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- Administrative Officer a proposed annual budget covering the anticipated expenditures of the OPA; (7) expend funds of the OPA (including without limitation, awarding contracts) in accordance with the provisions of the budget appropriations or of appropriations made after adoption of the budget; and (8) perform such other duties as may be prescribed by ordinance.
- (d) The City Council shall by ordinance establish provisions for the administration and operation of the OPA, which provisions shall include at a minimum: (1) reporting requirements and schedules and (2) consumer protection and complaint procedures.
  - (e) The OPA shall have access to information to fulfill its responsibilities.
  - (f) The employees of the OPA shall include a Ratepayer Advocate and additional positions as prescribed by ordinance. The OPA shall periodically issue public reports.
  - (g) The Department shall include a budget for the OPA as shall be set by ordinance at a level not less than 0.025% of Department annual revenues from the sale of water and electric energy for the previous fiscal year.
  - (h) Nothing contained in this section shall reduce or otherwise affect the authority of the City Controller to conduct fiscal and performance audits of the Department.
  - (i) The Section shall be operative on July 1, 2011.

## **RECOMMENDATIONS**

**Recommendation 12. Ensure that the Ratepayers function is clearly defined and that the function is not captured by politicians or a bureaucracy that will stagnate their independence and ability.**

It is important to identify what the function will be focused on and, as importantly, what it will not be focused on. The Ratepayer Advocate will have enough work to do without taking on the “savior of LADWP operations and public perception” role. The position should not be involved in the management of the Department or have the right to veto management decisions or set rates.

The OPA should not be involved in holding LADWP accountable for meeting the City’s or Mayor’s goals, some of which will be extremely expensive to the ratepayer. That should be the job of the Board of Commissioners, City Council and the Mayor. They should, however, have input into various rate alternatives and timing differences prior to the policy decision being made so that the impact to the ratepayer is known.

The OPA should take a long-term perspective on its review of rates. For example, it should shine the light on long-term plans that will have massive implications for residential and commercial rates, not just on the rate increase that may be mentioned for next year. It is important that the position provide advice and counsel to lawmakers on balancing LADWP’s plans to invest in clean power, as one example, with its need to fulfill Charter responsibility to keep rates lower than others. The primary focus should be what is best for the ratepayer.

The Advocate can highlight the long term implication of these decisions. This long term perspective and visibility is more important than just blocking specific rate hikes, which may be desired by many, but may not be in the long term best interest of the City or the ratepayer. In summary, the function should provide visibility to the public and guidance to the Council on various anticipated rate increases, and provide expert advice on rate actions and strategies which will protect the ratepayer by identifying the most economical method to accomplish the City's policy goals and the LADWP's long-term interests. The ratepayer should be placed first in implementing the Advocate's responsibility.

The Advocate can also be instrumental in ensuring that large categories of costs, such as DSM, RPS and the City Transfer, have visibility on the customer bills. (Also see Recommendation 10.)

**Recommendation 13. Ensure that the public has primary input into the appointment of the Ratepayer Advocate. The "citizen's committee" should have ample representation from Neighborhood Councils and other citizen-based organizations.**

It is only with broad based input that the public will have the confidence that the position won't bend to any specific political will. As important as the actual information provided by the Ratepayer Advocate is the fact that the existence of the position itself should be viewed by the public to be honest, independent, trustworthy and knowledgeable. This is probably the single best opportunity for the City and Department management to improve the perception of LADWP with the rate paying public.

## Summary of Report Findings and Recommendations

### FINDINGS

1. The governance of the Department of Water and Power is distributed among several different groups including the Board of Water and Power Commissioners, the Mayor, the City Council, the City attorney and IBEW.
2. There has been a significant turnover in both Commissioners and General Managers for the LADWP, especially in recent years, which diminishes the overall governance continuity.
3. There is a perception that political contributions rather than specialized skills or experience may play a primary part in the decision to appoint personnel to the Commission or other governance positions.
4. There are a variety of governance structures in place at other municipal utilities; there is no one structure that meets all needs.
5. Although there was originally some concern that personnel were taking higher paying jobs at LADWP for only a short time (pension spiking) in order to increase lifetime pensions, such does not appear to be the case. However, the number of transfers from the City to the Department may have a negative impact on the pensions for the Department.
6. Succession planning does not take place within LADWP to any meaningful extent.
7. The IBEW is very active in local and state elections, local and state legislation and in ongoing City politics. It also contributes substantial time and money to the election of City politicians, including various Council members, the Mayor and the City Attorney which potentially allows for a substantial amount of power in the day-to-day governance of the Department.
8. There is considerable belief that the unions are increasingly involved in the operations and management of the Department.
9. The public sector unions, especially IBEW, have been successful for their members by accomplishing a higher level of salary and benefits than other employee unions. This information is of concern to many ratepayers since it will increase the rates developed to pay for services.
10. The IBEW represents about 88% of all LADWP employees which is an unusually high percentage for utilities.
11. Although the LADWP and the IBEW engage in “mutual gains bargaining” through a Joint Labor Management Resolution Board (JRB), the bargaining results are reportedly more in favor of the Union. The number of grievances filed by the Union has not materially changed as a result of this process.

12. The LADWP is at risk by having a high percentage of essential personnel in the same Union and does not have a current “strike plan” to continue operations and serve the citizens of Los Angeles in case of a work action.
13. The Department has provided substantial funds to the City of Los Angeles in the form of Power and Water transfers for many years.
14. Although the Department had numerous reasons for not wanting to make the transfer without a rate increase that it felt it deserved, holding the City “hostage” under these circumstances was inappropriate since the Department had the cash to make the transfer, although they had it reserved for other uses.
15. The ECAF as currently constituted at LADWP contains several elements that typically would not be found in a Cost Adjustment Factor.
16. The current ECAF design does not provide for adequate oversight and transparency into long-term commitments made by the Department, particularly with respect to Renewable Portfolio Standard (RPS) and Demand Side Management (DSM).
17. The implementation of a Ratepayer Advocate at LADWP would be unusual in the municipal utility industry.
18. Some people believe that the impact of the Ratepayer Advocate ballot measure is minimized because other proposed Charter amendments were not approved for the same ballot.

## **RECOMMENDATIONS**

1. LADWP’s governance needs clarification and simplification. A stronger, independent Commission system is warranted.
2. Establish guidelines for Commissioner appointment and reduce the politics of appointment, real or perceived.
3. Expect LADWP Commissioners to serve full five-year terms.
4. Reduce the bureaucratic impact to the Department due to Mayoral or Council involvement.
5. The City and LADWP should come to an agreement to rescind the reciprocity agreement until such time as the number of employees transferred back and forth between the City and LADWP reaches equilibrium. Personnel should only be transferred as required by LADWP and then only with full financial contribution to the pension fund.
6. Fully staff and fund the Workforce Planning Group to encourage a full review of options for future LADWP employment and work with City Personnel Department and the Civil Service Office to allow some changes in hiring and promotional practices for high level essential jobs.

7. Determine if the current state of union/management relations is equitable and not favorable to one side at the expense of the other.
8. Immediately develop a confidential strike preparation plan and ensure that cross training and documentation of essential functions is included in the process and plan.
9. Take steps to ensure that this transfer problem doesn't happen again.
10. The CGJ agrees with the CCF Recommendation that a "new proposal for rate restructuring should be drafted and analyzed. One aspect of this proposal would be to split the current ECAF into several separate rate components. This will provide the Council (and the public) with greater visibility of LADWP's cost structure and of the justification for any rate increases."
11. Increase the transparency of the cost of each current ECAF item by showing the item and amount of the ratepayer bill.
12. Ensure that the Ratepayer Advocate's function is clearly defined and that the function is not captured by politicians or a bureaucracy that will stagnate their independence and ability.
13. Ensure that the public has primary input into the appointment of the Ratepayer Advocate. The "citizen's committee" should have ample representation from Neighborhood Councils and other citizen-based organizations.

## REQUEST FOR RESPONSE

California Penal Code Sections<sup>2</sup> §933 (c) and §933.05 requires a written response to all Recommendations contained in this Report which shall be made no later than ninety (90) days after the Civil Grand Jury publishes its Report (filed with the Clerk of the Court).

Respond to:

Presiding Judge  
Los Angeles County Superior Court  
Clara Shortridge Foltz Criminal Justice Center  
210 West Temple Street,  
Eleventh Floor, Room 11-506  
Los Angeles, CA 90012

All responses for the 2010 - 2011 CGJ Report's Recommendations must be submitted to the above address on or before the end of business **September 30, 2011**.

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12	City of Los Angeles (LADWP Board of Commissioners)
13	City of Los Angeles (LADWP Board of Commissioners)

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<sup>2</sup> Reference California Penal Code Sections §933(c) and §933.05 at the beginning of this 2010-2011 Civil Grand Jury Report

## ACRONYMS

LADWP	Los Angeles Department of Water and Power
CCF	Council Consulting Firm (PA Consulting)
CSU	Colorado Springs Utilities
CPS	City Public Service
CPUC	California Public Utilities Commission
DRTF	Debt Reduction Trust Fund
DSM	Demand Side Management
ECA	Energy Cost Adjustment
ECAF	Energy Cost Adjustment Factor
EAA	Engineers and Architects Association
ED	Executive Directive
ERRA	Energy Resource Recovery Account
FCA	Fuel Cost Adjustment
IOU	Investor Owner Utilities
IBEW	International Brotherhood of Electrical Workers
ISO	Independent Systems Operator
JEA	Jacksonville Electric Authority
JRB	Joint Labor Management Resolution Board
LACERS	LA City Employees Retirement System
MEA	Management Employees Association

MLGW	Memphis Light, Gas and Water
MOU	Memorandum of Understanding
NAPE	National Association of Public Employees
NRDC	Natural Resources Defense Council
OPA	Office of Public Accountability
OSE	Organization of SMUD Employees
PGE	Pacific Gas and Electric
RPS	Renewable Portfolio Standard
SEIU	Service Employees International Union
SMUD	Sacramento Municipal Utility District
SCE	Southern California Edison
SDGE	San Diego Gas and Electric
TVA	Tennessee Valley Authority
UAAL	Unfunded Actuarial Accrued Liability
WPERP	Water and Power Employee's Retirement Plan

# SUB-ACUTE HEALTH FACILITIES IS THE FOX INSPECTING THE HENHOUSE?



Committee Members

Chairperson: Brian Twomey  
Judy Packer

# **SUB-ACUTE HEALTH FACILITIES**

## **IS THE FOX INSPECTING THE HENHOUSE?**

### **SUMMARY**

The County of Los Angeles (LAC) has three hundred ninety-two (392) healthcare facilities operating as nursing homes. Forty-eight (48) of these participate in the Medicare/Medi-Cal Sub-Acute (Program). These facilities are normally licensed by the California Department of Health Care Services (DHCS). The County of Los Angeles Department of Public Health (DPH), Health Facilities Inspection (HFI) Division has the authority and responsibility for licensing and certifying of health facilities and ancillary health services including Skilled Nursing Facilities in LAC.<sup>1</sup> Through a contract LAC has with the State, it is the only county to license and inspect its own healthcare facilities. The 2010-2011 Los Angeles County Civil Grand Jury (CGJ) investigated this possible conflict of interest.

### **PURPOSE**

The purpose of this investigation was to:

1. Ascertain if Sub-Acute facilities in Los Angeles County are in compliance with State and Federal laws and regulations
2. Determine if HFI is sending inspectors/surveyors to sub-acute facilities without proper qualifications addressing requirements of the health facility being inspected

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<sup>1</sup> See [www.publichealth.lacounty.gov/hfd/index.htm](http://www.publichealth.lacounty.gov/hfd/index.htm)

## BACKGROUND

Established in July 1983 by the DHCS, the Program makes provisions for patients who meet Sub-Acute care criteria as defined in the Welfare and Institutions Code, Section 14132.25 as outlined below:

1. DPH, Health Facilities Inspection Division, has the authority and responsibility for the licensing and certification of health facilities and ancillary health services, including Skilled Nursing Facilities in LAC. Sub-Acute facilities are Skilled Nursing Facilities.<sup>2</sup>
2. The HFI Division enforces State and Federal laws and regulations in State licensed and Federally certified health facilities. Their mission is to improve the quality of health care in the facilities it regulates through standards enforcement. The term "Sub-Acute care" has been applied to a broad range of medical and rehabilitative services and settings that provide care to post-acute patients. The earliest literature on the topic used the term "Sub-Acute care" to refer to patients who did not meet established criteria for medically necessary acute care but who remained in hospital beds licensed for acute care, largely due to a lack of suitable alternative placements. Long Term Care (LTC) Nursing Homes may or may not participate in the Sub-Acute Program.
3. In addition to being licensed, nursing homes that choose to participate in the Medicare and Medi-Cal programs must be certified by the Federal government in order to qualify for payments from these programs. Federally certified facilities must meet Federal standards as well as the California requirements. Most California nursing homes are certified to participate in both Medicare and Medi-Cal.
4. All nursing homes are not alike. There are several types of licensing and certification categories for nursing homes, which are described below:
  - a. Most nursing homes in California are licensed as Skilled Nursing Facilities (SNFs), which California broadly defines as a health facility that provides skilled nursing and supportive care to persons who need this type of care on an extended basis.
  - b. Medicare also uses the term "skilled nursing facility" for nursing homes that are certified to receive its payments. Medi-Cal uses a similar term, "nursing facility (NF)," for nursing homes that are certified to receive Medi-Cal payments. Most, but not all, licensed skilled nursing facilities in California are certified to participate in Medicare and Medi-Cal.
  - c. Medi-Cal contracts with certain skilled nursing facilities to provide Sub-Acute care to adults and children who need specialized care. Sub-Acute care is a Medi-Cal program (not a licensing or certification category) that pays higher rates for Medi-Cal beneficiaries (patients) who have exceptional needs, such as pulmonary care and brain trauma.
5. HFI has licensed approximately 1,964 health facilities, 392 nursing/convalescent facilities, referred to as Long Term Care and 48 Sub-Acute facilities under the regulation of the State of California. These Sub-Acute facilities can stand alone as a

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<sup>2</sup> [cdph.ca.gov/certlic/facilities/pages/aacounties.aspx](http://cdph.ca.gov/certlic/facilities/pages/aacounties.aspx)

SNF or act in concert with LTC facilities. The fulfillment of this licensing responsibility requires inspections of health care facilities in order to evaluate compliance. It also requires written reports which document the Division's findings. These inspections are performed by "surveyors" or "evaluators" employed by the Los Angeles County Health Facilities Inspection Division. Inspectors conduct routine inspections or "surveys" and investigate complaints. LAC is the only county in the State that is authorized to conduct its own surveys/inspections and to monitor itself. State inspectors are responsible for all other counties.

6. To qualify for the Program, the patient must need one of the following criteria. The inspector must possess qualifications necessary to conduct this part of the inspection:
  - a. Tracheostomy care with continuous mechanical ventilation for at least 50% of the day
  - b. Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the six (6) treatment procedures listed below
  - c. Administration of any three (3) of the six (6) treatment procedures
    - i. Total parenteral nutrition
    - ii. Inpatient physical, occupational, and/or speech therapy, at least two (2) hours per day, five (5) days a week
    - iii. Tube feeding (nasogastric or gastrostomy)
    - iv. Inhalation therapy treatments every shift for a minimum of four (4) times per 24-hour period
    - v. Intravenous (IV) therapy involving: the continuous administration of a therapeutic agent, the need for hydration or frequent intermittent IV drug administration via a peripheral and/or central line (for example, with a Heparin lock)
    - vi. Debridement, packing and medicated irrigation with or without whirlpool treatment

## **METHODS AND PROCEDURES**

The CGJ reviewed documents from the following agencies:

1. California Department of Health Care Services, Health and Human Services Agency
2. California Department of Health Care Services, Sub-Acute Care Unit
3. California Department of Public Health, Sacramento
4. County of Los Angeles Department of Public Health, Health Facilities Inspection Division
5. State of California Health and Safety Code, Section 1569.2
6. Title 22 of the California Code of Regulations, Section 87101
7. Centers for Medicare Services (CMS)
8. Ten (10) Form 2567 CMS surveys
9. California Watch.org
10. State of California, Department of Justice, Office of the Attorney General
11. State of California Operations Manual, Appendix P
12. California Advocates for Nursing Home Reform (CANHR)

In addition, the CGJ interviewed representatives from the following:

1. Long Term Care Advocate of the California Advocates for Nursing Home Reform (CANHR)
2. Health Facilities Inspection Division Staff members, Los Angeles County Public Health
3. Center for Medicare Services officials in San Francisco
4. Los Angeles County Supervisor

## FINDINGS

Research conducted by this CGJ for the period 2007 - 2009 indicated the following:

1. State surveys/inspections of nursing homes resulted in seventy-three (73) AA citations (the most severe) not including LAC.
2. LAC surveys/inspections of licensed nursing homes resulted in eleven (11) AA citations by HFI in LAC.

The population of California is roughly 37,000,000 with approximately 10,000,000 living LAC. 27% of California's population resides in LAC.<sup>3</sup> The number of AA citations in LAC does not correlate to the population percentage when compared to the State of California. Based on population comparison for State vs. LAC, HFI should have issued twenty three (23) AA citations. LAC issued eleven (11) AA citations, less than one half of what the State issued. There appears to be a reluctance or negligence to issue AA citations. The number of AA citations issued by the State is much higher when compared to those issued by LAC<sup>4</sup>

3. The CGJ reviewed a random selection of Sub-Acute nursing home surveys provided by employees from the Los Angeles County Health Facilities Inspection Division in Norwalk, California. While these inspections appear to be very extensive they seemed to lack intensity and due diligence. For example, an employee working in Sub-Acute must be trained in CPR or on the proper use of oxygen. The survey does not show if the facility being inspected is in compliance. Personnel records were not inspected for this due to privacy issues. Basically, the section of the nursing home providing Sub-Acute care is inspected in the same general manner as is the LTC section of the nursing home even though their roles are distinctly different. If the patient must meet Sub-Acute criteria to qualify for the Sub-Acute Program, it would stand to reason that the inspector's qualifications must meet the same criteria as the patient being inspected.
4. Of particular concern to this CGJ is that after the death of a patient at a convalescent hospital in LAC an investigation was requested. The initial investigation stated that the convalescent hospital was in compliance. Not satisfied with the result of that investigation, a second investigation was conducted<sup>5</sup>.
  - a. On October 2, 2007 a ninety (90) year old resident of a sub-acute unit died because a system was not in place to prevent the tracheostomy tube from disconnecting from the ventilator. This failed to activate the remote alarm system designed to alert staff to such emergencies because an employee had turned off the alarm.
  - b. On February 4, 2008, an unannounced visit was made to the facility to investigate a complaint of alleged gross negligence. Based on interviews and review of records, it was determined the licensed nurses and respiratory therapists failed to provide adequate supervision and assistance devices.
5. The second investigation resulted in a AA citation and fine issued to the facility of \$100,000 and one (1) or two (2) other minor citations. The facility failed to:

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<sup>3</sup> quickfacts.census.gov

<sup>4</sup> CANHR

<sup>5</sup> Class AA Citation number 95-1313-0005435F

- a. Have a system in place to prevent resident's tracheostomy tube from disconnecting from the ventilator tubing, which was a direct proximate cause of the residents death
- b. Monitor that the remote alarm (located directly outside the resident's room on the wall) was in the ON position after care was provided

The above violations jointly, separately or in any combination, presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result. These cited violations were a direct proximate cause of death.

6. It appears that:
  - a. Inspectors are not properly trained in Sub-Acute care.
  - b. Inspectors are not certain the facility being inspected is a participant in the Sub-Acute Program.
  - c. LAC is not sending inspectors with the proper qualifications.
  - d. LAC is remiss in issuing appropriate AA citations. This may result in exposing patients to further neglect.
  - e. Sub-Acute patients in LAC convalescent hospitals or SNFs are in immediate jeopardy of losing their lives unless a policy is enacted to address Sub-Acute inspections, surveys and/or recertifications conducted by DHS.

## RECOMMENDATIONS

1. Ensure that a Sub-Acute facility being inspected has a separate and distinct Sub-Acute policy in place. All Sub-Acute personnel must be trained in that policy
2. Ensure that during each inspection a policy is in place and used consistently for the Remote Ventilator Alarms Connecting and Usage. The policy must state that the Remote Ventilator Alarm must remain ON at all times. Stipulate that it may be turned off when the nursing home employee is in the room with the ventilator patient; however, it must be turned back to the ON position before the employee leaves the patient's room
3. Ensure that each licensed facility has a policy regarding proper procedure in handling tracheostomy tubes, ensuring it is not disconnected from the ventilator tubing
4. Ensure that each licensed facility has a policy is in place for use of a "crash cart"<sup>6</sup> and that it is enforced
5. Ensure that each licensed facility has a policy for the administration of oxygen and is followed judiciously
6. Require evaluators inspecting a health facility participating in the Sub-Acute program have the same qualifications as required by the State of California to administer the following:
  - a. Tracheostomy care with continuous mechanical ventilation for at least 50% of the day
  - b. Tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the six (6) treatment procedures listed below
  - c. Administration of any three (3) of the six (6) treatment procedures listed below:
    - i. Total parenteral nutrition
    - ii. Inpatient physical, occupational, and/or speech therapy at least two (2) hours per day five (5) days a week
    - iii. Tube feeding (nasogastric or gastrostomy)
    - iv. Inhalation therapy treatments every shift for a minimum of four (4) times per 24-hour period
    - v. Intravenous therapy involving: the continuous administration of a therapeutic agent; the need for hydration; and frequent intermittent INTR drug administration via a peripheral and/or central line (for example, with a Heparin lock)
    - vi. Debridement, packing and medicated irrigation with or without whirlpool treatment
    - vii. Inspections are required to include Recommendations 1 through 6 above when a survey or recertification is performed.

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<sup>6</sup> A **crash cart** is a set of trays/drawers/shelves on wheels used in hospital [emergency rooms](#) for transportation and dispensing of emergency medication/equipment at site of medical/surgical emergency for life support protocols ([ACLS/ALS](#)) to potentially save someone's life.

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5	Los Angeles County (Department of Public Health)
6a	Los Angeles County (Department of Public Health)
6b	Los Angeles County (Department of Public Health)
6c	Los Angeles County (Department of Public Health)
7	Los Angeles County (Department of Public Health)

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## ACRONYMS

DHCS	California Department of Health Care Services
DPH	Los Angeles County Department of Public Health
HFI	Los Angeles County Department of Public Health, Health Facilities Inspection Division
LTC	Long Term Care
LAC	Los Angeles County
CMS	Centers for Medicare/Medi-Cal Services
CANHR	California Advocates for Nursing Home Reform
NF	Nursing Facility
SNF	Skilled Nursing Facility
IV	Intravenous

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# THE SIX PODS OF MODULE 172

## The Most Dangerous Cells in the County Whaddya' Mean, No Cameras?



Committee Members

Chairperson - Leah Markus  
Linda Loding  
Virginia Smith-Rader

# **THE SIX PODS OF MODULE 172**

## **THE MOST DANGEROUS CELLS IN THE COUNTY WHADDYA' MEAN, NO CAMERAS?**

### **SUMMARY**

The Los Angeles County jail system has two remarkable distinctions:

1. It is the single largest system of jails in the United States.
2. Twin Towers "... is the largest de facto mental health facility in the nation."<sup>1</sup>

In August 2010, the Civil Grand Jury (CGJ) was given a tour of Twin Towers Correctional Facility (Twin Towers) which included an unscheduled stop – Module 172. Module 172 is comprised of six (6) Pods.

These pods are part of a tiered system, known as "Step Down." Within this system are the most dangerous mentally ill inmates in the County. The Pods in Module 172 house the most acute cases.

There are no observation cameras.

A capacity of ninety-six (96) inmates and nine (9) deputies exist in a vacuum of visual accountability.

The CGJ launched an investigation, interviewing a full spectrum of officers within the Department. It was concluded that, given the inherent dangers and legal pitfalls of such an environment:

- Installation of cameras is a high priority.

And, to further widen the safety net inside the County's jails, the CGJ concluded:

- Exploration of new technologies as they relate to incarceration is recommended.

### **PURPOSE**

At issue is an environment of severely mentally ill inmates prone to violence at any time. It may be inmate-on-inmate, inmate-on-deputy, deputy-on-inmate, or an inmate's self-inflicted harm – even suicide.

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<sup>1</sup> Education Based Incarceration. LA County Sheriff's Department P. 18.

As there is a complete lack of video surveillance in Module 172, the CGJ determined it would shine a spotlight on the inherent safety and risk-management issues.

The purpose of this Report is to:

- Determine the viability of cameras as a tool for the deputies of Module 172
- Provide evidence that cameras act as a deterrent to violence and as a witness when it does occur
- Provide evidence that the presence of cameras could save the County hundreds of thousands of dollars brought on by inmate litigation, settlements and related legal fees
- Explore new technologies for law enforcement as they relate to security issues throughout the County jails

## **BACKGROUND**

POD: Tiers of cells laid out in an open pattern arranged around a central control station. Individual cells are 8' x 10'.

Located in downtown Los Angeles, Twin Towers was designed to house maximum security inmates, including a large portion of the County's mental health inmates.

Countywide, the mental health treatment population comprises approximately one-third of the inmate population which ranges from fourteen thousand (14,000) to twenty-one thousand (21,000). Those requiring mental health attention reach upwards of seven thousand (7,000).

The question is: How did L.A. County come to be the 'largest de facto mental health facility' in the United States?

### Lanterman-Petris-Short Act

"The Lanterman-Petris-Short Act, often abbreviated LPS Act, (Cal. Welf & Inst. Code, sec. 5000 et seq.) concerns the involuntary civil commitment to a mental health institution in the State of California. The Act set the precedent for modern mental health commitment procedures in the United States. It was co-authored by California State Assemblyman Frank Lanterman (R) and California State Senators Nicholas C. Petris (D) and Alan Short (D), and signed into law in 1967 by Governor Ronald Reagan. The Act went into full effect on July 1, 1972...The Act in effect ended all hospital commitments by the judiciary system, except in the case of criminal sentencing, e.g., convicted sexual offenders, and those who were 'gravely disabled', defined as unable to obtain food, clothing, or housing (Conservatorship of Susan T., 8 Cal. 4<sup>th</sup> 1005 – 1994)."

## Fallout

When the LPS Act went into effect, there were to be numerous benefits. One of them would be community-based care that would replace the soon to be shut mental hospitals.

“When Ronald Reagan was Governor of California he systematically began closing down mental hospitals, later as president he would cut aid for federally-funded community health programs. It is not a coincidence that the homeless population in the state of California grew in the seventies and eighties. The people were put out on the street when mental hospitals started to close all over the state.”<sup>2</sup>

## Unintended Consequences

In another era, thousands of the County’s incarcerated mentally ill population would be in mental hospitals. Today, they are inside the walls of Twin Towers.

Module 172 is not an anomaly. It is symptomatic of decades-old government policy. Module 172 does not exist in a vacuum. It is the outgrowth of converging legal, political and societal factors.

The Los Angeles County Sheriff’s Department inherited the situation. Cameras are not a panacea, but they would help.

## **METHODS AND PROCEDURES**

In order to evaluate video surveillance for Module 172 and make appropriate recommendations, the CGJ met with a wide spectrum of members from the Sheriff’s Department. Numerous interviews were conducted (mostly at Twin Towers) to determine need, practicality and financial justification for cameras.

In addition, members of the CGJ attended a camera demonstration held at Twin Towers, where three (3) different vendors showed the latest technology suitable for detention facilities.

Lastly, the Pods of Module 172 were revisited where in-depth interviews were conducted with deputies.

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<sup>2</sup> <http://www.dailynugget.com/2004/06ronald-reagan-the-bad-and-the-ugly>

## **FINDINGS**

### Risk Management and Mentally Ill Inmates

As stated previously, Twin Towers houses the largest correctional mental health population in the United States. This fact, compounded by the unpredictable behavior and acute condition of the inmates, creates significant liability for the Sheriff's Department.

Although specially trained personnel are assigned to areas of the facility which house the most acute mentally ill, inmate behavior sometimes requires the use of force. In the past five (5) years, force was necessary on one hundred and eighty-six (186) occasions in Modules 171 and 172 which house the most critically mentally ill.

Anytime Sheriff's personnel are required to use force, it exposes the County to liability and is a risk management concern for the Sheriff's Department managers.

In addition, anecdotal evidence points out the need for cameras:

1. Last year, there were three (3) suicides in Tower 1.
2. An inmate filed suit against a deputy for (allegedly) beating him about the head. But video surveillance revealed that the inmate repeatedly banged his head against the wall! Injuries and bruises had been self-inflicted.
3. Accusations that an inmate was killed by a deputy have been derailed because a camera revealed the inmate actually committed suicide.

The question always is: What could have been prevented had there been cameras? The strong might be less likely to prey on the weak. Members of the Sheriff's Department would be more accountable. Instances of deputies being held responsible for an inmate's self-harm would be reduced.

### Lawsuits

Incidents have occurred inside Twin Towers which have caused lawsuits to be filed against both the Sheriff's Department and the County. In the past five (5) years, approximately \$345,000 has been paid as a result of lawsuits filed by inmates at Twin Towers.

This figure represents incidents where video surveillance could have been a determining factor – had it been in place.

In addition, it is important to note that, while \$345,000 illustrates settlements or judgments, this amount in no way includes the fiscal commitment necessary to defend the Sheriff's Department in litigation. In the past five (5) years, nineteen (19) lawsuits were filed, where cameras might have played a role in affirming or refuting the case, had they been in place. An early affirmation or rebuttal could have significantly reduced the Sheriff Department's defense costs. The same can be said for the forty-nine (49) lawsuits currently pending at Twin Towers. Suffice it to say that the County pays millions of dollars in settlements, judgments and attorney fees, much of which could be mitigated with video surveillance.

## Bad Press

Within the past year, there have been accusations of inmate maltreatment by Sheriff's deputies – often toward the mentally ill. Cameras would invite transparency. Transparency would mitigate the inherent dangers of Module 172.

## Funding

The overall Sheriff's Department budget is \$2.4 billion. However, due to the current fiscal crisis, the Department is in the middle of a \$128 million cost reduction. The price tag for installation of video surveillance in Module 172 and the other floors in the tiered system would be approximately \$750,000. Monies could come through a grant, or a combination of monies allocated by the County of Los Angeles Board of Supervisors. Even in the current economic climate, it is important to consider risk management issues; costs of litigation could far outweigh the cost of cameras.

## Emerging Technologies/Security Enhancements

Emerging technologies will not only improve safety for staff and inmates but also be utilized as risk management tools to reduce the County's exposure to liability.

While start-up costs are relatively high, the goals are to reduce litigation and improve safety. In the long term, this should result in cost savings.

Identified below are two (2) specific additional technological advancements that the Sheriff's Department believes would impact liability, improve safety and inmate control:

1. TRANSMISSION IMAGING – With this low-dose X-ray scanning system, the inmate steps onto a platform, where a monitor performs a scan in seconds. Unlike airport scanners, this does not reveal body details such as breasts or genitalia. This new technology does reveal, however, any articles that have been concealed by the prisoner.

One of the biggest challenges is the control of contraband entering a jail. Current practices include metal detectors, pat-down and strip searches. The influx of weapons, narcotics, or inmate "kites" (jail slang for informational notes) represents a direct threat to the safety of staff and the inmate population.

Although there has been significant success with current search methods, the sophistication of smuggling techniques and the inherent liability of strip searches is problematic.

This technology is not without detractors. While a valid tool, it should not be a complete substitute for physical body searches.

Proponents believe that transmission imaging would not only increase the discovery of contraband but likely reduce the County's liability, a conclusion reached by Sheriff Department's own research.

2. RADIO FREQUENCY IDENTIFICATION (RFID) – Similar to tracking inventory at big box retailers, a chip would be inserted into the inmate's wristband.

According to the Sheriff's Department, these chips would provide a vast array of management tools. Not only would the chips facilitate the mandatory inmate counts in real time, they would also identify the specific location of each inmate. This is critical for those classified with "Keep Away" status. (Keep Away inmates are those segregated from others for their own safety or the safety of others.)

Managing the inmate population is key. An ancillary benefit would be the reduction of liability.

## **RECOMMENDATIONS**

Given the inherent dangers and legal pitfalls, the evidence clearly supports the need for cameras.

When this CGJ stepped into Module 172 in August of 2010, it entered a world rarely seen by anyone on the outside.

The burden of caring for these inmates has fallen on the Sheriff's Department. Likewise, the burden of protecting deputies and inmates falls to the County.

Cameras are one solution.

NOTE: As of the writing of this Report, the Sheriff has initiated a proposal for cameras to the County Board of Supervisors. This is a Funding Request to provide video surveillance equipment and software, for the purpose of monitoring inmates in mental health housing located in high observation modules.

1. The CGJ recommends that the Board of Supervisors considers both the Sheriff's Proposal along with the CGJ's Report and approve cameras – beginning with the Pods of Module 172.
2. The CGJ recommends that pilot programs for new technologies (Transmission Imaging and RFID) be implemented.