducted, very little visible supervisory oversight of day-to-day operations and serious flaws in the Department’s records and case management systems. In some cases, we found that supervisors either knew or should have known that subordinates were violating Department policy, but took no corrective action. Some officers were allowed to operate extremely close to the line of legality with little or no visible oversight from supervisors who either knew or clearly should have been aware of their subordinates’ actions. These supervisors had a responsibility to the Department, their subordinates and the people of Pasadena to correct these deficiencies, but they did not. Equally important, their managers did not hold them accountable.

It is important to keep in mind that most of the cases reviewed in this audit occurred between 2005 and 2009; many improvements have been made over the past few years including changes that were being implemented while this audit was being conducted. We have noted those improvements throughout the report. Additionally, this audit focused almost exclusively on homicide and felony-assault cases. This engagement makes no findings regarding the investigations done by other detective “tables.”

Prior to continuing, we want to take this opportunity to dispel two potential misconceptions:

1. Ron Sanchez, President and COO of Veritas, is not related in any way to Police Chief Philip Sanchez. In fact, the two men had not met prior to this engagement.

2. Veritas’ two principals, Ron Sanchez and Senior Performance Auditor Dan Koenig, are both retired law enforcement executives. This may lead some to believe that our audit of the Pasadena Police Department could be something less than completely objective. To that skeptical group, we can only say you have never actually met us and are not familiar with our work.

CHAPTER II: ACKNOWLEDGEMENTS

We were extremely pleased with the professionalism, transparency and receptivity displayed by nearly every member of the Pasadena Police Department we encountered during this engagement. We very much appreciate their candor and commitment to providing the people of Pasadena with the best possible police service. In particular, we would like to recognize four individuals who provided invaluable support to this engagement.

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4 Police Officers approving felony bookings and failure to report uses of force are two prime examples.
5 Please see audit sampling methodologies which follow throughout this report.
6 References are available.
• **Police Chief Philip Sanchez** was consistently receptive and supportive during this entire effort. Throughout this engagement each and every person we contacted clearly understood that Chief Sanchez expected complete transparency and cooperation. That expectation was met and the members of the Department did everything in their power to provide us with the information we needed. We must point out, that on two occasions we encountered potential impediments that could have jeopardized the audit; but, in both cases Chief Sanchez dealt with the issues quickly, decisively and most importantly, with honesty. His commitment to a thorough and honest review is greatly appreciated.

• **Deputy Chief Darryl Qualls** ensured that we had access to the training and internal affairs material we needed to conduct those parts of the audit. In spite of his very busy schedule, he always made himself available to answer questions, share his vast institutional knowledge and ensured that we were provided with any missing information.

• **Commander John Perez** facilitated our review of detective operations. He was the person we notified whenever we found a weak policy or system in disarray. Rather than trying to defend the status quo, Commander Perez saw each discovery as an opportunity to improve the Department’s detective operations. Most of the improvements the Department initiated since we began this audit were Commander Perez’ doing.  

• **Lieutenant Terysa Rojas** was our day-to-day contact. She assisted us with obtaining cases, describing Departmental workflow and interpreting the myriad subtleties that are part and parcel of every large organization. She proved herself to be, without question, one of the most competent mid-managers we have ever encountered.

We would also like to acknowledge the key detectives we interviewed with assurances of anonymity. While they won’t be named in this report, they deserve to be recognized. It isn’t comfortable having a group of strangers come in and dissect your investigations in order to point out every mistake you made. Homicides are very complex investigations with a lot of “rapidly moving parts.” As one of our Subject Matter Experts commented, “You can’t create ten inches of paperwork and not make some mistakes.” The detectives we interviewed were honest and candid. We greatly appreciated their cooperation.

We also want to recognize the Chief’s Office Staff for their assistance with this audit. We would like to personally thank Ms. Beverly Bogar, Ms. Olga Baray, Ms. Susana Castro and Ms. Lola Fyles. Lastly, we want to take this opportunity to recognize Police Cadet Brandon Anderson who provided flawless administrative assistance. His attention to detail was simply amazing and greatly appreciated!

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7 These improvements are enumerated in Chapter VI: Detective Policies & Procedures.
CHAPTER III: ENGAGEMENT STAFF QUALIFICATIONS

The Project Manager (PM), Ronald C. Sanchez, has 39 years of related professional experience. Thirty-one of those years were as a law enforcement professional including investigative, supervisory, mid-level management and command positions. The PM has extensive experience as a law enforcement performance auditor and Chief Audit Executive (CAE). He is a Certified Government Auditing Professional (CGAP), and a Certified Law Enforcement Auditor (CLEA) and has an Accreditation in Internal Audit Quality Assessment/Validation from the Institute of Internal Auditors. The PM has completed numerous professional post graduate courses including The Regulatory Craft at Harvard University’s Kennedy School of Government and Statistical Sampling Methods offered by the United States Department of Agriculture (USDA) Graduate School in conjunction with the Institute of Internal Auditors (IIA). The PM currently teaches audit related subjects on a national level and his company, Veritas, provides audit related services, training and expert testimony for numerous clients. The PM has extensive experience as a detective, detective supervisor, detective lieutenant and detective captain. The PM’s detective and detective management assignments include robbery, gangs, narcotics, homicide, burglary, auto theft and surveillance. The PM is a certified Robert Pressley Institute of Criminal Investigations (ICI) Instructor and is a Management Consultant and Auditor for the California Commission on Peace Officer Standards and Training (POST).

The Senior Consultant and Person Most Knowledgeable (PMK) of this engagement, Dan Koenig, is a retired law enforcement executive with over 41 years of professional experience, 33 of which were as a law enforcement professional. During his career, he conducted criminal investigations and, as a command officer, supervised and managed detectives assigned to investigate major crimes including homicides, robberies, bombings and extortions. He has conducted numerous management audits and has published several major reports that have proven themselves to be of interest to the broader law enforcement community. He has served as the executive director for a major city police department’s Board of Police Commissioners. He has extensive experience providing management support to several public safety agencies including the development of risk management strategies as well as assessment and adjudication of personnel complaints and use-of-force incidents. Veritas’ Senior Consultant is also a Management Consultant and Special Auditor for the California Commission on Peace Officer Standards and Training (POST).

This engagement’s Senior Subject Matter Expert, Mike Thrasher, is a retired Detective Supervisor with more than 32 years of Law Enforcement experience with a major city police department. He spent 21 of those years supervising detectives responsible for the investigation of robbery, kidnap, extortion, fraud, gang-related crimes, officer-involved shootings (non-hit), sexual assault and homicides. He has extensive knowledge in the areas of robbery and homicide investigation. He has investigated more than 150 homicides and over 5,000 robbery and
major assault cases. He was the Officer-in-Charge (OIC) of a Robbery and Gang Crimes Unit for six years and the OIC of a Homicide, Gang Crimes and Sex Crimes Unit for five years. He is a court-qualified expert on homicide and robbery investigations and has testified in Municipal, Superior and Civil Courts. Upon retiring from his full-time position, he became a founding member of another local Law Enforcement Agency's Cold Case Homicide Unit. He has kept abreast of detective “best practices” by attending the Los Angeles County District Attorney's DNA Awareness course at the Criminal Justice Institute, completing the five-day Homicide and Forensic Death Investigation course through the Public Agency Training Council and attending the Cold Case Seminar through the Naval Criminal Investigation Service and the Federal Law Enforcement Training Center. Mr. Thrasher is a long-time member in good standing of both the California Robbery Investigator's Association and the California Homicide Investigator's Association.

Subject Matter Experts Rick Marks retired in 2008 as a Detective Supervisor after 35 years with a major city police department. During that time he was the primary investigator on 128 murder investigations and assisted with or supervised the investigation of several hundred more. During the last five years of his career, Marks led a team of investigators who were responsible for the investigation of officer-involved shootings and arrest-related deaths, along with their attendant risk-management issues. Since 1990, he has co-instructed a block of instruction on Crime Scene Investigation at a POST accredited Homicide School.

Subject Matter Expert Jim Freund has 33 years of law enforcement experience, 25 of which were in a variety of investigative assignments including homicide, robbery, sexual assault, burglary, auto theft, extortion, embezzlement, insurance fraud and street gangs. During his last 20 years he was assigned specifically to homicide and death investigations. Twelve of those years he was assigned as a homicide investigator/supervisor and for the last eight years, led a team of investigators who were responsible for the investigation of homicides. As a homicide detective, Freund was involved in over 200 homicide investigations and, as team leader, he supervised the investigation of over 100 more homicides. During his career, Freund has testified approximately 100 times in Superior Court and has also testified as an expert on street gangs and narcotics.

Subject Matter Expert Jayne Stabler has nearly 30 years of law enforcement experience which includes conducting homicide investigations and supervising detectives. She has extensive training and experience in the investigations of assault-related crimes, particularly those of a sexual nature. She has worked in several assignments as a homicide investigator and at one point was assigned to spearhead a Gang Homicide Unit. When her law enforcement agency decided to form a centralized Sexual Assault Unit, she was selected as the unit’s Assistant Officer-in-Charge. She has also been assigned to Internal Affairs where she investigated a wide range of misconduct complaints against the department’s
employees. Prior to her retirement two years ago, she supervised detectives assigned to investigate Major Assault Crimes as well as detectives assigned to investigate Crimes Against Persons.

CHAPTER IV: ENGAGEMENT WORK PLAN

On May 20, 2013, Veritas provided the Department with a detailed audit work plan which was subsequently approved. That plan detailed Veritas' commitment to conduct a full review of the Department's policies, practices and procedures governing detective operations, as well as, the level of investigative training provide to its detectives and Professional Standards (Internal Affairs) investigators. Veritas also committed to conducting in-depth audits of homicide investigations, non-homicide investigations and personnel investigations involving allegations of unconstitutional policing.

Generally, Veritas begins its audit reports with a chapter describing the audit’s scope, methodology and sampling techniques. However, in this audit each of the audited areas—homicides, non-homicides and personnel investigations—required a slightly different approach. Therefore, each audit chapter begins with a description of the scope, methodology and sampling utilized for that audit area. As applicable, each chapter also identifies any audit impairments that were encountered.

Audit Scope and Methodology

Consistent with sound audit methodologies, auditors conducted a full and thorough review of each investigation selected for this engagement. Specifically, auditors used the standard of due professional care to evaluate each investigation for sound investigative practices, completeness, timeliness, appropriateness of disposition, report accuracy and evidence of supervisory and management reviews. Auditors also evaluated each case for compliance with Department policies and procedures as well as any evidence of inordinate risk-management exposures.

Auditors developed a unique audit matrix for each of the three audit categories. This allowed auditors to capture specific data points for each investigation in the audit sample. In keeping with sound audit standards and, as communicated in the Audit Work Plan, all work papers went through at least two levels of review. All homicides and the other higher-risk cases were subjected to a third or quality assurance level of review. The Project Manager, who has an Accreditation in Internal Audit Quality Assessment/Validation from the Institute of Internal Auditors, conducted additional quality assurance measures. The results were entered into a spreadsheet which was used to compile the audit’s findings and support the recommendations proposed to address anomalies and the inherent risk associated with criminal and administrative investigations.

Audit Sampling

Each of the three audit areas utilized a sampling approach tailored to the scope and purpose of the audit, type of investigation being audited and the sampling impairments encountered. In most cases, extracting
reliable data from the Department’s computer systems in order to identify the audit population was a significant challenge. Auditors worked with the Department’s subject matter and information technology experts to obtain the best possible data available from which the audit samples were selected. In some instances auditors evaluated entire populations while in others samples were drawn, some random and others using directed and purposeful auditing methodologies.

“The directed or purposeful sample is used when auditors suspect serious errors or manipulation and want either to obtain evidence to support their suspicion or to find as many of the suspected items as they can. This process has nothing to do with statistical sampling. It is pure detective work. And the better a sleuth the auditor is the more useful his or her sample will be. But auditors may not draw conclusions about a population from a directed sample.”

Additionally, some audit samples had to fluctuate in order to compensate for unreliable data or to probe areas of concern that arose during the audit. Nonetheless, our findings and recommendations are clearly supported by competent, relevant, reliable and sufficient audit evidence.

Report Submission and Exit Conference
A Preliminary Draft Report was submitted to the Department on September 25, 2013. On October 1, 2013, an exit conference was held with Chief Philip Sanchez; Deputy Chief Darryl Qualls; Commander John Perez; Pasadena City Attorneys Tim Halford and Frank Rhemrev; Veritas President/COO Ron Sanchez; Veritas Senior Consultant Dan Koenig; and, Veritas Subject Matter Expert (SME) Mike Thrasher. From that discussion an Exit Conference Draft report was finalized and submitted to the Department on October 7, 2013, for review and comment. According to the Department it comprehensively reviewed the audit and developed and initiated a strategy to implement the audit’s recommendations. On September 1, 2014, Veritas received a list of 14 errors the Department found in the report, all of which were very minor in nature. That response also identified two (of the fifty-eight) recommendations with which the Department did not agree. Veritas concurred with six of the corrections and made appropriate corrections or notations in the report. All the changes were extremely minor in nature and none of them impacted the substance of the audit’s findings or its conclusions. A final report was submitted to the Department on December 8, 2014, after which Veritas prepared this executive summary.

Audit Impairments
Each of the audit chapters describes the impairments encountered during that portion of the audit. But in order to provide an overview of the Department’s challenges in this area, we will summarize the difficulties encountered in our effort to identify the population of non-homicide investigations.

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8 See Audit Impairments to follow.
9 Sawyer’s Internal Auditing 5th Edition, The Practice of Modern Internal Auditing, Lawrence B. Sawyer, JD, CIA, PA, et-al (Page 438)
The first set of data we received was supposed to identify the number of cases assigned to each detective; separate them by the “solvability” factor they were assigned (A, B & C); and, identify the disposition code for each case. The data we received showed that 15,743 cases were assigned to detectives, but 7,135 of those cases (45%) were recorded under a heading titled “blank.” While it is not unusual for police departments to assign miscellaneous incidents a case number solely for tracking purposes, these “blank” cases included 2 homicides, 3 rapes, 3 robberies, 3 purse snatches and 48 burglaries. Cases of that nature are always assigned to an investigator, so the “blank” designation had to be incorrect. In order to test the data, PPD experts selected a sample of cases to query the database in several different ways. They found different disposition codes for the same case depending on how the query was structured.

In addition to the unreliability of case classification and disposition data, there were reliability issues in two other key areas. First, the data indicated that no arrestees were released by detectives without seeking prosecution in 2011, only 3 in 2010 and only 2 in 2012. In auditors’ experience, it is virtually impossible for that to have occurred. (The subsequent audit findings verified that there were substantially more of these releases.) Secondly, the data did not identify cases where a detective opted to seek a misdemeanor filing (bi-pass) without first presenting the case to the District Attorney. While there was absolutely no indication of any impropriety on the part of PPD detectives, detective releases and misdemeanor referrals have created problems in other departments. In the most egregious cases, abuse of release and referral authority has led to police corruption when unscrupulous detectives literally sold releases and misdemeanor referrals to criminals. So, these investigative decisions need to be reported accurately, judiciously reviewed and approved. Failure to capture accurate data for these activities presents a serious exposure in the Department’s ability to manage risk.

In May, auditors met with the Department’s Technical Services Section Administrator to clarify the relationship between the Department’s key data systems. The Computer Aided Dispatch System (CAD) manages calls for service and other field activity. Case file numbers are issued in CAD upon request by the officer handling a call. When the officer completes the reports, preliminary data is entered into the Records Management System (RMS). Follow-up information on cases assigned to detectives is supposed to be entered into the Managing Criminal Investigations (MCI) module which, in turn, updates RMS. When MCI is not updated properly, which was not being done to one degree or another during most of the period covered by this audit, then neither MCI nor RMS is able to produce reliable information such as the disposition of individual cases, case dispositions by crime category or detective caseloads.

10 Solvability factors and disposition codes are described in Chapter VI: Detective Policies and Procedures
11 Releases and referrals are discussed in detail in Chapter VI: Detective Policies and Procedures
12 This was NOT a Pasadena Police Department case.
This lack of reliable information is exacerbated by the fact that no one has been assigned overall responsibility for imputing data into these systems and verifying the data’s accuracy.

**Recommendation No. 1:** The Department should require that detective personnel use MCI to track and manage cases.

**Recommendation No. 2:** The Department should conduct a full review of its automated systems to ensure that data is being captured correctly and that those systems are producing quality information that will assist managers and supervisors with their responsibilities.

**Recommendation No. 3:** While the automated systems are being reviewed, the Department should identify the entity best positioned to verify the accuracy of this data and assign that entity the resources and responsibility for fulfilling that critical function.

**CHAPTER V: TRAINING**

**Training Programs for Investigators**

Detectives in California are truly fortunate to have an entire array of training available to them through the Commission on Peace Officer Standards and Training’s Robert Presley Institute of Criminal Investigation (ICI POST). This unique program was started in the mid-1980s when State Senator Robert Presley expressed his concern that training for criminal investigators seemed to be missing from POST’s training programs. After holding several planning meetings, a core course curriculum was developed and piloted in 1989. The success of the core course quickly led to the development of foundational specialty courses and resulted in the creation of ICI. In 1994, ICI was formalized under California Penal Code Section 13519.9 which states:

“The Robert Presley Institute of Criminal Investigation will make available to criminal investigators of California’s law enforcement agencies an advanced training program to meet the needs of working investigators.”

The end goal of the ICI program is to graduate highly trained and competent investigators who are able to meet today’s investigative challenges. To receive a Certificate from ICI, students must complete the Core Course, one foundation specialty course and three elective courses relating to the student’s specialty.
The ICI Core Course is specifically designed to meet the needs of the Law Enforcement Investigator in performing the multi-disciplined, multi-leveled tasks required for a thorough and comprehensive criminal investigation. Through the use of practical and interactive experiences, officers are exposed to investigative techniques, including the use of cutting edge technology. At the conclusion of the course the student will be able to:

- Manage and reconstruct a crime scene;
- Organize and employ effective case management skills;
- Utilize effective interview and interrogation techniques to work effectively with victims, witnesses and suspects;
- Identify and access useful sources of information; and,
- Validate their work through documentation and case presentation.

Another core ICI course is the Interview and Interrogation class, which is a “universal elective.” It is specifically designed to improve an investigator’s ability to gather testimonial evidence legally from victims, witnesses and suspects. It is specifically designed for the full-time investigator and is not intended for general law enforcement use. In addition to the Core and Interview/Interrogation courses, ICI POST offers a wide variety of specialty courses including:

- Burglary Investigations
- Crime Scene Investigation (Basic)
- Crime Scene Investigation (Advanced)
- Criminal Investigations
- Death Investigation
- Domestic Violence Investigations
- Gang Investigation
- Homicide Investigation (80 hour)
- Homicide Investigations (36 hour)
- Identity Theft Investigations
- Internal Affairs Investigations (Basic)
- Internal Affairs Investigations (Updates)
- Narcotics Investigation
- Officer-Involved Shooting Investigations
- Robbery Investigations
- Sexual Assault Investigation

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13 A universal elective can enhance any student’s training program regardless of specialty.
Objective No. 1: Training Management System. Determine if the Department’s Training Management System provides adequate oversight of the Department’s officer training program

Assessment
Auditors interviewed key Department personnel including the Department’s Training Coordinator and her assistant. Auditors reviewed the Department’s Training Plan and examined printouts of the training provided from 2005 to 2012 to all officers assigned to Detectives and Professional Standards.

Findings
The Department clearly has made a major investment in providing its officers with high-quality training. The training records for the vast majority of the supervisors and managers selected for this portion of the audit indicate that they have attended either the Supervisory Leadership Institute or Command College. These are both high-intensity “masters level” courses designed to develop leadership and critical thinking skills in organizational leaders.

We also noticed a high concentration of training in firearms and other self-defense skills. While not minimizing those critical skills whatsoever, one has to wonder if the proper balance is being maintained between those and core investigative skills. With respect to the Training Plan, it does not appear that supervisors have much input and, therefore, little responsibility in the training their subordinates receive. Additionally, oversight and review of training completion appears to be minimal. For example, we found two detectives’ training histories which indicated they attended the same 40+ hour class twice within a few months. In researching the apparent duplication we found in each case that the original class was cancelled and the detective was rescheduled for the next available class. However, no one notified the Training Coordinator so the detectives were shown as having attended the class twice. While beyond the scope of this engagement, this raises the possibility of a detective’s training history indicating the completion of a class that was canceled, but never rescheduled. Finally, we noticed numerous TMS entries of detectives attending multi-day classes described only as a “training seminar.” Without a description of the material that was taught there is no way to document an officer’s actual training history.

Recommendation No. 4: The Department should include supervisors in the process of officers training requests. This will allow supervisors to fulfill their responsibility of ensuring their subordinates are properly trained.
**Recommendation No. 5:** The Department should require that supervisors review their subordinate’s training records with them in conjunction with annual personnel evaluations. That review should verify the record’s accuracy and establish the employee’s training plan for the following year.

**Recommendation No. 6:** The Training Management System should include a description of any seminar lasting 8 hours or more.

**Objective No. 2: Training for Detectives.** Identify the detective-related training programs that the Department’s detectives have received.

**Assessment**
Auditors obtained list of all Police Officers, Corporals, Sergeants and Lieutenants who were assigned to Detectives from 2005 to 2012. Then auditors obtained:
- The entire training history for everyone who was assigned to Detectives when the audit began (March 2013)
- The training history since 2005 for everyone who was no longer assigned to Detectives.

Auditors reviewed all of those training records to identify the detective-related training courses each officer attended.

**Findings**
From 2005 to 2012, there were 7 Lieutenants, 8 Sergeants, 32 Corporals and 25 Officers assigned to Detectives for a total of 72 officers. The following chart shows the detective schools each group of officers attended by rank.

**Detective Training by Rank 2005 to 2012**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Assigned to Detectives</th>
<th>Basic or Core Course</th>
<th>Crime Scene</th>
<th>Interview or Search &amp; Seizure</th>
<th>Investigative Specialty 14</th>
<th>Homicide</th>
<th>Officer-Involved Shooting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lieutenant</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Sergeant</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>4</td>
</tr>
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</tr>
<tr>
<td>Total</td>
<td>72</td>
<td>9</td>
<td>13</td>
<td>45</td>
<td>57</td>
<td>23</td>
<td>15</td>
</tr>
</tbody>
</table>

14 Specialties other than homicide and OIS investigations.
From the data we received for this portion of the audit, it appears that:

- The one Lieutenant who attended the Basic or Core Detective Course did so in 1998.
- The one Lieutenant who received crime scene training did so in 1990.
- Six of the 7 Lieutenants attended SLI or Command College.
- The 2 Sergeants who attended the Basic or Core Course did so in 1999.
- The 2 Sergeants who received crime scene training did so in 1992 and 2007.
- The only Sergeant who did not attend an investigative specialty class also did not attend a Basic or Core course, a Crime Scene course or an Interview or Search & Seizure course.\(^{15}\)
- Six of the 8 Sergeants (75%) attended SLI.
- Of the 6 Corporals who attended the Basic or Core Course, 1 attended in 1997, 3 in 2004, 1 in 2006 and 1 in 2008.
- All but 7 of the Corporals attended an Interview/Interrogation or Search & Seizure course.
- Six of the Corporals have not attended a specialty course. (We were unable to determine if they were in an investigative assignment with mandated training.)
- No Police Officer (excluding Corporals) has been to the Basic or Core Course since at least 2005.
- The one Police Officer who received Crime Scene training did so in 2005.
- Eight of the Police Officers (excluding Corporals) have not attended a specialty course. (We were unable to determine if they were in an investigative assignment with mandated training).

Generally, mandated training is required within the first year of an officer’s assignment to a regulated specialty. Because Police Officers are “rotational” and are supposed to return to patrol after a year in detectives, one could argue the requirement does not apply to them. But, failure to provide adequate formal training to anyone assigned to conduct follow-up investigations is a significant risk management exposure. Clearly, the Department has a great deal of work to do in ensuring its investigative personnel receive the formal training required for their jobs. Some will argue that years of “on-the-job training” can compensate for a lack of formal training; however, that is absolutely not true when it comes to detectives who must:

- Have a thorough understanding of the myriad scientific resources, investigative techniques and interview skills that are available to solve crimes.
- Be prepared to pass *voir dire* should their testimony be challenged in court;
- Remain current on case law pertaining to nearly every aspect of police work; and,

\(^{15}\) Note: This is the same Sergeant who supervised the Homicide/Major Assault Unit during the time that most of the homicide investigations selected for this audit occurred.
- Have a good working knowledge of computer systems and resources available in the cyber world.

**Recommendation No. 7:** The Department needs to conduct a full review of its training programs for detectives. The Department must begin the process of ensuring that each and every detective, including officers rotating through the division, receives the training they need to be successful in their assignments.

**Recommendation No. 8:** The Department should audit its compliance with detective training that is mandated by law, e.g., sexual assault, domestic violence, etc.

**Objective No. 3: Training for Professional Standards.** Identify the investigative training programs attended by sworn staff assigned to the Department’s Professional Standards (Internal Affairs) Unit.

**Assessment**
Auditors obtained list of all Corporals, Sergeants and Lieutenants who were assigned to Professional Standards from 2005 to 2012. Then auditors obtained:
- The entire training history for everyone who was assigned to Professional Standards when the audit began (March 2013)
- The training history since 2005 for everyone who was no longer assigned there.

Auditors reviewed all of those training records to identify the internal affairs and detective-related training courses each officer attended.

**Findings**
From 2005 to 2012, there were 4 Lieutenants, 5 Sergeants and 1 Corporal assigned to Professional Standards.\(^\text{16}\) The following chart shows the investigative schools each group of officers attended by rank.

**PSU Training by Rank 2005 to 2012**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Officers Assigned</th>
<th>Basic or Core Course</th>
<th>Crime Scene</th>
<th>Interview or Search &amp; Seizure</th>
<th>IA Invest</th>
<th>Officer-Involved Shooting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lieutenant</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Sergeant</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Corporal</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>10</td>
<td>7</td>
</tr>
</tbody>
</table>

\(^\text{16}\) Technically, Lieutenants are not assigned to PSU; they manage PSU as well as several other units.
From the data provided to us for this portion of the audit, it appears that:

- **No one** who has been assigned to PSU since 2005 attended the Basic or Core Course for detectives.
- Only one person assigned to PSU since 2005 attended a course on crime scenes and that was in 1989.
- None of the Lieutenants assigned to PSU since 2005 attended the Interview or Search & Seizure course.
- Every one assigned to PSU since 2005 attended the IA Investigation course.
- Six of the ten officers assigned to PSU since 2005 attended OIS school. (Two of the four who have not attended OIS school are currently assigned to PSU.)

Internal and administrative investigations routinely involve complex investigations. With that said, the Department clearly has a great deal of work to ensure its key personnel, such as those in the PSU, receive the training required for them to excel in their assignments. While beyond the scope of this audit, the Department should also ensure that PSU has sufficiently trained personnel to investigate critical specialties such as domestic violence and narcotics/alcohol-related misconduct.

**Recommendation No. 9:** The Department should conduct a full review of its investigative training programs for PSU. The Department must begin the process of ensuring that each and every investigator receives the training they need to excel in their assignments.

**Recommendation No. 10:** The Department should ensure that PSU investigators are sufficiently trained to investigate critical specialties such as domestic violence and narcotics/alcohol-related misconduct.

**CHAPTER VI: DETECTIVE POLICIES AND PROCEDURES**

**6.1 Detective Organization**

Criminal Investigations Division (CID) is one of three operational divisions headed by a Commander who reports directly to the Department's Deputy Chief. The CID Commander is responsible for conducting all of the Department's follow-up criminal investigations as well as special investigations including, but not limited to, vice, narcotics and the Department's participation in various investigative task forces.

From about 2001 to mid-2011, CID was organized under crime-specific “units” or “tables” which was the industry standard at that time. For example, the Robbery table handled all robberies, but they also
handled purse snatch crimes. The Burglary table handled residential and commercial burglaries, but they also handled thefts. Detectives were assigned to the tables based upon the table’s projected workload.

In May 2011, the Department shifted its approach to detective staffing and implemented a two section approach. One section handles crimes against person and the other handles crimes against property. There is a lieutenant in charge of each section and sergeants are distributed to manage the various units within the sections.

The following table reflects the detective operation structure from 2001 to the present time:

<table>
<thead>
<tr>
<th>Detective Organizational Structure: 2001 to Present</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Jan 2001 to May 2011</strong></td>
</tr>
<tr>
<td>CID</td>
</tr>
<tr>
<td><strong>Robbery/Homicide</strong></td>
</tr>
<tr>
<td>Homicide (Deaths &amp; Assaults)</td>
</tr>
<tr>
<td>Robbery (Purse Snatch)</td>
</tr>
<tr>
<td>Missing Person</td>
</tr>
<tr>
<td>Sexual Assaults</td>
</tr>
<tr>
<td><strong>Auto Theft</strong></td>
</tr>
<tr>
<td>(Auto Theft &amp; BFMV)</td>
</tr>
<tr>
<td><strong>Burglary/Theft</strong></td>
</tr>
<tr>
<td>Residential Burglary/Theft</td>
</tr>
<tr>
<td>Commercial Burglary/Theft</td>
</tr>
<tr>
<td><strong>Forgery</strong></td>
</tr>
<tr>
<td>(Checks &amp; Credit Cards)</td>
</tr>
<tr>
<td><strong>Youth &amp; Family</strong></td>
</tr>
<tr>
<td><strong>Special Investigations</strong></td>
</tr>
<tr>
<td>Vice, Narcotics, Organized Crime, Task Forces</td>
</tr>
</tbody>
</table>
6.2 Investigative Procedures

Over the years, the Department has published various directives governing its policies, rules and procedures for follow-up investigations. In June 1996, a lengthy directive was issued identifying the functions and responsibilities of Departmental entities including CID.\textsuperscript{17} That directive was revised in December 2001 to reflect a variety of organizational changes. Additionally, directives were issued in July 2012 addressing the investigation and prosecution of criminal cases and control of confidential informants.\textsuperscript{18}

Without becoming mired in too many details, the Department’s process for handling cases has been essentially the same for at least the last 20 years:

1. Cases are given to the detective supervisor who is responsible for investigating that type of case.
2. The supervisor reviews the reports and assigns it one of three "solvability" classifications:
   - "A" Good investigative leads.
   - "B" No particular leads, but actionable, such as requesting forensic analysis or contacting the victim for a serial number.
   - "C" No viable leads.
3. A copy is sent to the assigned detective and another copy to detective clerical staff.
4. Clerical staff enters the case into the detective Case Management System (CMS).
5. The detective investigates the case:
   - If he seeks a criminal filing, he completes a Complaint Disposition Form (CDF) indicating the disposition.
   - If he does not seek a filing, he completes an ADD report stating why.
6. The case is returned to the supervisor for review and approval.
7. The case is forwarded to clerical staff to update CMS and file it.

There have been some variations to this process over the past two decades, but that is essentially how the Department (and most other police departments) process their criminal cases. With respect to case dispositions, the Department uses the following codes:

\textsuperscript{17} Order No. A-6
\textsuperscript{18} Policies 200 and 608 respectively
Case Disposition Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAF</td>
<td>DA Filed</td>
</tr>
<tr>
<td>DAR</td>
<td>DA Reject</td>
</tr>
<tr>
<td>CPF</td>
<td>CP Filed</td>
</tr>
<tr>
<td>CPR</td>
<td>CP Reject</td>
</tr>
<tr>
<td>C</td>
<td>Closed</td>
</tr>
<tr>
<td>O</td>
<td>Open</td>
</tr>
<tr>
<td>S</td>
<td>Suspended</td>
</tr>
<tr>
<td>RP</td>
<td>Refuse to Prosecute</td>
</tr>
<tr>
<td>R/U</td>
<td>Resolved/Unfounded</td>
</tr>
<tr>
<td>P</td>
<td>Pending</td>
</tr>
<tr>
<td>ROA</td>
<td>Refer Outside Agency</td>
</tr>
</tbody>
</table>

Note: These codes are consistent with those used by most other law enforcement agencies.

In summary, every case is supposed to be given a solvability code; assigned to a detective; closed either with a CDF or ADD report; reviewed by a supervisor; and, entered into CMS.

6.3 Sample of Investigative Cases

Written policies and procedures are clearly important and should reflect actual organizational processes. In order to test for actual practices in place, auditors used the 125 cases that were selected for the Non-Homicide Investigation portion of this audit (Chapter VIII). It was determined that 77 of those cases either had a suspect in custody or appeared to have leads worth investigating. Those 77 cases were reviewed in detail to assess each case’s level of compliance with Department standards.

- Nine of the 77 cases were classified as “C” cases (no viable leads), but 8 of 9 cases (89%) had named suspects.
- Thirty-six of the 77 cases (47%) were shown in CMS as Open cases, but they had been disposed of generally by filing the case with a prosecutor.
- All of the cases had either a CDF or ADD report.
- All of the case closures were approved by a supervisor.
- The date entered into CMS for all the cases were always a day or two after the date the crime occurred and almost always a weekday. So, the date appeared to be the date the clerk entered the information. Recording the date and day-of-the-week an incident occurred has value for pattern assessment and case management, but recording the date a clerk enters a report into a system has no analytical value whatsoever.

In addition to testing for process compliance, auditors also tested for compliance and supervisory control of other high-risk detective processes.

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19 Those 125 cases were from 2010. Auditors used directed and purposeful sampling techniques that were fully disclosed to Department executives.
1. **Detective Releases.** Penal Code Section 849 (b) (1) allows an officer to release an arrestee when, "He or she is satisfied that there are insufficient grounds for making a criminal complaint against the person arrested." There was no evidence of supervisory approval prior to releasing an arrestee under this section in any of the cases evaluated. This is a significant risk management exposure. A supervisor simply must be involved in the decision to release an arrestee, if for no other reason than to prevent the appearance of impropriety. We brought this to the Department’s attention mid-audit and they now require a Lieutenant’s approval for these releases.

2. **Certificates of Release.** Section 851.6 PC requires officers to issue a Certificate of Release to any arrestee who is:
   - Released pursuant to 849 (b) (1); or,
   - Released when “no accusatory pleading is filed” (e.g. prosecutorial reject).

   Certificates of Release are not being issued to all arrestees who are released under these provisions. Again, we brought this to the Department’s attention mid-audit and they now require a Certificate of Release to be issued.

3. **DA Bypass.** When a charge is punishable either as a felony or a misdemeanor, Penal Code Section 17(b) (4) allows the case to be referred to the City Prosecutor (CP) for misdemeanor prosecution. The referral can be made by the District Attorney or the detective. Several cases were referred for misdemeanor prosecution by the detective, but there was no evidence of supervisory approval for that decision.

4. **Juvenile Arrests.** The vast majority of juvenile arrests only show the criminal code violation without the usual 602 WIC prefix. Technically, a juvenile cannot violate a criminal code, but falls under the delinquency statute defined in section 602 of the Welfare and Institutions Code. Laws pertaining to juveniles are unique. The Department should require all juvenile arrests to use the WIC prefix to the arrest and booking charge in order to readily recognize those cases.

   **Recommendation No. 11:** The Department should require supervisory approval before referring an alternate felony/misdemeanor case directly to the City Prosecutor.20

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20 The Department has opted to address this issue through training and supervisory case review. This may suffice as the City Prosecutor can always return a case for felony consideration.
**Recommendation No. 12:** The Department should require all officers to enter the appropriate WIC prefix for all juvenile arrestees.

### 6.4 Corporals as Homicide Detectives

The Department utilizes officers from the senior Police Officer rank of Corporal to investigate homicides and other major cases including officer-involved shootings. In most major law enforcement agencies, that function is performed by supervisory-level officers who are, in some cases, compensated at a higher level than patrol supervisors. Using Corporals to conduct these critical investigations is not inherently risky, but they must receive support in two critical areas:

1. They must receive the formal training required to develop and maintain their technical expertise in conducting these critical investigations; and,
2. They must work under the consistent guidance, mentorship and control of experienced supervisors. Investigating homicides can be arduous and is absolutely physically and mentally draining. While youth can be an asset, it has to be tempered with the wisdom and experience that can only come from the supervisors assigned to oversee these critical investigations.

### Recent Changes

Throughout the course of this engagement we have kept the Department informed of our progress and findings. In particular, we have notified the Department promptly whenever we encountered a situation that we believed posed a significant risk-management concern. This feedback provided the Department an opportunity to deal with issues in a timely manner rather than waiting for the audit to be completed and the report written. In nearly every case, the Department’s reaction to the problems identified was to verify our findings and initiate remedial action. Nowhere was this more evident than in our finding that there was a lack of supervisory control taking place with detective-initiated releases of felony arrestees. After examining the situation and considering the risk-management ramifications, the Department immediately issued a directive requiring the section lieutenant’s approval for all such releases.

We would also like to take this opportunity highlight the following Detective operational improvements, policies, procedures and controls that the Department has initiated in the past two years:

- Development of an Excel spread sheet to track Witness Relocation funds.
- Development of a confidential informant registry to be queried prior to the disbursement of funds
- Requiring section lieutenants to review Operations Plans before submittal to the Divisional Commander

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21 This list represents the highlights, but not all changes to detective operations.
Consolidation of myriad forms and conversion of many to a simplified electronic format
Implementation monthly CID audits
Requiring monthly reporting of overdue investigations
Development and implementation of a Latent Print ID hit log
Development of CID and Forensic major incident debriefs
Development of a format to track minimum and advanced training required by assignment.
Development of an intra-net repository for all manuals and directives
Development of a Detective Resource Guide for training new detectives
Utilization of the Detective Resource Guide by detectives to enhance skill sets
Updated training on MCI and mandated use by sergeants and detectives
Use of MCI system as a chronological log for all major investigations
Development of logs to record discovery requests
Requiring Discovery requests logs signed by DA are copied and filed in investigative records
Mandating sergeant’s review of on-going cases every 30 days
Requiring tape recording of informant agreements
Requiring annual audits of informant files
Purchasing and using of video cameras by detectives
Monthly Major Case Brief for managers with a memo detailing the cases discussed and direction for follow-up
Editing & Updating the Detective Manual (on-going)
Requiring the approval of a Section lieutenant to modify Certificates of Release
Mandating six month performance review for rotational detectives
Providing Brady training provided to all detectives by the DA’s Law Enforcement Liaison
Encouraging Detectives to move from six pack photo line-ups to sequential photo presentation
Completing a total re-write of the Department’s Informant Manual

The Department is also in the process of revising its Detective Resources Guide to incorporate these changes and establish more consistent and effective supervisory and management control of detective operations. The Department is to be commended for that outstanding effort! In that regard, we suggest the Department test the on-going manual revisions to see if they address the following broad issues with respect to detective operations:

1. Is the detective command structure accurately described?
2. Is the detective command efficiently organized?
3. How are cases received, assigned, tracked and monitored?
4. How are cases classified and are the indicated classifications appropriate?
5. How does management monitor backlogged cases?
6. How does management review case clearances and are they consistent with the FBI Uniformed Guidelines?
7. How are investigative case packages reviewed for completeness and quality of investigation?
8. Are investigative case packages filed and stored in an accessible manner that allows for easy retrieval?
9. What are the time limits for investigations and the procedures for extensions?
10. What is the process to “bypass” a felony prosecution (17 (b) (4) PC)?
11. What is the process to release an arrestee without seeking prosecution (849(b) (1) PC)?
12. Is there an audit schedule?
13. What are the types of cases on that audit schedule?
14. Are the findings and recommendations from Detective Operations’ Audits acted upon and considered for detective training?
15. Do supervisors complete biopsies of completed cases?
16. What is the policy regarding due diligence and how are due diligence efforts being documented?
17. What is the policy regarding supervisory and management review of search warrant affidavits and arrest warrants prior to presenting them to a magistrate?
18. Are the policies regarding sources of information and the use of informants effective and being utilized?
19. How are digital media, recorded interviews, photo line-ups and crime scene documentation being maintained?
20. What are the performance measurements for detective personnel, supervisors and management personnel?

These are some of the main topics we use to evaluate detective operations and determine if the appropriate level of risk management is occurring.

CHAPTER VII: HOMICIDE INVESTIGATIONS

Audit Sample
Department records show that from January 1, 2005, through December 31, 2012, the detectives assigned to the Department’s Homicide/Major Assault Unit conducted 53 major investigations. Four of those investigations were officer-involved shootings (OIS) and the rest were homicides. Of the 49

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22 There have been some changes to the unit’s name over the years, but its area of responsibility has remained fairly consistent.
23 Some of these cases involved more than one victim. As previously indicated, throughout this report all percentages were rounded up or down to the nearest whole number.
homicides, 20 were either open or still pending in court and 29 had been completed and were through at least the trial court level\(^{24}\) when the sample for this portion of the engagement was selected.\(^{25}\)

Initially, the Department considered having Veritas audit a random sample of all 53 cases. However, that sample methodology was refined during discussions with the Project Manager and Veritas’ Senior Auditor. The Department already contracts with the Los Angeles County Office of Independent Review for a complete and independent audit and analysis of the Department’s OIS investigations. So, four OIS investigations were removed from the audit population as auditing them would be redundant, not cost effective and essentially result in a meta-audit of the work done by the Office of Independent Review, which is beyond the scope of this engagement.

Discussions next centered on the 49 homicide investigations. It was decided that investigations still pending in court would not be audited at this time. One factor was the additional investigative work that routinely occurs prior to and during the trial process which would change the audit work papers (investigative files and related documents) and require auditors to analyze and draw conclusions from cases that were constantly changing. Further, in active cases, the defendant(s) and the people are both ably represented by trained lawyers (and their supporting staff) whose job is to present and challenge evidence before the trial court judge. The strengths and weaknesses of those cases pending trial are more appropriately addressed in that forum. Thus, the 20 homicide cases still open or pending in court were removed from the audit population.

That left 29 homicide cases that were recorded as having been closed or processed through the court system, at least at the trial level.\(^{26}\) In 13 of the 29 cases one of the detectives who was the focus of this engagement was the lead investigator; so, all 13 of those investigations were selected for the audit. Then 14 of the remaining 16 homicide investigations were selected for the audit. But after completing 7 of the randomly selected cases, auditors determined that at least one case had been audited for each homicide detective and that ample audit evidence had been collected to support meaningful risk management and process efficiency recommendations. At the same time, the Department and auditors recognized that auditing more recent cases may provide some insight into the effectiveness of several significant changes the Department has made to their detective procedures. Consequently, the remaining 7 homicide cases were removed from the audit and 8 contemporaneous major felony assault cases were added to the non-homicide case audit (Chapter VIII of this report).

\(^{24}\) At least some of those cases are in various stages of appeal.

\(^{25}\) The sample was selected on April 2, 2013.

\(^{26}\) Towards the end of the audit auditors discovered that one case was actually an open unsolved case; but at that point auditors had invested significant time in evaluating the case, so the audit was completed.
Audit Methodology

Consistent with sound audit methodologies, auditors conducted a full and thorough review of each homicide case selected for this portion of the audit. Specifically, auditors used the standard of due professional care to evaluate each investigation for sound investigative practices, completeness, timeliness, appropriateness of disposition, report accuracy and evidence of supervisory and management review. Auditors also evaluated each case for compliance with Department policies and procedures as well as any evidence of risk-management exposures. Auditors developed an audit matrix designed to capture over 65 specific data points for each investigation in the audit sample. The matrix facilitated the auditors’ evaluation of each case to determine whether:

- The Department’s response to the initial crime scene was adequate, witnesses were identified and the initial response was thoroughly documented;
- Physical evidence was identified, collected and analyzed;
- Interviews and interrogations were conducted in a professional manner and summarized accurately in police reports;
- The investigation was documented properly and all relevant documents retained in the case file;
- Each case book was organized in a manner that facilitated a thorough investigation as well as supervisory and management review; and,
- There was evidence of supervisory and management review and oversight of the investigation.

All work papers went through two levels of review. Each investigation was subjected to a quality assurance process by Veritas’ Senior Consultant. The results of each audit were entered on a spreadsheet which was used to compile the audit’s findings in this area. The Project Manager, who has an Accreditation in Internal Audit Quality Assessment/Validation from the Institute of Internal Auditors, conducted additional quality assurance measures. Specific recommendations were proposed to address anomalies and minimize risk exposures. The process was arduous considering that homicide casebooks often required multiple three-inch binders and, in some cases, storage boxes to retain the case’s investigative material.

Audit Impairments

Record Keeping

At the start of the audit, Veritas asked the Department to produce a list of all homicides from 2005-2011 and indicate which were solved cases (not pending in trial court) that did not involve an OIS. The original list provided by PPD consisted of 39 cases matching those criteria. During the review process it was discovered that several of the cases provided to Veritas were still in court and one was actually an open/unsolved case. In order to ensure effective case management oversight detective supervisors and
managers simply must have **reliable** and **readily available** status information on their major case investigations.

**Recordings**
During the audit process, Veritas made several formal requests for additional documentation on specific cases regarding recordings or written reports for interviews referred to in ADD Reports that were missing from the case file or Records Unit copies. In several instances, PPD was unable to locate recordings and/or documentation. This inability to produce investigative documentation impaired our ability to complete assessments and made it difficult to reach reliable conclusions on certain key aspects of those cases. More to the point, it appears that poor record maintenance is one of the significant causal factors in the Department’s difficulty responding to Discovery requests and its responsibility to provide evidence which may be exculpatory. As discussed in Chapter VI, the Department desperately needs to reassess its automated systems to ensure it is capturing and relying on accurate data.

**Objective No. 1: Response to Crime Scenes.** Review the Department’s initial response to each homicide scene in the audit sample to determine if the scene was secured in a timely manner, the area was canvassed for witnesses and the initial responders provided the detectives with a written report of their activities and observations.

**Assessment**
Auditors reviewed each case selected for the audit sample and reviewed documentation to determine how the initial responders managed the crime scene and associated witnesses. As necessary, auditors interviewed key PPD personnel including managers for policy issues and detectives for any questions on specific cases.

**Findings:**
Patrol officers and supervisors were the first responders to most of the homicide cases reviewed in this audit and there were very few issues in those initial responses. Most response times were well within two to four minutes, as established by Incident History printouts. The initial responding officers and supervisors rapidly established both inner and outer crime scene perimeters and set up Command Posts as needed. Auditors were impressed with the number of personnel assigned to each crime scene and in every case there were more than adequate personnel on hand. With very few exceptions, the case files contained Crime Scene Logs that were thorough and documented the arrival times, departure times and duties of those at the scene. Most crime scenes were photographed, some with video and/or aerial perspectives. The PPD personnel utilized an extensive repertoire of crime scene techniques and units in an effort to locate witnesses, evidence and suspects. Those included, but were not limited to, gang officers, K-9 units from other agencies, forensics personnel and LASD ballistics experts. Due to patrol’s efficient response, the suspect(s) were often taken into custody before the detectives arrived.
Patrol officers typically conducted an extensive canvass to identify witnesses. Their efforts were chronicled in multiple ADD Reports documenting both the locations where they contacted people and those where there were no answers. However, with few exceptions, the contact reports listed only a single occupant at each address, generally the person who answered the door. Rarely was there any documented follow-up effort by detectives to re-canvass the “no answer” addresses or locations not included in the initial canvass.

While the ADD Reports completed by officers accurately documented their individual efforts, the overall parameters of the initial canvass (as established by a patrol supervisor) were never documented. Without that information, detectives would have difficulty confirming that all locations within the designated area had been contacted.

Recommendation No. 13: Patrol officers should receive periodic training on the importance of documenting all occupants at each address within the designated canvass area and indicating who was or was not present when the incident occurred. The parameters of the initial canvass need to be documented in the case file as well.

Objective No. 2: Evidence Collection & Analysis. Examine the manner in which evidence was identified, collected, recorded and analyzed for each of the homicide cases in the audit sample.

Assessment
Auditors reviewed the documentation for each case selected for the audit sample to determine how the evidence was identified, collected, recorded and analyzed for each case. As necessary, the auditors interviewed key PPD personnel including managers for policy issues and detectives for any questions on specific cases.

Findings
2.1 Crime Scene Investigation
In most cases, the detectives and civilian Technicians received a briefing at the crime scene from the first responders. Then, the Technicians processed the crime scene while the detectives began their investigation and interviews. This practice basically let the Technicians decide what evidence to collect and preserve. The Technicians would then document their discoveries in ADD Reports, which usually included a diagram of the crime scene and site survey. Other than an initial crime scene walk through, there was no documentation indicating that the detectives participated in the detailed examination and
retrieval of evidence from the crime scene.\textsuperscript{27} We understand from our interviews of key detective personnel that the Department implemented a policy in about 2008 requiring that detectives stay with the crime scene Technician when possible; however, there was no evidence of that occurring in the five post-2008 homicide cases in the audit sample.

\textbf{Recommendation No. 14:} The Department should implement a policy requiring that a detective who is familiar with the basics of the case work side-by-side with the Technician(s) during the processing of each crime scene and include documentation of that collaboration in the investigation.\textsuperscript{28}

\subsection*{2.2 Evidence Collection & Documentation}

The Department uses three separate reports to document evidence. One is a Physical Evidence Report that is used to list photographs, latent prints and other evidence collected by crime scene Technicians. The second is a Property & Evidence Report with check boxes for: 1) Found property; 2) Property booked for safe keeping; 3) Evidence; and, 4) Items seized pursuant to a search warrant. The third is a Property/Evidence Continuation Report which has check boxes for the four types of evidence and property listed above.

The use of multiple forms by several people retrieving and booking evidence during a murder investigation often resulted in different items receiving the same item number as well as large gaps in the item numbers. For example, in one case 25 Property/Evidence Continuation Reports were completed by 15 different detectives, officers and Technicians. There were several other cases with multiple items of evidence listed under the same item number. This makes it difficult to identify the precise piece of evidence that needs to be analyzed.

The Department’s current practice also produces gaps in the numbering of itemized evidence. This opens the door for claims of missing, misplaced or secreted evidence; presents unnecessary obstacles in proving an item’s chain-of-custody; and, exposes detectives and Technicians to accusations of carelessness in processing crime scenes. While item numbering and reporting discrepancies can be explained later during testimony, there is no reason for generating reports in this fashion.

\textsuperscript{27} If this did occur, it should have been documented in the investigation.
\textsuperscript{28} Auditors were told that such a policy may have been adopted in 2008, but we were unable to locate it in writing and there is no evidence it was followed in the five post-2008 cases we reviewed.
Recommendation No. 15: The Department should adopt a more streamlined, practical system for numbering evidence and other items gathered during criminal investigations. Each item should be listed separately and assigned its own unique item number. The Department should also consider transitioning to a single evidence report specifically designed to address the Department's needs.

Another area of concern was investigations in which multiple officers and technicians recovered various items of evidence. For example, at two search warrant locations no less than six different personnel were listed as locating and recovering evidence.

Recommendation No. 16: An “Evidence Officer” should be designated for each search location, especially when a search warrant is involved. The Evidence Officer is responsible for retrieving and documenting all evidence seized at the location. Anyone else who sees a piece of evidence should leave it in place and notify the “Evidence Officer” who would then photograph the evidence in place, recover it and complete the evidence report.29

2.3 DNA Analysis

This audit identified several areas of concern regarding the request or failure to request appropriate analysis of booked evidence. For example, at one crime scene technicians processed the inside of a restaurant with “an emphasis on” a particular table. But there were no indicia in any of the reports that the suspects were ever inside the restaurant and there was no explanation for the focus on that table. In another case, a cigarette butt was recovered from the sidewalk where the suspect had been standing and a buccal swab was collected from a potential suspect, but there was no evidence the swab was compared to the cigarette butt or that the cigarette butt was examined for a possible DNA profile. In a third case, there was no documentation of any request for analysis on the clothing, bedding, or cutting instruments that had been booked as evidence.

Recommendation No. 17: The Department should establish a working group of senior homicide detectives and evidence technicians to propose appropriate policy and procedure recommendations associated with requests for DNA and other scientific analysis.

29 In lieu of this recommendation, the Department requires that the search warrant officer photograph evidence in place prior to collection. This effectively satisfies the concern addressed by this recommendation.
2.4 Firearms Analysis

In one case an LASD Forensics Lab analysis on one suspect’s clothing showed a particle of gunshot primer residue on the shirt, but there was no evidence of any request by the detectives for an analysis of the victim’s clothing or that of the other suspects. When the defense asked an independent lab to analyze the victim’s clothing the lab submitted a report stating they found one particle of gunshot primer residue on the victim’s shirt.

In another case, there was no documentation in the case file indicating whether the 9mm cartridge casings collected at the scene had been inter-compared and entered into the NIBIN database or if the evidence and coroner projectiles had been examined for type/caliber and inter-compared. This would have established whether more than one firearm was involved and may have provided a link to any other incident involving the same weapon.

Eyewitnesses in another case believed that two suspects fired 5 to 10 shots at the victim, but the ten cartridge casings recovered at the scene were found to have been fired from the same 9mm firearm. The projectiles recovered by the coroner from each of the victims all had similar rifling characteristics, but there was no documentation that the projectiles were inter-compared to determine if they had been discharged from a single or different firearms.

2.5 Other Analyzed Evidence

It is apparent that the detectives are generally aware of the various types of scientific analysis available to support their investigations. However, it does appear there were incidents where they did not recognize circumstances in which scientific analysis could strengthen a case, or eliminate suspects so they could better focus their investigative efforts. Most importantly, it is abundantly clear that a “fresh set of eyes” is not reviewing these cases and ensuring that every reasonable investigative lead is being pursued.  

For example, a murder suspect had two cell phones in his possession when he was arrested, but only one of the phone numbers was included in a requested court order for subscriber information, call records and cell tower sites. The detective’s Follow-Up Report offered no explanation for not including the second phone number in the court order, nor did it indicate whether any relevant information was gleaned from the voluminous materials furnished by the service provider.

In another case, a search warrant was obtained to seize a murder suspect’s cell phone and computer in order to identify any co-conspirators, determine if he had a mistress, or locate evidence of financial difficulty. Though the search warrant was served and the items seized, there was no documentation indicating that any forensic analysis was requested or completed on either the computer or cell phone. If any analysis was conducted and nothing was found, that in and of itself, could be interpreted as

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30 That shortcoming is addressed in Objective 6: Supervisory Oversight.
exculpatory evidence and should have been documented. In that same case, a suicide letter purportedly written by the victim and a partial eulogy written by the suspect contained sufficient handwriting similarities to warrant forensic examination. If both documents were authored by the same person, it could support the notion that this incident may have been a premeditated murder.

**Recommendation No. 18:** Supervisors should be held accountable for ensuring that the detectives assigned to them receive sufficient training to maintain their expertise on the various scientific analysis tools to needed to fulfill and to excel in their investigative responsibilities.

### 2.6 Disposition of Evidence

The Evidence Disposition section of the Complaint Disposition Form (CDF) includes a section for evidence disposition and a check box to indicate if a copy should be sent to Property & Evidence. Auditors noted that none of the CDFs indicated property dispositions and none of them indicated a copy should be sent to Property & Evidence. During our interviews with key detectives we were informed that they never fill out the Evidence Disposition portion of the form because, “It does not go to Property.” Instead, they wait for Property to send out a written request for instructions and deal with it at that time.

**Objective No. 3: Interview & Interrogation.** Examine the manner in which witnesses were interviewed and suspects interrogated to determine if they were conducted in a professional manner, recorded when appropriate and summarized accurately in police reports.

**Assessment**

Auditors reviewed the documentation and available recordings for each case selected for the audit sample to determine how the interviews and interrogations were conducted for each case. As necessary, auditors interviewed key PPD personnel including managers for policy issues and detectives for any questions on specific cases.

**Findings**

**3.1 Witness Interviews**

We noted many investigations where detectives conducted thorough and comprehensive witness interviews. For example, in one case every percipient witnesses was interviewed in a timely manner and those interviews were quite thorough. The detective recognized that the suspect’s mental state was a factor in the case, so he conducted a full investigation into the suspect’s past that included interviews of friends and acquaintances to determine the extent of his mental health issues, if any. Those follow-up efforts were thoroughly documented in ADD reports.

In another case, each interview was very thorough and digitally recorded by the detective. The suspect was interviewed three times by the primary detective and then a fourth time by another detective. Each
interview yielded additional information from the suspect ultimately resulting in a criminal filing and conviction. However, there were no corresponding notes to the interviews.

There were other cases where supervisors should have returned the investigation to the detective for clarification. In one case, the lead detective wrote in his ADD report that a credible witness told another detective the suspect said, “I better not see you (victim) on the street” only a short time before the victim was murdered. The lead detective referred to another detective’s ADD report for specifics on the statement, but that statement was not in that ADD report and there was no other documentation that this witness was ever interviewed.31

Another example occurred in a case, which appears to have been witnessed by several people who were never identified or interviewed. Those potential witnesses included a man reportedly taking pictures of the scene immediately after the shooting, a named witness who allegedly told some passersby about the shooting and a security guard who may have been in the parking lot during the shooting.

### 3.2 Photo Identification of Suspects

In the Department’s Policy Manual, issued June 3, 1996 and revised in December 15, 2001, Section 600.5 Photographic Identification of Suspects states: “When practicable, the employee composing and the employee presenting the photo lineup should not be directly involved in the investigation of the case.” Subsection (c) states: “The employee presenting the photographs to a witness should not know which photograph depicts the suspect.” Subsection (d) states: The employee presenting the photographs to a witness should do so sequentially (i.e., showing the witness one photograph at a time) and not simultaneously.” Section 600.5 further states: “The procedure employed and the results…..should be documented in the case report. A copy of the …lineup….should be included in the case report. Witness comments….should be quoted in the appropriate report.”

The Department’s Criminal Investigations Division, Detective Resource Guide, dated May 2011, is silent on the subject of who should present the photographs to the witness. But the Department’s Investigation and Prosecution Policy Manual, issued July 13, 2012, reiterates long-standing policy that, “When practicable, the employee composing and the employee presenting the photo lineup should not be directly involved in the investigation of the case.”

In spite of these long-standing policies requiring an uninvolved detective to present a witness with photos, none of the cases in this audit sample complied with those policies. One could argue that the policy says “when practicable” but then one would also have to argue that it was never practical to comply with the

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31 Because the detective referred to another detective’s ADD report, there is a possibility he assumed the other detective conducted the interview.
policy. We also understand from our interviews of detective personnel that record personnel are used on occasion to put the six-pack photo lines together.

It is the auditors’ opinion that the Department’s existing policy regarding an uninvolved detective presenting the photos to a witness and the manner in which those photos are to be presented is a widely accepted “best practice” in conducting criminal investigations. Unfortunately, detective supervisors appear to have allowed their subordinates to deviate from this sound policy in every case evaluated during this audit.

**Recommendation No. 19:** Supervisors should be held accountable for ensuring their subordinates comply with Department policy governing the conduct of Photo Line-Ups and that regular inspections are conducted to ensure detectives and officers comply with this policy.

There was one case in which a witness’ photo identification was reported inaccurately by the detective. At the conclusion of the witness’ first (tape recorded) interview, the witness was shown a prepared photo line-up. The witness can be heard on the tape saying the suspect “looks like this guy” but no one vocalized or otherwise recorded the photo being identified. When the detective asked the witness to explain the selection, the witness mentioned the suspect’s hair and facial features. The detective instructed the witness to ignore the “hair” as it was subject to change. However, the witness did not alter what was, at best, a very tentative identification of what was most likely a “filler” photograph. The photo display presentation, the witness’ tentative identification of the “filler” photograph and the descriptors provided by the witness were not included in the detective’s ADD Report.

A month later, the detective re-interviewed the witness. According to the detective’s ADD report, he showed the witness a six pack photo lineup and the witness declared, “That’s the guy.” The six-pack photo array in the case package has one of the photograph numbers circled, it is initialed by the witness and dated the same date as the second interview.\(^{32}\)

First, the detective’s ADD report states the identification occurred during the initial interview even though it occurred and the array was dated a month later. Further, a review of the tape recording of the second interview shows that the interview and identification unfolded quite differently. Listening to the recording, the detective can be heard saying, “Look at this photo” indicating that the witness was first shown a single photo. When the witness expressed doubt over the complexion and width of the nose, the detective

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\(^{32}\) It is unclear from the case file if this was a new array or the same array presented to the witness a month earlier.
stated that the person did have a wider nose and asked “Does that look like the individual?” When the witness answered, “No”, the detective asked him to explain why not. The witness replied that the eyebrows were different. The detective asked if, despite the hair and eyebrow differences, if the person depicted looked like the shooting suspect and the witness answered yes. The detective asked if the person depicted looked like the shooting suspect without the beard and the witness agreed. The detective then produced another photo of the same individual without the “pointed” eyebrows with which, the witness used for elimination earlier to demonstrate the change in appearance. At that point, a six-photo array was presented and the witness was asked to “point out the individual who did the shooting.” After almost eight seconds of silence, the witness indicated “Right here.” The detective vocalized the photograph’s numerical position. At no time was a witness declaration of “That's the guy” audible on the recording. (The suspect was not arrested and this case remains unsolved.)

**Recommendation No. 20:** The Department should conduct a full biopsy of this investigation and take appropriate action.\(^{33}\)

**Recommendation No. 21:** The Department should consider a “cold case” review of this investigation since there appear to be several potential leads and scientific evidence available to support further investigation.

### 3.3 Interrogation of Suspects

Case and statutory laws allow police officers a great deal of latitude in the manner in which they interrogate suspects. Legally, officers are allowed to exaggerate and even lie. But eventually any statement they elicit must withstand scrutiny in court where various statutes and prior court decisions are applied to determine if the statement was “free and voluntary” or “coerced and under duress.” But even when a statement is admitted in court, the manner in which the detective obtained it will be scrutinized by a judge and/or jury who are ultimately responsible for determining if statement is credible.

Recognizing the importance of all this, police officers are taught interrogation skills early on in their careers and those skills are continuously refined and honed, often through experiential learning or “trial and error.” So it is within the broader context of developing a high-quality investigative process, not just

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\(^{33}\) Auditors evaluated multiple other cases involving this detective and the findings stated in this instance were unique to Audit No. H-13.
staying within the confines of statutory mandates, that auditors evaluated the manner in which Pasadena Police Department detectives interrogate suspects. That review identified the following areas of concern:

- Inappropriate or potentially coercive statements;
- Three or more interrogators present in the interview room;
- Failure to identify participants in the interview, as well as the date and time of the interview;
- Failure to accurately synopsize the interview in police reports;
- Failure to document all contacts and/or interviews (discovery);
- Extensive use of an “implied waiver;” and,
- Continued questioning after invocation of Miranda.

There were several cases in the audit sample that provide good examples of these areas. During one interrogation, the detective told the suspect (paraphrasing) “As far as this case is concerned you’re not controlling your life, I’m controlling it. I’m controlling who gets filed on. I’m controlling who gets the death penalty. I’m controlling who gets 2nd degree murder, manslaughter or self-defense.” These statements could easily be construed as coercive by the courts and unnecessarily jeopardize an otherwise diligent and thorough investigation. It also indicates a lack of training in the area of sound interview and interrogation techniques.

In another case, the lead detective’s interview of the primary suspect was tape recorded and thoroughly documented in the detective’s report. But a supporting detective’s tape recorded interview of a juvenile suspect clearly shows that the detective continued questioning the juvenile not once, but twice after the juvenile stated he did not want to talk to the detective. That was not documented in the detective’s report and could have caused any subsequent confession to be deemed inadmissible. During one interview, two secondary detectives told a juvenile suspect that this was a death penalty case and if he did not cooperate or show remorse they would file on him as an adult. They also told him that if he showed remorse the court would be more lenient with him. Statements like that, especially when made to a juvenile in a custodial setting (even if the juvenile is no stranger to custodial settings) could be construed by a court as coercive rendering any statement and its products involuntary and inadmissible. We also noted that one of the secondary detectives used many leading questions, seeming to encourage the juvenile to say he was afraid for his safety and was acting in self-defense. Detectives need to use an abundance of caution when using leading questions or offering a suspect the “out” of self-defense if there is no evidence to support it.

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34 Auditors are highly experienced law enforcement professionals, but not attorneys. The Department is encouraged to discuss our findings in this objective with District Attorney representatives.
Another case had no documented or written summary of one suspect having been interviewed, but there was a 36 minute audio recording of his interview in the case package. The recording showed the suspect being interviewed by three unidentified detectives. (No one was introduced on the recording.) The suspect was asked if he remembered his rights from a few days prior and he indicated that he did. He continually denied shooting the victim. A second suspect in this case was interviewed twice. In the first interview, the lead detective obtained an implied waiver and wrote in his report that the suspect “understood each of her rights and gave a statement.” But in the material auditors received from the Records Unit (it was not in the case file) there was a “Prisoner Intake Health Screening” form stating the suspect was taking three medications daily for schizophrenia, but had not taken them in several days. The detectives should have recognized this as a potential impediment in the suspect’s ability to give a knowledgeable and intelligent waiver of her rights. It is quite common for detectives to inquire as to a suspect’s health including medications and the last time they slept or ate to gather information which is directly associated with the admissibility of any statements obtained. This same suspect’s second interview by three detectives starts with an unidentified detective asking if she remembered her Miranda Admonition from a few days earlier. Though the interview lasted over an hour, the detective’s synopsis was just three lines on his ADD Report. At one point the lead detective left the room and a secondary detective took over the interview. (This is the same secondary detective who used coercive statements in the earlier case above.) The secondary detective told the suspect, “You could spend the rest of your life in prison. You’ll never see your kids or mother again. This is a life case, no funerals, no Christmas, can’t talk to your kids or grandkids.” Again, those types of statements could be construed as coercive and should be avoided by interrogators.35

In this case a secondary detective wrote in his report that the suspect “admitted arming himself” prior to confronting the victim. But a review of all three of the suspect’s interview transcripts showed that the suspect consistently either denied taking any weapon with him or could not remember having a weapon. A discrepancy of this magnitude should have been caught by a supervisor or manager and points out the necessity for the interviewer to review the recording as he writes his report and for the second interviewer to proofread it for accuracy.

The arrest report for one of the suspects in another case does not mention any Miranda admonition or interview. In fact, other than the arrest report, there was no documentation for that suspect in any reports even though he was charged with murder, convicted and sentenced to state prison. It is highly unlikely that at some point the detectives didn’t at least try to interview him, but there is no evidence of that in the case book. The girlfriends of two additional suspects were arrested as accessories to the murder. But,

35 California POST “Basic Course Workbook” Investigative Interrogations section.
there was no evidence in the case file or Records Unit that either of the women were interviewed regarding their knowledge of the crime or their boyfriends' involvement. In response to a document request from Veritas, the Department was able to provide a crime report for one of the women, but could find no documentation for the other.

**Recommendation No. 22:** The Department needs to decide the manner in which it expects its detectives and officers to conduct their interrogations, document those expectations in its policies, procedures and training materials and hold supervisor accountable for ensuring their subordinates’ compliance.

**Recommendation No. 23:** All detectives and their supervisors be required to attend periodic POST certified Interrogation Law and Tactics courses in order to keep current on case law and best practices.

**Recommendation No. 24:** Detective supervisors should listen to their detectives’ recorded interviews as frequently as possible and compare the interview to what is written in the ADD report to ensure the interview was documented completely and accurately.

**Recommendation No. 25:** The Department should conduct complete biopsies, including a review of court records and interviews of key witnesses, for these five cases and take appropriate action.

### 3.4 Recording Interviews and Interrogations

Auditors found inconsistency in detective decisions to record the statements of key witnesses and suspects but not others. When those statements were not recorded, there was no rationale given in the reports and there was no evidence of supervisory oversight or involvement in those decisions. In high-profile investigations such as a murder and particularly in gang cases, witnesses may later equivocate or dramatically alter their statements often due to fear of retaliation, to hide their own actions, or in furtherance of an ongoing gang conflict. A recording of witnesses and/or suspects original statements adds another level of documentary evidence in the event there is a dispute over what was stated or understood. When a statement is recorded, failure to document it in the reports raises credibility issues during discovery at trial.
Recommendation No. 26: The Department needs to decide the type of interviews it wants recorded, publish those expectations in the appropriate policy and training directives and hold supervisors accountable for ensuring their subordinates’ compliance with that policy. In those cases where the Department gives detectives discretion in the recordation of interviews, the detectives should be required to document their rationale in the investigative file whenever they decide not to record an interview.

During the course of this audit, Veritas requested copies of recorded media to assist in the audit analysis process. On numerous occasions the digital media copies could not be opened because the recordings were created in myriad electronic formats. On those occasions, auditors were unable to compare a written synopsis of an interview to the recording. The Project Manager discussed this issue with the Detective Lieutenant who indicated that the Department has received complaints from both the District Attorney and defense attorneys regarding the inability to open recorded digital media. Apparently, in addition to the audio/video equipment provided by the Department, officers have their own audio recording devices as well as the audio equipment found in some of the patrol and detective vehicles. Each of these systems has its own electronic format and the media from one cannot be opened in the other. As of this report, the Department has not resolved this problem.

Recommendation No. 27: As a matter of utmost urgency, the Department needs to do whatever is necessary to ensure that recorded interviews are in a standard format that allows them to be reviewed.

Objective 4: Investigative Documentation. Determine the completeness of investigative documentation both in the case file and records unit file.

Assessment
Auditors reviewed the documentation for each case selected for the audit sample to determine if the reports were complete and accurate, if the documentation reflected a thorough and complete investigation and, if the various investigative reports reconciled with one another and the physical, documentary, testimonial and/or other evidence. When necessary, auditors interviewed key PPD personnel, including managers for policy issues and detectives for questions on specific cases.

Findings
There were numerous reports in the case packages for the audit sample that contained inaccurate or conflicting information and, in some cases, misstatements of fact. Those errors occurred in many of the ADD Reports as well as in Statements of Probable Cause in support of Search Warrants and PCDs.
every case we reviewed, there was no documentation for the case after it was presented to the District Attorney and no information regarding the court disposition or sentencing. Therefore, in order to determine each case’s disposition, auditors had to request PIMS Reports from the District Attorney’s Office.

One of the causal factors for this finding appears to stem from the lack of consistent training in basic detective skills for both detectives and their supervisors. Another factor is that in many cases the detectives worked for days with little or no sleep pursuing leads, serving search warrants and arresting suspects. But in a much larger sense, the poor documentation flows from a complete lack of supervisory oversight of the detectives’ work product. None of the cases we reviewed had any documentation that a supervisor (or anyone other than the author) reviewed affidavits before they were presented to a judge, or that a supervisor reviewed the case before it was presented to a prosecutor. There can be no doubt that this lack of supervisory review was a significant contributor to most, if not all the discrepancies found in this audit. As discussed in the introduction of this report, some of those errors surfaced in court hearings. This resulted in cases being dismissed, charges being reduced and the reputation and credibility of the Department and its officers being challenged in the media.

4.1 ADD Reports

In too many cases, officers and detectives would refer to another officer’s ADD Report for pertinent investigative information, but the referenced report either did not exist, did not contain the referenced information, or the referenced information was incorrect. For example in one case there was no indication in the detective’s ADD Reports that the primary suspect was interviewed. But the case file had notes from a secondary detective indicating that he tried to interview the primary suspect, but he invoked his Miranda privilege. It appears the secondary detective tried to continue the interview, but the suspect adamantly refused to make any statement. There were no indicia that the interview was recorded or that the secondary detective completed an ADD report. One of the detective’s ADD reports was found in the case file, but not in the Records Unit file. Another of his ADD reports was in the Records Unit file, but not in the case file. This raises a serious question as to which reports were presented to the DA and which reports were produced for discovery.

The primary detective’s ten-page summary of a homicide investigation was a poorly sourced report with representations and conclusions often unsupported and overly reliant on faulty memory. The detective’s Follow-Up Report referred to three ADD reports completed by other officers as detailing significant investigative activities, but those reports were not in the casebook nor were they in Records and the Department was unable to produce them. The original Crime Report completed by a patrol officer and

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36 This is addressed and appropriate recommendations proposed in Chapter V of this report.
the foundation for the murder investigation referenced ADD Reports by two other officers neither of which was in the homicide casebook, but one of which was located in the Records Section. (The Department could not locate the second report.)

The primary detective’s ADD report for another homicide referred to an officer’s ADD report as containing a summary of a witness’ statement, but that ADD report could not be found and there was no summary of the witness’ interview in the case file. There was also a conflict in the reports regarding the viewing of a surveillance video that captured the murder scene.

4.2 Search Warrants
There were numerous homicide cases in which the detectives obtained search warrants for residences, business, cars and records. Their diligence in obtaining those warrants is truly commendable. However, many of the reports and affidavits submitted in support of those search warrants contained incomplete and incorrect information, or referred to reports that could not be located. There were myriad cases where there was no documentation that the court received a return on the search warrant. Additionally, several returns occurred after the ten-day return requirement. Finally, there was no evidence of supervisory review before a search warrant application was made to a judge.

**Recommendation No. 28:** A detective supervisor should be required to review and approve a search warrant before detectives submit it to a magistrate and the supervisor’s approval needs to be documented (initial each page). The Department also needs to implement controls to track the return of search warrants and it needs to conduct regular audits and inspections to ensure compliance with these requirements.

4.3 Arrest Reports and PCDs
One of the fundamental risk-management strategies employed by most law enforcement agencies is a requirement that an officer making an arrest obtain written booking approval from an uninvolved supervisor before they are allowed to book a suspect into jail. Whenever possible the supervisor who gave booking approval should also be the supervisor who approves the reports in order to ensure the reports reflect the information the supervisor was told and relied upon when approving the booking. This risk management control process is commonly referred to as “Separation of Duties” and is intended to prevent any conflict of interest, ensure arrests are legally justified and prevent personal involvement from interfering with what should be a very objective fact-based decision.

The Pasadena Police Department has had an essentially similar policy in place for many years. However, there was no evidence of supervisory booking approval or report review in the homicide cases.
we reviewed. During interviews with key Department personnel we were informed that the booking and report approval requirement has not applied to arrests made by detectives for several years. We also noted that the Department’s Pre-Booking Review form\(^{37}\) does not capture the name and serial number of the supervisor who approved the booking.

We found several arrest reports and PCDs in the homicide case files that did not articulate any probably cause whatsoever for the booking charge. In four cases not only was no probable cause articulated in the arrest reports, but there was no probable cause \textit{for the booking charge} in the entire case file.\(^{38}\) For example, the primary detective in one case sought a murder filing on three suspects and accessory to murder on a fourth. The DA filed murder charges against two suspects, but rejected a murder filing against the third and accessory on the fourth due to insufficient evidence. Two weeks later, the detective told two SES officers that “if they successfully detained the accessory suspect” to take him to the station and notify the detective so he could interview him. The SES officers found the accessory suspect and brought him to the station, but they were unable to contact the detective. So, the SES officers booked him for murder even though there was no probable cause or any other rationale articulated in their reports to do so. The suspect declined to waive a Probable Cause Hearing and there was no PCD. After being interviewed by the detective the next day, he was released and issued a Certificate of Release.

In another case, three suspects in their late-teens or early 20’s were in a car and intentionally ran over the victim who was on a bicycle. The officers and detectives did a great job of identifying the car and found it leaving an auto repair shop. There were three occupants in the car, two of whom fit the suspect description and a third, a 44-year old man, who bore no resemblance whatsoever to the suspect descriptions. Nevertheless, all three occupants were booked for murder. The DA rejected a filing on the 44 year old stating he was a “witness…not a suspect.”

The PCDs for three arrestees in another case mistakenly indicated the wrong name for the third suspect identified by an eyewitness from photo line-ups. The same three PCDs also contained a concluding paragraph stating that a K-9, “had confirmed that (two correct names; one incorrect name) scent matched” a scent pad developed from a 9mm cartridge casing at the murder scene. But the fact is that the K9 alerted on two of the suspects and not the third. In another case, the primary detective requested an additional filing on each suspect for robbery and a gang enhancement; but, no documentation was found to substantiate a robbery charge and no documentation was found for the gang enhancement on two of the suspects.

\(^{37}\) PPD 0729 (Rev 09/08).
\(^{38}\) In each case, several lesser felony charges were available, but not the one for which they were booked.
Recommendation No. 29: The Department should conduct a biopsy of the four cases cited in Objective 4.3 and take appropriate action.

Recommendation No. 30: The Department should amend its Pre-Booking Review form to include the name and serial number of the supervisor approving the booking.

Recommendation No. 31: The Department needs to enforce its policy that every arrest must be reviewed and approved in writing by an uninvolved supervisor and every arrest report must be reviewed and approved by a supervisor, preferably the one who approved the booking.

4.4 Chronological Logs

Note keeping is an essential tool in managing the tremendous volume of information generated in a typical homicide investigation and for establishing a chronology of events. The ultimate note keeping tool for an investigator is a comprehensive Chronological Log.

None of the homicide cases we reviewed contained a comprehensive chronological log. The necessity for all detectives to keep a chronological log for their cases cannot be overstated. Of most importance, chronological logs are an invaluable tool required for an effective management review of complex and/or inherently high risk investigations. Finally, chronological logs can be used to document the detective’s due diligence efforts to locate and apprehend suspects. For example, one of the cases involved a homicide suspect who was a fugitive for over three years; but, the case file had no information on the Due Diligence performed on the murder warrant between the time it was issued in 2007 and its service in 2009.

Recommendation No. 32: The Department should create a Chronological log and require all detectives to use it and document their actions including court proceedings, discovery requests and final court disposition. The log should also indicate when the detective supervisor reviewed the case to ensure the investigation was thorough and on track.

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39 Practical Homicide Investigation, Vernon Geberth, Elsevier Press, 1983
4.5 Documentation of Recordings  
(This is addressed in Objective 3.4 Recording Interviews and Interrogations.)

**Objective 5: Organization of Homicide Case Books.** Review the case book(s) for each murder investigation selected for the audit to determine if it was complete and organized properly.

**Assessment**

Auditors reviewed the case book for each murder investigation selected for the audit sample to determine if it contained all necessary information relative to the case and to determine if the book(s) was (were) organized in a manner that facilitates effective management of the case and allows supervisory and management review and oversight. Auditors also compared the material in the case file with material available in Records to ensure all relevant reports had been included in the case book. As necessary, auditors interviewed key PPD personnel including managers for policy issues and detectives for any questions on specific cases.

**Findings**

The audit material provided to Veritas consisted of copies of the material in the Case File, as well as copies of reports from the Records Unit files. Auditors conducted a detailed comparison of the copies of the case files to the originals to ensure they were consistent, which they were. Auditors found that in most cases, the Records Unit files did not contain all of the reports found in the Case Files. Conversely, there were reports found in the Records Unit file that had not been included in the Case File. Auditors also found that most detective-generated ADD Reports found in the case file had not been signed by a supervisor but, the same reports found in the Record Unit files had been signed. In most cases, the signed and unsigned reports appeared to be the same but, in one case they were substantially different. We were also unable to establish which reports (Records or Case File) were produced for the prosecutor or in response to discovery requests. This finding is an untenable risk exposure that surfaced repeatedly throughout the engagement.

There was no uniformity of the Table of Contents (TOC) sections used by different investigating officers. The organization of the TOC also differed between cases investigated by the same investigating officer. Many of the case books we examined had no labeled tabs indicating the material that was supposed to be filed within that section. We also found numerous loose reports within the case folder rather than being filed in the appropriate section.

In the auditors’ opinion, the lack of clear expectations for the organization and maintenance of these case books, along with the utter disorganization of most homicide case books evaluated during this engagement, creates a significant risk exposure in the Department’s ability to evaluate its investigative efforts, ensure compliance with discovery requests and document the materials that were presented to prosecutors.
Recommendation No. 33: All detectives and their supervisors need to receive periodic training on case management and organization.

Recommendation No. 34: The Department needs to develop a system so that the content and organization of all homicide case files is consistent and uniform.

Recommendation No. 35: The Department should assign an external hard drive (flash drive) to the primary investigator for each major police investigation. The detective should store all of the case's investigative material on that device and maintain a Table of Contents to identify the drive's contents. When the case is completed the drive should be maintained with the Case Book in a secure location.

Objective 6: Supervisory Oversight Homicide Investigations. Review the case file for each murder investigation selected for the audit to assess the level of documented supervisory oversight for each case.

Assessment
Auditors reviewed the documentation for each case selected for the audit sample. These included reports, correspondence, logs and emails to identify the frequency and thoroughness of the supervisory review and input for each case. Included were report approvals and evidence of supervisory review at critical junctures such as obtaining search warrants, presenting the case to the prosecutor and reviewing the case package before it was filed away.

Findings
The vast majority of the errors identified through this audit were caused both by supervisors failing to review reports thoroughly before signing them and failing to periodically review the case, especially at critical junctures, such as before the detectives sought a search warrant or presented the case to the prosecutor. In one sense, a supervisor's report approval signifies that the supervisor is familiar with the information being reported and concurs with it. But the supervisor is also responsible for ensuring the reports are written clearly, that any errors are corrected and that the investigating officer's actions were appropriate. Most of the reports cited in this chapter bore a supervisor's signature. But the approving supervisors either did not recognize the significant issues as pointed out in this chapter, or they simply failed in their responsibility to provide their subordinates with effective critique, direction, guidance, or training. Several of those subordinates now find themselves the subjects of intense public and judicial
scrutiny for errors that in many cases, but not all, could and should have been caught and corrected by the supervisors who approved their reports.

In most of the homicide cases, there was little or no evidence of actual supervisory oversight of the investigation. The interviews with key detective personnel, which were supported by the audit evidence, showed that though supervisors would have periodic meetings and “round table” cases, there was no requirement that a supervisor review and approve reports prior to seeking a search warrant or even before presenting the case to the prosecutor. This is inconsistent with the risk management principles of maintaining a "separation of duties and effective monitoring." While reports completed by patrol were generally thorough and always signed by a supervisor, very few of the reports detectives initiated were signed by a supervisor. While patrol and detective supervisors were almost always at the initial scene and frequently accompanied detectives during the initial investigation, there was no documentary evidence of supervisory oversight during the rest of the investigation or evidence that a supervisor reviewed the case file when it was completed. In fact the numerous obvious errors found during this audit support a conclusion that case files were not reviewed by a supervisor.

For example, the reports in one case file were either signed or initialed by the homicide supervisor, but there was no Death Report or Autopsy Protocol in the case file. Additionally, the original charge was battery with serious bodily injury with a special allegation of inflicting great bodily injury, but the suspect eventually pled guilty to involuntary manslaughter. There was no documentation in the very thin Case File indicating when the charges were amended to manslaughter. In another case, two reports referred to statements taken by supervisors, but neither supervisor completed a report documenting those interviews. A secondary detective in another case authored a search warrant affidavit containing erroneous information regarding an arrestee’s supposed admission that his car was repaired at a particular body shop. There was no indication of supervisory review before the affidavit was presented to the magistrate. Several weeks later, one of the victims, now in custody on another charge, was being transported for a court-ordered line up. The victim was inadvertently handcuffed to the suspect he was about to be asked to identify and the suspect threatened him. There was no evidence of supervisory oversight to ensure the Sheriff’s Department was given a “keep away” instruction for the two prisoners.

In another case, a detective supervisor was at the scene of a second arrest associated with the investigation. In spite of that, he failed to identify and correct serious documentation errors including a lack of documentation on the recovery of a second gun, a reporting discrepancy on when the detectives arrested the second suspect and retrieved the murder weapon and a secondary detective’s misstatement of facts claiming that a suspect "admitted arming himself" when other documentation in the investigation indicated the suspect either denied having a weapon or could not remember having a weapon.
Recommendation No. 36: The Department needs to clearly articulate its expectations of detective supervisors and Department managers who oversee investigative functions. Those expectations should include, at a minimum, a review of inherently high risk investigations, search warrants, felony arrest reports, case filings and the seizure of high risk evidence including narcotics, money and firearms. The Department should also conduct regular periodic biopsies of major cases to ensure adequate and documented supervision is being provided.

Use of Informants

Note: Due to the risk of inadvertently disclosing the identification of informants, the Chief of Police has deemed much of the material in this section to be confidential. So, specific information has been communicated confidentially to the Chief of Police but details have not been provided in this section. Nevertheless, we are able to discuss our findings in this critical area in general terms.

The use of informants is a legitimate and judiciously accepted law enforcement tool. In many cases the effective use of informants is crucial to the successful apprehension and prosecution of suspects. However, informants, especially criminal informants, pose investigative and officer safety risks. Criminal informants have a well-deserved reputation for being self-serving and manipulative. They require careful handling by detectives, including close supervision and good management oversight. We discussed the use of informants with the Department’s detective managers. Detective supervisors are always supposed to be aware of a detective’s use of an informant.

Over half the homicide cases in this audit sample involved the use of informants, to one degree or another. However, none of those informants were identified beyond a broad term such as Confidential Reliable Informant, Confidential Informant, or Anonymous Informant. This was particularly true when the expertise and contacts of the Gang Unit were used. Those cases often referred to leads from a “Confidential Informant” or a “former Confidential Informant.” But, none of the informants were identified by a control number and it was often unclear if these were actual registered informants or simply citizens who provided information.

It appears that juvenile informants were used in two cases, but there was insufficient information in the case files to determine if court approval was required to use either juvenile as an informant pursuant to Penal Code Section 701.5 and, if it was required, whether judicial approval was obtained.
Recommendation No. 37: The Department needs to conduct a biopsy of both cases involving juvenile informants to determine if judicial approval was required and, if it was, whether or not it was obtained.

We found several cases that underscore the need for the Department to further refine its standards governing the use of informants. For example, in one report the detective wrote that he received information from an “anonymous informant” but in another report he wrote that he obtained the information from a “Confidential Informant.” The same informant cannot be both “confidential” and “anonymous.” In another case the primary detective’s ADD report identified his partner’s Confidential Reliable Informant by name and moniker. In two other cases someone with access to the case file (discovery) would have little difficulty identifying the Informants. These oversights place the informants at risk and should have been reviewed very carefully to ensure the informant's identity was protected. But again, the detective supervisor responsible for providing that oversight either did not read the reports or failed to recognize the issue.

Recommendation No. 38: The Department should conduct a management review of the cases cited in Objective 6.1 and take appropriate action.

Recommendation No. 39: All detectives and their supervisors should receive periodic POST certified training regarding the use and documentation of informants.

Recommendation No. 40: The Department should conduct a thorough review of its policies, practices and procedures governing the use of informants. This should include supervisory review, management oversight and implementation of effective control systems.

Recommendation No. 41: The Department should conduct regular and periodic audits of its informant files, policies and controls.

During the course of this engagement our findings associated with the use of informants were communicated to Department management. The Chief of Police responded immediately and directed that an Informant Manual be developed promptly. By the time the audit was completed, a draft Informant
Manual had been prepared and was in the review process. The Department is to be commended for its prompt response to this critical issue!

CHAPTER 7: NON-HOMICIDE INVESTIGATIONS

Note: Many of the issues identified during this portion of the audit mirror issues that have already been addressed in earlier chapters of this report, mostly the Homicide Chapter. To avoid redundancy, we have not proposed recommendations when the underlying factors have already been addressed in our previous recommendations.

Audit Sample and Impairments

One of the detectives who was a significant focus of this engagement was only assigned as the lead investigator on non-homicide cases. So a sample of his non-homicide cases was selected for the audit.

During our initial meeting with the Department in February 2013, we received a one-inch thick printout of what was purported to be a list of this detective’s cases. However, a cursory review of that material disclosed that most of the cases occurred while the officer was in patrol rather than detectives. In April 2013, we submitted a second request for a list of cases he handled while assigned to detectives. In May 2013, we received a printout of the investigations, to which he was assigned during the two periods he was assigned to detectives. However that data indicated the detective was assigned less than two cases per month while he was assigned to detectives. Further examination of the data disclosed huge discrepancies demonstrating that the data was unreliable. After discussing the data issues with PPD managers and data experts, another request was submitted for a list of cases assigned to the detective during 2010, the most recent full year in which he was assigned to detectives. There were 125 cases reported as being assigned to him during that time and those cases were separated into the following categories:

- 41 “A” cases, Suspect Not in Custody
- 37 “A” cases, Suspect in Custody
- 47 “C” cases, No Viable Leads

A review of those 125 cases gave auditors very strong indications that this data was also unreliable. For example, 13 of the 47 “C” cases, No Viable Leads, had named suspects. Two of the other “C” cases did not have a named suspect, but the disposition for both cases was “Filed with the City Prosecutor.”

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40 Data problems were discussed extensively in Chapter VI.
41 Cases are assigned a letter indicating solvability: A: strong lead; B: forensic evidence; C: no viable leads
Twenty-one of the 37 “A” cases, Suspect in Custody, showed Open. Lastly, 21 of the 41 “A” cases, Suspect Not in Custody, showed Open though there were named suspects.

Auditors reviewed the data with Department experts and concluded that, while unreliable, it was the best information available. Auditors reviewed the data and, applying their expertise, identified 38 cases that appeared to have involved the arrest of one or more suspects. All 38 of those cases were included in the audit sample.

In addition to those 38 cases, 8 more current non-homicide felony assault cases, assigned to other detectives, were selected to test the Department’s implementation of several improvements to its detective follow-up procedures.\textsuperscript{42} Four of those cases were from 2011 and four were from 2012. These 8 cases were selected by auditors in consultation with Department managers as examples of the Department’s most current closed non-homicide cases that have been completed at the trial court level.\textsuperscript{43}

Forty-six cases were selected for the audit of non-homicide investigations. Even with all this, it was discovered in the midst of the audit that two of the 2010 cases were not assigned to the subject detective. There were no significant issues with those cases and they were removed from the audit analysis. This resulted in a sample of 44 cases for this objective.

**Audit Methodology**

Consistent with sound audit methodologies, auditors conducted a full and thorough review of each case selected for this portion of the audit. Specifically, auditors used the standard of due professional care to evaluate each investigation for sound investigative practices, completeness, timeliness, appropriateness of disposition, report accuracy and evidence of supervisory review. Auditors also evaluated each case for compliance with Department policies and procedures, as well as, any evidence of unnecessary or excessive risk-management exposure.

Auditors developed an audit matrix designed to capture 28 specific data points for each investigation in the audit sample. That matrix facilitated the auditors’ evaluation of each case to determine whether:

- A follow-up investigation was required for each case and when it was, to determine if the investigation occurred and if it was documented properly and all relevant documents retained in the case file;
- The appropriate charge was sought and if the case was disposed of properly;
- Any evidence collected was disposed of correctly;
- Data for the case was entered into the Department’s Case Management System properly; and,

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\textsuperscript{42} These are the 8 cases selected in lieu of 7 homicide investigations and not purported to be random. These cases were purposefully selected to determine if the recent policy improvements were working as intended.

\textsuperscript{43} Because auditors were unable to validate the completeness of the population statistically valid sampling could not be conducted. Appropriate recommendations have been proposed in this report.
There was evidence of both supervisory and management review and oversight of the investigation.

The work papers for all 44 cases went through two levels of review and one-third (17) of the cases were subjected to a random quality assurance process by Veritas’ Senior Consultant. The results of each audit were entered in a spreadsheet which was used to compile the audit’s findings in this area, which included specific recommendations to address anomalies and minimize risk exposures. The Project Manager, who has an Accreditation in Internal Audit Quality Assessment/Validation from the Institute of Internal Auditors, conducted additional quality assurance measures.

**Objective 1: Follow-up Investigation.** Determine if the follow-up investigation of the cases in the audit sample were complete and well documented.

**Assessment**

Auditors reviewed the documentation for each case selected for the audit sample to determine if the documentation reflected a thorough and complete investigation. When necessary, auditors interviewed key PPD personnel including managers for policy issues and detectives for questions on specific cases.

**Findings**

Unlike homicide cases where detectives almost always respond to the crime scene to begin their investigation, the preliminary investigation of non-homicide cases is usually completed by patrol officers. The next business day, a detective is assigned the case and given the reports patrol completed. In this scenario, the detective fulfills two critical functions within a law enforcement agency and by extension within the Criminal Justice System:

1. **Develop Good Cases.** The reality of police work is that most criminal cases are “solved” by the patrol officers who respond to the scene and arrest the suspect(s). When patrol officers do that well and write good reports, the detective has little to do except present the reports to a prosecutor. But when there is a piece missing or the reports are not clear, it is the detective’s job to identify those issues and locate the missing information or clarify the facts. For example, locating a key witness can bolster any case; a medical report has far more evidentiary value than someone’s statement; photographs of injuries are critical when a case goes to trial long after the injuries have healed; and, a suspect’s alibi needs to be investigated. These are just some of the “missing pieces” that turn a good arrest into a good case.

2. **Pursue Investigative Leads.** When the suspect is not in custody, the detective needs to follow any viable lead to identify the suspect(s) and take them into custody. This requires, among other things, a working knowledge of forensic evidence, good interview/interrogation techniques and expertise in the myriad computer systems available in a modern law enforcement agency,
In assessing the quality of the follow-up investigations for the non-homicide cases, we considered both of these responsibilities. In 19 of the 44 cases (43%), the reports completed by patrol contained sufficient information to file the case “as is.” So those cases did not require nor did they receive any follow-up by the assigned detective.

1.1 Cases with Deficient Reports Filed “As Is.”
Auditors discovered 6 cases in the audit sample in which the detective determined that the reports were adequate and submitted the case “as is” to a prosecutor, but should have been subject to additional investigation. For example, an ADW case contained only a two sentence statement from the arrestee and the detective filed it “as is” without trying to obtain a more detailed statement.

1.2 Cases with Follow-up Investigation.
There were 13 cases in which the detective assigned the case conducted a follow-up investigation. In 5 of the cases the follow-up investigation was good and in 3 others it was satisfactory and in three others it was lacking. In the “good” category was the investigation into a major altercation at the Rose Bowl during which the investigator located a video recording of the incident leading to the identification of all three suspects. In another case, detectives responded to a shooting scene during the early morning hours. The victim could not be interviewed due to his injuries, but the detectives found a witness who identified the suspect. They placed the suspect under surveillance and took him into custody without incident. The DA rejected the case at that time pending further investigation. So, the detectives continued their investigation and gathered sufficient evidence to obtain a filing resulting in the suspect’s conviction.

In 3 cases the follow-up investigation was completely deficient. For example, in one case there were notes on the back of the Pre-Booking Review Sheet strongly indicating that the detective interrogated the suspect. However, there was no report or recording of that interrogation or what anyone said. (This may have occurred in another case which is discussed under Objective 2 which follows.) In another case, the detective arrested both the victim and the suspect, but there was no arrest report explaining the rationale for arresting the victim. (This case is discussed further under Objective 2 that follows.)

1.3 Cases with Investigative Leads Not Pursued. There were two cases with clearly viable investigative leads that were not the subject of a follow-up investigation by the assigned detective. In the first case patrol officers conducted a traffic stop of two gang members and recovered a loaded revolver under the front passenger seat. Both suspects were arrested and booked for felony possession of a firearm. The arresting officer verified there was no history of the weapon in AFS and he had evidence technicians swab the firearm for DNA. The detective submitted the case to the prosecutor without trying to trace the firearm or obtaining a buccal swab from the suspects to compare to the swabs recovered from the firearm. In another case patrol officers took a suspect into custody for possession of narcotics and recovered two stolen firearms. The detective filed the case, but there was no evidence in the case
package that the firearms were removed from AFS or that they were test fired and entered into NIBIN for linkage.

**Objective 2: Charge & Case Disposition.** Determine if the charges filed and case disposition were appropriate for each case in the audit sample.

**Assessment**

Auditors reviewed the documentation for each case in the audit sample to identify what, if any, charges were filed and to assess the final disposition for each case. When necessary, auditors interviewed key PPD personnel including managers for policy issues and detectives for questions on specific cases.

**Findings**

The charges filed and case disposition for 41 of the 44 cases (93%) selected for this audit were supported by the facts found in the case package. That is not to say that every one of those cases was pristine, for many of them (as pointed out elsewhere in this Chapter) were missing documents and important, but not crucial, information.

In three cases, auditors were unable to assess the case disposition due to a lack of documentation in the case package. In the first case, two men were fighting when one of them pulled up his shirt to display a handgun. The other man hit him several times with a piece of wood and left in his car. The man with the firearm fired two shots at the fleeing car. Patrol officers recovered two shell casings at scene along with a large puddle of blood. About an hour later, the non-shooter called the police. Patrol officers interviewed him, impounded his car and recovered a bloody piece of wood from his car. It appears the case lay dormant until the “shooter” called the detective eleven days later. The detective interviewed him during which he admitted firing the shots “from his duty weapon” because he was traumatized from the altercation. (There are some indications he may have been a security guard, but that was not pursued.)

The detective booked him for ADW. The CDF prepared by the detective states the DA filed felony ADW on the “shooter,” but there was no charge sheet in the package. The detective wrote that the CP rejected charges against him due to “self-defense.” But, there was a DA’s charge sheet in the package showing the case was referred to the CP for misdemeanor consideration and a Disposition of Arrest and Court Action shows the CP filed 4 misdemeanor counts against him, all of which were dismissed because the “people’s witness is un-cooperative.” There was no evidence of any follow-up on the bloody piece of wood nor was there any documented follow-up on the “duty weapon.”

In another case, a detective assigned to the Homicide/Felony Assault Unit was assigned to handle a burglary arrestee. (This was the only property crime arrestee assigned to a detective from that unit in the entire audit.) A store’s loss-prevention personnel saw the suspect remove one of the store’s bags from
his clothing and begin putting store merchandise into the bag. They arrested him for shoplifting, but patrol officers re-arrested him for burglary. The arrestee had several felony convictions including one for murder in the 1980s for which he was sent to CYA. Two days after being booked, the detective issued the arrestee a Notice to Appear for felony burglary and released him. There is no evidence the case was ever presented to anyone (DA or CP) and the case still shows “open.” There is also no evidence that any paperwork was submitted to a supervisor. (This is the only case in this audit sample where the CDF was not signed by a supervisor).

**Recommendation No. 42:** The Department should conduct a full biopsy of this case including: the issuance of a Notice to Appear to a felony arrestee; how this was allowed to take place without any evidence of supervisory intervention; and, what control systems are in place for detective supervisors to track arrestees assigned to their subordinates.

In the third case five suspects were booked for attempted murder. The primary detective and his assistant interviewed the suspects several times as evidenced by their notes on the back of the suspects’ Pre-Booking Review Form. But, there were no reports in the case package describing any of those interviews and the department was unable to locate them. This is a discovery and risk management concern.

**Objective 3: Disposition of Evidence.** Determine if evidence seized during an investigation was disposed of properly.

**Assessment**
Auditors identified those cases in which evidence was seized and determined if an appropriate disposition was made for that evidence. When necessary, auditors interviewed key PPD personnel including managers for policy issues and detectives for questions on specific cases.

**Findings**
There was evidence booked for 24 of the 2010 cases selected for this audit sample. Of those 24 cases, only 1 had the evidence portion of the CDF completed. In contrast, 6 of the 8 more recent (2011 and 2012) Non-Homicide cases with evidence booked had the evidence portion of the CDF completed. While the majority of the evidence cases resulted in a prosecutorial filing, the prosecutor rejected two cases so the CDF should have authorized the evidence to be destroyed or released.

**Objective 4: Case Management System.** Determine if the cases in the audit sample were entered accurately into the Case Management System (CMS).
Assessment
Auditors reviewed the CMS entries to determine if they accurately captured the information for each case in the audit sample. When necessary, auditors interviewed key PPD personnel including managers for policy issues and investigative personnel for questions on specific cases.

Findings
As we have discussed several times in this report, the information produced by the Department's automated systems is extremely unreliable. With respect to non-homicide investigations, 22 of the 38 pre-2010 and earlier cases (58%) showed they were Open when, in fact, 21 of them had been closed. There is no record of any disposition on one case from 2010 in which a detective was assigned to process a felony arrestee, but there is no record of him having done so. Three years later the case remains “Open” which should have stood out and been addressed by a supervisor. Instead the case got lost in the 29 other cases that also showed as “Open” but were not. Now, three-plus years later, the Department will have great difficulty ascertaining the basis for the release of this felony suspect and why the investigation was never completed.

Objective 5: Supervisory Oversight. Review the case file for each investigation selected for the audit to assess the level of supervisory oversight that occurred for each case.

Assessment
Auditors reviewed the documentation for each case selected for this audit sample to identify any documented supervisory oversight of the case and to determine if the supervisor returned or should have returned the case to the detective to correct deficiencies in the case.

Findings
As stated earlier in this chapter, every one of the non-homicide cases selected for this portion of the audit had a supervisor’s signature at least on the CDF. As with the homicide cases, the vast majority of the errors identified in the non-homicide cases were caused by supervisors failing to review reports thoroughly before signing them. In the interest of brevity, we won’t repeat the litany of errors that should have been caught and corrected nor will we repeat our recommendation that supervisors must review these cases carefully and consistently. We will, however, discuss two cases where there was no documentary evidence of supervisory oversight. In the first case patrol officers responded to a traffic collision where a woman in one car threw a bottle at a woman in another. The officers arrested the woman for ADW and impounded her car with a “hold for detectives.” Within hours of the booking, the arresting officer released the woman and issued her a Certificate of Release deeming the arrest to have been a Detention Only. There is nothing in the case file explaining why the woman was released. The ADW case was assigned to a detective who determined that the original “victim” was actively engaged in several identity theft/fraud cases. The detective pursued those leads, obtained a search warrant and
seized evidence proving the fraud. The DA filed numerous counts of False Impersonation against the original “victim” and the detective completed the case paperwork and submitted it to his supervisor who signed the reports. But, there was no disposition of the original ADW report and there was no documentation in the case file regarding the impounded vehicle or the woman who was released. While the detective’s pursuit of the fraud leads was commendable, a supervisor should have ensured that the completed investigation addressed all the issues and disposed of all the reported crimes.

In another case, the suspect brandished a gardening tool at the victim and officers took him into custody for a felony weapons charge but at the station officers realized the gardening tool “weapon” did not qualify under the felony section. So, the suspect was booked for misdemeanor brandishing and released. No one seems to have questioned the arrest for “felony possession of a gardening tool” or how an officer could make a warrantless arrest for a misdemeanor that was not committed in his presence.

Finally, several of these cases contained reports that clearly documented the officers’ failure to comply with Department policy. This included patrol officers releasing felony arrestees, patrol officers giving booking approval for felony arrests and an officer on loan to detectives working a special detail at the Rose Bowl giving a sergeant direction to book a suspect for attempted murder.

Regardless of assignment, supervisors have a responsibility to take corrective action any time they become aware of employees violating Department policy especially when the policy being violated is a risk management control e.g., having an uninvolved supervisor review and approve a booking. In these (and many other) cases the detective supervisors had an obligation to at least notify their patrol counterparts of these violations. But, there was no indication they did so.

CHAPTER 9: UNCONSTITUTIONAL POLICING PERSONNEL COMPLAINTS

Background
The focus of this engagement was to examine the Department’s detective operations and, in particular, the manner in which it conducted homicide investigations. However, because the issues underlying this audit involve allegations of Unconstitutional Policing, the Chief of Police asked auditors to also examine personnel complaints alleging Unconstitutional Policing by detectives.

With respect to personnel complaints, Penal Code Section 832.5 requires that:

“Each department or agency in this state that employs peace officers shall establish a procedure to investigate complaints by members of the public against the personnel of these departments or agencies and shall make a written description of the procedure available to the public.”

Penal Code Section 832 goes on to state that:

“Complaints and any reports or findings related to those complaints shall be retained for a period of at least five years” and,
“The department or agency shall provide written notification to the complaining party of the disposition of the complaint within 30 days of the disposition.”

The California State Attorney General has issued a formal opinion that:

“A California law enforcement agency may destroy peace officer internal investigation files after a five-year retention period … when the destruction is solely a matter of administrative routine and no other factors are present that would establish ‘bad faith.’”

In that opinion, the Attorney General went on to note that:

“As a matter of prudent policy, a law enforcement agency may determine that a longer period would promote greater public confidence in its procedures and practices.”

In accordance with Government Code Section 34090, the Pasadena Police Department is allowed to destroy personnel complaint files older than five years; however, Pasadena Ordinance requires that the Department obtain approval from the City Council prior to destroying any personnel complaint files. One of the personnel complaint files being considered for evaluation during this engagement had been destroyed pursuant to that process. Auditors were provided with ample documentary evidence that the file had been destroyed in full compliance with state law and local ordinance. We also noted that the Council Report for that destruction stated that, “The Police Department will maintain all internal investigations, regardless of age, involving allegations of sexual misconduct, integrity, lies and officer involved shootings.”

Audit Sample and Methodology

This portion of the engagement was limited to completed personnel investigations which contained one or more allegations of unconstitutional policing by detective personnel. Initially, auditors obtained a printout from the Department’s Professional Standards Unit (IA) of all personnel complaints involving detective personnel for the past five years (2007 to 2012). In some cases, that list was expanded to include all complaints made against certain officers since their employment.

The summaries for several complaints in the IA printout were too vague to determine if a case fell within the audit parameters. For example, some complaints contained no description whatsoever, while others summarized the allegation as improper investigation or improper witness identification. In those cases, the auditor reviewed each case and made a more specific determination as to the allegation(s).

Due to the nature and intended purpose of this audit engagement, auditors conducted preliminary interviews of the Department’s IA personnel and preliminary evaluations of personnel investigations.

44 California Attorney General Opinion 99-1111 issued May 2, 2000
45 City Manager’s report to the Public Safety Committee October 6, 2008.
involving allegations of unconstitutional policing. Pursuant to our initial findings, we elected to use a directed and purposeful audit sample.

Ultimately auditors identified and selected 30 personnel investigations involving potential allegations of unconstitutional policing for the audit. As will be discussed in the following section, the Department’s policy governing personnel complaints was amended in 2004 and again in 2011. Fourteen of the audited complaints occurred prior to the 2004 change, 12 occurred between 2004 and the 2011 change and 4 occurred after the 2011 change.

Auditors requested and reviewed the Department’s file for each of the 30 cases selected for the audit. It was discovered that one of the cases did not contain an allegation of unconstitutional policing so it was removed from the audit. An analytical assessment tool was developed to capture information regarding the background, investigation adjudication, discipline (sustained allegations) and overall quality for each investigation. The Department was given a summary for each case identifying any missing information as well as any issues identified by auditors. This gave the Department an opportunity to provide any missing information and clarify any significant issues. Then the findings were placed on an Excel spread sheet to facilitate analysis of the nearly 1,500 data points.

Policies Governing Personnel Complaints
As mentioned above, there have been several directives issued governing the Department’s intake, investigation and adjudication of personnel complaints. Pasadena Police Department Order No B-8 was issued in June 1996. This 12 page directive addressed the full array of duties and responsibilities regarding personnel complaints. That order was superseded by another order, which essentially maintained the same process for initiating and investigating personnel complaints, but used more esoteric classifications for complaint disposition such as “consistent with Department values.” It also activated the Values Review Board, which met periodically to adjudicate complaints.

More recently, the Department has adopted a modified version of the policies provided by Lexipol, a private company that provides law enforcement agencies with template policies which allows customization to fit their unique needs. Along with that revision, the Department also adopted the Review Panel model in which management personnel meet to adjudicate personnel investigations. This process, which is generally regarded as the industry’s “best practice” for adjudicating personnel complaints, is divided into four parts:

1. Investigators brief the Panel on the investigation and Panel members ask whatever questions they may have. If important information is missing, the investigator is asked to obtain it and report back to the Panel.
2. If the Panel concludes that the investigation is complete, the investigators are dismissed and the Panel deliberates on the case. If an allegation is sustained, the Panel also deliberates on the penalty.

3. A report is prepared for the Chief of Police regarding the Panel’s recommendations. The report contains any minority opinions, should the Panel be unable to reach consensus.

4. The Chief of Police then makes the final determination on the case.

Without getting bogged down on the subtle differences between these evolving directives and while the exact words may change, there are several fundamental principles inherent in all these directives:

1. A personnel complaint is defined as an alleged violation of the law or allegation which, if true, could result in disciplinary action;

2. In order to instill public confidence in the Department and protect its integrity, all personnel complaints are to be documented and investigated;

3. Personnel complaints are supposed to be referred to an on-duty supervisor immediately and the supervisor is supposed to interview the complainant (recorded, if possible), provide the complainant with a citizen’s complaint form and take whatever remedial action is appropriate;

4. The complaint is to be forwarded to the Professional Standard’s Unit (PSU) for recordation and assignment;

5. Either PSU or a supervisor will conduct a thorough investigation and submit it through his chain-of-command to PSU;

6. The complaint will be adjudicated based on a preponderance of evidence; and,

7. The complainant will be notified of the disposition.

Auditors used these broader standards to make their assessments and comparisons of the personnel complaints in the audit sample.

**Objective No. 1: Complaint Intake.** Determine the Department’s policy and practice for the intake of personnel complaints made by members of the community.

**Assessment**

Auditors reviewed the Department's policies since 2000 governing the intake of personnel complaints made by members of the community. Auditors reviewed the personnel complaints contained in the audit sample to determine the manner in which they were brought to the Department’s attention. As necessary, auditors interviewed key PPD personnel including managers for policy issues and investigators for any questions on specific cases.

**Findings**

The Department does not display information in its public areas informing the public of its expectations regarding employee behavior and there is no signage or printed material regarding the procedure for
someone to make a personnel complaint. There is a form titled “Service Excellence Survey” on display in the lobby and someone could use that form to file a personnel complaint. But most of the complaints reviewed in the audit sample involved the complainant filling out a “Contact Form” which allows the author to indicate whether the “Nature of the Contact” was “Positive or Negative.” At the bottom of the form there is a place for the intake supervisor to sign and indicate the date and time the complaint was made.

**Recommendation No. 43:** The Department should prepare a brochure describing the process for citizens to make a personnel complaint. That brochure should be available in the Department’s public spaces and on its webpage in languages commonly spoken in the community.

None of the 24 pre-2010 cases selected for this audit contained any intake information from a supervisor or manager. This is inconsistent with Department policy and makes it impossible to determine the statute of limitations for the completion of the investigation.

**Recommendation No. 44:** All personnel complaints should be brought to a supervisor’s and manager’s attention immediately and that notification must be documented.

None of the 30 complaints in this audit contained any documentation of a preliminary investigation by a supervisor. Department policy requires that the intake supervisor collect any physical evidence supporting or refuting the allegation, but this was never done. One egregious example is the case in which a complaint alleged that officers brought him to the station for an interview and beat him in the interview room when he would not talk. Immediately on release it appears he submitted a written complaint form at PPD’s front desk; but, there was no examination or photographs of the interview room and no medical examination of the complainant to support or refute the allegation.

**Recommendation No. 45:** A supervisor who is notified or otherwise becomes aware of a personnel complaint should be required to conduct a thorough preliminary investigation and submit it to PSU along with the personnel complaint before end-of-watch. Failure to do so should result in discipline.

Without exception the supervisor assigned to investigate alleged misconduct would ask the complainant what he or she wanted to do regarding the complaint. The supervisor would, in effect, give the complainant complete authority to decide if the Department was going to pursue the allegation or not. But, the Department simply cannot abdicate its responsibility to investigate personnel complaints based on the desires of a complainant. Once a complaint is made, the Department should pursue it to the best
extent possible. Even if a complainant becomes uncooperative, the Department still needs to interview key witnesses and examine physical, scientific and documentary evidence.

For example in one case, two very credible witnesses alleged that an officer used unnecessary force and used profanity. The entire investigation was closed after the complainant allegedly withdrew his original complaint of unnecessary force. Exacerbating the matter, the withdrawal request was not recorded, the investigator never said he actually talked to the complainant and the complainant was never notified of the complaint disposition.

Recommendation No. 46: Department policy should state very clearly that, once a complaint is made, it is the Department's responsibility to determine how it should be handled. A complainant's mere desire to withdraw a complaint should not result in the complaint's automatic closure.

Recommendation No. 47: When a complainant recants a complaint, the recant must be tape recorded whenever possible. When it is not possible, the supervisor needs to state in the report what prevented it from being recorded.

Objective No. 2: Classification of Complaints. Determine if personnel complaints were classified correctly by the intake personnel.

Assessment
Auditors reviewed the Department's policies since 2000 governing the intake classification of personnel complaints made by members of the community. Auditors reviewed the personnel complaints contained in the audit sample to determine they were classified in accordance with the policy that existed at that time. As necessary, auditors interviewed key PPD personnel including managers for policy issues and investigators for any questions on specific cases.

Findings
Prior to 2011, there does not appear to have been much consistency in the classification of complaints. For example, the classification of Administrative Investigation (AD) was supposed to be used for, "Complaints involving an employee of the police department initiated by another employee of the
But all 12 complaints in the audit sample that were classified as AD were initiated from a community complaint.

Beginning in about 2006, the classification of Resolved Complaint (RC) started appearing in the audit sample as a disposition classification. While we understand RC was to be used for minor issues or conflicts in which a citizen disagrees with the way they were treated or an incident was handled, it was used as the disposition for significant allegations such as perjury, excessive force and false arrest. For example, one case alleging false testimony in court was classified initially as an Internal Affairs Investigation and issued an IA number, but the divisional investigation recommended that the complaint be re-classified as a Resolved Contact. Following chain-of-command review and concurrence, PSU approved the reclassification. The original PSU/IA number was cancelled and the complaint was issued a new tracking number. The accused officer was advised (via email) that, “As a result, no entry will be made into the PSU/EWS (Early Warning System) data base….”

Eight complaints were closed either because the complainant allegedly withdrew the complaint (4) or the complainant was uncooperative with the investigation (4). None of the four withdrawals were recorded and only one of the complainants who allegedly withdrew their complaint was notified of the complaint’s disposition. Of the four cases closed because the complainant would not cooperate, only one did not receive a notification of disposition.

Finally, the personnel complaint printouts produced by PSU often contained incorrect or vague information. The resolution was often shown as “Closed” rather than Unfounded, Exonerated, Not Sustained or Sustained. The type of complaint column titled “Complainant’s Concern” often did not provide sufficient information to describe the allegation, e.g., “improper conduct” and “treated unfairly.” In fairness, auditors did not review the entirety of PSU’s data base and we recognize we were provided information in response to our specific requests. So, the system may well have the capacity to provide Department managers with adequate information for its risk-management efforts. But, the information we received often did not match the information gleaned from reviewing the actual complaint files.

**Recommendation No. 48:** The Department should review all of the classifications for personnel complaints and ensure those classifications are adequately defined.

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46 Department Order B-8, page 6, section V, issued June 24, 1996.
**Recommendation No. 49:** The Department needs to review its procedure for populating the PSU databases to ensure the summary information captured for those systems is accurate and provides sufficient detail to meet its risk-management responsibilities. (Data shortcomings will be addressed again under Quality of Adjudication.)

**Objective No. 3: Quality of Investigations.** Determine if personnel complaint investigations provide adequate information to support a reliable adjudication.

**Assessment**

Auditors reviewed the personnel complaints contained in the audit sample to determine if the investigator gathered sufficient information to adequately investigate the complaint. This included a review of documentary, physical evidence and testimonial evidence. As necessary, auditors interviewed key PPD personnel in an effort to locate any evidence not found in the IA package.

**Findings**

Most of the 25 pre-2010 personnel complaint investigations contained in the audit sample were either flawed or contained insufficient information to adjudicate the complaint with any degree of confidence. One case involving an allegation of excessive force during an arrest outside a night club was not investigated at all. In four of the cases, the supervisor assigned the investigation was intimately involved in the activity that generated the complaint. In one case, the supervisor witnessed the complainant being searched and then was assigned to investigate the allegation that the search was done to humiliate the complainant. In three cases alleging false arrest, the supervisor assigned to the investigation either approved the arrest at the time it was made or actually made the arrest. This is not necessarily a reflection on the supervisors, one of whom went to great lengths in his report to document that he brought the conflict to the Department’s attention, but was told to investigate the complaint anyway. We understand that during that time the Department’s practice was to assign personnel complaints to the accused officer’s supervisor regardless of the conflict of interest. That practice has been discontinued and complaints are now either assigned to PSU or an uninvolved supervisor.
Recommendation No. 50: Department policy should prohibit the assignment of a personnel investigation to a supervisor who was in any way involved in the incident being investigated or who has a conflict of interest with the accused officer. In that regard, the Department should develop a form to be completed and signed by the supervisor assigned to investigate a personnel complaint stating whether or not there is any actual, potential, or perceived conflict of interest.  

Three of the pre-2010 investigations conducted by PPD supervisors were extremely well done as were the three post-2010 investigations conducted by the Los Angeles Sheriff’s Department. In one of the Sheriff’s cases the investigation not only proved that the accused officer did not commit the alleged misconduct, but proved that the alleged vehicle stop never even occurred.

Finally, it appears the Department allowed investigators to make recommendations regarding the adjudication of personnel complaints. As we have previously stated, sound risk management control procedures mandate a separation of duties and effective monitoring in inherently high risk activities. In the law enforcement arena, inherently high risk activities include the investigation and adjudication of personnel complaints and any other administrative investigation (e.g. use of force, pursuit, or traffic collision). The investigator’s job should be to conduct a thorough investigation, gather all the evidence and submit a well-documented report of his/her findings. The adjudicator’s job then is to review that investigation, ensure it is complete, identify the final allegations and determine the appropriate disposition for each allegation. Investigators should not adjudicate and adjudicators should not investigate.

Recommendation No. 51: Department policy and procedures must clearly ensure the separation of duties in the investigation and adjudication of personnel and administrative investigations.

Objective No. 4: Quality of Adjudications. Determine if management’s adjudication of personnel complaints had a sound factual basis using the preponderance of evidence standard.

Analysis
Auditors reviewed the personnel complaints contained in the audit sample to determine if there was adequate evidence to support the adjudication using the preponderance of evidence standard. As necessary, auditors interviewed key PPD personnel in an effort to locate any documents not found in the IA package and to clarify any issues that arose.

47 We understand the Department disagrees with this recommendation; but, there really is no other way to ensure complaints are investigated by an impartial supervisor.
Findings

First, responsibility for the inadequate investigations discussed above rests with the adjudicator who should have ensured that an adequate investigation was conducted by an impartial supervisor. But, 7 of the 25 pre-2010 cases contained no evidence in the case package that they were ever reviewed by a manager. Those cases appear to have been submitted directly from the investigator to PSU where they were filed. Where there was evidence of management review, it frequently consisted only of a Lieutenant’s signature or initials.

Several of the complaints that were adjudicated by a manager had significant deficiencies that appear to have gone unnoticed in the review process. In one case, the investigator consistently referred to the complainant by the wrong name. In another case, PSU wrongly identified two officers in the complaint they sent to the officers’ supervisor for investigation. The supervisor identified the error in his investigation, but the error was not corrected and the complaint remains, to this day, on the wrongly identified officers’ complaint histories.

Recommendation No. 52: The PSU complaint files and the officers’ complaint histories must be corrected in a case where the wrong two officers were recorded as the accused.

There were several serious complaints that appear to not have been thoroughly investigated. In one case, the complainant, whose son was a suspect in a murder case, alleged that officers seized guns from his house pursuant to a search warrant and then threatened to charge him with weapons violations if he did not get his son to turn himself in. A month later the complainant discovered that a warrant had been issued for his arrest, so he turned himself in. After filing a complaint he became uncooperative and, as a result, the investigation was closed. We were unable to determine if a manager reviewed the case, but there was no search warrant, return of search warrant, arrest warrant (and supporting material), or arrest report in the case package. When we asked for a copy of that missing material, we were informed that those reports have now been destroyed as part of the Department’s regular records destruction process (2004 case). Without being able to read those reports there is no way to determine if the complaint had any validity, let alone adjudicate the complaint with any degree of confidence.

This same situation occurred in another case, which was reviewed by the Values Review Board (2008 case). After a complainant became uncooperative, the supervisor closed the case and submitted his report. The Values Review Board found that even though the complainant became uncooperative, the investigating supervisor should have done a more thorough investigation. The same supervisor investigated both the 2004 and 2008 cases. Despite recognizing that the investigation was inadequate, the Values Review Board decided to adjudicate the case as “No Misconduct” any way.
On the positive side, two of the pre-2010 case adjudications were very well done. One case even included a discussion of the accused officer's prior complaints (both sustained and not-sustained). In the other case, the adjudicator ensured that the complainant was reimbursed for her impound fees, even though the impound was reasonable given the facts known to the officer at the time. As noted earlier, both of the investigations for these two cases were also extremely well done.

**Recommendation No. 53:** Department policy and procedures must clearly mandate an adjudicator's responsibility to ensure the investigation is adequate and contains all supporting documentation required for a thoughtful adjudication.

The Department’s current practice for reviewing personnel complaints was described in the opening part of this section. The use of a Review Board is an industry “best practice” and serves law enforcement agencies well. Three of the cases in this audit sample were adjudicated using that procedure. Those adjudications were extremely thorough and the dispositions were well thought out. The reports containing the Board’s rationale were exceptionally well done!

On a final note, the Department should consider requiring adjudicators to take a broader view in their adjudication of personnel investigations. Specifically, managers should seize the opportunity to conduct a biopsy on each case and examine the entire incident. This should include adequacy of reports, supervisory effectiveness, compliance with Department procedures, exercise of discretionary authority, etc. For example:

- In two cases, plain clothes officers decided to initiate non-emergency police work outside the City of Pasadena. While the officers had the legal authority to take police action, there was no documented management insight regarding a lone plain clothes officer engaging in police work outside of the City limits.
- In one case, officers working with a Probation Officer conducted a probation search of a residence at 0400 hours. The investigation did not contain any management insight or commentary related to the time of the search or the related inherent risks.

**Recommendation No. 54:** Department policy and procedures should require a manager adjudicating a personnel complaint to identify any other significant issue that arose during the incident under review and take appropriate corrective action.

Finally, all these investigations were submitted to PSU. There is no indication in any of the packages that PSU reviewed them for deficiencies or returned them for correction if they did. Further, PSU’s authority and responsibility for the final review and approval of completed personnel investigations is not entirely
clear. Our review of the cases in this audit sample indicated that prior to 2010 the division lieutenant and/or captain seem to have made the final determination on these cases. That authority has now shifted to the Review Board for major cases. But, the Chief of Police does not have the time to conduct a Review Board for every complaint made to the Department. Therefore, the authority, responsibility and accountability for reviewing and approving all other complaints, in whatever form they may take and under whatever name they may be given, needs to be placed under the direct authority of a Department executive and not a mid-level manager.

**Recommendation No. 55:** The Deputy Chief of Police should be designated as the final review authority for all personnel complaints that are not presented to the Review Board.

**Objective No. 6: Retention of Personnel Complaint Case Packages.** Determine if personnel complaints are being retained properly.

**Analysis**
Auditors reviewed the case packages for the personnel complaints selected for this audit sample to determine if the investigative material was maintained in each package and if the packages themselves were being retained in a secure manner in compliance with local and state laws.

**Findings**
Once a personnel complaint is completed, the entire package is supposed to be retained at PSU. The package should include all the reports pertaining to the complaint, all material gathered for the investigation and any material used in the adjudication. Twelve of the 29 audited cases were missing tape recordings or critical documents.48

- There were three cases in which critical interviews were recorded. However, the recordings were not in the IA case package and the Department was unable to locate them. In one of those cases, an email from the accused officer clearly shows that he attached four recordings to the email he sent PSU. But, the recordings were not in the personnel complaint package and PSU could not locate them. Those recordings were critical in determining whether the allegation was unfounded.

- There were seven cases in which critical documents were missing or not included in the IA case package and the Department was unable to locate them. In one case, the second page of the original complaint could not be located.

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48 The Department was able to locate the missing recordings for one of those cases.
The Department must conduct a thorough review of each personnel complaint package and ensure that all the material comprising that investigation and adjudication are included in the package. Material retained anywhere else can be destroyed inadvertently.

**Recommendation No. 56**: All documentation and every recording that is part of a personnel investigation should be placed in the case package and retained at PSU.

**Recommendation No. 57**: PSU should inventory every personnel complaint package to ensure that all materials are in the package before it is closed and filed.

**CHAPTER 10: CLOSING COMMENTS**

In conclusion, we would like to take this opportunity to again thank Chief Philip Sanchez for his unwavering support for this engagement. His willingness to put his Department under this level of scrutiny is a testament to his character and his commitment to ensure that the Pasadena Police Department provides the best law enforcement service possible. While this engagement did identify numerous risk exposures and findings that require the Department’s immediate attention, it also identified numerous improvements that have been made or are in the process of being implemented under Chief Sanchez’ leadership.

Those improvements notwithstanding, leadership cannot be successful without having the proper information and control systems in place. The Department’s supervisors and managers must be held accountable for doing their job effectively and correctly. For that to occur, the Department’s leaders must have access to an objective, timely, accurate and unfiltered analysis of the Department’s inherently high risk functions. This goal can only be met by establishing a professional audit unit assigned to the Office of the Chief of Police and responsible for the regular audit and analysis of the Department’s inherently high risk functions.

**Recommendation No. 58**: The Chief of Police should request funding to staff an audit and inspections function, which would be assigned to his office, to conduct regular audits of inherently high risk functions including, but not limited to: use-of-force investigations; officer involved shooting investigations; detective operations; search warrants; arrest, booking and charging reports; gang enforcement; the control and use of Informants; and, deployment, command and administrative functions.
This has been discussed with the Chief of Police on several occasions and he supports this recommendation.
SUMMARY OF RECOMMENDATIONS

1. The Department should require that detective personnel use MCI to track and manage cases.

2. The Department should conduct a full review of its automated systems to ensure that data is being captured correctly and that those systems are producing quality information to assist managers and supervisors with their responsibilities.

3. While the automated systems are being reviewed, the Department should identify the entity best positioned to verify the accuracy of this data and assign that entity the resources and responsibility for fulfilling that critical function.

4. The Department should include supervisors in the process of officers training requests. This will allow supervisors to fulfill their responsibility of ensuring their subordinates are properly trained.

5. The Department should require supervisors to review their subordinate’s training records with them in conjunction with annual personnel evaluations. That review should verify the record’s accuracy and establish a training plan for the employee during the following year.

6. The Department’s Training Management System should include a description of any seminar lasting 8 hours or more.

7. The Department needs to conduct a full review of its training programs for detectives. The Department must begin the process of ensuring that each and every detective, including officers rotating through the division, receives the training they need to be successful in their assignments.

8. The Department should audit its compliance with detective training that is mandated by law, e.g., sexual assault, domestic violence, etc.

9. The Department should conduct a full review of its investigative training programs for PSU. The Department must begin the process of ensuring that each and every investigator receives the training they need to excel in their assignments.

10. The Department should ensure that PSU investigators are sufficiently trained to investigate critical specialties such as domestic violence and narcotics/alcohol-related misconduct.

11. The Department should require supervisory approval before referring an alternate felony/misdemeanor case directly to the City Prosecutor.

12. The Department should require all officers to enter the appropriate WIC prefix for all juvenile arrestees.

49 The Department has opted to address this issue through training and supervisory case review. This may suffice as the City Prosecutor can always return a case for felony consideration.
13. Patrol officers should receive periodic training on the importance of documenting all occupants at each address within the designated canvass area and indicating who was or was not present when the incident occurred. The parameters of the initial canvass need to be documented in the case file as well.

14. The Department should implement a policy requiring that a detective who is familiar with the basics of the case work side-by-side with the Technician(s) during the processing of each crime scene and include documentation of that collaboration in the investigation.

15. The Department should adopt a more streamlined, practical system for numbering evidence and other items gathered during criminal investigations. Each item of evidence should be listed separately and assigned its own unique item number. The Department should also consider transitioning to a single evidence report specifically designed to address the Department’s needs.

16. An “Evidence Officer” should be designated for each search location, especially when a search warrant is involved. The Evidence Officer is responsible for retrieving and documenting all evidence seized at the location. Anyone else who sees a piece of evidence should leave it in place and notify the “Evidence Officer” who would then photograph the evidence in place, recover it and complete the evidence report.\(^{50}\)

17. The Department should establish a working group of senior homicide detectives and evidence technicians to propose appropriate policy and procedure recommendations associated with requests for DNA and other scientific analysis.

18. Supervisors should be held accountable for ensuring that the detectives assigned to them receive sufficient training to maintain their expertise on the various scientific analysis tools to needed to fulfill and to excel in their investigative responsibilities.

19. Supervisors should be held accountable for ensuring their subordinates comply with Department policy governing the conduct of Photo Line-Ups and that regular inspections are conducted to ensure detectives and officers comply with this policy.

20. The Department should conduct a full biopsy of a homicide investigation and take appropriate action.

21. The Department should consider a “cold case” review of that same homicide investigation since there appear to be several potential leads and scientific evidence available to support further investigation.

\(^{50}\) In lieu of this recommendation, the Department requires that the search warrant officer photograph all evidence in place prior to collection. This effectively satisfies the concern addressed in this recommendation.
22. The Department needs to decide the manner in which it expects its detectives and officers to conduct their interrogations, document those expectations in its policies, procedures and training materials and hold supervisors accountable for ensuring their subordinates’ compliance.

23. All detectives and their supervisors be required to attend periodic POST certified Interrogation Law and Tactics courses in order to keep current on case law and best practices.

24. Detective supervisors should listen to their detectives’ recorded interviews as frequently as possible and compare the interview to what is written in the ADD report to ensure the interview was documented completely and accurately.

25. The Department should conduct complete biopsies, including a review of court records and interviews of key witnesses, for the five cases cited in Objective 3.3 and take appropriate action.

26. The Department needs to decide the type of interviews it wants recorded, publish those expectations in the appropriate policy and training directives and hold supervisors accountable for ensuring their subordinates’ compliance with that policy. In those cases where the Department gives detectives discretion in the recordation of interviews, the detectives should be required to document their rationale in the investigative file whenever they decide not to record an interview.

27. As a matter of utmost urgency, the Department needs to do whatever is necessary to ensure that recorded interviews are in a standard format that allows them to be reviewed.

28. A detective supervisor should be required to review and approve a search warrant before detectives submit it to a magistrate and the supervisor’s approval needs to be documented (initial each page). The Department also needs to implement controls to track the return of search warrants and it needs to conduct regular audits and inspections to ensure compliance with these requirements.

29. The Department should conduct a biopsy of the four cases cited in Objective 4.3 and take appropriate action.

30. The Department should amend its Pre-Booking Review form to include the name and serial number of the supervisor approving the booking.

31. The Department needs to enforce its policy that every arrest must be reviewed and approved in writing by an uninvolved supervisor and every arrest report must be reviewed and approved by a supervisor, preferably the one who approved the booking.

32. The Department should create a Chronological log and require all detectives to use it and document their actions including court proceedings, discovery requests and final court disposition. The log should also indicate when the detective supervisor reviewed the case to ensure the investigation was thorough and on track.
33. All detectives and their supervisors need to receive periodic training on case management and organization.

34. The Department needs to develop a system so that the content and organization of all homicide case files is consistent and uniform.

35. The Department should assign an external hard drive (flash drive) to the primary investigator for each major police investigation. The detective should store all of the case’s investigative material on that device and maintain a Table of Contents to identify the drive’s contents. When the case is completed the drive should be maintained with the Case Book in a secure location.

36. The Department needs to clearly articulate its expectations of detective supervisors and Department managers who oversee investigative functions. Those expectations should include, at a minimum, a review of inherently high risk investigations, search warrants, felony arrest reports, case filings and the seizure of high risk evidence including narcotics, money and firearms. The Department should also conduct regular periodic biopsies of major cases to ensure adequate and documented supervision is being provided.

37. The Department needs to conduct a biopsy of both cases involving juvenile informants to determine if judicial approval was required and, if it was, whether or not it was obtained.

38. The Department should conduct a management review of the cases cited in Objective 6.1 and take appropriate action.

39. All detectives and their supervisors should receive periodic POST certified training regarding the use and documentation of informants.

40. The Department should conduct a thorough review of its policies, practices and procedures governing the use of informants. This should include supervisory review, management oversight and implementation of effective control systems.

41. The Department should conduct regular and periodic audits of its informant files, policies and controls.

42. The Department should conduct a full biopsy of an arrest that does not appear to have been closed including: the issuance of a Notice to Appear to a felony arrestee; how this was allowed to take place without any evidence of supervisory intervention; and, what control systems are in place for detective supervisors to track arrestees assigned to their subordinates.

43. The Department should prepare a brochure describing the process for citizens to make a personnel complaint. That brochure should be available in the Department’s public spaces and on its webpage in languages commonly spoken in the community.

44. All personnel complaints should be brought to a supervisor’s and manager’s attention immediately and that notification must be documented.
45. A supervisor who is notified or otherwise becomes aware of a personnel complaint should be required to conduct a thorough preliminary investigation and submit it to PSU along with the personnel complaint before end-of-watch. Failure to do so should result in discipline.

46. Department policy should state very clearly that, once a complaint is made, it is the Department’s responsibility to determine how it should be handled. A complainant’s mere desire to withdraw a complaint should not result in the complaint’s automatic closure.

47. When a complainant recants a complaint, the recant must be tape recorded whenever possible. When it is not possible, the supervisor needs to state in the report what prevented it from being recorded.

48. The Department should review all of the classifications for personnel complaints and ensure those classifications are adequately defined.

49. The Department needs to review its procedure for populating the PSU databases to ensure the summary information captured for those systems is accurate and provides sufficient detail to meet its risk-management responsibilities.

50. Department policy should prohibit the assignment of a personnel investigation to a supervisor who was in any way involved in the incident being investigated or who has a conflict of interest with the accused officer. In that regard, the Department should develop a form to be completed and signed by the supervisor assigned to investigate a personnel complaint stating whether or not there is any actual, potential, or perceived conflict of interest.

51. Department policy and procedures must clearly ensure the separation of duties in the investigation and adjudication of personnel and administrative investigations.

52. The PSU complaint files and complaint histories for two officers incorrectly identified as the accused must be corrected.

53. Department policy and procedures must clearly mandate an adjudicator’s responsibility to ensure the investigation is adequate and contains all supporting documentation required for a thoughtful adjudication.

54. Department policy and procedures should require a manager adjudicating a personnel complaint to identify any other significant issue that arose during the incident under review and take appropriate corrective action.

55. The Deputy Chief of Police should be designated as the final review authority for all personnel complaints that are not presented to the Review Board.

56. All documentation and every recording that is part of a personnel investigation should be placed in the case package and retained at PSU.
57. PSU should inventory every personnel complaint package to ensure that all materials are in the package before it is closed and filed.

58. The Chief of Police should request funding to staff an audit and inspections function, which would be assigned to his office, to conduct regular audits of inherently high risk functions including, but not limited to: use-of-force investigations; officer involved shooting investigations; detective operations; search warrants; arrest booking and charging reports; gang enforcement; the control and use of Informants; and, deployment, command and administrative functions.