



Chief Executive Office.

COUNTY OF LOS ANGELES

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ACTING CHIEF EXECUTIVE OFFICER

Joseph M. Nicchitta

November 13, 2025

To: Supervisor Kathryn Barger, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Lindsey P. Horvath
Supervisor Janice Hahn

From: Joseph M. Nicchitta 
Acting Chief Executive Officer

PRIORITIZING DIGNITY AND LIFE IN THE LOS ANGELES COUNTY JAILS (ITEM NO. 21, AGENDA OF MAY 13, 2025)

On May 13, 2025, the Board of Supervisors (Board) directed the Chief Executive Office Risk Management Branch and the Auditor-Controller, with support from Department of Health Services' Correctional Health Services, Los Angeles County Sheriff's Department and Medical-Examiner, in consultation with County Counsel, to audit and evaluate the corrective action plans related to in-custody deaths from the past five years (2020-present), and provide any additional recommendations for the Correctional Health Services and Los Angeles County Sheriff's Department to improve and address the increased number of deaths.

The Chief Executive Office Risk Management Branch, with assistance from the Auditor-Controller, has concluded the various aspects of the Board's direction and attached are the responses.

Should you have any questions or concerns, please contact me or Destiny Castro, Assistant Chief Executive Officer at (213) 738-2194 or DCastro@ceo.lacounty.gov.

JMN:JG:DC:RUC:mld

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Auditor-Controller



"To Enrich Lives Through Effective and Caring Service"

CHIEF EXECUTIVE OFFICE – RISK MANAGEMENT BRANCH

**PRIORITIZING DIGNITY AND LIFE IN THE LOS ANGELES COUNTY JAILS
(ITEM NO. 21, AGENDA OF MAY 13, 2025)**

The Board of Supervisors' (Board) Motion on May 13, 2025, directed the Chief Executive Office Risk Management Branch and the Auditor-Controller to audit and evaluate the corrective action plans (CAPs) related to in-custody deaths from the past five years (2020-present) and provide any additional recommendations for the Department of Health Services Correctional Health Services (CHS) and the Los Angeles County Sheriff's Department (LASD) to improve and address the increased number of deaths.

Response

The Chief Executive Office Risk Management Branch assumed the lead role in this endeavor and conferred with the Auditor-Controller throughout the evaluation to obtain their feedback and perspective. CAPs are confidential risk management documents that are developed by County departments as part of a response to tort liability settlements that exceed \$100,000. CAPs contain corrective actions that are intended to prevent future losses by mitigating root causes of loss, in this case by preventing deaths in County jails. A total of 16 CAPs were identified for the five-year period (2020-present) specified in the Board motion with a total of 63 corrective action steps across all CAPs. Although these CAPs were approved during the period specified in the motion, many were related to claims which occurred prior to 2020. After evaluation of the incidents leading up to the settlements and related corrective action steps listed in the CAPs, the following conclusions were made:

- All 63 corrective action steps were implemented by LASD and CHS.
- The causes of the inmate deaths while in LASD custody could be grouped into similar causation groups (i.e., suicide, drug overdose, natural causes) but each incident encompassed factors which did not contribute to any patterns or trends.
- An issue identified during the review of the CAPs involved the quality of Title 15 Safety Checks, which are safety protocols in facilities that are conducted at set intervals to ensure the health, welfare, and safety of inmates in local detention facilities. These checks will be discussed in detail below.
- Several of the CAPs identified emergency medical response issues including delays in the initiation of resuscitation efforts, failures to immediately request and respond with an Automated External Defibrillator (AED), and failures to recognize the severity of an inmate's condition and significance of vital signs.
- There are no additional recommendations for CHS and LASD to improve and address the increase of inmate deaths based on the review of the 16 CAPs.

At the request of Supervisorial District Four, the analysis of inmate deaths while in custody was extended to recent inmate deaths (calendar year 2025) for which CAPs are not available. There are several factors which may have impacted the recent increase in inmate deaths. These factors include, but are not limited to, the increase in the inmate population resulting from the passing of Proposition 36 in November 2024 for drug and theft crimes, the increase in the unhoused population and the lack of medical care they receive prior to entering an LASD custody facility, an increase in the age of the jail population, and the increased use of fentanyl, difficulty in detecting it and its impact on overdose deaths.

The evaluation of recent inmate deaths involved consulting with several internal and external entities including CHS, LASD Custody Compliance and Sustainability Bureau, County Counsel (present during LASD meetings), Medical Examiner, Sybil Brand Commission for Institutional Inspections, Office of Inspector General (OIG) and Sheriff Civilian Oversight Commission. The discussions took place over several weeks and provided valuable insight into several areas which may impact the recent increase in inmate deaths while in custody. Most of the discussions identified similar concerns and insights. The following issues and concerns were brought to our attention during our evaluation:

Introduction of Narcotics into the Custody Environment

- Those consulted opined that LASD should ensure all individuals (e.g., employees, visitors) entering custody facilities are screened for narcotics and other prohibited items. Several entities indicated the screening process was inconsistent (i.e., the individual was not screened or the individual observed others who were not screened) or lacked thoroughness (e.g., did not inspect food or bags). The lack of a consistent screening process increases the risk individuals will attempt to bring narcotics and other prohibited items into custody facilities. LASD could evaluate alternatives such as hiring contractors to perform the screening or increasing the random use of canine units to assist in the screening if there is a lack of staff available to perform this function.
- Those consulted opined that LASD should ensure the screening process of inmates upon reintroduction into the custody environment after transferring to and from courthouse facilities in a manner that is similar to those at the initial custody intake. Inmate movement outside of a custody facility allows for the potential acquisition and reintroduction of contraband into the custody environment. Minimally invasive technologies such as body x-ray imaging and canine units can be used for more effective searches, and we encourage LASD to keep using both. LASD provided information that this is already its practice: inmates are body scanned when they return from court and those who refuse to be scanned are subject to a visual body cavity search. In addition, while criminal defendants have a constitutional right to be physically present at many hearings in their criminal cases, LASD should continue to work with the Los Angeles Superior Court and County justice partners to evaluate options to the increased use of video conferencing for court appearances to minimize inmate movement.

- LASD should ensure body scanners are available at all facilities to facilitate more consistent and regular use of the scanners. Increasing availability would also strengthen detection of narcotics entering custody facilities via inmates returning from court or intake. Currently, all facilities have body scanners except for the Twin Towers Correctional Facility, but inmates housed there are scanned at the adjacent Inmate Reception Center upon their return from court. It is our understanding that, with funding and support from your Board, LASD has purchased 17 new body scanners to replace current machines and that these will provide higher resolution imaging and allow for better detection with less radiation.
- LASD should consider increasing the use of random and routine searches of inmate housing for narcotics control due to increasing inmate population and the dynamic nature of jail populations. We note that as part of recent Joint Quality Improvement Projects related to medication hoarding and razor control at Men's Central Jail, interventions included increased unscheduled searches. The increased use of canines during searches for narcotics should also be considered.

Title 15 Safety Checks

- LASD should ensure staff complete Title 15 Safety Checks as required. Title 15 Safety Checks include observing for signs of life and distress and ensuring the general area is clear of obstructing items. Several entities expressed quality concerns of Title 15 Safety Checks, which are essential for ensuring safety and the well-being of inmates. For example, they observed LASD staff quickly walked past housing areas without verifying signs of life, and LASD staff did not quickly remove observed obstructions, such as hanging bed sheets that obstructed the line of sight. We note that LASD has recently made a strong effort to improve both the quality and timeliness of Safety Checks, which is closely monitored in connection with the United States Department of Justice Settlement Agreement.
- Those consulted opined that LASD should evaluate performing Title 15 Safety Checks at random intervals or order (but within requirements). Title 15 Safety Checks may be predictable as they are usually conducted at set schedules.
- LASD should evaluate the use of other staff classifications such as Custody Assistants to assist in performing these checks. Due to staffing shortages, some Title 15 Safety Checks could be at risk of being missed, delayed or rushed.
- LASD should monitor cameras where available. Several entities reported that LASD staff were not monitoring cameras during their walkthroughs of facilities. LASD should also consider the use of other staff, such as Custody Assistants or non-sworn personnel to assist in monitoring cameras to ensure continual monitoring occurs.

- LASD should expedite deployment of the body worn cameras for custody staff after finalizing the Custody Body Worn Camera Policy in September 2025. According to LASD, the rollout of Body Worn Cameras in custody began on October 1, 2025.

Death Book Evaluations

- LASD and CHS should continue to look into ways to improve their death review process by establishing Key Performance Indicators, such as corrective action and/or death review completion timeliness requirements, and periodically (e.g., monthly) monitor and escalate the death review statuses to Executive Management to ensure death reviews and their respective corrective actions are completed and implemented timely to try and prevent future deaths. Although LASD and CHS track death review aging timeframes and statuses, there are no Key Performance Indicators (i.e., timeliness) associated with CAP completion, and death review cases may take months or even years to be completed. LASD notes that the Custody Compliance and Sustainability Bureau works with facilities to ensure that all corrective actions are completed, and that CAPs from the death review process are not closed until proof of practice is provided by the concerned facility, to ensure that corrective actions are implemented.
- LASD should periodically review completed corrective actions and share the results with their management to identify emerging trends and assess whether corrective actions were effective in preventing deaths.

Emergency Response Equipment

- LASD should implement an inventory control and inspection mechanism to ensure emergency response equipment is available, inspected and in working order, and replaced if necessary. The availability of Naloxone (Narcan) and AEDs is critical when responding to life-threatening emergencies like opioid overdoses and sudden cardiac arrests, and LASD and CHS has had Narcan directly accessible to individuals in the custody environment since 2021. However, instances have occurred where an immediate response was hindered due to the lack of availability of Narcan and/or an AED was not functional when needed.
- Additional units of Narcan and AEDs should be maintained to immediately replace missing or malfunctioning equipment.

LASD Understaffing

- LASD should evaluate their use of alternative job classifications for tasks that are currently performed by Deputy Sheriffs to reduce mandatory overtime. Several entities indicated the LASD is understaffed and requires deputies to work mandatory overtime which has led to a decline in recruitment. Mandatory overtime may lead to job fatigue and burnout. In addition, LASD should evaluate requesting additional positions be opened to reduce overtime requirements.

Access to Healthcare

- Several entities mentioned that health service request forms are sometimes lost, misplaced or unavailable, resulting in the delay of treatment for inmates. The current health services request system is primarily paper based, allowing for delays in the delivery of medical treatment due to time required for completion of the request, routing the request and ultimately being received and reviewed by CHS staff. Moving to an electronic system can increase accessibility and efficiency for medical staff.
- In recent years, the County has dramatically expanded funding for Medication Assisted Treatment in the jails, investing \$179,344,000 since Fiscal Year 2022-23, but unmet demand remains. CHS staff reported insufficient funding for various types of medications including those utilized for addiction to narcotics, impacting the availability of treatment for inmates.
- CHS staff reported that inmates have missed medical appointments due to coordination issues between medical and court appointments. CHS's Online Real-Time Centralized Health Information Database (ORCHID) does communicate with LASD's Automated Jail Information System and Defendant Inmate Movement Management System, although the frequency that ORCHID accesses the information may allow for missed medical appointments since both ORCHID and the Automated Jail Information System develop lists of inmates with court appointments and medical appointments daily. CHS and LASD should evaluate the procurement of an electronic inmate movement/appointment system that can assist in properly tracking upcoming appointments for inmates and flagging conflicts in scheduling so that medical appointments can be rescheduled instead of missed.
- The entities engaged reported that inmates have stated that several requests are made before they are seen for medical care. Evaluate whether CHS staff can conduct daily walkthroughs where inmates can submit their non-emergency health request forms. In addition, the use of kiosks should also be evaluated to allow inmates to make requests for medical care.