SANTA CLARA COUNTY: OFFICE OF CORRECTION AND LAW ENFORCEMENT MONITORING

Final Report on the Andrew Hogan Incident while in Custody on August 25, 2018

October 2022

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OCLEM

OIR GROUP

Introduction

In 2018, Andrew Hogan was a pre-trial detainee with a history of mental illness, housed in the custody and care of the Santa Clara County jails. He sustained a traumatic brain injury on August 25, 2018, when he harmed himself as he was being transported from the Elmwood Corrections Facility to Santa Clara County's Main Jail's psychiatric unit.[1] Based on the injury, Mr. Hogan's parents filed a government claim on his behalf. It alleged that jail personnel and leadership were deliberately indifferent to his serious medical needs in violation of his civil rights under state and federal law by failing to provide him safe transport. The claim also alleged a failure to summon medical care, negligence, negligent supervision, intentional and negligent infliction of emotional distress and violations of the Americans with Disabilities Act.

After an investigation and review by the County's Office of the County Counsel ("CCO"), this Board approved a settlement of $10,000,000 plus payment of a Medi-Cal lien (approximately $200,000) in March 2020.

On August 17, 2021, this Board directed the Office of Correction and Law Enforcement Monitoring ("OCLEM") to review, assess, describe, comment, and make recommendations on the issue of disciplinary action or lack thereof undertaken by the Sheriff's Office in connection with the Hogan case.

On September 14, 2021, we issued a report setting out our initial review of the incident. That review identified several substantive concerns about what had happened and identified the limited nature of the Sheriff's Office administrative response. The final section of that report included the following passage:

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[1] The government claim filed on behalf of Andrew Hogan states that the incident occurred when Mr. Hogan was being moved to the "psychiatric unit" of the jails. This report employs the term used in Mr. Hogan's claim.

> *…the reality is that mentally ill individuals who do happen to be in custody incur an obligation on the Sheriff's Office to keep them safe from themselves. Here, there was an abject failure to do so, resulting in liability and, more importantly, the life-altering injury of a party to whom the County was responsible.*
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> *But in spite of these dire consequences, there remains no available evidence to establish that appropriate accountability measures or comprehensive remedial actions were pursued by the Sheriff's Office. On the contrary, irregular procedures and incomplete explanations have compounded the initial concerns that were generated by the incident itself. This reality falls well short of the reasonable expectations for transparency and understanding that are sought by your Board and the general public.*

Central to the concerns articulated above was the seeming irregularity with which a pending Internal Affairs investigation into the Hogan matter was closed prior to being completed. Indeed, not a single investigative interview with involved parties had yet occurred. The consequences of this were significant: not only was the potential for individual accountability nullified without explanation or evidentiary basis, but fact-gathering that otherwise might have produced beneficial systemic reforms came to an abrupt, artificial end.

Our initial report to your Board was constrained by a lack of access to documents and personnel in the Sheriff's Office who could cast light on the agency's handling of this matter. Accordingly, we subsequently issued a subpoena in order to address these gaps. The Sheriff then agreed to provide the additional requested information and access to personnel who had knowledge of the incident. We were also able to access unsealed transcripts of the civil grand jury testimony related to the Sheriff's response to OCLEM's efforts to obtain information about the Hogan incident.[2]

[2] On December 13, 2021, the Santa Clara County Civil Grand Jury issued an Accusation pursuant to Government Code section 3060 accusing Sheriff Smith

Informed by these sources, we were able to proceed with our review, the results of which form the basis of this second report on the Hogan matter. In the interest of creating a single "stand-alone" document regarding the entirety of our assessment of the Hogan incident and its aftermath, we have included sections from the original report that provide necessary factual background as to what occurred.

A key finding is that Sung[3] personally ordered Internal Affairs to close down the investigation into alleged Sheriff's Office misconduct, providing the Internal Affairs unit no explanation for the decision. However, we were not able to obtain a definitive reckoning of whether Sung's order was at the behest of Sheriff Laurie Smith, or at least given with the Sheriff's concurrence or knowledge. This is largely because both the Sheriff and Sung declined to speak with us as part of this inquiry.

While interviews with the Sheriff and Mr. Sung would obviously have been helpful, the additional information that we did glean during this process allowed us to draw conclusions and make logical inferences regarding the motivation to terminate the investigation. First, it is apparent that there was no legitimate reason to call off the investigation into the Hogan incident. Moreover, as detailed below, the timing of that decision – and its favorable implications for an involved supervising officer – suggest that it was intended to benefit a particular person.

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of willful or corrupt misconduct in office, including one count alleging failure to cooperate and promptly supply information to OCLEM relating to the Internal Affairs investigation into the Hogan matter. The relevant transcripts of testimony before the civil grand jury were unsealed by order of the Santa Clara County Superior Court on January 24, 2022 and can be obtained by members of the public.

[3]Rick Sung was indicted by a grand jury for his alleged role in furthering a bribery scheme involving the issuance of concealed weapons permits. On November 20, 2020, the Sheriff's Office publicly announced that as a result of the indictment, Sung was placed on administrative leave. The criminal charges against Sung remain pending.

Then Undersheriff Sung ordered the closure of the investigation soon after the re-election of Sheriff Smith in 2018, and in conjunction with the promotion to captain of Amy Le, then-president of the correctional peace officers' union and a supporter of the Sheriff's successful candidacy.

Le, a then-lieutenant at the Main Jail, had been directly involved as a decision-maker during the Hogan incident.[4]

Based on the notoriety of the Hogan matter and the involvement of newly promoted Captain Le, the Sheriff's influence over, or direct awareness of Sung's order to close the investigation seems likely. Nonetheless, it is not possible to determine this issue conclusively without their participation.[5] However (and as described in further detail below), witness accounts show that once the Hogan matter became a matter of both public and internal discussion, the Sheriff advised command staff members that she did not believe that Le had done anything wrong in her handling of the Hogan matter. Nor did our sources for that information (or anyone else with whom we spoke) report hearing any concern from the Sheriff that her then Undersheriff had terminated the Hogan investigation unbeknownst to her.

The Sheriff's putative views on the *substance* of the incident would obviously be germane to an outcome that exonerated the then-lieutenant. They do not, however, justify the irregularity of a *process* that prevented normal fact-gathering and objective, documented assessment, nor do they address whether other Sheriff's Office personnel shared some culpability for the way the Hogan matter was

[4] Le's involvement in the Hogan matter has been publicly disclosed in news reports and the unsealed civil grand jury testimony. Portions of this report that identify retired Captain Le are based on information obtained from such public sources.

[5] It should also be noted, and is discussed further below, that Le – who is no longer with the Sheriff's Office – offered Civil Grand Jury testimony in which she asserted that she had herself recommended an investigation into the Hogan case, that she believed she had not done anything wrong that day, that no one had informed her that she was even the subject of a misconduct allegation, and that she considered her promotion to be merit-based.

handled. We explain the nature of that irregularity – and its consequences – in the body of this Report.

In addition to recounting the implications of the decision to terminate the Hogan investigation, we offer recommendations intended to ensure that future investigations into serious misconduct are insulated from inappropriate executive interference. Moreover, consistent with progressive principles of risk management, we recommend the development of additional constructs for the review and remediation of policies and practices leading to Constitutional violations (and resulting liability).

Pursuant to protocols set out in our contract with the County, we have shared a draft of this report with the Offices of the Sheriff, Custody Health and County Counsel.

Methodology – and Continuing Limitations

Beginning in April of 2021, OCLEM made requests to the Sheriff's Office for materials relating to the Hogan matter. Initially, all that we received was two documents relating to current inmate transport protocols. Several months later, we received additional materials including summary reports, attachments, video recordings, and photographs. OCLEM also obtained the government claim submitted by the Hogan family and a February 10, 2020, County Counsel memorandum that raised civil liability concerns about the incident and recommended the multi-million-dollar settlement.[6]

However, as we indicated in our initial report, despite four requests from OCLEM and her own public assertions of support and willingness to cooperate, the Sheriff (through her outside attorney) expressly declined to provide us any information relating to the Internal Affairs investigation into the Hogan case that her agency initiated and then summarily closed. Because of this impasse, and availing ourselves of the subpoena authority granted us by this Board, we issued a subpoena on November 23, 2021, for access to relevant internal affairs materials and Sheriff's Office employees that had familiarity with the aborted Hogan investigation. Following issuance of the subpoena, the Sheriff finally agreed to provide us the requested information and access to the employees with relevant knowledge.

Since that time, we have reviewed the Internal Affairs documents and talked with employees who were involved in the short-lived internal investigation into the Hogan incident. We also obtained additional information relating to the Hogan matter from Custody Health. Finally, in January 2022, civil grand jury testimony relevant to the Hogan matter was released, and we obtained transcripts of those proceedings.

[6] The Board of Supervisors directed County Counsel to publicly release this memorandum, with redactions required by law, on August 17, 2021.

The access that the Sheriff's Office did ultimately provide was certainly helpful and deserving of acknowledgment. However, as noted above, we were not able to talk with Sheriff Smith and Mr. Sung about the Hogan matter. Through his attorney, Sung said he would decline to submit to an interview due to ongoing criminal charges against him relating to the pending bribery and concealed weapons permit prosecution. While we have asked over a several month period (through her attorney) repeatedly for the opportunity to talk with the Sheriff, she has failed to agree to such a conversation.

Our overall assessment of these events is necessarily impeded by the absence of the perspectives from Sung and Sheriff Smith. Nonetheless, we have worked with available evidence to reach conclusions where possible.

Factual Summary

What follows is a detailed factual recapitulation of the incident in which Andrew Hogan suffered severe and permanent damage. It includes a timeline of the key events on the morning Mr. Hogan's mental health crisis escalated at the Elmwood Jail, prompting the decision to transfer him to the Main Jail for housing in a special unit. Unfortunately, he was able to engage in considerable self-harm during the transport between facilities in a Sheriff's Office van. The Report then recounts the actions and documented observations of Sheriff's Office personnel who were part of the agency's response at the Main Jail.

Prior to the incident in question, Andrew Hogan had a documented history of mental illness. Then, on August 10, 2018, he was arrested for a relatively minor offense. Mr. Hogan, who was 24 at the time, was booked into the Santa Clara County jail, medically evaluated, and initially housed at Elmwood. The dormitory houses some mentally ill inmates who are not suicidal, not aggressive, and who are behaviorally stable when medicated.

Later that day a correctional officer reported that Mr. Hogan had threatened to jump off his top bunk, and Mr. Hogan was then transported to the psychiatric unit at the Main Jail, some five and a half miles away from Elmwood, where inmates experiencing acute mental health symptoms are housed.[7]

Mr. Hogan was returned to general population at Elmwood. But after he expressed concern that inmates would attack him, Elmwood staff moved Mr. Hogan to a direct supervision dorm[8] at Elmwood where he could be

[7] Public filings indicate that Mr. Hogan was placed in the psychiatric unit soon after being booked into the jail.

[8] This means that staff is stationed within the housing area, thereby allowing them to more immediately and closely monitor the detainees assigned there.

more closely monitored. Mr. Hogan functioned independently in the dormitory and without further incident from August 17 to August 25.

Elmwood: The Beginning of the Incident

According to an incident report prepared by an Elmwood supervisor, on August 25, 2018, at approximately 5:20 am, Andrew Hogan advised Elmwood correctional staff that he was hearing voices. Mr. Hogan was removed from his housing and placed in a holding cell, and correctional staff requested an assessment from Custody Health.

At approximately 7:25 a.m., Sheriff's staff called Custody Health and asked a clinician when the assessment might occur. According to the Sheriff's Office report, the clinician said that the request for an assessment was not an urgent matter based on the information provided about Mr. Hogan's current status.[9] The Sheriff's Office reported that the clinician advised that Mr. Hogan be placed back into his dorm and that he would be seen later in the day.

A Sheriff's Office deputy told Mr. Hogan that he would be seen later and that he was going to be returned to his dorm. The Sheriff's Office reported that Mr. Hogan refused and said he wanted to stay in the holding cell. The deputy advised a sergeant of Mr. Hogan's refusal.

At approximately 8:06 a.m., the same deputy radioed requesting a sergeant respond to the holding cell. The deputy reported that Mr. Hogan was banging his head against the door. Two sergeants responded to the holding cell.[10]

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[9] It is unclear to what degree the clinician considered Mr. Hogan's prior custodial behavior set out above in determining the urgency of the situation.

[10] By this point, Mr. Hogan had been in the holding cell for 2 ½ hours without being evaluated. A review of camera footage confirms that Mr. Hogan had become restless, had begun to kick and punch the holding cell door, and banged his head on the door.

One of the sergeants reported that when they arrived, Mr. Hogan was demanding to be let out of his cell. The other sergeant attempted to have a conversation with Mr. Hogan, calm him and learn about his needs but reported that Mr. Hogan was responding in "incomplete sentences."[11]

The two sergeants decided to move Mr. Hogan to the processing lobby area of the jail for medical evaluation and in order to expedite his clinical assessment. One of the sergeants instructed Mr. Hogan to place his hands through the tray slot of the holding cell so he could be secured in waist chains. Initially, Mr. Hogan declined to do so, but eventually he did comply and was waist chained and escorted to the processing area.

Upon arrival in processing, Mr. Hogan was secured to a chair in the lobby. A nurse attempted to conduct a preliminary medical screening Mr. Hogan, but he declined.

At approximately 8:27 a.m., a mental health clinician interviewed Mr. Hogan. According to the incident report, following that interview, custody staff prepared to transfer Mr. Hogan to the psychiatric unit at the Main Jail, which houses inmates experiencing acute mental health symptoms.[12] The sergeant told Mr. Hogan that he was going to the Main Jail where he would be able to see a doctor. Both sergeants left the area with Mr. Hogan being supervised by deputies.

At approximately 9:25 a.m., the sergeants were called to assist with the movement of Mr. Hogan to the transport vehicle. Upon arrival, the sergeants observed Mr. Hogan attempt to stand up from the lobby chair; he requested that he be unsecured from the chair so that he could walk around. Mr. Hogan said that he did not feel safe and wanted to be taken somewhere else. The sergeant reported that he soon would be taken to see a doctor downtown. The sergeant reported that Mr. Hogan

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[11] Much of the interactions between Mr. Hogan and Sheriff's Office staff at Elmwood was captured on body-worn or other jail camera video/audio.

[12] This is consistent with Mr. Hogan's claim, which states that on August 25, 2018, County staff "decided to move Andrew Hogan to the psychiatric unit of their jails located at the main jail."

repeatedly mumbled incomplete sentences, was sweating profusely, and displayed “bizarre” behavior.

Two transport deputies arrived to drive Mr. Hogan to Main Jail. Prior to un-securing Mr. Hogan from the lobby chair, the sergeant asked him if he would cooperate with staff by walking to and getting into the van. Mr. Hogan said that he would cooperate.

Mr. Hogan was unsecured from the lobby chair and stood on his own, but then became uncooperative by declining to walk. The sergeant reported that the two escorting deputies held onto Mr. Hogan’s arms in order to prevent him from walking away. Mr. Hogan reluctantly allowed staff to reapply leg shackles but had to be coaxed to the van.

Once at the van, Mr. Hogan refused to enter. After much conversation, deputies were able to persuade Mr. Hogan to go into the van. The sergeant reported, however, that Mr. Hogan refused to place his left foot into the caged area of the van, so that the door was not able to be closed and secured. Mr. Hogan then attempted to push the cage door open and leave the vehicle. Over the course of several minutes, Sheriff’s Office staff were not able to gain compliance from Mr. Hogan. The sergeant requested assistance from Custody Health staff.

A mental health clinician responded and began speaking with Mr. Hogan. After another several minutes, Mr. Hogan placed his foot into the caged area, allowing the door to be closed and secured.[13]

The van in which Mr. Hogan was transported did not have seat belts or any other restraints in the inmate seating area.

[13] The course of concerning conduct observed of Mr. Hogan that day did not cause any of the Elmwood staff to recommend that he be transported by ambulance or patrol car.

The Transport from Elmwood to the Main Jail

The two deputies then left Elmwood and began to transport Mr. Hogan at approximately 9:45 a.m.[14] According to the deputies, as indicated in an incident report, during the trip Mr. Hogan advised that he did not feel well. One of the deputies told Mr. Hogan that they were taking him to see a doctor. The deputy that was driving the van reported that he heard what sounded like someone hitting the walls in the back of the van. The deputy said that because he was concentrating on driving, he did not activate his body worn camera.

The passenger deputy advised that while enroute to Main Jail, Mr. Hogan began hitting his head against the caged area of the van and he immediately activated his body worn camera.[15] The deputy stated that he told Mr. Hogan to stop hurting himself, relax, and sit down. The deputy reported that Mr. Hogan ignored his commands and continued hitting his forehead against the van's wall.

The passenger deputy wrote that he saw Mr. Hogan bleeding from his face and head area, so he contacted a sergeant to advise of the situation. Once Mr. Hogan began self-harming, the transportation deputies sped up and after they pulled off the freeway activated the van's lights and siren. It appears that despite contacting the sergeant, the deputies were not instructed to return Mr. Hogan to Elmwood or transport him to the emergency room of a local medical facility.

Upon arrival, a Main Jail supervising officer (Supervisor 1) met the transport deputies and Mr. Hogan.

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[14] Mr. Hogan was waist-chained but not otherwise restrained or wearing a safety helmet after being placed in the cage of the van.

[15] Mr. Hogan was violently banging his head on the roof and steel beam in the back of the van. As detailed below, one of the deputies estimated that Mr. Hogan struck his head at least 50 times.

The Elmwood sergeant's written incident report concluded that the actions of the deputies appear to have been "reasonable, justified and consistent with policy."

A Jail Crimes Unit detective interviewed the passenger transport deputy who said that while enroute to Main Jail, he heard the sound of banging from the back of the van and initially believed that Mr. Hogan was kicking the cage. The passenger deputy said he told Mr. Hogan to relax and that everything was going to be ok. The deputy advised that he looked back into the cage to see what Mr. Hogan was doing and saw him repeatedly bang the back of his head on the roof of the van.

The passenger deputy said that he activated his body worn camera and pointed it in the direction of Mr. Hogan who continued to self-inflict wounds. The deputy said he ordered Mr. Hogan to sit down but Hogan did not comply.

The passenger deputy said Mr. Hogan began to hit his forehead with much force on the wall where a metal bar is used to reinforce the van. The passenger deputy said he radioed a Main Jail supervisor of the incident while continuing to record Mr. Hogan's activities. The passenger deputy estimated that Mr. Hogan hit his head at least 50-60 times. The deputy reported that Mr. Hogan's face was covered in blood and there was blood throughout the cage.

The passenger deputy said that at approximately 10:00 am, they arrived with Mr. Hogan at the ramp of the Main Jail. The supervisor he had contacted arrived at the location along with a nurse who requested an emergency response from medical personnel. The passenger deputy said that when they arrived at the Main Jail, Mr. Hogan was talking and conscious.

The passenger deputy said that the jail's Emergency Response Team arrived on scene and removed Mr. Hogan from the van but by then Hogan was no longer conscious. The deputy said that Mr. Hogan was placed in an ambulance and the deputy rode with Hogan to the hospital. The passenger deputy said that he did not see Mr. Hogan regain consciousness.

The driving transport deputy told the jail detective that as they began heading for Main Jail, Mr. Hogan asked for water, stated that he did not feel well, and wanted to see a doctor. The deputy said he told Mr. Hogan that they were on their way to see a doctor at Main Jail.

The driver deputy said that as he was about to access the freeway, he heard Mr. Hogan hitting something. The driver said his partner deputy looked back and saw Mr. Hogan hitting his back against the ceiling of the van. The driver deputy said that his partner called a supervisor and notified him of the situation. According to the driver, the supervisor told him to head wherever was closest to get assistance. The driver deputy said that he believed it was best to head straight to Main Jail since it was just a couple miles away.

The driver deputy said that upon arrival at the Main Jail, they were met by two supervisors and a nurse. According to the driver, the nurse looked at Mr. Hogan from outside of the cage and requested an emergency response from medical personnel. The driver deputy said that Mr. Hogan was not removed from the vehicle because staff was awaiting arrival of the Emergency Response Team ("ERT") in case Hogan was assaultive. The driver reported that when the ERT made contact with Mr. Hogan, he was no longer conscious.

Other than collecting video, documentary, and other physical evidence and endeavoring to learn more about Mr. Hogan's prognosis, the interviews of the transport deputies were the full extent of the jail crimes detective investigation.

Activity at the Main Jail: Written Accounts from Involved Supervisors

There were several internal incident reports prepared by Sheriff's Office personnel about the sequence of events surrounding Mr. Hogan's arrival at the Main Jail, his time within the transport van as it sat in the jail's intake area, and his ultimate departure for the hospital inside an

ambulance. The following are summaries of those reports that reflect the different roles and perspectives of the involved parties.

Report of Supervisor I

It was four days after the incident that Supervisor 1 was asked to prepare a report relating to the Hogan incident. According to the report, on the date of the incident, Supervisor 1 asked a higher-ranking officer (Supervisor 2) whether a report was necessary. The report indicates that Supervisor 2 initially said that the only report required was an Emergency Response Team Activation Report[16] because the incident "belonged" to Elmwood.[17]

According to the report, on the date of the incident, at approximately 10:00 a.m., Supervisor 1 received a call from the Elmwood complex advising that they had a "combative" inmate and that he was being transported to the Main Jail psychiatric unit. Supervisor 1 had been advised by Elmwood staff that the inmate had to be placed by force into the van.[18] Supervisor 1 also received a cellphone call from the transporting deputies. Supervisor 1 wrote that it was difficult to hear but that the information was that Mr. Hogan had injured himself and was combative, there was a lot of blood, and they were going to need assistance on the ramp. Supervisor 1 wrote that the deputy's tone of voice did not reflect a sense of urgency; nor was Supervisor 1 made aware of the extent of Mr. Hogan's self-inflicted injuries. The report indicates that Supervisor 1 assumed that by "assistance," the transport deputy meant officer assistance as well as medical assessment, but

[16]The Emergency Response Team ("ERT") is a specially trained team that has access to tactical and Hazmat gear and responds to emergencies in the jail. Per Sheriff's Office policy, when the ERT is called to respond, an activation report is routinely generated.

[17] It is unclear what caused the change of position by Supervisor 2 about whether Supervisor 1 should write a report about the incident.

[18] As detailed above, this statement is incorrect; no force was necessary to place Mr. Hogan into the transport van.

Supervisor 1 did not expect a “bodily injury event” upon their arrival. Supervisor 1 wrote that all calls were within minutes of each other.

The report also stated that Supervisor 1 had learned from these calls that a Main Jail sergeant who was working that day was related to Mr. Hogan. Supervisor 1 contacted the sergeant, who confirmed the relationship. Supervisor 1 then asked if the relationship was such that the sergeant’s presence might help de-escalate the situation. However, Supervisor 1 wrote that the sergeant advised that he did not have a good relationship with Mr. Hogan.

According to the report, Supervisor 1 called a nurse, advised the nurse of the circumstances, and asked the nurse to accompany her to the van upon its arrival. Supervisor 1 continued doing paperwork in intake, until hearing radio traffic from the transport deputies that they had arrived.[19] The report stated that Supervisor 1 immediately responded to the ramp with the nurse (for medical assessment) and with a deputy (for assessment of whether Mr. Hogan’s actions called for an Emergency Response Team activation).

Supervisor 1 wrote that one of the transport deputies stepped out of the van and told Supervisor 1 that Mr. Hogan had been banging his head, and that there was blood and excrement everywhere. Supervisor 1 wrote that they opened the transportation van side doors and saw Mr. Hogan standing up against the gate, talking and asking for water and medical assistance.[20] Supervisor 1 wrote that there was an extreme amount of blood coming from the top of his head dripping onto his face. Supervisor 1 further noticed excessive blood splattered throughout the van cabin.

[19] As a result, no medical or jail staff were waiting when the van arrived at the sally port at 10:00 a.m.

[20] Despite his request, neither water nor medical assistance was provided to Mr. Hogan at that time. Instead, he was left in the van by himself.

According to the report, Supervisor 1 asked the nurse what she wanted to do, and the nurse indicated that they should call a Code 3 ambulance[21] as a result of the major head injury.[22]

The report indicated that due to the amount of blood, as well as the additional information provided, Supervisor 1 advised facility control via radio to call for a Code 3 ambulance, and for the ERT team to "suit up" because there was a lot of blood and a deputy had advised that Mr. Hogan had defecated. Supervisor 1 advised a deputy to ensure ERT wore the "bunny suits" as personal protective equipment for precaution and to alleviate cross-contamination.[23]

According to the report, Supervisor 1 then went back into the intake area with the nurse and deputy to retrieve a hand-held camera. Supervisor 1

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[21] This terminology relates to the need for an emergency, expedited response for the ambulance such as lights and sirens.

[22] A review of camera footage indicated that two minutes after the van's arrival, Supervisor 1 is first observed in the sally port area. Supervisor 1 opened the van door for approximately eight seconds and then closed it. Camera footage also established that approximately one minute later, Mr. Hogan yelled that he needed to use the bathroom, although no one was monitoring him. Even though Supervisor 1 had been placed on notice by the nurse of Mr. Hogan's very serious needs, Supervisor 1 did not endeavor to provide him any immediate medical assistance. Further, Supervisor 1 did not personally monitor Mr. Hogan nor assign anyone else to do so.

[23] Supervisor 1 was aware of the nurse's initial assessment of a major injury. However, as an apparent concern about jail staff becoming contaminated from the existence of Hogan's bodily fluids observed on him and in the van, Supervisor 1 decided that Mr. Hogan would remain in the van until the ERT assembled to remove him. The audio from jail cameras recorded Supervisor 1 saying that, in the meantime, Mr. Hogan could "do all the damage he wants."

Supervisor 1 closed the doors of the van, leaving no one to monitor Mr. Hogan as he continued to bleed and decompensate. On the recordings, Mr. Hogan can be heard over the course of several unattended minutes, repeatedly yelling irrational statements with less and less vigor as he eventually lapsed into unconsciousness.

gave the camera to one of the deputies to record Mr. Hogan's activity while he remained in the van.

Supervisor 1 wrote that Supervisor 2 and another supervising officer (Supervisor 3) arrived on scene. The report indicated that Supervisor 2 took over authority of the scene and advised Supervisor 1 to request mental health to assist. Supervisor 1 wrote that the nurse then began preparing the paperwork for the ambulance's arrival.

According to the report, Supervisor 1 went back outside and saw the ambulance at the gate and advised control that the ambulance had arrived. Supervisor 1 asked for an estimated time of arrival for ERT and that they indicated they were on their way. Supervisor 1 wrote that a San Jose Fire rescue team then arrived.

According to Supervisor 1's report, the ERT arrived, and Supervisor 3 was advised of the plan of entry. According to Supervisor 1's report, the gate was opened and ERT members removed Mr. Hogan from the van and placed him on a gurney, at which point ambulance personnel began to provide care to Mr. Hogan.[24]

The report stated Supervisor 1's view that based on observations and information provided, Supervisor 1 made the safest and most reasonable decision as events were unfolding, keeping in mind the safety of staff and the inmate as a priority. According to the report, Supervisor 1 wanted responding staff to wear personal protective

[24] A review of camera footage establishes that the arrival of the ambulance occurs at 10:14 a.m. The camera that had been placed in the van shows Mr. Hogan speaking rationally for the last time at 10:15 a.m. as he then begins making repeated incoherent statements. At 10:16 a.m. a San Jose fire truck arrives. However, since the ERT had not yet assembled, neither ambulance nor fire personnel immediately provided medical treatment to Mr. Hogan. At 10:21 a.m., the ERT finally appeared; by that time, it appears as if Mr. Hogan had become unconscious. Cameras captured the teams of outside medical assistance standing around waiting for ERT and talking casually with jail staff as Mr. Hogan lapses into unconsciousness.

At 10:23 a.m., the ERT removed Mr. Hogan from the van. Mr. Hogan arrived at the hospital at 10:50 a.m.

equipment prior to entering the area or moving the inmate. Supervisor 1 did not know if Mr. Hogan had a weapon or if he had any injuries which would be exacerbated if they moved him without medical guidance.

The report also stated that Supervisor 1 advised the nurse that Supervisor 1 did not recall seeing medical assist in observing Mr. Hogan while the nurse was completing her paperwork.

Report of Supervisor 2

According to a report prepared on the date of the incident by Supervisor 2, at about 10:04 a.m., Supervisor 2 heard Supervisor 1 request via radio for a Code 3 ambulance and activated the Emergency Response Team to the Main Jail intake ramp. The report stated that Supervisor 2 immediately responded to the intake ramp area with another supervising officer. Supervisor 2 reported that Supervisor 1 was next to the transport van with the two transport deputies.

Supervisor 2 reported that after receiving a debriefing from the transport deputies, Supervisor 2 entered the front passenger door to talk with Mr. Hogan. Supervisor 2 reported that Mr. Hogan requested to see a doctor. According to Supervisor 2's report, it appeared that Mr. Hogan was hearing voices. Supervisor 2 also noted that he was yelling profanity and advising that he had been "set up."

Supervisor 2 reported stepping out of the van and instructing Supervisor 1 to have Mental Health and a nurse standby. According to the report, Supervisor 1 informed Supervisor 2 that Mr. Hogan had already been evaluated earlier at Elmwood.

Supervisor 1 also told Supervisor 2 that the nurse had assessed[25] Mr. Hogan when he arrived and had already requested a Code 3 ambulance. Supervisor 2 advised Supervisor 1 that mental health and

[25] It is unclear what the "assessment" by the nurse consisted of, whether it was based on merely speaking to Mr. Hogan and/or visual observations through the van window. Because the cage was not opened until ERT arrived, it was certainly not based on any sort of "hands on" physical assessment.

medical staff needed to be on scene while they were waiting for the ambulance in order to help calm Mr. Hogan as well as provide emergency triage as needed.[26]

Supervisor 1 told Supervisor 2 that Mr. Hogan was uncooperative, aggressive, and there was blood "everywhere." Supervisor 2 learned that Supervisor 1 activated ERT to assist removing Mr. Hogan out of the van.

Supervisor 2's report is consistent as to the chronology of paramedic and San Jose Fire Department response, followed by the delay in any first aid action until the arrival of Main Jail ERT. The report adds that, at approximately 10:18 a.m., jail medical staff also responded to the intake ramp; however, they left the scene upon observing the presence of outside emergency personnel.

ERT members eventually carried the unresponsive Mr. Hogan from the van onto the ground and then placed him on the gurney. Paramedics then transferred Mr. Hogan to the hospital.[27]

Supervisor 2 advised a sergeant to contact the Jail Crimes Unit ("JCU") to notify them of the incident. While the van was initially "secured" for evidence, the JCU sergeant advised a Main Jail sergeant to contact Hazmat to clean the van.

At about 10:45 a.m., the Assistant Sheriff was advised of the incident.

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[26]Camera footage confirmed that Supervisor 2 arrived at the sally port area at approximately 10:08 a.m. and video shows the supervisor talking to Supervisor 1. Supervisor 2 is seen talking to Mr. Hogan briefly and remaining in the area, but there is no video (or other) evidence that Supervisor 2 ensured that jail staff attempted to attend to Mr. Hogan's expressed needs, medically triaged him, or otherwise assisted him. And, Supervisor 2's report and purported instruction notwithstanding, neither medical nor mental health were in the ramp area when the ambulance arrived.

[27]To reiterate, ambulance personnel were on scene for six minutes waiting in the ramp area before the ERT removed Mr. Hogan from the van. By then, Mr. Hogan was unconscious.

At about 11:00 a.m., Supervisor 2 conducted a debriefing with a group of Main Jail supervising officers and advised them that it was critical to have mental health and medical staff on scene during a medical incident or when dealing with mentally ill inmates, especially inmates who were pending transfer to the jail psychiatric unit. Supervisor 2 reported that the supervising officers were advised that medical and mental health staff needed to stay engaged with an individual such as Mr. Hogan to try to keep him calm and to provide emergency treatment as needed.

Report of Supervisor 3

The aforementioned Supervisor 3 was also working Main Jail on the date of the incident. Supervisor 3 was asked five days later to document Supervisor 3's own actions.[28]

The resulting report indicates that Supervisor 3 heard that the ERT was being activated for a combative inmate on the booking ramp. Supervisor 3 indicated that the combative inmate, later identified as Andrew Hogan, was being transferred from the Elmwood facility to Main Jail.

Supervisor 3 contacted other staff and Supervisor 2 on the booking ramp. Supervisor 2 told Supervisor 3 to make sure that Mental Health representatives were coming to the booking ramp. According to the report, other jail staff informed Supervisor 3 that there was blood and feces spread throughout the van cage area. Supervisor 3 reported that Mr. Hogan continued to yell and bang the cage inside the van. Supervisor 3 further reported that the van was directed to move to the other side of the ramp in order to gain a tactical advantage for ERT and provide more room for EMS and Fire personnel to work.

Supervisor 3 reported that by the time EMS arrived, Mr. Hogan had become "quiet" inside the van. The report indicates that Supervisor 3 advised EMS personnel of the situation and made them aware of the blood and feces in the van. Supervisor 3 reported that a few moments

[28] Best investigative practices would have been for Supervisor 2 to order Supervisors 1 and 3 to complete their reports on the date of the incident.

later San Jose Fire arrived, and Supervisor 3 advised them of the situation. Supervisor 3 reported that EMS personnel returned with protective equipment and that Supervisor 3, EMS, and Fire walked up to the van.

Supervisor 3 reported that the van doors were opened and that San Jose Fire wanted to open the van cage door but Supervisor 3 recommended not doing so given Mr. Hogan's prior hostile behavior. Supervisor 3 reported that Mr. Hogan was lying on the van bench with his leg stretched out and pressed against the cage door. Supervisor 3 wrote that Mr. Hogan was breathing but not responding to verbal commands. The report states that, fearing that this was a "ploy or trick," Supervisor 3 wanted to be safe and wait until ERT was present when the cage door was opened just in case Mr. Hogan became physically hostile. Supervisor 3 further wrote that it was necessary to have ERT members in protective equipment in case they were exposed to bodily fluids.

Supervisor 3 wrote that after a few minutes, ERT arrived and lined up for the extraction of Mr. Hogan. Supervisor 3 reported that the cage door was opened, and Mr. Hogan was removed from the cage without any resistance and placed on the floor on his side. Supervisor 3 reported that ERT assisted EMS personnel while they evaluated Mr. Hogan and then placed him in the ambulance for transport to the hospital.

ERT Report

A member of the ERT also prepared a Team Activity Report. The ERT report indicated that the team was activated at 10:04 a.m. by Supervisor 1 due to a "combative" inmate. According to the report, the inmate (later identified as Andrew Hogan) was covered in blood and refused to get out of the transportation vehicle. Seven members of ERT responded to the ERT "dress out" room and changed into special protective gear.

The ERT report indicated that at approximately 10:10 a.m., the ERT members responded to the Main Jail entrance. According to the report, once the team had fully deployed, an ERT sergeant and deputy directed Mr. Hogan to exit the vehicle, but he refused to comply with their orders.

The report indicated that Mr. Hogan, who was previously displaying hostile behavior, being argumentative and thrashing around in the security cage was now laying on top of the bench unresponsive. The report stated that the ERT leader gave Mr. Hogan directives to exit the van, but Hogan continued to be unresponsive.

The ERT report stated that at approximately 10:18 a.m., the ERT leader directed the team to take control and help Mr. Hogan out of the vehicle in order to be medically assessed by paramedics. The report indicated that Mr. Hogan did not respond to the team's orders but did not resist efforts to remove him from the van. According to the report, team members first placed Mr. Hogan on the ground and then were directed to place him onto a gurney so that he could be assessed and treated by paramedics. The report indicates that at approximately 10:19 a.m., Mr. Hogan was secured to the gurney using leather restraints and at 10:31 a.m., Hogan was placed inside the paramedic van.[29]

Report by Supervisor 2: Additional Information[30]

Supervisor 2 reported that the next day a review of facility video footage revealed additional information that supplemented Supervisor 2's understanding of what had occurred. The video showed that the two transport deputies arrived at the intake ramp at 10:02 a.m., and one of them walked into intake control and requested assistance. The review showed that Mr. Hogan was yelling as follows:

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[29] The ERT report raises a number of questions regarding its accuracy. OCLEM has seen no evidence (video or otherwise) suggesting that Mr. Hogan was "combative" in the sense of being physically aggressive to any jail, medical, or mental health staff. Nor has OCLEM seen any evidence that Mr. Hogan "refused" to get out of the transport van prior to ERT arriving; Mr. Hogan was never ordered to exit the van by initial jail staff and he was non-responsive to verbal commands issued by Supervisor 3. And Mr. Hogan "refused" to comply with ERT's orders to get out of the van because he was unconscious when those orders were given.

[30] Even though the original report is dated, August 25, 2021, Supervisor 2's report includes a "Conclusion" that references observations made the next day.

> Get me out of here. I am fuckin' dying. Please get me out. Please, I need medical. Hey, my fuckin' head split open. My fuckin' head is bleeding. Please, get me out of here. I need to talk to a doctor. I need water….

Supervisor 2 reported that at 10:04 a.m. a nurse arrived and assessed Mr. Hogan while outside the van and requested an ambulance to transport Mr. Hogan to a local hospital, Code 3. Supervisor 2 reported that after the nurse assessed Mr. Hogan, the nurse and Supervisor 1 left the scene and walked into the intake sally port. Supervisor 2 wrote that two minutes later, Main Jail deputies left the scene and returned to the intake sally port, leaving the transport deputies with Mr. Hogan by themselves.

Supervisor 2 wrote that review of the video footage gave the impression that Supervisor 1 did not engage or interact with Mr. Hogan during the entire incident. Supervisor 2 wrote that there was therefore uncertainty as to how Supervisor 1 could have made a determination that Mr. Hogan was uncooperative and aggressive – a characterization that had supposedly formed the basis for requesting an ERT response. Supervisor 2 wrote that as a result of waiting for ERT to suit up, Mr. Hogan did not receive first aid until after paramedics arrived.[31]

Supervisor 2 wrote that after the nurse assessed Mr. Hogan, no other jail medical staff were present until after paramedics arrived. Supervisor 2 reported that, even though Mr. Hogan had sustained a major head injury, no additional medical staff responded despite an express request for them to do so.

Supervisor 2 wrote that Supervisor 3 arrived on scene at 10:11 a.m. and that Supervisor 2 did not see Supervisor 3 make verbal contact with Mr. Hogan during the entire incident.

[31]In fact, Mr. Hogan was not given any medical attention until ERT suited up, arrived, and pulled him out of the van, minutes *after* EMT had already arrived.

Based on these factors, Supervisor 2 recommended further inquiry into this incident.[32]

[32] It should be noted that Supervisor 2's multi-pronged criticisms of Supervisor 1 emerged from a scene at which Supervisor 2 was personally present but had not intervened or directed the lower-ranking officer to take another course of action.

Aftermath of the Hogan Matter: Shortcomings of The Sheriff's Office Administrative Response

Whenever a person in the care and custody of a law enforcement agency experiences a significantly harmful outcome of any kind, the situation obviously calls for a reckoning on several potential fronts. Mr. Hogan's permanent injuries, and the circumstances surrounding them, merited a rigorous internal response by the Sheriff's Office that, as described below, did not come to proper fruition. This meant important issues were not addressed, not only in terms of accountability for involved personnel, but also with regard to responsive systemic improvements.

Custody Health's "Root Cause Analysis"

The first formal effort to address the Hogan incident was initiated by Custody Health, pursuant to County protocols. That group convened a "Root Cause Analysis" or "RCA" meeting on September 14, 2018 – some three weeks after the van transport that left Mr. Hogan incapacitated.

An RCA meeting is part of a peer review process aimed at learning how and why a critical incident occurred and examining the root causes to understand how similar events can be prevented in the future. RCA meetings result in corrective action or risk reduction plans, with specific assignments and timelines for implementing certain tasks. RCAs are facilitated by Custody Health personnel and have a heavy emphasis on

issues surrounding patient treatment. Custody Bureau staff also regularly attend these meetings.

In the Hogan matter, the discussion addressed the entirety of Mr. Hogan's psychiatric and medical evaluations and care while in custody. But the only part of the review related to Custody Bureau issues was discussion about transport procedures. Custody Bureau leadership did not make incident reports available to the RCA facilitators, indicating that the matter was under investigation.[33] Of course, Custody Bureau's deflection of questions during the RCA meeting relied on reference to an investigative process that had yet to be formally initiated, and that we now know was later shut down.

Custody Bureau leadership did represent during the review that additional safety measures would be implemented to address the identified factors related to transportation. As we discuss elsewhere in this report, a new directive for transporting those in custody was put in place following this incident, and this constituted important progress for which the agency deserves credit. Nonetheless, no formal corrective actions items related to Custody Bureau were identified, and no accountability measures were developed as a result of the Custody Health-led review for either Custody Health or Sheriff's Office employees.

Internal Affairs Investigation

The formal center of the Sheriff's Office response to this incident was an Internal Affairs investigation into allegations of possible misconduct by involved personnel.

Our initial Report on this matter described the course of that investigation. It identified its abrupt closure – seemingly with several key questions unresolved – as a perplexing choice that lent itself to suspicions about improper motivations. And it explained that the premature end of the investigation – prior to interviews with involved

[33] In fact, as detailed below and unexplainedly, the matter was not officially under Sheriff's Office investigation until September 25, 2018.

personnel – also meant that much of the incident's value as a basis for corrective action had been lost.

However, our then-lack of access to records and knowledgeable personnel meant that there were inevitable gaps in our understanding of what had happened and why, both substantively (with regard to the real time handling of the incident) and in terms of the investigative history itself. Since the time of that report, the lifting of that blockade on information has shed additional light on the history behind this investigative process.

According to investigator records, the case was assigned to an Internal Affairs investigator on September 25, 2018.[34] The IA tracking database relating to the Hogan case identified two supervising officers as the subject employees of the investigation. The two transport deputies were listed as "witnesses" to the incident.[35]

Other available information tracks the further steps taken by the investigator. That person requested from various sources all reports relating to the Hogan matter, Mr. Hogan's classification file, involved staffs' training files, and documents relating to the County Emergency Medical Services and Fire Department response.[36] Documentation further indicates that the investigator viewed the Personnel and Training Files of the subject officers, downloaded the body-worn camera footage

[34] There is no documentary explanation for why it took a month to initiate the investigation.

[35] In our view, it was a debatable choice to refrain from including them as subjects (as well as their supervisors), given their obvious connection to relevant events in an incident that had ended badly. Presumably, though, this could have been rectified later if further investigation so warranted.

[36] Another notation showed that the investigator requested information about the status of Mr. Hogan and was advised that the last report from Sheriff's Office staff was on September 12, 2018, at which time he was still in the hospital and unconscious.

and audits, and received documentation of the SJFD response.[37] These all appear to have been appropriate and routine initial steps.

[38]Documentation from the Internal Affairs file showed that the investigator met with Sung and others and received a thumb drive with the results of an email audit in relation to the investigation.[39]

Documentation further indicates that on December 3, 2018, Sheriff Smith's secretary advised all staff via email that one of the subject officers was to be promoted effective immediately. In response to this development, the Internal Affairs investigator queried his supervisor several days later. The point was to inquire about the promotional eligibility of personnel with an active disciplinary investigation. The investigator wondered whether the announcement meant that the supervisor being promoted was "off the hook."

Case records then show that, as of December 12, 2018, the investigation was to be closed per the instruction of Sung. The documentation further indicates that any concerns relating to the two

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[37] While the investigation was open, the investigator emailed the head of Internal Affairs about another supervisor and asked why that supervisor wasn't being investigated. The investigator noted that based on the supervisor's report, the officer made relevant decisions once on scene. It is unclear whether the Internal Affairs head responded to the investigator's question. There is no documentary evidence that this supervisor was ever designated as a subject employee, although a strong case can be made (as the investigator articulated to his supervisor) that this supervisor should have been.

[38] In September 2018, a media outlet made a California Public Records Act request for video and radio transmissions relating to the Hogan incident. The Sheriff's Office denied the request on the basis that release would infringe on the privacy rights of Mr. Hogan and that the Sheriff's Office was currently investigating the incident and releasing the recordings could compromise the investigation.

[39] The investigator expressed a concern to his supervisor about using the regular Sheriff's Office technology channels to conduct portions of the investigation, indicating that he did not trust those channels.

transport deputies were to be returned to the Custody Bureau, Elmwood Division, for any appropriate action.[40]

When the order came to shut the investigation down, none of the underlying issues that had animated the original framing of the investigation had been definitively resolved. Nor had the interviews with either witness or subject officers – presumably a key component of any effort to better learn the witnesses' observations and the subjects' decision-making – taken place.

In discussions with knowledgeable parties that shared the same basic recollection of events, we were advised that the investigator was attending a meeting on December 12, 2018, where active cases were being discussed. It was there that he was instructed by Sung to close the investigation with no explanation as to why. The investigator strongly disagreed with the decision to close the case before any real investigation had begun but did not believe that he could question the then-Undersheriff's order.

The formal tracking of the case was updated in the aftermath of this meeting to include a terse resolution that was authored by the investigator. It asserts – inaccurately – that the investigator was able to determine through review of video that the subject officers had not violated policy, and that the case was accordingly closed as "Unfounded" against them. Our understanding is that the investigator wrote this as a way of accounting for the directive to close the case, in part because of the mechanical limitations of the database itself. That it did not reflect the reality of the situation is apparent in several ways – from the obvious irregularity of an investigator reaching unilateral conclusions to the failure of this "explanation" to account for other aspects of the case that extended beyond available video evidence.

In short, the case was closed abruptly and without investigative justification. The investigator's disagreement with the decision and its implications, along with a perception of powerlessness to do anything

[40] The referral is perplexing considering that, as explained above, the two transport deputies had not been named as subjects of the investigation.

other than accepting it, extended throughout the Internal Affairs investigative unit and its supervisory staff.[41]

After the Internal Affairs investigation was closed and the transport deputies were referred to Elmwood jail for handling, a report was prepared by an Elmwood supervisor and sent to Supervisor 2 relating to the transport deputies. The report reflects that the Elmwood Supervisor conducted some analysis of the transport deputies' conduct and took some limited measures to address the incident, including discussing the incident with just one of the deputies and reportedly talking to him about the deputies' conduct. However, these measures—taken with just one of the transport deputies—were minimal and largely inapposite and ineffectual in response to the serious questions raised about the deputies' performance.

[41] We were advised that there was at least one other case during this time frame where then-Undersheriff Sung ordered that an investigation be terminated before it was completed. In that case, the subject of the investigation was considered a "friend" of the Sheriff, and various witnesses expressed their view that this person was protected from any accountability as a result.

The Impacts of a Curtailed IA Case: Lost Chances for Accountability and Improvement

As noted above, while the remediation efforts undertaken by the Elmwood supervisor were minimal and largely inapposite to the concerns identified, there was at least some analysis by the Elmwood supervisor and subsequent discussion, albeit with just one of the involved deputies. And, importantly, apart from the internal review itself, the transport memoranda directives discussed elsewhere are evidence of some constructive steps being taken toward the prevention of future similar incidents.

We mention this in part to illustrate the contrast that even these imperfect measures represent as compared to the glaring lack of follow-through across many other issues of potential accountability and reform, particularly as to the involved supervisors at Main Jail.

In our initial Report, we cited numerous questions regarding the officers' performance and possible violations of Sheriff's Office policy that were suggested by the known facts, and that merited a comprehensive administrative investigation that never occurred. They included the following:

Supervisor 1

As noted above, Supervisor 2's incident report raised several issues regarding Supervisor 1's decision-making and recommended "further inquiry." In addition to the issues identified by Supervisor 2 and cited above, potential questions that should have been explored in a comprehensive administrative investigation include:

- Whether Supervisor 1 violated Sheriff's Office policy or the duty of care by failing to immediately respond to the jail ramp area for

receiving detainees after being telephonically advised of the situation and that Mr. Hogan would be soon arriving.

- Whether Supervisor 1 violated Sheriff's Office policy or the duty of care when the supervisor spent a total of eight seconds assessing Mr. Hogan.
- Whether Supervisor 1's comment that "he could do all the damage that he wants" (referring to Mr. Hogan) was inconsistent with Sheriff's Office policy regarding the professionalism and care expected of custody supervisors and suggested indifference about whether Mr. Hogan might continue to self-harm as well as a failure to develop a plan to immediately attend to his medical needs.
- Whether Supervisor 1's decision to wait until ERT suited up and responded, rather than authorizing rescue personnel who had arrived to immediately attend to Mr. Hogan's medical needs, amounted to a failure in providing Mr. Hogan the immediate care that the situation demanded.
- Whether Supervisor 1's decision to leave Mr. Hogan largely unattended and not treated until the ERT responded violated Sheriff's Office policy or the duty of care.
- Whether the information provided in Supervisor 1's incident report was factually accurate.

Supervisor 2

The known facts also raised serious questions that should have been explored regarding the performance and decision-making of Supervisor 2 with regard to the care afforded Mr. Hogan:

- Whether Supervisor 2 failed to sufficiently supervise the Sheriff's Office response after Mr. Hogan arrived at the jail.
- Whether Supervisor 2 violated Sheriff's Office policy or the duty of care by failing to consider and countermand Supervisor 1's

decision to wait until ERT arrived before providing medical care to Mr. Hogan.

- Whether Supervisor 2 violated Sheriff's Office policy or the duty of care by failing to ensure that Mr. Hogan was adequately monitored by jail staff, medical staff, and mental health staff prior to him being extracted by ERT to determine if his condition was worsening.

Supervisor 3

And there were also questions raised with regard to Supervisor 3's response at Main Jail relating to the Hogan incident:

- Whether Supervisor 3 violated Sheriff's Office policy or the duty of care by refusing to allow on-scene emergency rescue personnel to open the cage door and attend to Mr. Hogan.
- Whether Supervisor 3's decision to wait for ERT to suit up and respond as Hogan's physical condition deteriorated rather than immediately provide first aid violated Sheriff's Office policy or the duty of care.[42]

Emergency Response Team Leader

As detailed above, there were concerns about the accuracy of the report prepared by the ERT team leader. They included:

- The unsupported and misleading statement that Mr. Hogan was being "combative" to jail, medical, or mental health staff.
- The unsupported and misleading statement that Mr. Hogan "refused" to get out of the transport van prior to ERT arriving, since he was never ordered to get out of the van by jail staff and likely could not have done so without assistance.

[42] This is a clear example of how further investigation would have been clarifying: analysis of these decisions could have been better informed if it had been based on investigative interviews of outside emergency medical personnel who responded to the jail but had to wait around for ERT to arrive and were reportedly kept by the on-scene supervisors from providing immediate care.

- The unsupported and misleading statement that Mr. Hogan "refused" to comply with ERT's orders to get out of the van since Hogan was unconscious at the time.

The Inordinate Delay by Custody Health Personnel in Interviewing Mr. Hogan at the Elmwood Facility[43]

As noted above, Custody Health failed to respond to conduct the requested assessment for over two hours while Mr. Hogan was required to wait in a holding cell and as his situation deteriorated causing him to begin to hit his head on the cell door. When Custody inquired about the delay, they were reportedly advised that Mr. Hogan was not a priority and that he should be returned to the dormitory. And it was only after custody staff walked Mr. Hogan to space near the clinician's office that he was seen and examined by mental health staff. There was no apparent follow up of this issue by Custody Health, and there are no indicia that the clinician was asked to document and explain the reason for the delay in the interview process.

The Decision to Transport Mr. Hogan in the Caged Van

It was foreseeable that Mr. Hogan might harm himself during the trip to the Main Jail, given that he banged his head against the holding cell walls earlier that day and initially would not allow the van doors to be closed. Yet the Sheriff's Office made no further inquiry into the choice by supervisory jail staff (in concert with an Elmwood Custody Health clinician) to remain committed to the transport van. The van was not equipped to prevent self-harm, and no one rode with Mr. Hogan in the back of the van to prevent him from harming himself. Once inside the moving van, Mr. Hogan began striking his head in a caged area where no one could readily stop him.

The Sheriff's Office should have investigated these issues so that a more complete factual record could have been compiled, and an

[43] Since this involved employees of Custody Health, ideally this issue would have been flagged during the Root Cause Analysis review and, if warranted, referred to an administrative investigation of identified personnel.

appropriately robust analysis be made of the decision-making and conduct of involved personnel. Moreover, Custody Health should have made further inquiry during the Root Cause Analysis review regarding the participation by the clinician in "persuading" Mr. Hogan to enter the van.[44]

The Decision to Continue to the Main Jail After Mr. Hogan Began to Harm Himself in the Van

The transport deputies radioed for advisement and direction to supervisors once Mr. Hogan began hitting his head against the van walls and were instructed to continue to the Main Jail. Yet there was no formal inquiry into whether that instruction was appropriate under the circumstances. Nor was there any formal inquiry into whether the transport deputies could have taken other action to halt the self-harm, such as pulling the van over and attempting to control Mr. Hogan so that he could no longer injure himself.

[44] While, as detailed above, there was no policy preventing Elmwood staff from using the caged transport van to transport mentally ill inmates, the question was whether the particular circumstances in this case warranted a consideration of potential alternatives, especially considering the prior indicia of Mr. Hogan's attempt to self-harm and his articulated reluctance to enter the van.

Additional Background: Later Developments in the Hogan Matter

Sung Revisits the Case File

We were provided documentation that the then-head of the IA unit called the Hogan investigator to advise that the then Undersheriff had requested him to bring the case file to Sung the next day. This was on February 20, 2020 – well over a year after the case was originally closed.[45] The entry indicates the investigator requested that the file be copied and that a copy be provided to Sung, while the original remained at Internal Affairs. The investigator wrote that he expressed concern about Sung destroying the original file. The investigator also used his County phone to take several time-stamped photos of the original handwritten case notes in an effort to ensure the preservation of those notes.

Text messages from the supervisor of the Internal Affairs unit also expressed concern about the request from Sung for the file. He asked if someone in the unit could scan the whole case so it wouldn't disappear. He further advised that they could give Sung a "clone" and lock up the original file citing lack of trust and the concern about the file going missing.

We were advised that a copy of the file was ultimately provided to Sung; this was not returned to Internal Affairs. We were further advised that

[45] The timing is likely not coincidental; it is shortly after the preparation of County Counsel's February 10, 2020 memorandum, and just prior to the Board meeting where the Hogan settlement was approved. As one investigator advised us, when then-Undersheriff Sung asked for the file, he advised he needed to look at it because he was "in trouble" with County Counsel. The County Counsel memorandum, which the Board made public last year, analyzes potential liability arising from the premature closure of the Internal Affairs investigation; Sung's comment may have been a reference to this analysis.

after Sung was relieved of duty after charges were filed against him by the District Attorney for his alleged role in the concealed carry permit scandal, the new interim Undersheriff did not locate the Hogan file copy in his office.

Civil Grand Jury Proceedings

In August 2021, this Board asked County Counsel to refer the Hogan matter to a number of entities, including the Santa Clara County civil grand jury. At some point, the civil grand jury initiated an inquiry into possible misconduct by Sheriff Smith, including in relation to OCLEM's efforts to obtain information about the Hogan matter. At the conclusion of the process, in December 2021, the Civil Grand Jury accused Sheriff Smith of multiple counts of "willful and corrupt misconduct in office."

Six of the seven counts are connected to allegations of trading concealed weapons permits for contributions to her re-election campaigns. The final count deals with Sheriff Smith's failure to cooperate with our inquiry into the Hogan matter. Specifically, it alleges that Sheriff Laurie Smith committed willful misconduct in office by failing to cooperate with and promptly supply records and information to the Santa Clara County Office of Correction and Law Enforcement Monitoring, OCLEM, in violation of Santa Clara County Ordinance Code Title A Division A20, section A20-64, subdivision (a).

The civil grand jury called a number of witnesses who testified and whose transcripts of testimony have been released and can be obtained by members of the public. Here, we provide summaries of those witness accounts that were relevant to the handling of the Hogan case aftermath and the issue of OCLEM access to investigative materials.

Among the witnesses was Captain Neil Valenzuela, who was a lieutenant in charge of internal affairs when the Hogan investigation was initiated and then terminated. Captain Valenzuela testified that then-

Undersheriff Rick Sung ordered him to look into the Hogan incident, and Valenzuela then assigned an investigator to investigate the incident.

Captain Valenzuela testified that during a monthly review of pending internal affairs cases, then-Undersheriff Sung ordered him to stop the Hogan investigation. Captain Valenzuela testified that Sung provided no explanation for why he wanted the investigation closed. Captain Valenzuela said that he had not agreed with the order to close the investigation.

Retired Captain Amy Le testified that she was familiar with the Hogan incident. She said she was on duty at the rank of lieutenant at the time of the incident, working as the watch commander at Main Jail. Le said that she was in her office and heard from a sergeant that she needed to activate the emergency response team to respond to inmate booking, so Le responded to the area.

Le testified that after the incident occurred, she reviewed the reports, video and debriefed with her staff. Le testified that she recommended further inquiries because she was upset with how the incident was handled. Le said that when a detainee is to be transferred from Elmwood to the Main Jail, that the watch commander at Elmwood is supposed to call the watch commander at Main Jail but that she had not received such communication.

Le testified that her sergeant never advised her of the transport so that Main Jail staff could prepare. Further, Le testified that the sergeant should have had medical staff on scene so that they could have immediately assisted the inmate. Le said that when she responded to the location, her on-duty sergeant was not in front of the van to talk with the inmate and there was no nurse or mental health staff on scene.

Le also testified that it took the emergency response team a long time to suit up. She wanted to know whether the delay was a lack of equipment issue or if there was a way to prevent the delay in the future. Le testified that she was very upset with one of the statements that the on-duty sergeant made and wanted to know why the sergeant left the scene, slammed the door, and left the inmate in the van. Le testified that while

there were things that were not handled correctly by medical, mental health, and her staff, she personally had done nothing wrong with regard to the Hogan incident.

Le testified that her recommendation was for the case to go to Internal Affairs for further inquiries but, unbeknownst to her, the investigation was stopped. Le testified that she was not given any notice by Internal Affairs that it had opened an investigation into the Hogan incident. Le testified that she was never contacted by either Sheriff Smith or Undersheriff Sung about the Hogan incident.

Le testified that from 2016 to 2018, she was the President of the Santa Clara County Correctional Peace Officer Association ("SCCCPOA"), the union representing correctional officers assigned to the County jails.[46] Le testified that during the 2018 primary and general election, the SCCCPOA endorsed Sheriff Smith and donated funds to her campaign.

Le testified that she was forced to donate to Sheriff Smith's campaign, noting that then-Undersheriff Sung would ask her "is that all you can give?" When Le said she and her sister had given the maximum amount allowed by law, Sung asked her about whether her children and other relatives could donate.

With regard to the outcome of the Hogan case, she did not think she had been the recipient of improper protection from accountability – either as a reward for political support or for any other reason. Her view was that she had done nothing wrong on the day in question.

On November 2, 2021, Lara McCabe testified that she was a Program Manager for the Sheriff's Office. McCabe told the grand jury that as recently as November 1, 2021, she had heard the Sheriff instruct Undersheriff Binder to delay meetings with the unions about the OCLEM information sharing agreement as long as he could. McCabe confirmed

[46] Le said that after she was promoted to Captain in December 2018, she resigned her position since Captains are not eligible to be in the SCCCPOA.

her understanding that no information sharing agreement would be signed until the meetings with the union were convened.

Juan Gallardo testified that he was the Administrative Services Director for the Sheriff's Office until November 2020. Gallardo testified that he was present at a meeting when Sheriff Smith said that she was interested in slowing down the process relating to meeting with the employee unions so that it would slow down any execution of the OCLEM information sharing agreement.

Jennifer Roth testified that she was the Sheriff's Confidential Secretary and recalled hearing OCLEM contacting the Sheriff's Office and either requesting information or wanting to set up a meeting. She testified that the response from the Sheriff was a lot of deferrals, putting off, and not wanting to engage.

Assistant Sheriff Dalia Rodriguez testified that in the summer/fall of 2021, Sheriff Smith said to her and other people that based on the information they had relating to Hogan, the actions of staff were appropriate, and an Internal Affairs investigation was not necessary. Assistant Sheriff Rodriquez testified that she advised the Sheriff that an Internal Affairs investigation should have been conducted.

Undersheriff Binder testified before the grand jury that Sheriff Smith advised him that she supported the decision of then Undersheriff Sung to not investigate two supervisors who were on scene at the Hogan case at the time.

Undersheriff Binder testified that after OCLEM requested information relating to the Hogan incident, Sheriff Smith gave instruction initially to only release what was publicly available until the Information Sharing Agreement between OCLEM and the Sheriff had been completed. Undersheriff Binder testified that because the Hogan incident was outside of the timeline of scope of documents that were to be produced to OCLEM, even after the Information Sharing Agreement was signed, it

would require OCLEM to issue a subpoena before any Hogan materials would be produced.

The trial of the grand jury charges, including the willful misconduct charge against Sheriff Smith for failing to promptly cooperate with OCLEM in its review of the Hogan matter began on September 21, 2022.

A Truncated Investigation: Understanding Why

As we stated in our initial report, once an Internal Affairs investigation is initiated, it should be the extraordinary circumstance that would cause it to be closed without a finding. This is particularly true when the underlying incident involved such serious harms and raised so many questions about decision-making – including at the supervisory level.

Here, the records show that the investigator, once assigned the case, began to dutifully request, collect, and review all pertinent documents and video evidence.[47] As detailed above, the investigator also raised questions about the scope of the investigation, querying his supervisor about whether another supervisor should be added as a subject to the investigation. However, before the investigator was able to interview even one witness, he was advised by then-Undersheriff Sung to close the investigation, with no further information or explanation provided.

As our original Report identified, contextual information suggests that the halting of the investigation may have been irregular in ways that merit attention. Beyond the inherent deviation from regular practice that ending the investigation comprised, the lack of any effort to explain the basis for that decision compounded the investigation team's sense that it was unjustified and problematic.

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[47]As noted in our initial report, there were issues with regard to the initial collection of information from involved personnel both at Main Jail and at Elmwood. While Supervisor 2, the leader of the ERT, and a sergeant at Elmwood all prepared contemporaneous incident reports, it was not until several days later that Supervisor 1 (and other supervising officers) were asked to prepare reports. An incident of this magnitude should have triggered an order from Sheriff's command that contemporaneous reports be written by all Sheriff's Office personnel who were involved with Mr. Hogan from his initial movement out of the dorm in Elmwood to his eventual transport to the hospital from Main Jail.

The circumstantial evidence points to a likely motivation for this break from normal practice. Publicly available information[48] establishes that retired supervisor Amy Le, one of the supervising officers involved in the incident, was a leader of the Santa Clara County Correctional Peace Officers' Association. That organization provided significant support for the Sheriff's 2018 reelection, which followed a contested campaign.

A timeline of events is helpful to recount here:

> August 25, 2018: Hogan incident
> September 25, 2018: Internal Affairs investigation opened
> November 6, 2018: Sheriff Smith re-elected
> December 3, 2018: Lieutenant Le promoted to Captain
> December 12, 2018: Internal investigation closed with no explanation

The timeline shows that Le was promoted to Captain less than a month after the Sheriff was re-elected and that nine days later, then-Undersheriff Sung closed down the investigation. His reason for doing this – and the extent to which Sheriff Smith was informed or even directed the move – is not definitively known. No explanation to subordinates was offered at the time, and both Sheriff Smith and then Undersheriff Sung have been steadfast in declining to answer questions about the matter.

What we do know is that the chronological overlap between the election, Lieutenant Le's promotion, and the abrupt, substantively unjustified closure of the Internal Affairs review is noteworthy on its face. And, as noted above, we have been advised of at least one other instance during this approximate time period in which the then Undersheriff altered the course of a misconduct investigation in a way that benefitted a known supporter of the Sheriff. In the absence of another plausible rationale, the goal of protecting Le from additional scrutiny or accountability seems the most likely impetus for the decision.

[48] This includes the recently released Civil Grand Jury testimony by several knowledgeable parties, which we discuss above.

As for Sheriff Smith's own responsibility, our years of experience cause us to conclude that it would be extremely unusual for a decision to close down an investigation of a serious incident involving a newly promoted Captain to be undertaken without the knowledge and endorsement of the head of the agency. We also know from the grand jury testimony of Undersheriff Kenneth Binder and Assistant Sheriff Dalia Rodriguez that Sheriff Smith advised them (albeit well after the fact) that she agreed with the decision to close the case, based on her assertion that no misconduct had occurred.

The procedural step of halting an open case abruptly – and literally without explanation – had several negative ramifications, not only from a liability perspective as set out in County Counsel's memorandum. The interruption of the fact collection process means that leadership remains largely clueless about precisely what happened and why. And the failure of the Sheriff's Office to view the matter through the important prisms of accountability, professionalism, fairness, and learning means that the levers for agency improvement that a law enforcement possesses will not be effectively deployed.

The internal investigative process of any law enforcement agency has the daunting responsibilities of timely, thoroughly, and objectively collecting facts so that leadership of the organization can evaluate any performance or decision-making concerns and appropriately address those concerns through the disciplinary system. When such an investigation is stopped, it means that there will be no accountability and any misconduct or mistakes of employees will fail to be addressed.

And when such an investigation is halted for unprincipled reasons of favoritism or pay back, the implications are dire to the organization. Those entrusted with conducting the internal investigations soon recognize that unprincipled reasons will insulate certain individuals from misconduct, regardless of its nature. When employees learn that there are two systems of accountability, based on rank or favoritism or relationships, it undermines trust and compromises *all* outcomes of the process. For the knowledgeable parties in the Hogan matter, that loss of trust was real and abiding.

A corrupt accountability system leads to serious undermining of trust within an organization that leads to decreased morale and a lack of respect for leadership and command. And when the public learns that an agency has two systems of accountability depending on relationships and political support, it further undermines trust in law enforcement and its ability to police itself. Finally, to the degree that a full collection of facts can inure to the benefit of improving the organization's policies so that a future tragedy can be avoided, the stop here resulted in the forfeiting of any such opportunity for learning and betterment. In addition to the ramifications for liability, the implications of the decision to halt the internal investigation in the Hogan matter cannot be understated.

Relevant Policies and Protocols: Avoiding a Recurrence

Need to Codify the Revised Transport Policy

At the time of the incident involving Mr. Hogan, the Sheriff's Office did not have any policy governing transport of mentally ill inmates between jails. Policy did exist that stated that inmates could be transported by ambulance to a medical facility, but that was not the practice at the time. Instead, inmates were regularly waist-chained (but not seat-belted) and placed within a secured cage in the back of a van.

In the aftermath of the Hogan incident, the Assistant Sheriff at the time authored a memorandum in September 2018 that advised correctional staff that inmates placed on a 5150 hold were only to be transported via sedan or ambulance. This was a positive, timely innovation for which the Sheriff's Office deserves credit.

Similarly, and one day later, a subsequent memo authored by an Elmwood lieutenant advised Sheriff's Office staff that the jail had designated a former patrol car for use in transporting inmates placed on

a 5150 hold from Elmwood to the Main Jail. The memorandum indicated that the primary purpose of the vehicle was for transporting mentally ill inmates and this function was to take precedence over all other purposes.

We have been advised by Sheriff's Office personnel that the jail continues to follow the protocols set out in the memoranda referenced above. Again, this is creditable. However, in the almost four years since these adjustments were made, they have yet to be transformed into formal policy. In the absence of such a step, there is increased likelihood that the reason for responsive changes – designed to address a systemic shortcoming that the transporting of Mr. Hogan had exposed – will fade from memory, and practices will revert to ones less safe.

Deviation from the current approach, which we endorse, would be much less likely if current guidance was elevated to policy. For those reasons, the Sheriff's Office should convert the transport memoranda into policy.[49]

Apparently, the transport of individuals from Elmwood to the acute psychiatric unit at Main Jail is a relatively common phenomenon. However, we have been advised that there is no centralized log that documents these transports. In order to ensure better monitoring of the transport program and availability of ascertainable records, it is incumbent on the Sheriff's Office to better track the transports in a centralized database or in another manner that would provide an efficient and accurate means of verifying that the transport protocols are being followed.

Finally, without attribution but presumably in reliance on a Sheriff's Office source, the County Counsel Memorandum cited different rationales for not using a seatbelt during the transport process. It explained that "[a]n officer affixing a seatbelt near an agitated inmate compromises officer safety. Inmates can also use the seatbelt clasp to

[49] During our months-long review of the incident, we have been advised that this is the intent of the Sheriff's Office. However, as of this writing it has yet to be this accomplished.

bend their handcuffs and there have been cases where inmates tried to kill themselves using seatbelts."

Despite the passage quoted above, we have been advised that detainees are indeed seat-belted in the new paradigm of transport. We are left to surmise that the safety and security concerns about buckling detainees have dissipated, at least in balance with the heightened vehicle safety of passengers that seatbelts are obviously intended to provide.

This is a change we support, but the relevant memoranda do not specify it as a requirement. In order to be unequivocal on this point, the new policy should so advise.

RECOMMENDATION ONE: The Sheriff's Office should convert its memoranda regarding transport of detainees from Elmwood to the acute psychiatric unit at Main Jail into policy.

RECOMMENDATION TWO: The Sheriff's Office should maintain a centralized data base of such transports from Elmwood to Main Jail or otherwise maintain that information in a manner that allows for efficient and accurate verification that the transport protocols are being followed.

RECOMMENDATION THREE: The Sheriff's Office should ensure that the transport policy include an express direction that if detainees are transported via sedan, that they should be seat-belted into the back seat of the vehicle.

Need to Codify the Responsibility of Jail Staff to Immediately Provide First Aid to Injured Detainees

In this case, as stated above, Mr. Hogan spent minutes at the ramp of Main Jail with his physical condition and mental capacity rapidly deteriorating. Yet no one effectively monitored his condition nor moved to provide first aid after the decision was made to muster the ERT. Even after external rescue emergency personnel arrived and tried to treat Mr. Hogan, they were advised by Supervisor 3 to wait until the ERT suited up, responded, and extracted Mr. Hogan from the van.

While the ERT has its place in jail operations, authorities cannot wait for such a team to assemble and arrive when there is a seriously injured detainee who is in apparent need of immediate medical attention. In this case, it was an error to prioritize security and the well-being of responding deputies over the need to immediately provide first aid to Mr. Hogan. In addition to being severely injured, Mr. Hogan was waist chained and confined to a van in a secure facility; the concern that he would revive and injure staff, or that his bodily fluids created an intolerable risk of endangering staff, was excessive and should not have taken precedence. The decision that deferred intervention until the ERT arrival meant that outside emergency rescue units who had responded to the jail waited for precious minutes while Hogan's condition deteriorated, even when those units wanted to attend to him immediately.

In order to prevent this error in priorities, the Sheriff's Office should write and promulgate a policy instructing its supervisors and staff that when a detainee is clearly injured, there needs to be an immediate response and that attending to those injuries is the predominate concern. Explicitly, Sheriff's Office staff should be instructed by policy that all reasonable efforts should be made to immediately provide first aid when a detainee is observed to be seriously injured.

RECOMMENDATION FOUR: The Sheriff's Office should develop policy requiring all jail staff to *immediately* provide first aid to detainees whenever there are indicia of serious injury.

Need to Set Out in Writing A Rationale Prior to Shutting Down an Investigation

The Sheriff's Office needs to write a policy relating to the conditions under which an Internal Affairs investigation should be closed prior to completion. Those conditions should be extremely narrow, such as when it is discovered that the alleged perpetrator is not a member of the organization. Moreover, policy should require that in the rare case where a closing of the investigation is warranted, a memorandum should be written by the decision-maker, setting out the rationale for the closing

of the investigation. Finally, any closing of an investigation prior to its natural conclusion should require written approval of the Sheriff and other personnel involved in the decision.

RECOMMENDATION FIVE: The Sheriff's Office should write policy articulating the rare conditions under which an Internal Affairs investigation can be terminated prior to its conclusion, requiring a written memorandum setting out the reasons, and approval from the Sheriff.

Conclusion and Next Steps

As with many other aspects of life in Santa Clara County, the passage of time since August of 2018 has brought significant changes within the Sheriff's Office. Individuals who prominently affected the events discussed in this Report are no longer with the agency, and the Sheriff herself has announced her plans to retire at the end of this term. New mechanisms for oversight, new state laws, and newly rigorous public expectations are reflections of a time of real transition for local law enforcement agencies. And a significant component of this movement is the active reconsideration of how best to address the needs of people like Andrew Hogan, whose mental health challenges brought him into contact with the justice system in a way that ended tragically.

This review is illustrative of the need for – and potential value of – the kind of meaningful outside scrutiny that the OCLEM ordinance was designed to provide. We are pleased to note that the model is increasingly moving in that direction, thanks to the various inroads supported by this Board and to recent increased cooperation from Sheriff's Office command staff.

And as detailed above, this Board's referral of the Hogan matter still has the potential to be relevant to the remediation of that particular incident. Any useful "after-action" review process looks both backward and forward, at not only appropriate accountability but also needed change. We hope the recommendations we have provided will provide an impetus for closing gaps that were left unresolved by the early

termination of the Hogan investigation. Finally, as one meaningful check on the abuse of authority, we look forward to fulfilling our oversight role as set out in the originating ordinance and advising you and the County's public on what we find.