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March 19, 2024

**Los Angeles County
Board of Supervisors**

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

FROM: Christina R. Ghaly, M.D. 
Director

SUBJECT: **ADDRESSING IN-CUSTODY OVERDOSE DEATHS
IN THE LA COUNTY JAILS (ITEM NO. 5 FROM THE
DECEMBER 19, 2023 BOARD MEETING)**

Christina R. Ghaly, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Deputy Director, Clinical Affairs

Nina J. Park, M.D.
Chief Deputy Director, Population Health

Elizabeth M. Jacobi, J.D.
Administrative Deputy

The Board of Supervisors (Board) directed Correctional Health Services (CHS) in collaboration with the Los Angeles County Sheriff's Department (LASD), Department of Public Health (DPH), and the Office of Inspector General (OIG) to respond to directive three of the motion titled, [Addressing In-Custody Overdose Death in the Los Angeles County \(LA County\) Jails](#).

Herein is the response to the Board.

3. Direct Correctional Health Services and request LASD, in collaboration and consultation with the Office of Inspector General, and the Department of Public Health's Substance Abuse Prevention and Control (SAPC), to provide the Board with a report back, in writing, in 90 days, on a feasibility and implementation plan to:

a. Reevaluate existing and create evidence-based strategies for identifying individuals at risk of substance use dependencies and pairing them with a treatment plan upon intake

Epidemiological data demonstrates that individuals in jails have a higher rate of Substance Use Disorder (SUD) than the general population. Therefore, patients seen in a jail setting are at high risk for substance dependencies and may benefit from being screened and evaluated for specific needs. CHS relies on self-reporting to identify patients who are willing to receive medical care or services for SUDs. Although there are institutions that use urine drug screens to identify people who have illicit substances in their system, CHS has not found this method helpful as they generally only show drugs that patients may have taken in the previous 72 hours. Also, if a patient is not interested in discussing their drug use despite reassurances that they will not be punished for a history of drug use, they generally do not consent to receiving medical or psychosocial support.

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*"To advance the health of our
patients and our communities by
providing extraordinary care"*



CHS currently screens all patients on entry for opioid use disorder, alcohol use disorder, and illicit drug use. Patients that screen positive based on self-reporting, are seen by a medical provider (medical doctor or nurse practitioner). All patients who have had alcohol in the last 72 hours are sent to the detox unit, and a protocol to prevent alcohol withdrawal is initiated. This protocol includes performing a Clinical Institute Withdrawal Assessment for Alcohol (CIWA) and providing benzodiazepines if needed to prevent withdrawal. Patients are monitored for three days before being released to their designated housing area. Patients with alcohol use disorder are offered naltrexone (either oral or by a monthly injection). If naltrexone is contraindicated, they are offered acamprosate.

For patients who self-report using opioids, they are offered sublingual buprenorphine-naloxone (suboxone) for up to seven days. They receive their first dose immediately if needed to help with withdrawal symptoms. They are then offered to transition to the monthly buprenorphine injection (sublocade).

All patients who screen positive for opioid use disorder or alcohol use disorder meet with a SUD counselor. The SUD counselor explains treatment options and harm reduction. All patients with any substance use disorder are offered to be put on the list for the START (Substance Treatment and Reentry Transition) program, if interested. SUD counselors also provide information about where patients can receive services when released.

Due to the immediate and deadly risks associated with alcohol withdrawal, and untreated opioid use disorder, most of CHS's attention and resources thus far have been dedicated to expanding and optimizing medical care and services for these SUDs. However, to reach all patients affected by substance use, individualized treatment plans will need to be developed for patients with stimulant use disorder, benzodiazepine use disorder, and other SUDs. At the current time, patients with high benzodiazepine use and benzodiazepine use disorder are given a four-to-six-week clonazepam taper, depending on their need, and patients with amphetamine use disorder are offered mirtazapine 30 milligrams (mg) per night to help reduce amphetamine use.

- b. Provide Peer (formerly incarcerated individuals/incarcerated individuals with lived experience) support and therapeutic and rehabilitative programming to incarcerated patient who are receiving Medication-Assisted Treatment (MAT)**
- c. Develop programming and provide supportive services to those who may not be receiving MAT services, but are on the substance use dependency spectrum**

The START program provides direct in-custody SUD counseling, group therapy, and case management. START services are evidence-based utilizing cognitive behavioral therapies as well as motivational interviewing approaches to treat addiction. START program services support patient re-entry services by linkages and referrals to community SUD treatment providers' post-release. START program participants are offered transportation within the eight Service Planning Areas (SPA) to SUD treatment services, participants' engagement navigation services, housing, and social service sites as needed. Participants who complete the program are celebrated with a certificate of completion.

Currently, most of the START providers/counselors have lived experience and have struggled with drug addiction or have family members who have struggled with addiction. They can provide real-world experiences and relate to the inmates in the program. Many of the inmates in START receive MAT services. Some of the inmates upon release, seek additional counseling training provided to them through the START coordinators under L.A. CADA (a contracted service provider). LASD has found that some of the inmates who are enrolled in or have completed the program are the biggest advocates for the START program by providing information about the program and how it has helped them with their addictions.

START is seeking to further expand the program by adding classes and housing in each facility dedicated to START and MAT. LASD and START have learned that housing inmates who have similar struggles, have common non-addictive goals, and participate in START groups together with MAT services, has helped ensure successful completion of the program. LASD personnel have attended START groups at all facilities, and in doing so, have heard many inmates speak of the encouraging effects of being around others who share their struggle and desire for positive change. Although having this dedicated housing module available at every facility will be a benefit, it should not be the only way in which inmates receive these services. There will always be special circumstances where inmates will not want to be rehoused, but want to participate, such as inmate workers, Education Based Incarceration (EBI) participants, etc. As inmates graduate from START, they move on to make room for new students due to the limited housing space in the jail facilities. Currently, there are 400+ individuals on the waiting list for START services. The primary barrier to expanding services is space for additional providers to hold classes. Funding exists to hire additional START-qualified contracted providers. It is recommended that START be expanded through telehealth to meet the high demand for this service.

d. Create a feasibility and implementation plan for a pilot to develop a peer-support model, similar to the Forensic Inpatient (FIP) Stepdown Program, for people who are incarcerated and have substance use dependencies who can be supported by Merit Masters and community-based providers

LASD is working in collaboration with CHS Mental Health Leadership to implement and provide the Mental Health Assistants (MHAs) with a Peer Support certification, and substance abuse counseling certification and to also include opportunities to earn credits. LASD has been in contact with the Tarzana Treatment Centers College (TTCC) which is currently submitting the Request for Statement of Interest (RSI) to provide services at no cost to the department through the Medi-Cal peer assistant program to the MHAs. Once the TTCC contract application is received, the Inmate Services Bureau (ISB) will review and approve it. In addition, to further support the initiative the Substance Abuse Disorder Counseling certification will continue to be explored. This certification requires an internship, as each participant will need one hour of individual clinical supervision per week in addition to oversight of their work. For this certification to be pursued, CHS would also require additional staff to provide supervision.

e. Develop better coordination between CHS and SAPC to:

- i. Ensure clients are participating in substance use dependency services and programs upon reentry through data collection, assessments, and evaluation**
- ii. Strengthen and streamline processes to allow eligible people who are incarcerated to benefit from Medi-Cal services 90 days prior to their release for substance use dependency services, among others**

In late 2022, CHS and the Department of Public Health's SAPC- Bureau signed a Memorandum of Understanding (MOU) that established a data-sharing agreement between the two organizations, to address the gaps in the continuity of care for those with SUD. According to the terms of the agreement, CHS provides monthly data reports listing all clients released from jail who were given a referral to a SAPC network, SUD treatment provider. In return, SAPC provides an aggregate report of clients who were open to accepting the initial referral and admitted to community SUD services post-release. Services available to the population include access to the full continuum of prevention, harm reduction, treatment, and recovery services.

The scope and timeline for implementation of the State-mandated CalAIM Justice Involved (JI) initiative are still being determined and are dependent on a variety of factors, including the degree of funding made available by the State to onboard the new staff that will be needed. As designed by the State, the CalAIM JI program must include a robust plan for identifying individuals with all forms of SUD and linking them either directly to a provider or to an enhanced care management program that will assist the patient with linkage to medical, behavioral, and addiction medicine services. SAPC and CHS are involved in discussions to ensure that the departments work together on this effort.

f. Provide additional recommendations to:

- i. Reduce illicit substances from entering the facilities**
- ii. Limit accessibility of illicit substances in the facilities**

LASD proposes the following recommendations as a collective effort to help mitigate dangerous, illicit contraband from entering the LA County jail system:

Narcotic Scanning Equipment Needs

- Replace all 17 outdated existing body scanners with higher resolution modern solutions and request additional body scanners to service the medical jail ward at the Los Angeles General Medical Center (LA General MC). The implementation of enhanced body scanners has emerged as an indispensable tool in our ongoing efforts to thwart the smuggling of illicit substances into our jail system. Given its pivotal role, the inclusion of LA General MC is not merely desirable but an absolute imperative, as it has been identified as a conduit for such illicit activities. The estimated cost of this initiative is \$3,205,349.66.

- Add 90 new staff who can be dedicated to body scan positions to ensure appropriate monitoring of the scanning output of both employee and inmate scanners. The estimated cost of this initiative is \$21,487,000.00.
- Implement body scanners and 10 property X-ray machines at all employee security entrances. Property X-ray machines play a pivotal role in LASD's campaign to halt the flow of illicit substances into our jail system. Their utilization represents a less intrusive alternative to manual searches of personal property and offers a robust measure for ensuring the safety and security of our facilities. The estimated cost of this initiative is \$201,647.25.
- Procure mobile mail scanners capable of detecting illegal foreign substances. These devices utilize spectrometry technology which does not damage the mail; whereas physical inspections require opening the mail and possibly sampling a piece for the lab which is time-consuming and damages the correspondence. The department proposes to contract with an outside vendor to photocopy inmate mail before distribution, which will help mitigate contaminated mail from entering our jail facilities. Further exploration of costs with installation is required. The estimated cost of this initiative is \$24,549.00.
- Implement tablet solutions for obtaining email in lieu of actual paper mail to help mitigate mail laced with harmful illicit narcotics from entering our facilities. This technology is also capable of providing complete communication, entertainment, efficiency, and education solutions to a correctional environment. Further exploration of costs is required.
- Increase the searches of property and personal items of everyone entering custody facilities with the assistance of five custody canine investigators and 10 canines. Custody canines are trained in scent detection and are not influenced by factors such as race, gender, ethnicity, or employee status. Canines focus solely on identifying specific odors or substances, making them valuable tools for tasks such as narcotics and contraband detection. The estimated cost of this initiative is \$1,860,000.00.
- Establish a dedicated Search Team assigned to each facility security entrance to search property and personal items of everyone entering the custody facilities and to monitor personnel as they enter/exit. Having a dedicated Search Team will allow for accountability and continuity of searches. It is recommended the Search Teams be staffed with two Deputy Sheriff Generalists, two Custody Assistants, and one Sergeant per shift. The estimated cost of this initiative is \$26,632,000.00.

Surveillance Technology Needs

- The department proposes two options to manage landscaping services to mitigate inmate workers from having outside security access and attempting to smuggle hidden narcotics back into the facility. Access to exterior areas such as public lobbies, visiting, and trash collection are significant points of vulnerability for contraband. Option one is to

hire 26 county landscaping employees, estimated cost of \$3,188,000.00. Option two would be to solicit a contractual proposal.

- Expand closed-circuit television (CCTV) camera capabilities to the exterior of all facilities to address existing blind spots. The expansion of CCTV coverage ensures round-the-clock security throughout our facilities. These additions will effectively eliminate blind spots that have served as entry points for smuggling illicit substances into our jail system. The cameras have demonstrated their effectiveness by providing crucial video evidence in numerous cases involving attempted smuggling. The estimated cost of this initiative is \$153,600. Further exploration for infrastructure costs with installation is required.
- Increase camera capabilities at all facility visiting areas. Cameras have demonstrated their effectiveness by providing crucial video evidence in numerous cases involving the attempted smuggling of narcotics and contraband into the jail facilities.
- Increase Drugloo Ranger staff for contraband watch operations. Additional Drugloo Rangers are imperative to ensure the safe and sanitary handling of contraband watch operations while upholding the dignity of those involved. The estimated cost of this initiative is \$16,753.50.
- Provide additional funding to conduct biannual narcotics training for all custody personnel. With the prevalence of narcotics and their increasing potency and toxicity (e.g. fentanyl), custody personnel should be apprised of current narcotics, smuggling strategies, exposure risks, the detection, intervention, and recovery strategies, and safe handling practices. The estimated cost of this initiative is \$1,526,964.00.

Increase staffing for the Inmate Telephone Monitoring System (ITMS)

- Increase by four to six additional Deputy Sheriff Generalists. The enhanced staffing model is indispensable for bolstering the security of our jail system while facilitating crucial functions such as jail intelligence, assault prevention, and interception of illicit substances. ITMS personnel possess the capability to monitor inmate phone calls during investigations, a practice that has demonstrated exceptional effectiveness in gathering jail intelligence, preventing assaults, and intercepting illicit substances. The estimated cost of this initiative is \$2,166,000.00.

Custody Investigative Services Unit (CISU) Needs

- Increase CISU staffing.
 - CISU investigators perform intelligence gathering, surveillance, and interdiction operations, file cases, and attend the subsequent court hearings. During the year 2023, CISU investigators were assigned 6,791 cases, averaging 242 cases per detective. Increased searches facilitated and/or monitored by CISU and criminal filings for narcotics possession and distribution would assist with limiting the accessibility of illicit substances.

- Increase staffing for the Jail Investigations Unit to 25 Detectives – Bonus I position. The estimated cost of the initiative is \$7,310,000.00.
- Increase staffing for the Organized Crime Task Force to one Lieutenant, two Sergeants, 10 Detectives – Bonus I, and four Deputy Sheriff Generalist positions. The estimated cost of the initiative is \$5,110,000.00.
- Lease office space to accommodate the additional staffing for CISU.
 - The requested office space should be centralized to the jail facilities and have physical security features (i.e. access control) due to the confidential nature and complexity of investigations.

iii. Increase the availability of resources and services to be provided in and out of the facilities

To address the needs of all patients with substance use disorders and patients on the substance use dependency spectrum, CHS will need more medical providers to perform assessments, discuss treatment options, chart patients, and follow up to determine if the treatment is tolerated, effective, or should be adjusted. To support the needs of this time-sensitive work, CHS will submit a Supplemental Budget request in the Fall of 2024, to re-purpose existing funding that will allow CHS to hire the appropriate personnel. To preserve these staff items long-term, CHS is working to re-structure existing staff items to meet the patient population needs and the required medical follow-up.

In addition, as CHS identifies more patients in need of treatment, CHS will eventually require more SUD counselors to assist with assessments, evaluations, and to counsel patients on treatment options, harm reduction, abstinence strategies, therapeutical coping mechanisms, and re-entry services.

To provide optimal care, all patients using substances should have access to the START program. Currently, the START program carries an active caseload of 400-500 patients per month with 130-160 new enrollments each month, START is serving a fraction of the total patient load that might benefit from services. To reach all patients, funding would need to be increased, additional space would have to be identified, and custody presence would have to be increased to allow access to all who are eligible. To overcome the need for physical space, the provision of SUD treatment services can also be facilitated using telehealth.

Telehealth would allow in-custody patients to have timely access to treatment services and re-entry linkage upon discharge. More importantly, it would also overcome barriers that are currently experienced with an individual's security levels and their ability to participate in group therapy sessions.

CHS' recommended implementation plan is for START services to be provided through telehealth, as space continues to be a challenge for START expansion. In the Fall of 2024, CHS will be requesting 26 new staff members which will cost \$3 million, through the Supplemental Budget request. If CHS were to receive approval for the additional funding the implementation timeframe for expansion is six months.

Each Supervisor
March 19, 2024
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The departments are committed to working collaboratively to preserve the well-being and health of its patients. The above describes the inter-departmental efforts that are underway as well as those that could be added to address in-custody overdose-related deaths.

If you have any questions, you may contact me or your staff may contact Dr. Timothy Belavich, Director of Correctional Health Services by email at tbelavich@dhs.lacounty.gov.

CRG: tb

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Los Angeles County Sheriff's Department
Department of Public Health
Office of Inspector General



Reform and Oversight Efforts: Los Angeles County Sheriff's Department

January through March 2024

Issued May 22, 2024

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between January 1 and March 31, 2024, unless otherwise noted. Quarterly reports may also examine particular issues of interest. This report includes special sections on the following topics:

- An update on recommendations on alcohol use in the Sheriff's Department Safety of Firearms Policy.
- Compliance with the requirements of the settlement in *Johnson v. Los Angeles Sheriff's Department* for people in custody with mobility impairments.
- The evaluation of force in two incidents by the Custody Force Review Committee (CFRC).
- The lack of access to emotional support services for in-custody victims of sexual assault over a lack of funding.

This quarterly report also includes two new sections that will be included in future quarterly reports on Sheriff's Department's policies on and use of Tasers (or other conducted electrical weapons) and in-custody overdose deaths in Los Angeles County jails.

During the first quarter of 2024, the Office of Inspector General also issued the following reports relating to the Sheriff's Department:

- [Report Card on Sheriff's Department's Reforms – 2019 to 2023](#)
- [Los Angeles County Sheriff's Department's Legal Compliance: Deputy Gangs](#)
- [Third Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421](#)
- [Report Back on Support for Mental Health Assistants in Furthering the Sustainability and Success of the Forensic In-Patient Stepdown Unit Program](#)
- [Report Back on Inquiry into Investigations of Allegations of Harassment of Families by the Los Angeles County Sheriff's Department](#)
- [Tenth Report Back on Implementing Body-Worn Cameras in Los Angeles County](#)

- [Inspector General's Eighth Implementation Status Report - Johnson v. Los Angeles County Sheriff's Department](#)

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. This quarter, there were eight incidents in which people were shot or shot at by Sheriff's Department personnel. The Office of Inspector General staff responded to each of these deputy-involved shootings. Eight people were struck by deputies' gunfire, six fatally. The information in the following shooting summaries is based on the limited information provided by the Sheriff's Department and is preliminary in nature. While the Office of Inspector General receives information at the walk-through at the scene of the shooting, receives preliminary memoranda with summaries, and attends the Sheriff's Department Critical Incident Reviews, the statements of the deputies and witnesses are not provided until the Sheriff's Department completes its investigation. The Sheriff's Department permits the Office of Inspector General's staff limited access to monitor the ongoing investigations of deputy-involved shootings. The Sheriff's Department also [maintains a page on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.

Century Station: Hit Shooting - Fatal

On January 13, 2024, at approximately 3:15 p.m., a food-truck worker flagged down Century Station deputies on Florence Avenue. The food-truck worker reported that a Hispanic man had pointed a gun at her and demanded money, causing her to seek shelter inside the cabin of the truck. She described the suspect, who she said fled westbound on Florence Avenue. A short time later and a few blocks from the call location, deputies located and contacted a man matching the description. The suspect brandished a handgun, and one of the deputies fired six rounds at him. Both deputies provided medical aid until Los Angeles County Fire Department paramedics arrived and transported the 37-year-old man to the hospital, where he was pronounced dead. The Department recovered a semi-automatic handgun and a box containing a large amount of cash at the scene, and later determined that the handgun and cash were taken by the man during a robbery which occurred approximately two hours earlier.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website, which includes body-worn camera video of the shooting.

Areas for Further Inquiry:

Did the deputies provide information to other units on the radio or request back-up? Did the deputies use appropriate tactics while contacting the man?

Norwalk Station: Hit Shooting – Non-Fatal

On January 27, 2024, at approximately 5:40 p.m., Norwalk Station deputies responded to a call of a robbery in progress at a business on Rosecrans Avenue in the city of Norwalk. Surveillance video from the business released by the Sheriff's Department shows the suspect armed with a shotgun placing a duffel bag on the store's counter and demanding money and merchandise. Responding deputies located the suspect, a 38-year-old White man, standing between several parked cars in the rear parking lot of the business. The man refused to comply with the deputies' commands to surrender. The deputies devised a tactical plan to approach the suspect. As they approached, the man raised the shotgun above his head, prompting four deputies to fire 40 rounds at the man, striking him one time in the left hand. The suspect continued to be uncooperative. Deputies took him into custody using control holds and a taser. They transported the suspect to the hospital, where he received medical treatment for his injury. Deputies recovered a loaded shotgun from the scene next to the suspect. Two additional AR-15 rifles were recovered from the black duffel bag seen with the suspect in the surveillance video.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website, which includes body-worn camera and surveillance video of the shooting.

Areas for Further Inquiry:

Was the shooting backdrop problematic due to people being in the parking lot? Could deputies have de-escalated the situation? Was the Special Enforcement Bureau requested to assist or was there an armored vehicle available? Were the number of rounds fired reasonable under the circumstances? Was there contagious fire? Was the deputies' tactical plan sound?

Lancaster Station: Hit-Shooting - Fatal

On February 6, 2024, approximately 3:45 a.m., Lancaster Station deputies received a call regarding an assault with a deadly weapon at a gas station in the city of Lancaster. They spoke to the gas station employee, who told them that a White man had attacked her with a machete and fled before the deputies arrived. The deputies obtained a description and alerted all Lancaster deputies to look out for the suspect.

Several hours later, deputies received a call from an employee at a large grocery store located on 20th Street West, who reported a White man with a machete in their store.

When deputies arrived, they noted that the suspect matched the description of the suspect in the gas station assault. The suspect stood outside of the automatic entry doors of the grocery store with two machetes. Deputies ordered the suspect to put the machetes down, which he refused to do. Deputies continued to communicate with the man, asking his name and what was going on, and telling him they could resolve the situation if he put his knives down. After several minutes, the man walked back into the store with the deputies following him and using less-lethal weapons — a .40mm baton launcher and Tasers — which proved ineffective. After several attempts with a Taser, the suspect said the deputies were “pissing [him] off” and moved to charge toward them. Three deputies fired a total of 21 rounds, hitting the suspect. Deputies rendered medical aid while waiting for Los Angeles County Fire paramedics to respond. The suspect, a 38-year-old White man, was transported to the hospital where he was pronounced dead. Two machetes, approximately 24 inches in length, were recovered from the scene.

The Sheriff’s Department posted a [Critical Incident Briefing](#) on the LASD website which includes body-worn camera video of the shooting.

Areas for Further Inquiry:

Was there a way to close the grocery store’s door remotely to prevent the suspect from going back into the store? Was the backdrop of the shooting problematic? Were there any issues with deputies being in the line of fire?

Palmdale Station: Hit-Shooting - Fatal

On February 23, 2024, at approximately 6:32 a.m., Palmdale Station deputies responded to a call for service at a gas station market on Pearblossom Highway in unincorporated area of Pearblossom. The clerk reported that a male suspect holding a sharp object told her to call 911 and threatened to stab her in the neck unless she did so.

After arriving, the deputies saw a man holding a sharp object walking eastbound away from the market. Deputies ordered the man to drop the object and show them his hands, but he did not comply. The deputies slowly followed the suspect in their patrol vehicle as he continued to walk eastbound, eventually stopping at another gas station. Deputies tried to communicate with the man and repeatedly ordered him to drop what was in his hand. The man ignored the deputies' commands and told them they would have to shoot him. Another deputy arrived on scene and also tried to communicate with the man. The man then began to walk slowly towards the deputies with his hand in his jacket pocket. One deputy repeatedly warned the man to stop walking towards him, then fired two rounds at the man. The deputy fired an additional two rounds as the man turned and fled on foot, eventually collapsing near a door to the gas station. The

deputies followed and provided medical aid until Los Angeles County Fire paramedics arrived. The 30-year-old White man was transported to a local hospital where he was pronounced dead. Investigators recovered a hook tool with a sharpened tip from where the man collapsed.

The Sheriff's Department posted a [Critical Incident Briefing](#) that includes video from surveillance cameras and body-worn cameras.

Areas of Further Inquiry:

Why didn't the responding deputies have less lethal weapons options available? Were the tactics used while contacting this subject consistent with Sheriff's Department training and best practices? Did simultaneous communications from two deputies follow Department training? Did the backdrop of the shooting pose concerns? Did the shooting deputy properly reassess the situation before firing the final two shots? Was there any indication that the man had mental health issues? If MET was called, what was their estimated time of arrival?

East Los Angeles Station: Hit-Shooting - Fatal

On March 16, 2024, at approximately 9:20 p.m., East Los Angeles Station deputies responded to a call for service at a neighborhood convenience store in the unincorporated area of East Los Angeles. The caller first stated that a person holding a metal stick was harassing customers in front of the store then updated that this person had drawn a handgun. Multiple deputies responded and, upon arriving, observed the suspect, a 28-year-old Hispanic man, standing on the sidewalk in front of the store. The suspect pointed the handgun at deputies as they drove up. Within seconds of arriving, five of the six deputies on scene fired more than 50 rounds, striking the man multiple times. Deputies provided first aid until Los Angeles County Fire paramedics arrived. The suspect died at the scene. Investigators recovered a replica firearm at the scene.

Because the reported handgun turned out to be a replica weapon, the Department turned the criminal investigation over to the California Department of Justice Police Shooting Investigation Team as a shooting of an unarmed civilian under [Government Code section 12525.3](#).

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from body-worn cameras and surveillance cameras from a nearby business.

Areas of Further Inquiry:

Did the deputies formulate a tactical plan before making contact? Did the deputies activate their body-worn cameras consistent with Sheriff's Department policy? Did contagious fire contribute to the number of rounds fired by the deputies?

Lakewood Station: Hit-Shooting - Fatal

On March 19, 2024, at about 9:18 p.m., Lakewood Station deputies responded to a residence on Indiana Avenue, in the city of Paramount, for a call regarding a restraining order violation. They contacted the victim, who stated that her ex-boyfriend had violated a protective order by showing up at her residence and demanding she let him inside. Deputies observed the subject, a 40-year-old Hispanic man, driving near the victim's residence in an orange Pontiac. Deputies followed him until he stopped in a traffic lane on Artesia Boulevard in Long Beach. As deputies positioned their vehicles behind the man in preparation for a traffic stop, he suddenly put his vehicle in reverse and accelerated backwards, crashing into the front of one of the patrol vehicles so violently that both vehicles became inoperable. Deputies immediately exited their patrol vehicles and observed the man exit the driver's door of his vehicle with a knife in his right hand. He fell down and immediately stood up, ignoring the deputies' orders to drop the knife and charged them, at which time one deputy fired five rounds and a second deputy fired eight rounds at the suspect. Deputies rendered aid until Los Angeles County Fire paramedics arrived. The man died at the scene. Investigators recovered a folding knife with an approximately three-inch blade at the scene. One deputy was treated at a local hospital for non-life-threatening injuries sustained during the collision.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from body-worn cameras and surveillance cameras from a nearby business.

Areas of Further Inquiry:

Did the deputies activate their body-worn cameras in compliance with Sheriff's Department policy? Did deputies coordinate to form a tactical plan before attempting the stop?

Century Station: Hit-Shooting – Non Fatal

On March 29, 2024, at approximately 6:15 p.m., Century Station deputies patrolling an unincorporated area of Los Angeles checked the license plate of a white Ford cargo van and discovered information that the vehicle was reported stolen, and the same vehicle was used in an assault with a firearm, thus flagging the driver as potentially armed and dangerous. When deputies activated their emergency lights, the driver of the van fired a gun out of the window at the deputies on a busy road. The deputies pursued the vehicle a short distance as the suspect driver tried to evade them by turning on various streets until he crashed into a center railroad median. As the suspect exited the car, he again shot at the deputies, who had come to a stop a few yards away. One deputy fired approximately eighteen rounds, and another deputy fired approximately five rounds at the suspect as he fled into nearby industrial buildings. Deputies established a building containment. Special Enforcement Bureau (SEB) responded to the scene and took over

the operations, evacuating all civilians from the building and unsuccessfully attempting different tactical operations to get the suspect to surrender. Finally, SEB deployed a dog, which assisted in capturing the suspect by biting him in the face. The suspect was taken to the hospital to be treated for his wounds from the dog bite.

Neither gunfire from the suspect nor that from the deputies struck any person.

Areas for Further Inquiry:

Did deputies attempt any coordination with other deputies or request Aero Bureau before attempting to initiate the stop? Did deputies request Aero Bureau support immediately? Did both deputies properly reassess as they fired?

East Los Angeles Station: Hit-Shooting – Fatal

On March 30, 2024, at about 11:30 p.m., East Los Angeles Station deputies responded to North Herbert Avenue, in unincorporated Los Angeles, regarding a call of a woman screaming for help and being followed by a van. Upon arrival, deputies contacted a Hispanic woman who told them her boyfriend had just assaulted her. While deputies spoke to her, they spotted the van belonging to her boyfriend, a 44-year-old White man, driving past. Deputies followed the van in their patrol vehicle until they reached a cul-de-sac at the end of a steep narrow road. Deputies exited their patrol vehicle and, with guns drawn, ordered the man to stop his vehicle. The subject turned his van so that it faced the deputies and attempted to drive around the driver's side of the patrol vehicle, where the deputy who had been driving stood in the street. As the subject drove toward the deputy, both deputies fired their weapons — one fired eleven rounds and the other fired four rounds. The subject sustained gunshot wounds to the upper torso. Deputies rendered first aid until Los Angeles County Fire Department paramedics arrived and transported the man to a local hospital, where he was pronounced dead. One deputy was transported to a local hospital where he was treated for non-life-threatening injuries sustained during the incident.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from body-worn cameras and surveillance cameras from a nearby business.

Areas for Further Inquiry:

Did the deputies comply with the Sheriff's Department's policy on shooting at moving vehicles? Was there possibly a crossfire situation?

Civilian Self-Inflicted Fatal Shooting with a Deputy's Firearm at Industry Station

On March 24, 2024, at approximately 7:25 p.m., two deputies from Industry Station responded to a residence for a call for service regarding a family disturbance. The reporting party indicated that their 17-year-old female foster daughter was suffering from a mental breakdown and had already left the location. At about the same time, the girl went to Industry Station and knocked numerous times on the unlocked entrance door to the station lobby. The watch deputy came out to the lobby and opened the entrance door. The girl immediately lunged into the lobby and quickly grabbed the deputy's firearm from the holster. The deputy applied two head-strikes as the subject turned away, raised the firearm to her head, and fired one round. The girl fell to the ground, where the watch deputy and others were able to disarm her and render first aid until Los Angeles County Fire Department paramedics arrived. The girl died at the scene.

Areas for Further Inquiry:

Were deputies aware that the girl was suicidal and or going to the Sheriff's Station? Was the holster worn by the watch deputy Department approved? Were deputies wearing body-worn cameras at the time of the incident, and if so, were they activated?

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.¹ For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and which occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

¹ In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. See [A.B. 1506 \(McCarty 2020\)](#) (codified at [Govt. Code § 12525.3](#)). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*. Until the law took effect in 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet.

Between January 1 and March 31, 2024, the District Attorney's Office did not issue findings on any deputy-involved shooting cases involving the Sheriff's Department's employees.²

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has fourteen shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a December 21, 2022, shooting in the jurisdiction of Lancaster Station. For further information as to that shooting, please refer to the Office of Inspector General's report [Reform and Oversight Effort: Los Angeles Sheriff's Department, October to December 2023](#). The oldest case that the Bureau has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent one deputy-involved shooting case to the District Attorney's Office for filing consideration.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.³ The DOJ [is currently investigating](#) three shootings involving deputies from the Sheriff's Department, the oldest of which occurred in January 2023. During the last quarter, the DOJ [issued no written reports](#) regarding shootings involving Sheriff's Department deputies.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB

² The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#). The Office of Inspector General retrieves the information on District Attorney decisions from this webpage.

³ Gov't Code § 12525.3(b).

investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.⁴

The Sheriff's Department reports that ICIB has 75 active cases. This quarter, the ICIB reports sending six cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 32 cases from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

This quarter, the Sheriff's Department reported opening 134 new administrative investigations. Of these 134 cases, 44 were assigned to IAB, 73 were designated as unit-level investigations, and 17 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 141 cases were closed by IAB or at the unit level. There are 535 pending administrative investigations, of which 329 are assigned to IAB and the remaining 206 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between January 1 and March 31, 2024, the Civil Service Commission issued final decisions in

⁴ Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

five cases involving Sheriff's Department employees.⁵ In all five, the Commission sustained the Department's discipline.

All of these cases concerned sworn peace officers of the rank of deputy or higher. Three cases sustained Sheriff's Department decisions to discharge a sworn employee, while two sustained suspensions, of 15-days and 25-days.

Employee Position	Date of Department action	Case number	Department actions	Date of Civil Service Hearing	Civil Service decision
Deputy Sheriff	10-22-20	20-159	Discharge	1-31-24	Sustain the Department
Sergeant	4-5-20	20-58	25-day Suspension	1-31-24	Sustain the Department
Deputy Sheriff	10-21-22	21-235	Discharge	2-14-24	Sustain the Department
Deputy Sheriff	10-18-21	21-234	Discharge	2-28-24	Sustain the Department
Deputy Sheriff	4-4-22	22-85	15-day Suspension	3-6-24	Sustain the Department

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) twelve times between January 1 and March 31, 2024, as summarized in the chart below.

⁵ The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings posted on the County's website](#) for commission publications.

DATE	OPERATION TYPE	LOCATION	SUMMARY
1/1/2024	Search and Rescue	Gorman	SEB personnel assisting Santa Clarita SAR with a missing hiker. UAS utilized to locate hiker successfully.
1/11/2024	Barricaded Suspect	Los Angeles	SEB responded to location regarding a barricaded suspect. UAS used to view interior of location. Suspect surrendered.
1/13/2024	High Risk Tactical Operations	Compton	SEB personnel served a high-risk search warrant for murder. UAS used to search attic space for suspect.
1/24/2024	High Risk Tactical Operations	Metrolink Anaheim Station	UAS used to observe train rail tracks bordered by freeway. High risk area off limits to pedestrian danger.
1/27/2024	Search and Rescue	Angeles Forest Highway at Mile Marker 2	SEB personnel assisted Montrose Search and Rescue with a missing hiker. Hiker not located.
2/1/2024	Barricaded Suspect	Canyon Country	UAS used to assist SEB by locating suspect inside location and monitoring while arrest team took suspect into custody.
2/15/2024	High Risk Warrant Service	Little Rock	SEB personnel serving arrest warrant for murder suspect. UAS used to search interior / attic for suspect.
3/8/2024	High Risk Tactical Operations	Metrolink C Line Tracks, Hawthorne	UAS used to observe train rail tracks bordered by freeway in high-risk area off limits to pedestrian traffic.
3/10/2024	Search and Rescue	Angeles Forest Highway, Camp Bonita Rd, La Verne	SEB personnel assisted San Dimas Search and Rescue with a missing hiker. Hiker not located.
3/13/2024	Search and Rescue	Angeles Forest Highway, Camp Bonita Rd, La Verne	SEB personnel assisted San Dimas Search and Rescue with a missing hiker. Hiker not located.
3/14/2024	High Risk Search Warrant	Pearblossom	UAS used to assist entry team for a high-risk search warrant by observing entry and searching the large property for armed suspect. Suspect located and detained.
3/16/2024	Search and Rescue	Angeles Forest Highway, Camp Bonita Rd, La Verne	SEB personnel assisted San Dimas Search and Rescue with a missing hiker. Hiker not located.

Update on Recommendations on Alcohol Use in the Sheriff's Department Safety of Firearms Policy

In 2019, the Office of Inspector General published a report, [Los Angeles County Sheriff's Department Safety of Firearms Policy](#), analyzing the Sheriff's Department's policies and specific instances of off-duty Sheriff's deputies carrying and using their firearms while under the influence of alcohol. In 2023, we revisited the issue in a section of [Reform and Oversight Efforts: Los Angeles County Sheriff's Department July through September 2023](#), which reviewed similar firearms policies from other law enforcement agencies, identified problematic instances of deputies under the influence of alcohol while carrying firearms, and made recommendations to the Sheriff's Department to improve its off-duty firearms safety policies.

Following these reports, on January 23, 2024, the Board of Supervisors [passed a motion](#) directing the Sheriff's Department to review and revise its policies to address several of the concerns in the reports, and also directing County Counsel and the Office of Inspector General, in collaboration with the Sheriff's Department, to provide policies clearly restricting the use of or being under any influence of alcohol when on duty.

Current Sheriff's Department policy restricts the ingestion of any alcohol while on duty, and a deputy may not be on duty with a blood alcohol concentration (BAC) of .02 percent or higher:

A Department member shall not drink or be under the influence of any kind of alcoholic beverage when on duty and/or in Department uniform. No member shall report for duty or be on duty while under the influence of alcohol, or be unfit for duty because of its use. Members will be considered under the influence of alcohol if they have a blood alcohol content of .02 or higher in their system.

[Manual of Policy and Procedures \(MPP\) § 3-01/030.40.](#)

Current Sheriff's Department policy sets the same blood alcohol limit for driving a County vehicle. Whether on duty or off duty, Department members shall not operate a County vehicle while under the influence of alcohol and will be considered "under the influence" with a BAC of .02 or more. [MPP § 3-01/090.10.](#)

Pursuant to Sheriff's Department policies, a deputy may have a BAC of slightly less than .02 while on duty and still carry a firearm and drive a County vehicle. However, the National Highway Traffic Safety Administration notes that [a .02 BAC can result in a decline in a driver's visual functions and the ability to perform two tasks at the same time.](#) These impairments could also affect deputies' ability to perform law enforcement duties, including when discharging their firearms.

Office of Inspector General Recommendations

Because of the potential for impairment at even low BAC levels and the extraordinary power deputies have to use deadly force, including firearms, the Office of Inspector General recommends a zero-tolerance policy for the consumption of alcohol or the presence of alcohol in the system when on duty.

The following recommended policy provisions target reducing the risk of adverse outcomes from incidents involving alcohol and firearms while deputies are on duty:

- A Department member shall not drink any alcohol when on duty. This includes during lunch periods or breaks.
- No Department member who carries a firearm in the scope of their duties (deputies or security Officers) shall report for duty with any amount of alcohol in their system.

- Department members shall not possess any alcohol when on duty and shall not bring any alcohol into any County facility or vehicle, except as required in the performance of their official duties. This includes during lunch periods or breaks.
- If a Department member discharges their firearm on duty, the member shall immediately, or as soon thereafter as possible, submit to a preliminary alcohol screening (PAS). If the PAS detects the presence of alcohol, the Department member must submit to a full toxicology screening.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracing and Documenting Taser Use

On October 3, 2023, the Board of Supervisors directed the Sheriff's Department to revise its Taser use policies to incorporate best practices from other law enforcement agencies, ensure compliance with State and Federal legal standards, and consider recommendations by other law enforcement and advocacy groups.⁶

The Board of Supervisors also directed the Office of Inspector General to include in its Quarterly Reports to the Board an "[u]pdate on the status of the LASD's adoption of an updated Taser policy, the status of training personnel on the updated Taser policy, and deputy compliance with updated policies, once adopted, consistent with LASD trainings until full compliance;" and "[d]ocumentation and tracking on the Department's Taser use, including those that result in serious injury or death, in patrol and custody."

Updated Taser Policy

In a letter to the Board on January 30, 2024, the Sheriff's Department reported that it had circulated a draft of an updated policy on conducted energy weapons (commonly referred to as Tasers) and obtained feedback from the Civilian Oversight Commission (COC), the Office of Inspector General, the United States Department of Justice, the monitors for the Antelope Valley consent decree, and internal experts within the Sheriff's Department. The Department also reported that it remained engaged in a meet-and-confer process with labor representatives regarding the proposed policy.⁷

The Office of Inspector General has not reviewed any version of the proposed policy since the one the Department provided in July 2023, prior to negotiations with deputy

⁶ [Transparency, Accountability, and Oversight of Los Angeles Sheriff's Department's Taser Use Policy](#), Agn. No. 15, October 3, 2023.

⁷ [Undersheriff April Tardy, Los Angeles County Sheriff's Department Response to the Board Motion on the Conducted Energy Weapon \(CEW\) Policies and Use](#), dated January 30, 2024.

associations. The Sheriff's Department does not permit the Office of Inspector General to monitor union negotiations. However, in our review of that pre-bargaining draft, the Office of Inspector General identified concerns in line with those stated by the Board of Supervisors and COC, on issues including the clarity of its standards for authorized Taser use, the potential for use against passive resistance, the policy provisions limiting multiple applications of Tasers, and the extent to which the policy adequately conveyed the potential risks of Taser use. When the Department completes the process with labor associations and provides a final, updated policy, the Office of Inspector General will provide a full review of the substance of the revisions, as well as provisions for training on and compliance with that policy once it is fully implemented.

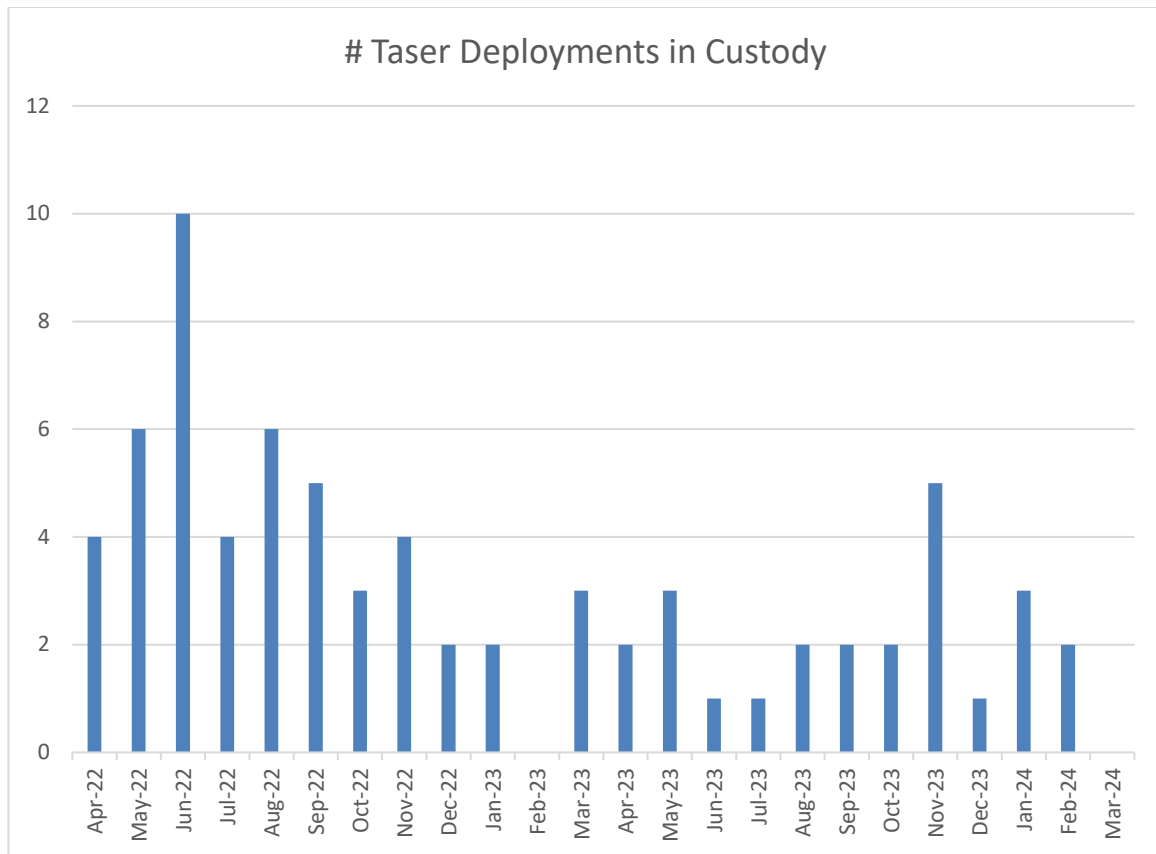
Documenting and Tracking Taser Use

On March 29, 2024, the Office of Inspector General requested information on Taser usage in order to comply with the Board's directive. The Sheriff's Department provided no data for Taser use in patrol during the first quarter of 2024, as it did not previously collect this data in a comprehensive manner and reported needing to upgrade its system of Taser data collection and tracking to capture the requested information about Taser usage. In May 2024, the Department launched [a web dashboard reporting Taser usage](#) after April 1, 2024, by patrol station or facility, date, and subject description.⁸ The Department reports that this system is currently in a testing phase and that data on the "Result of the Use of Force" category (i.e. serious injury or death) will not be available until July. The Sheriff's Department anticipates publishing all the requested data points on its website by August 2024.

Taser Use in Custody

The following chart reflects the number of use-of-force incidents in custodial settings over the past two years in which deputies employed a Taser, according to the *Monthly Force Synopsis* that the Sheriff's Department produces and provides to the Office of Inspector General each month:

⁸ The Sheriff's Department's Taser Deployment Dashboard is posted at <http://lasd.org/taser-reports>.



CUSTODY DIVISION

Compliance with the Settlement Requirements in *Johnson v. Los Angeles Sheriff's Department* for People in Custody with Mobility Impairments

The Office of Inspector General serves as the court-appointed monitor for the *Johnson v. Los Angeles County Sheriff's Department* class-action lawsuit, in which a class of people with mobility impairments in Los Angeles County Jails alleged that the Sheriff's Department denied them accommodations or provided inadequate accommodations, inappropriately segregated them, excluded them from jail programs and services, and subjected them to multiple and pervasive physical access barriers throughout the facilities.⁹ The Sheriff's Department entered into a settlement agreement ("agreement") to resolve the lawsuit and agreed to implement systemwide reform of the conditions of confinement for people with mobility impairments. The agreement has been in effect since 2015, and the Sheriff's Department has achieved compliance with a

⁹ *Johnson v. Los Angeles County Sheriff's Department*, Case No. CV 08-03515 DDP (C.D. Cal. Filed May 29, 2008).

majority of its provisions. The Office of Inspector General filed its [*Eighth Implementation Status Report*](#) on April 1, 2024, and reported that of the ten provisions that remain in effect, the Sheriff's Department has achieved substantial or sustained compliance with four, and partial compliance with six.

Although the Sheriff's Department has implemented many of the terms of the agreement over the nine years it has been in effect, the Office of Inspector General's report identified areas of noncompliance that make it unlikely that the Department will achieve compliance on the remaining provisions without additional extensions of its settlement term.¹⁰

First, the Sheriff's Department's recently expanded the areas where it houses class members with mobility impairments in Men's Central Jail and Twin Towers Correctional Facility into new areas, where it has failed to provide necessary accommodations. These housing areas lack access features such as grab bars and benches in the showers, making it difficult for mobility impaired class members to steady themselves while showering. The Department also failed to provide some class members in these areas with necessary accommodations such as bottom bunk assignments for people who have difficulties with getting up and down from the top bunk or providing egg crate mattress toppers, which Sheriff's Department leadership agreed to distribute to all class members. The Office of Inspector General recommended that the Sheriff's Department, in collaboration with Correctional Health Services ("CHS"), conduct a comprehensive assessment of its class member population to ensure that it houses all class members in appropriate areas of the jails and provides appropriate accommodations in accordance with the terms of the agreement.¹¹

In response to a draft of this report, the Sheriff's Department states that it is currently working on a solution to the housing and accessibility concerns regarding mobility impaired inmates. The Department provided the Office of Inspector General with no further details about these plans.

Second, nearly nine years into the implementation of the agreement, the Sheriff's Department has made little to no progress towards compliance with two provisions on the processing of ADA-related grievances. The Office of Inspector General has

¹⁰ The settlement agreement, which took effect on April 22, 2015, was originally set to expire on April 22, 2018. The parties have stipulated to, and the court approved, several extensions of settlement term, most recently extending the settlement term by two years to May 30, 2025.

¹¹ CHS is responsible for providing medical and mental health services to all people incarcerated in the Los Angeles County jails, including class members with mobility impairments, and for coordinating, as necessary, with the Sheriff's Department in providing required accommodations.

consistently noted that the Department must improve collaboration and coordination with CHS to achieve compliance with these provisions, since the Department bears responsibility for resolving ADA-related custody grievances and CHS remains responsible for resolving ADA-related medical grievances. Despite this ongoing recommendation, the Sheriff's Department decommissioned the previous grievance system, which CHS relied on, and instituted a new grievance system in July 2023 without sufficiently consulting with CHS. As a result, CHS does not currently use the new grievance system due to ongoing technical issues and instead manually processes and tracks physical forms for ADA-related medical grievances. The Department and CHS reports that they are working on resolving the technical issues.

The new grievance system also erodes earlier progress on a provision of the agreement that requires that grievances involving mobility assistive devices and the physical accessibility of the jail must be designated ADA grievances, even if the inmate who filed the grievance did not check the 'ADA' box. The new grievance system requires personnel to designate each grievance into only one category and certain categories, such as a grievance against staff, must be prioritized. For example, if a class member submits an ADA-related complaint regarding a mobility assistive device that involves a grievance against staff, it must be designated as a grievance against staff and not as *ADA*. This directly conflicts with the requirements set forth in provision G.2. The Sheriff's Department also did not consult the Office of Inspector General during the development of the new grievance system, which might have allowed this office, as the monitor, to identify the conflict so the Department could address it during development. However, the Department reports that, since publication of the status report, it has made changes to the grievance system to resolve this issue, which it plans to present to the Office of Inspector General in July.

The Department reports that it has met regularly with CHS to discuss issues with technology and system use training and is working with CHS to resolve technical issues with the new grievance application. The Department reports that, in collaboration with CHS, it has created a new component in the system to assist with incorporating Department forms into CHS records.

The Department also reports that it has modified the new grievance system to assist in properly tracking ADA grievances by incorporating a feature to allow the Department to identify ADA language in a grievance against staff so that the staff complaint and ADA component can be separated and handled appropriately. The Department has scheduled a demonstration of the new feature for the Office of Inspector General for July 2024.

Evaluation of Force in Two Incidents before the Custody Force Review Committee

Two recent cases involving head strikes on restrained inmates raise concerns about the evaluation of use of force incidents in the jails by the Sheriff's Department's Custody Force Review Committee (CFRC). CFRC consists of three custody commanders who evaluate use-of-force incidents, the quality of force investigations, and the effectiveness of unit supervision during and after a use-of-force.¹² If the CFRC determines that a use-of-force incident may have violated department policy, it refers the matter for an administrative investigation.¹³ Incidents presented at the CFRC are first analyzed by the Custody Force Review Team (CFRT), a team of sergeants who respond to [delineated uses of force](#) with the goal of aiding in high-quality custody force investigations through incident oversight, investigation, and evaluation. The CFRT responds to incidents involving major inmate disturbances, significant inmate injury resulting from employee contact, carotid restraints,¹⁴ strikes on a restrained inmate, Taser hits, force used on a pregnant person, and any Category 3 use-of-force.¹⁵

The Office of Inspector General attends CFRC meetings to monitor the Department's review of uses-of-force in custody. [Custody Operations Directive 22-002](#), entitled "Limitations on Force," states that a deputy may strike a restrained inmate with personal weapons (anywhere on the body) when (1) an inmate is assaultive, (2) presents an immediate threat of injury to personnel or others, and (3) there are no other more reasonable means to control the inmate. In both cases, the CFRT identified other

¹² See Los Angeles County Sheriff Department, [Custody Division Manual, § 7-07/020.00, Custody Force Review Committee](#).

¹³ [Custody Division Manual, section 7-07/020.00 Custody Force Review Committee](#).

¹⁴ Effective January 1, 2021, California law prohibits law enforcement agencies from authorizing use of carotid restraints by peace officers. [Govt' Code § 7286.5](#) (enacted by [Assem. Bill No. 1196](#) (2019-2020 Reg. Sess.) § 1).

¹⁵ Category 3 force includes the following: all shootings in which a shot was intentionally fired at a person by a Department member; any type of shooting by a Department member which results in a person being hit; force resulting in admittance to a hospital; any death following a use of force by any Department member; all intentional head or neck strikes with impact weapons; kicks or knee strikes intentionally delivered to a person's head or neck; intentional striking a person's head against a hard, fixed object; skeletal fractures caused by any Department member, with the exception of minor fractures of the nose, fingers or toes; any use of Improvised Weapons and/or Techniques; all canine bites; or any force which results in a response from the IAB Force/Shooting Response Team, as defined in MPP section [3-10/130.00](#). [MPP § 3-10/038.00, Reportable Use of Force and Force Categories](#).

reasonable means to control the inmate, yet the CFRC found that punching the inmate's head was reasonable and within policy.¹⁶

Case 1: A man in custody at the Los Angeles General Medical Center became irate after waiting for an extended time for pain medication. Deputies attempted to de-escalate the situation by allowing the man to change seating positions and asking medical staff for pain medication for the man. The man became increasingly agitated, and after waiting for more than two hours, he stood up, attempted to take a fighting stance, and said, "F*** this, I had enough." The man's hands were handcuffed behind his back. Two deputies moved forward, and each took control of one of the man's arms. The man struggled with the deputies, then turned and spat in the face of the deputy holding his right arm. The deputies pushed the man face-down on a hospital gurney as he continued to struggle. As the man was face-down on the gurney, he turned his head towards the deputy on his left and made a gargling noise in preparation to spit. Fearing that the man was about to spit on him, the deputy punched the man in the face one time. Two additional deputies approached to control the man's legs, and the deputies eventually subdued him.

The CFRT reviewed this case and observed that although there were attempts to de-escalate the situation, the involved personnel should have requested a supervisor pursuant to the [Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmate policy](#) (CDM 7-02/020.00).¹⁷ The CFRT commented that once the man was face down on the gurney, the deputy had other options, including positioning himself out of the suspect's line of sight to prevent being spat upon. The CFRT also noted that the deputy's report failed to explain why he had no other, more reasonable means to avoid serious physical injury besides punching the man in the face. Nonetheless, CFRC found that the deputy acted reasonably and within policy.

The CFRC's finding that the deputy acted reasonably and within policy in punching the man's face showed two significant problems. First, the panels' reasoning that the deputy had no other more reasonable means to control the inmate is at odds with the Department's own subject matter experts on the CFRT, who observed that the deputy had other options available. Moreover, the CFRC reached its conclusion even though the deputy's failure to explain why he felt there were no other more reasonable means to avoid injury left little factual support for such a finding. CFRC failed to specify its

¹⁶ See also [Custody Division Manual, § 7-03/020.00 Use of Force Against Restrained Inmates](#).

¹⁷ The two deputies initially involved in this incident were from North Facility, but the incident occurred in the Los Angeles Medical Center waiting room. So, the initial deputies were on the wrong radio frequency to call for a supervisor.

reasoning in this regard, a critical failing of Sheriff's Department decision-making at many levels in use of force and discipline analysis.

Second, the CFRC panel emphasized, during its deliberation on whether the force violated policy, that the deputy had no history or previous discipline regarding uses-of-force. The propriety of a deputy's use of force depends only on the facts of the incident and the deputy's conduct at that time. The deputy's prior use of force or disciplinary history may be relevant to the ultimate discipline or other corrective actions for any policy violations, but the CFRC must consider the policy violation separate from the issue of discipline. Only after a policy violation is founded should disciplinary history be considered.

Case 2: Deputies from the Twin Towers Correctional Facility were escorting people to transportation to court. A man began to mumble incoherently, made a gargling noise, then spat in the face of a deputy. The man then made another gargling noise as if preparing to spit on the deputy again. In response, the deputy punched the man in the face one time. Deputies restrained the man and placed him in a hobble with a spit mask over his face. The man made spontaneous statements, saying, "I'm sorry, I'm sorry. [The deputy] killed my mom!" The man was handcuffed during this entire incident. In his report, the deputy stated that he punched the man because he had no other reasonable means to prevent the man from spitting on him again.

The CFRT reviewed this case and noted that while the deputy stated that he had no other reasonable means, he did not articulate why he had no reasonable means other than a head strike to control the man and avoid serious physical injury. The CFRT noted that it was unclear how the reviewing Lieutenant determined the application of force was within Sheriff's Department Policy when the sergeant authoring the Supervisor's Report on Use of Force for this incident stated that "[t]he force [the deputy] used appeared to violate CDM 7-03/020.00, Use of Force Against a Restrained Inmate.

The Supervisor's Report on Use of Force also states that "it appeared that [the deputy] had other reasonable means to control the suspect such as utilizing a control technique on the suspect's head to re-direct the threat away from his person." This report opines that the sudden attack on the deputy appears to have triggered a stress response; the deputy could not think through all his options to determine the optimal choice, and he reacted automatically to the perceived threat with personal weapons. Whether or not this is true, it would not provide a valid reason under Department policy for the deputy to strike a restrained person in the face.

In this case, the CFRC also determined that the deputy had no other more reasonable means of controlling the inmate than punching him in the face. This conclusion again contradicted the opinions of their own subject matter experts—the CFRT and the line

sergeant who authored the Supervisor's Report on Use of Force report. The panel ignored the deputy's failure to explain why he felt there were no other more reasonable means to avoid injury, and reached their finding that there was no policy violation with little factual basis.

Spitting is an assault which can trigger a strong emotional response. But it is precisely in these situations that the law and Sheriff's Department policy requires that deputies respond professionally and based on real risks and available options. The Department must evaluate policy violations in these incidents based on the facts and an even-handed application of roles, in order to ensure deputies adhere to use-of-force policies. Here, the CFRC found both head strikes within policy despite evidence of alternative options advanced by their own subject matter experts on the CFRT. Only by making and documenting evidence-based decisions can the Sheriff's Department rationally and effectively address the challenges facing deputies in a manner that ensures lawful behavior.

Lack of Access to Emotional Support Services for In-Custody Victims of Sexual Abuse

The Federal Prison Rape Elimination Act (PREA), Standard 115.53, requires that custody facilities provide "access to outside victim advocates for emotional support services related to sexual abuse by giving inmates ... telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations." [28 C.F.R. § 115.53](#). In 2016, the Sheriff's Department, in collaboration with one such organization, Peace Over Violence (POV), started a 24-hour, confidential hotline for people in custody in CRDF, MCJ, and TTCF. With POV's hotline, people in custody could dial a posted shortcut number from any jail telephone to speak with trained advocates on an unrecorded and unmonitored line.¹⁸ In addition to operating the hotline, POV staff accompanied victims to the hospital for forensic medical exams following an allegation of sexual abuse in the jails, in compliance with the requirements of PREA Standard 115.21. [28 C.F.R. § 115.21](#). POV also provided victims of sexual abuse with classes in healing arts, emergency response, and building relationships.

As of December 31, 2022, POV ceased providing services to victims of sexual abuse in Sheriff's Department custody due to a lack of funding. POV's grant funding came from the California Office of Emergency Services (Cal OES) through the Victim Advocacy in

¹⁸ POV hotline staff receive 82 hours of training from subject matter experts and pass 15 role plays before they start answering hotline calls. Staff also receive 8 hours of annual in-service refresher training.

Detention Facilities (KA) Program. KA program funding must be renewed every five years and memorialized by an MOU between the agency receiving services and the organization providing them. Former Sheriff McDonnell signed the last MOU on April 13, 2018, and that MOU expired on April 13, 2021. The Los Angeles Sheriff's Department refused to enter into a new MOU as part of a campaign of extortion targeting oversight officials described in detail in a letter from County Counsel to the Attorney General on December 6, 2021, and which was the subject of public discussion.¹⁹

Despite a change in administration and the passage of a year and a half, POV reports that attempts to sign a new MOU have been unsuccessful. The Sheriff's Department reports that it has been in discussions with POV since September 2023 about resuming services. Since POV lost its grant funding as a result of the prior administration's refusal to enter a new MOU, the Department must now pay for the services. The Department has obtained a quote from POV and plans to submit a request for funding to the Inmate Welfare Commission at its May meeting. The Office of Inspector General recommends that the Sheriff's Department prioritize restoring victim advocacy and emotional support services at CRDF, MCJ, and TTCF and continue to work with POV to try to reinstate their services.

In-Custody Deaths

Between January 1 and March 31, 2024, seven people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for five deaths: two deaths resulted from homicide, one death was a suicide, and two deaths were natural. For the remaining two deaths, the DME findings remain deferred.²⁰ One person died at Twin Towers Correctional Facility (TTCF), one died at Men's Central Jail (MCJ), and five died at

¹⁹ See [Los Angeles County Counsel Rodrigo Castro-Silva, letter to Cal. Attorney General Rob Bonta](#) (undated); Frank Stoltze, [LA County's Chief Lawyer Accuses Sheriff Villanueva of 'Politically Motivated' Investigations](#), LAist (Feb. 1, 2022).

²⁰ In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: (1) natural, (2) accident, (3) suicide, (4) homicide, and (5) undetermined. Natural causes include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion, the Sheriff's Department and Correctional Health Services (CHS) use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parentheses.

hospitals where they had been transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on [a dedicated page on Inmate In-Custody Deaths](#) on its website.²¹

Office of Inspector General staff attended the Custody Services Division (CSD) Administrative Death Reviews for each of the seven in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of death: January 6, 2024

*Custodial Status: Sentenced.*²²

During Title 15 safety checks at MCJ, a person in custody alerted custody personnel of a "man down" who had fallen off his bunk and presented cyanotic (bluish in color due to lack of oxygen). Sheriff's Department staff, Correctional Health Services (CHS) staff, and paramedics rendered emergency aid including administering six doses of Narcan and transported the person to Los Angeles General Medical Center (LAGMC), where he died the same day. Areas for further inquiry include the quality of Title 15 safety checks and the lack of Narcan signage in the housing location. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: January 11, 2024

Custodial Status: Sentenced.

Custody personnel conducting Title 15 safety checks at TTCF found an unresponsive person seated on the floor of his cell with a noose around his neck attached to his bunk. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering two doses of Narcan. Paramedics transported the person to LAGMC, where he died four days later. Areas of concern include the quality of Title 15 safety checks, perceived lack of exigency during the emergency response (just under two minutes from staff's discovery to their entry into the cell, during which time the

²¹ As previously reported, the passage of AB 2671 amended the Penal Code to include section 10008 requiring the reporting of information on in-custody deaths within 10 days of a death, including the manner and means of death, with updates required within 30 days of a change in the information, including the manner and means of the death. This law went into effect on January 1, 2023, and requires that the information be posted on the agency's website.

²² For purposes of custodial status, "Pre-trial" indicates that the person is in custody awaiting arraignment, hearing, or trial. "Convicted, Pre-sentencing" indicates that the person is being held in custody based on a conviction, pending sentencing, on at least some charges, even if they are in pre-trial proceedings on other charges. "Sentenced" indicates that the person is being held on the basis of a sentence on at least some charges, even if they are in pre-trial proceedings on other charges.

person remained with a noose on his neck, and an additional minute before starting CPR), and how the person was able to acquire material to construct a ligature. Preliminary manner of death: Suicide. The DME website currently reflects the manner as suicide and cause of death as anoxic encephalopathy, hanging.

Date of Death: January 12, 2024

Custodial Status: Sentenced.

Custody personnel at TTCF found an unresponsive person on the floor of his cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, and CHS staff administered two doses of Narcan. The person was pronounced dead at the scene. Areas of concern include the quality of Title 15 safety checks, custody personnel's failure to administer Narcan, and CHS personnel assigning the person an inappropriate mental health level of care. Preliminary Manner of death: Unknown. The DME website currently reflects the manner of death as natural, and the cause of death as hypertensive cardiovascular disease.

Date of Death: February 6, 2024

Custodial Status: Pre-Trial.

On January 29, 2024, a person in custody with several pre-existing medical conditions was transported from TTCF's Correctional Treatment Center (CTC) to LAGMC after a medical evaluation. Eight days later, hospital staff transitioned the person to comfort care, where they died. Preliminary manner of death: Natural. The DME website currently reflects the manner as natural and cause of death as metastatic prostate cancer.

Date of Death: March 1, 2024

Custodial Status: Sentenced.

On February 25, 2024, custody personnel at TTCF were alerted to a "man down" following an assault in a Moderate Observation Housing (MOH) dorm. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, and CHS staff administered two doses of Narcan. Paramedics transported the person to LAGMC, where he died on March 1, 2024. Areas of concern include the quality and timeliness of Title 15 safety checks, emergency notifications, and CHS personnel assigning the person an inappropriate mental health level of care. Preliminary manner of death: Homicide. The DME website currently reflects the manner as homicide and cause of death as sequelae of blunt head trauma.

Date of death: March 25, 2024

Custodial Status: Pre-Trial.

On April 20, 2023, a person in custody presented at IRC with several pre-existing medical conditions due to a gunshot wound that occurred several years prior to his incarceration. Custody personnel transported him to LAGMC upon booking for a

heightened level of care. After remaining hospitalized for nearly one year, on March 25, 2024, the person died in the hospital during emergency surgery. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as homicide and the cause of death as sequelae of gunshot wound of the torso.

Date of Death: March 26, 2024

Custodial Status: Pre-Trial.

Custody personnel at MCJ Medical Outpatient Specialty Housing (MOSH) found an unresponsive person on the floor of his cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid and administered Narcan. The person died at the scene. Areas for further inquiry include determining why two of the three deployed Automated External Defibrillators (AED) did not have a proper charge. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Other Deaths

On March 8, 2024, Norwalk station deputies responding to a vandalism call discovered the suspect semi-conscious. Paramedics responded and transported the person to Coast Plaza Hospital, where the person died. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

In-Custody Overdose Deaths in Los Angeles County Jails

In December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff's Department to "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the OIG," and "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections." The Board also directed the Office of Inspector General to report quarterly on the Sheriff's Department's progress on these mandates, including progress on any recommendations including in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody deaths.

None of the seven people who died in the care and custody of the Sheriff's Department between January 1 and March 31, 2024, are either confirmed or presumed to have died due to an overdose.

To provide a benchmark for comparison, the Office of Inspector General examined in-custody deaths due to overdose in the previous year. In 2023, 45 people died in

Sheriff's Department custodial facilities. Of these deaths, 12 are confirmed to be due to an overdose.

In-custody Deaths Confirmed to be Due to Overdose in 2023			
Date of Death	Cause of Death	Housing Location	Location of Death
1/11/2023	Effects of Fentanyl	MCJ	MCJ
3/23/2023	Multiple Drug Toxicity	MCJ	MCJ
4/9/2023	Fentanyl Effects	MCJ	MCJ
5/2/2023	Effects of Multiple Drugs	East LA Station Jail	East LA Station Jail
5/2/2023	Fentanyl Toxicity	PDC-North	PDC- North
5/13/2023	Effects of Acetyl Fentanyl and Fentanyl	MCJ	MCJ
8/9/2023	Fentanyl and Diphenhydramine Toxicity	MCJ	MCJ
8/11/2023	Anoxic Encephalopathy; Status Post Cardiopulmonary Arrest Following Intake of Undetermined Substance;	NCCF	Henry Mayo Hospital
9/9/2023	Methamphetamine Effects	Norwalk Station-field	Norwalk Station-field
9/13/2023	Effects of Fentanyl	NCCF	Holy Cross Medical Center
12/5/2023	Fentanyl and Methamphetamine Toxicity	NCCF	NCCF
12/12/2023	Combined Effects of Fentanyl, Acetyl Fentanyl, Heroin, Mirtazapine, and Trazadone	MCJ	MCJ

Tracking Narcotics Intervention Efforts

The Board's motion directed that the Sheriff's Department "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions." To evaluate the efficacy of detection interventions, the Department must provide data on how often it performs different interventions and the quantity of narcotics seized – for example, data on how many cell searches the Department conducted and the quantity of narcotics discovered during each search, would allow analysis of how productive the searches are. Data on the time spent and number of deputies involved in each search would allow the analysis to address the efficiency of the search in staff time, while data on which facility or module each search targeted could allow the analysis to examine the efficacy of the searches in different housing types.

The Sheriff's Department reports that it does not presently compile the data required for such analysis. The Department requires staff to enter information detailing all narcotic

seizures in the Los Angeles Regional Crime Information System (LARCIS), a database generally used to track narcotics seizures for criminal prosecution. Although LARCIS contains complete narcotic seizure data, the drug detection intervention used to discover the narcotic is recorded only in the narrative, so that the Department cannot search seizures by detection intervention and would have to manually review each entry to compile data. The Department also tracks detection efforts inconsistently and using different systems for different interventions: staff might record cell searches in the Custody Automated Reporting and Tracking System (CARTS), narcotics obtained through contraband watch in the Line Operations Tracking System (e-LOTS), searches of employees upon entrance in the Custody Division Watch Commander Logs, and use of drug detection dogs in the K-9 unit's internal spreadsheet. But the Department does not require that staff report all narcotics intervention efforts, and some interventions such as facilities searches do not have a tracking mechanism. Even when staff record information about intervention efforts, the Department does not impose specific requirements on what data they should report, making the data collection inconsistent across the Department. As a result, while the Department provided some response to the Office of Inspector General's requests for data on how many searches they conducted, individual facilities could not validate the data reported. For example, in the first quarter of 2024, the Department deployed K-9 search units to staff check-in during a shift change at MCJ on three occasions. The Department either did not report staff and civilian searches at other jail facilities, or reported data that the facilities could not confirm.

The Sheriff's Department reports that it is continuing to evaluate its systems and mechanisms for narcotics tracking and is working to modify existing technology to resolve the issue of documenting and tracking searches and to ensure consistency across all facilities, but has not provided the Office of Inspector General with further details. The Department also states that it plans to message to the facilities the importance of employee searches and K-9 presence.

The Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. While this may be true, the Department should not wait for such a system to improve its tracking of narcotics detection. In the short term, Office of Inspector General recommends that the Department examine ways to comply with the Board's directive by improving reporting requirements for staff and compiling data on detection interventions and seizures using existing technologies.

Improving Searches of Staff and Civilians

The Board's second directive required that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails]." The Department previously reported that all jail facilities have discretion to conduct random searches of staff and civilians entering jails, but the Department did not have data available to detail how many staff searches each jail facility conducted. Currently, the Department requires staff and civilians entering jail facilities to carry their personal items in clear containers, but rarely employs K-9s or staff to conduct more thorough searches of staff and civilians and their belongings. The Department also has not outfitted the staff entrances to jail facilities with X-ray machines, body scanners, or dedicated search teams.

The Department states that it has submitted recommendations to the Board of Supervisors that the County fund the purchase and implementation of X-ray machines, body scanners, and dedicated search teams at jail facilities for staff and civilian searches.

Sheriff's Department command staff report that the Department takes the position that its current policy grants the Department broad authority to search staff and civilians entering the jails, so that no changes to existing Department policy are required to implement more comprehensive searches. The Department reports that it plans to conduct more frequent unannounced and randomized staff searches beginning in May 2024, and over the past quarter has focused on preparing staff for these increased searches by installing signs and briefing staff on prohibited items.

Status of Progress on Recommendations and Board Directives

The Office of Inspector General collaborated on a report with the Chief Executive Office, [Chief Executive Office's report Enhancing Illegal Drug Detection in the Jails and Courts](#). As mentioned in the CEO's report, the Office of Inspector General's top priority to prevent overdose deaths is to reduce the jail population to a manageable level that allows for adequate care and supervision of inmates. While the population is lower than it has been historically, facility conditions and staff levels are insufficient to provide the type of care needed to prevent most or all overdose deaths.

Below is a chart with the status of the proposals made by the Sheriff's Department and referenced in both the CEO's report and the Board's motion.

LASD Proposals	Status
1. Scent detection canines	Five additional canine units to be deployed at all facilities. Funded by the BOS and adopted by LASD.
2. Narcotics investigators	Not adopted by LASD.
3. Mail screening devices (3 devices at IRC, MCJ, and PDC-South).	Funded by LASD, adopted by LASD.
4. Mobile trace spectrometer	Not adopted by LASD.
5. Drugloo Ranger	1 at MCJ. Funded by LASD, adopted by LASD.
6. Bi-annual training refresher (4,084 custody staff split into two cohorts)	Not adopted by LASD.
7. Grounds maintenance staffing	Not adopted by LASD.
8. MERIT Master: SUD Program	Not Adopted by LASD.
9. Random personnel searches	Partially adopted by LASD
10. Body scanner replacement	LASD currently has 17 body scanners (1-MCJ; 6-IRC; 4-NCCF; 2-CRDF; 2-PDC-North; 2-PDC-South), but updated body scanners were not funded or adopted as a result of this report back. However, LASD is currently piloting updated body scanners.

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the first quarter of 2024, Office of Inspector General personnel completed 155 site visits, totaling 391 monitoring hours, at CRDF, IRC, LAGMC, MCJ, Pitchess Detention Center (PDC) North, PDC South, PDC East, NCCF, and TTCF.²³

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 142 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 165 monitoring hours related to uses of force, in-custody deaths, COVID-19 policies and protocols, Prison Rape Elimination Act (PREA) audits, and general conditions of confinement.

²³ These figures include site visits and meetings related to monitoring for compliance with the Prison Rape Elimination Act ("PREA").

Use of Body Scanners in Custody

The Sheriff's Department continues to operate X-ray body scanners at MCJ, CRDF, PDC North, PDC South, NCCF, and IRC. The Sheriff's Department policy for body scanners requires each facility using screeners to maintain a unit order describing when and where inmates shall be screened, the staffing requirements to do so safely, and the logistical considerations pertaining to their facility.²⁴ The policy also requires handling sergeants to document the discovery of contraband into the electronic Line Operations Tracking System (e-LOTS). Although the body scanners continue to detect anomalies that may be contraband, the Sheriff's Department reported that facility staff previously did not consistently complete documentation for contraband detected by body scanners. The Department reports that a division-wide email has been sent to all facilities outlining the policy and correct procedures for tracking detected contraband in e-LOTS, and that the Custody Investigative Services sergeant, who oversees the contraband watch procedure, now monitors the e-LOTS entries to ensure that staff make an entry for every request for placement on contraband watch and whether a recovery was made during the process.

Use-of-Force Incidents in Custody

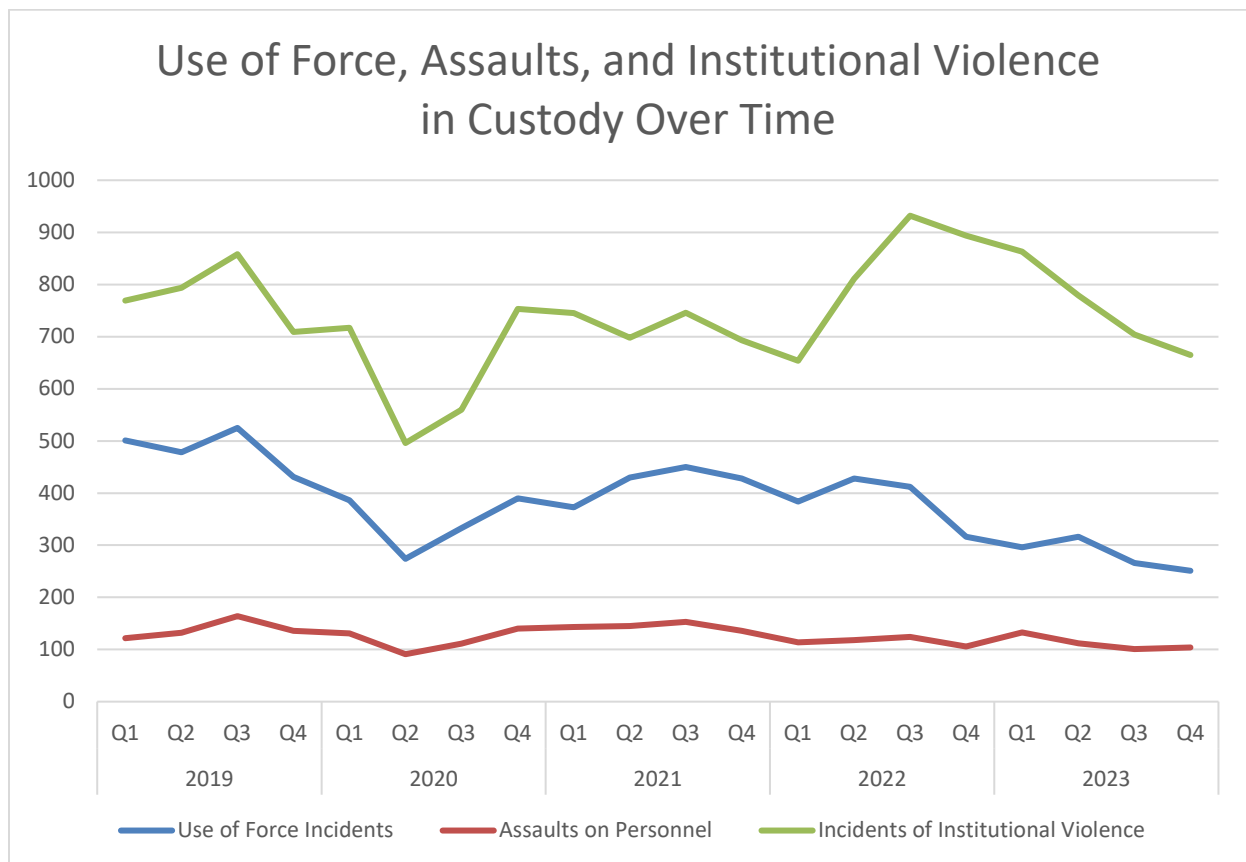
The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.²⁵ The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people in its custody.²⁶

²⁴ See Los Angeles County Sheriff's Department, Custody Division Manual, section 5-08/020.00, [Custody Safety Screening Program \(B-SCAN\)](#).

²⁵ Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

²⁶ The reports go through the fourth quarter of 2023 because the Sheriff's Department has not yet verified the accuracy of reports for the first quarter of 2024. In reviewing this report, the Department noted corrected information for assaults on personnel and incidents of institutional violence for the first quarter of 2022, which is reflected here and which differs from uncorrected information reported in previous quarterly reports.

		Use of Force Incidents	Assaults on Personnel	Incidents of Institutional Violence
2019	1 st Quarter	501	122	769
	2 nd Quarter	478	132	794
	3 rd Quarter	525	164	858
	4 th Quarter	431	136	709
2020	1 st Quarter	386	131	717
	2 nd Quarter	274	91	496
	3 rd Quarter	333	111	560
	4 th Quarter	390	140	753
2021	1 st Quarter	373	143	745
	2 nd Quarter	430	145	698
	3 rd Quarter	450	153	746
	4 th Quarter	428	136	693
2022	1 st Quarter	384	114	654
	2 nd Quarter	428	118	811
	3 rd Quarter	412	124	932
	4 th Quarter	316	106	894
2023	1 st Quarter	296	133	863
	2 nd Quarter	316	112	779
	3 rd Quarter	266	101	704
	4 th Quarter	251	104	665



HANDLING OF GRIEVANCES AND COMMENTS

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received 179 new complaints in the first quarter of 2024 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

Of these grievances, 158 related to conditions of confinement within the Sheriff's Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	66
Classification	21
Transportation	14
Personnel Issues	12
Property	8
Living Condition	7
Mail	6
Commissary	4
Education	2
Visiting	2
Bedding	2
Food	1
Telephones	1
Showers	1
Referrals	1
Other	10
Total	158

Twenty-one complaints related to civilian contacts with Department personnel by persons who were not in custody, as shown in the chart below:

Complaint/Incident Classification	Totals
Personnel	
Improper Tactics	4
Improper Detention	2
Force	1
Harassment	1
Neglect of Duty	1
Operation of Vehicles	1
Service	
Policy Procedures	4
Response Time	1
Other	6
Total	21

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 77 iPads installed in jail facilities: 46 at TTCF; 6 at MCJ; and 25 at CRDF. During the first quarter there were 8 new installations and 9 iPad replacements.

The Sheriff's Department continues to experience malfunctioning iPads and have identified power source problems as the major cause. To rectify this issue, the Department reports that Facility Services Bureau is currently working to install dedicated data drops and power supply for the iPads. The Department also reports that outdated equipment also contributes to the problem. Custody Support Services Bureau – Correctional Innovative Technology Unit (CITU) recently acquired two new MacBooks to use to reconfigure and program the iPads. The new MacBooks are currently being prepared and programmed by Data Systems Bureau. With the MacBooks, the Department reports CITU can update applications for outdated iPads. The Department states that CITU is also monitoring the Wi-Fi connectivity issues and exploring alternative solutions to assist with strengthening the Wi-Fi signal.

As [previously reported](#), the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in

custody.²⁷ The Sheriff's Department reports that between January 1 and March 31, 2024, no one in custody had been placed on restrictive filing and it therefore did not reject any grievances under this policy.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.²⁸ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.²⁹

The following chart lists the number and types of comments reported for each station or unit.³⁰

²⁷ See Los Angeles County Sheriff's Department, Custody Division Manual, § 8-04/050.00, [Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges](#).

²⁸ See [Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, Department Service Reviews](#).

²⁹ It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

³⁰ The chart reflects data from the Sheriff's Department Performance Recording and Monitoring System current as of January 9, 2024.

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
ADM : GEN POPL ADM HQ	1	0	0
ADM : NORTH PATROL ADM HQ	4	0	0
ADM : PROF STANDARDS ADM HQ	1	0	0
AER : AERO BUREAU	1	0	0
ALD : ALTADENA STN	5	3	2
AVA : AVALON STN	2	0	0
CAF : COMM & FLEET MGMT BUR	1	1	0
CEN : CENTURY STN	3	5	1
CER : CERRITOS STN	4	2	0
CIS : CUSTODY INVESTIGATIVE SERVICES	0	1	0
CMB : CIVIL MANAGEMENT BUREAU	13	0	1
CNT : COURT SERVICES CENTRAL	9	4	1
COM : COMPTON STN	4	4	3
CPB : COMMUNITY PARTNERSHIP BUREAU	1	2	0
CRV : CRESCENTA VALLEY STN	6	3	1
CSB : COUNTY SERVICES BUREAU	1	3	1
CSN : CARSON STN	6	4	2
CST : COURT SERVICES TRANSPORTATION	0	1	0
ELA : EAST LA STN	4	0	0
EST : COURT SERVICES EAST	1	1	0
HOM : HOMICIDE BUREAU	1	1	0
IAB : INTERNAL AFFAIRS BUREAU	1	0	0
ICI : INTERNAL CRIME INV BUR	1	0	0
IND : INDUSTRY STN	4	1	2
IRC : INMATE RECEPTION CENTER	1	0	0
LCS : LANCASTER STN	11	22	1
LKD : LAKEWOOD STN	10	10	0
LMT : LOMITA STN	10	5	0
MAR : MARINA DEL REY STN	5	4	4
MCB : MAJOR CRIMES BUREAU	3	1	0
MCJ : MEN'S CENTRAL JAIL	1	1	1
MLH : MALIBU/LOST HILLS STN	7	10	2
NAR : NARCOTICS BUREAU	0	1	0
NCF : NORTH CO. CORRECTL FAC	0	1	0

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
NWK : NORWALK REGIONAL STN	4	2	0
OSS : OPERATION SAFE STREETS BUREAU	2	1	1
PKB : PARKS BUREAU	0	1	1
PLM : PALMDALE STN	10	35	7
PMB : POPL MGMT BUREAU	2	0	0
PRV : PICO RIVERA STN	3	1	0
RMB : RISK MANAGEMENT BUREAU	2	0	0
SCV : SANTA CLARITA VALLEY STN	9	7	2
SDM : SAN DIMAS STN	5	5	2
SLA : SOUTH LOS ANGELES STATION	4	5	0
SSB : SCIENTIFIC SERV BUREAU	1	0	0
TEM : TEMPLE CITY STN	10	5	2
TSB : TRANSIT SERVICES BUREAU	1	0	0
USR : OFFICE OF THE UNDERSHF	0	0	1
WAL : WALNUT/SAN DIMAS STN	4	1	1
WHD : WEST HOLLYWOOD STN	8	5	0
WST : COURT SERVICES WEST	5	2	0
Total :	192	161	39



**Chief
Executive
Office.**

COUNTY OF LOS ANGELES

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, CA 90012
(213) 974-1101 ceo.lacounty.gov

CHIEF EXECUTIVE OFFICER

Fesia A. Davenport

June 24, 2024

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**RECOMMENDED ADJUSTMENTS TO THE 2024-25 RECOMMENDED BUDGET TO
REFLECT VARIOUS CHANGES AND REQUEST AUTHORIZATION TO EXECUTE
FUNDING AGREEMENTS
(ALL DISTRICTS AFFECTED) (3-VOTES)**

BUDGET OVERVIEW

The Chief Executive Office's (CEO) proposed Final Changes to the \$45.4 billion 2024-25 Recommended Budget adopted in April are detailed in this letter. "Final Changes" marks the second and shortest phase in the annual budget process and modifies, as needed, the adopted spending plan to reflect updated revenue projections and additional resources needed to support key priorities before the new fiscal year begins on July 1.

Once approved by the Board, these Final Changes would bring the budget total to \$45.6 billion—an addition of \$251.0 million—and grow the County's workforce to 116,571 budgeted positions with the addition of 412 positions.

Despite significant budgetary challenges at the State level, our key revenue projections for this budget phase remain unchanged. Although there was not time to accurately integrate the impact of State cuts and changes in this proposal, the limited scope of proposed new spending reflects our conservatism in the face of the State deficit. Those impacts will become clearer upon complete analysis of the final State Budget package, and my office will incorporate the full impact of that bill during a last round of budgetary changes to come before the Board of Supervisors (Board) in October when the Supplemental Budget concludes the annual budget process.



"To Enrich Lives Through Effective And Caring Service"

This budget recommends further investment in the Board's vision of *Care First, Jails Last*, such as adding 28 positions to the Department of Youth Development to help the department grow and advance its long-term goals, including expanding Secure Youth Treatment Facility programming and services at the Probation camps and halls, supporting youth development networks, advancing decarceration efforts for girls and gender expansive youth, and staffing in-house research, policy and administrative positions that will allow for faster expansion of diversion and development programs. An additional 10 positions are recommended for the Justice, Care and Opportunities Department (JCOD) to continue and expand pretrial services and provide administrative support.

It also includes \$12.0 million in Mental Health Services Act (MHSA) funding to expand the Office of Diversion and Reentry's Housing program to 3,450 beds.

The budget recommendations include an additional \$3.0 million to improve conditions in the County jail system by contracting cleaning services for clinical areas and adding five positions to the Department of Health Services Integrated Correctional Health Services (DHS-ICHS) to expedite the transfer of individuals to State hospitals in accordance with the U.S. Department of Justice consent decree.

Also, and as directed by your Board in April 2024, this budget includes the transfer of the Jail Closure Implementation Team operations from JCOD to the CEO.

Additional highlights and details of new funding to support County immigrants, mental health programming, interim housing for those experiencing homelessness, and more are provided below.

Our office continues to evaluate requests tied to motions under the Fiscal Resilience Protocol adopted by your Board on January 23, 2024. The Fiscal Resilience Protocol uses a tiered system to rank motions that require new net County cost (NCC) to ensure funding allocations are aligned with implementation readiness.

ECONOMIC OUTLOOK

Our U.S. economic outlook has remained substantially the same as our outlook during the preparation of the 2024-25 Recommended Budget. The latest national data on economic growth, inflation, employment, and interest rates reflect no significant fluctuations, and there are no substantial changes to economic conditions or the Federal Reserve Board's direction on the federal funds rate. Therefore, the economic outlook remains mostly positive from continued strength in the jobs market and consumption, which help drive modest economic growth. Conversely, the economy still faces

challenges from lingering elevated inflation and its negative impact on interest rates and the housing market.

We are recommending no budgetary changes to the Proposition 172 Public Safety sales tax and County unincorporated areas sales and use tax revenues included in the 2024-25 Recommended Budget. The most recent data on revenues and consumer spending have remained in line with prior projections.

Two significant factors that could have the largest impact on the economy in the intermediate term are the timing of any decision by the Federal Reserve Board to begin lowering the federal funds rate, which could ease high interest rates, and potential economic policy changes resulting from the November Presidential Election. Both of these factors are difficult to predict. In the meantime, the elevated interest rate environment continues to keep mortgage rates high which strains purchasing affordability. This results in lower home sales volume and discourages homeowners' willingness to move and sell their homes, since many of them are locked into historically low mortgage rates.

The Assessor issued his official 2024 Assessment Roll Forecast on May 15, 2024, which projected a 4.75 percent increase in assessed valuation over the prior fiscal year. This projection is in line with the forecast in the 2024-25 Recommended Budget, meaning we are not adding any new property tax revenues in this budget phase.

Our office will continue to monitor economic conditions and assess their impact on the County's various revenues. We will update our projections, as needed, in the Supplemental Budget, based on the latest available data and trends.

Adoption of the recommendations below, along with any approved Budget Deliberation matters, will result in the adoption of the 2024-25 County Budget, subject to revisions included in the Supplemental Budget set to go before your Board on October 8, 2024.

IT IS RECOMMENDED THAT THE BOARD:

1. Find that the proposed actions are not considered a project under the California Environmental Quality Act (CEQA) as stated in this letter and based on the record of the proposed activities.
2. Adopt the attached changes (Attachments I, II, III, IV, and V) to the 2024-25 Recommended County Budget.

3. Authorize the CEO, or her designee, to execute and, if necessary, amend or terminate funding agreements totaling \$95,441,000 with the Los Angeles County Development Authority (LACDA) for the following: Affordable Housing Development Trust Fund Notice of Funding Availability in an amount not to exceed \$65,000,000; Open Doors Program in an amount not to exceed \$19,545,000; Los Angeles County Housing Innovation Fund Revolving Loan Fund Program in an amount not to exceed \$10,000,000; South County Public Housing Scattered Sites in an amount not to exceed \$425,000; Affirmatively Furthering Fair Housing program in an amount not to exceed \$255,000; and LACDA Homeless Coordinator in an amount not to exceed \$216,000.
4. Authorize the Director of the Department of Economic Opportunity (DEO), or her designee, to execute and, if necessary, amend or terminate funding agreements totaling \$1,482,000 with LACDA for the Community Policing Program in public housing sites in an amount not to exceed of \$1,007,000, and for the Cooperative Extension Program in an amount not to exceed \$475,000.
5. Authorize the Executive Officer of the Board to execute and, if necessary, amend or terminate a funding agreement with the Los Angeles County High School for Arts for various costs associated with the Arts Program in an amount not to exceed \$125,000.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

Final Changes Budget Recommendations

The following reflects the CEO's proposed changes to the 2024-25 Recommended Budget, which was approved by your Board on April 23, 2024. This change letter addresses various critical programs and projects while being mindful of potential economic instability ahead.

Implementation of Strategic Plan Goals

These actions support the County's Strategic Plan North Star 3 – Realize Tomorrow's Government Today – by strengthening our internal controls and processes while being cognizant of efficiency to continue good stewardship of the public trust and fiscal responsibility.

FISCAL IMPACT/FINANCING

The attached recommended changes result in a total County Budget of \$45.6 billion and 116,571 positions as summarized below by fund group.

Fund Group (\$ in Billions)	2023-24 Final Adopted Budget	2024-25 Recommended	2024-25 Final Changes	Change From Recommended
Total General County	\$35.934	\$35.284	\$35.410	\$0.126
Special District/ Special Funds	10.809	10.093	10.218	\$0.125
Total Budget	\$46.743	\$45.377	\$45.628	\$0.251
Budgeted Positions	115,324	116,159	116,571	412

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Below are other highlights of various programmatic changes recommended in this budget phase.

Assistance to Immigrants

- **Refugee Assistance** – Adds \$5.0 million in federal funding to the Department of Social Services (DPSS) for the Housing Assistance for Ukrainians program providing resettlement assistance benefits to refugees.
- **Office of Immigrant Affairs** – Allocates \$0.2 million in ongoing NCC and 1 position to the Department of Consumer and Business Affairs (DCBA) to support the proposed countywide language access policy and strategic goal.

Health Care and Mental Health Services

- **MHSA-Funded Programs** – Invests \$66.9 million in MHSA funding to the Department of Mental Health (DMH) for various initiatives, including: the Children's Community Care Village primarily to build and operate 24 contract-provided child/family mental health care housing units, 16 crisis residential treatment beds, and mental health care coordination focused on children and their families in South Los Angeles (\$26.1 million); community mental health services throughout the County, specifically community family resource centers and third-party administered partnerships with community-based organizations (\$16.5 million);

hotel and motel rooms to serve as interim housing for clients reached through the Homeless Outreach Mobile Engagement (HOME) teams and the Women's Reentry program (\$6.3 million); the Workforce Education and Training incentive program to improve recruitment and retention of psychiatrists (\$6.0 million); and mental health wellbeing projects in County parks in partnership with the Department of Parks and Recreation (\$5.0 million).

- **Interim Housing Outreach Program** – Provides \$9.0 million to the Department of Public Health (DPH), fully offset by MHSA funding available for a 5-year period, from DMH for substance abuse prevention and treatment services at interim housing sites.
- **Alternative Diversion Pathway (ADP) Program** – Adds \$0.9 million in grant funding to the Public Defender to launch the ADP program and support community engagement by providing clients with mental health evaluations and linkages to appropriate treatment services, which will enable programming related to mental health diversion and if appropriate, release from custody.

Public Health

- **Public Health** – Adds 30 Environmental Health positions funded by revenue generated by the collection of fees to DPH to support operational needs, including in support of new ordinances governing the habitability of rental housing and compact mobile food and micro-enterprise home kitchen operations.

Homelessness and Affordable Housing

- **Rent Registry** – Allocates \$0.5 million in one-time fund balance to DCBA for enforcement and compliance in the Rent Registry Program, providing landlords required rental housing information in compliance with County ordinances, such as changes in tenancy, rental rates, and amenities, as well as pay annual registration fees that support the cost of administering and enforcing the program.
- **Military and Veterans** – Adds \$0.3 million in Assembly Bill 109 (AB 109) funding to the Department of Military and Veterans Affairs for a consultant to provide County departments military and veterans cultural competency training targeting homeless and justice involved veterans.

Public Safety

- **Probation** – Allocates \$3.5 million in Juvenile Probation Funding for additional security at Los Padrinos and Barry J. Nidorf juvenile halls.

Jobs and Workforce Development

- **Office of Labor Equity** – Adds \$0.8 million in one-time and ongoing NCC and 3 positions in DCBA's Office of Labor Equity to begin program ramp-up, provide education and outreach, and assist in countywide enforcement for the Fair Workweek and Fair Chance ordinances adopted by the Board in February and April of 2024, respectively.

Climate Change

- **Climate Budget** – Allocates \$1.6 million in one-time and ongoing NCC to the Internal Services Department (ISD) (\$1.1 million) and the Chief Sustainability Office (\$0.5 million) to support efforts in reducing County's carbon footprint.

Information Technology and Voting Systems

- **Voting Solutions for All People (VSAP)** – Transfers \$9.0 million in ongoing NCC funding from the Provisional Financing Uses budget unit and allocates \$10.8 million in one-time NCC for a total of \$19.8 million to the Department of Registrar-Recorder/County Clerk (RR/CC) to support the VSAP election system and voting model.
- **Cybersecurity** – Appropriates \$1.5 million in one-time NCC to ISD (\$0.3 million) and RR/CC (\$1.2 million) to protect and prevent growing threats against the County's information technology and voting infrastructure, and to reduce cybersecurity risks.

FOLLOW-UP BUDGET ACTIONS

The Board requested the CEO to report back on the following items during this budget phase.

Support for Mental Health Assistants (MHA) in Furthering the Sustainability and Success of the Forensic In-Patient Stepdown (FIP Stepdown) Unit Program

The MHAs are volunteer inmates who support other incarcerated individuals who have complicated and severe mental health needs as part of the FIP Stepdown at Twin Towers Correctional Facility (TTCF) and Century Regional Detention Facility (CRDF).

On November 21, 2023, the Board directed the CEO, in collaboration with the Office of Inspector General (OIG), Sheriff, and DHS-ICHS, to report back during the Final Changes budget phase on the fiscal impact and potential funding sources, including AB 109 funding, to support MHAs in FIP Stepdown programming, including providing incentives such as financial and time credits for MHAs and increasing the number of MHAs to enhance supportive services.

According to the OIG's February 21, 2024 report back to the Board's November 21, 2023 directives, the Sheriff currently uses 13 MHAs incarcerated at TTCF and 10 MHAs incarcerated at CRDF. As volunteers, the MHAs receive limited benefits for providing support.

The Sheriff is exploring options for providing additional food incentives and financial credits to MHAs. The MHAs at TTCF and CRDF traditionally received one hot incentive meal for lunch daily and access to snacks, such as cookies, muffins, and chips. The Sheriff has indicated that it has begun offering an additional incentive meal and healthier, high-protein snacks to MHAs as of March 1, 2024. The Department is piloting expanded snack options, primarily snacks high in protein, and working with its contracted food providers to revise existing menus to improve the quality and nutrition of food offered. Program patients also have access to snacks, which the MHAs distribute. Sustaining these changes would require additional funding since offering a greater variety of healthier foods results in new costs.

The Sheriff's Department does not currently provide monetary compensation to any inmate workers. There is currently no appropriate mechanism to provide wages to the MHAs. Offering this incentive would require evaluation from a legal, policy, and technical standpoint.

The CEO continues to work with the Sheriff to evaluate the potential funding of incentives described in the motion, particularly those related to wages and food. The Sheriff's Department must quantify the added costs of providing these incentives and formally define an incentive policy for MHA's and program participants. The Sheriff may submit a funding proposal detailing cost related to the motion's directives to be evaluated during a future budget phase. Funding recommendations will be made within the context of the County's overall budget and numerous competing funding priorities and requests.

Addressing In-Custody Overdose Deaths in the Los Angeles County Jails

On December 19, 2023, the Board instructed the CEO to assess the fiscal impact and potential funding sources, including AB 109 funding, for implementing the following directives a Board motion aimed at addressing in-custody overdose deaths in County jails:

1. Request the Sheriff to track and report opioid deaths in county jails and enhance search policies.
2. Have the OIG provide updates to the Sheriff Civilian Oversight Commission and the Board.
3. Require DHS-ICHS and the Sheriff, in consultation with the OIG and the DPH's Substance Abuse Prevention and Control, to report back in 90 days with strategies and recommendations to address overdose-related deaths in County jails.

According to a report filed by DHS-ICHS on March 19, 2024, in response to Directive 3 of the motion, the Sheriff identified an initial funding requirement of \$72.9 million and DHS-ICHS identified a need to repurpose \$3.0 million of existing funds. These estimates are preliminary and need further analysis and refinement. The scope of the directive involves multiple departments and strategies, which may evolve as more information becomes available and new insights are gained through ongoing research and collaboration. The report also advised that additional exploration of costs associated with certain Sheriff and DHS-ICHS initiatives would be needed. A thorough evaluation of cost is in-process to develop a complete and informed recommendation.

In the 2024-25 Recommended Budget, the Board approved \$0.2 million in NCC (\$95,000 in one-time funding and \$105,000 in ongoing funding) for the procurement and operation of five scent detection canines to address in-custody overdose deaths. As of the 2024-25 Final Changes budget, no further budget requests related to these efforts have been submitted by the Sheriff or DHS-ICHS, and therefore no additional funding is being allocated at this time. The CEO will work with the Sheriff and DHS-ICHS to refine funding needs for these efforts, and the departments will submit budget requests to the CEO for consideration in a future budget phase in line with the Fiscal Resilience Protocol, as necessary. Funding recommendations will then be made in the context of the overall budget and numerous competing funding priorities and requests.

Equitable Access to Supportive Services for Domestic Violence Survivors

On May 21, 2024, the Board instructed the CEO to work with DPH to identify \$6.4 million and the needed positions to establish a new program to provide supportive and wraparound services to domestic violence survivors that do not qualify for California Work Opportunity and Responsibility to Kids (CalWORKs). The Board further instructed the

CEO to conduct an evaluation and measure outcomes of the to-be established program to determine the effectiveness of the program providing supportive services to domestic violence survivors who are not CalWORKs eligible by the next budget cycle. After careful consideration during the 2024-25 Final Changes budget phase, the CEO was unable to identify the funding to support the establishment of the subject program for the provision of wraparound services due to constraints posed by limited available resources. If and/or when funding is allocated to establish this new program, CEO would recommend that DPH ensure they appropriately evaluate the outcomes of the program and provide relevant reporting to the Board.

STATE BUDGET UPDATE

On May 10, 2024, Governor Gavin Newsom released his 2024-25 May Budget Revision (May Revision) to address anticipated shortfalls in both 2024-25 and 2025-26. The \$288.0 billion May Revision forecasts State General Fund (SGF) revenues to be \$7.0 billion lower than projected in the Proposed Budget, raising the total 2024-25 deficit from \$37.9 billion to \$44.9 billion. After accounting for the early action budget package adopted in April, the remaining budget shortfall is approximately \$27.6 billion. To close the projected funding gap, the May Revision proposes additional cuts to government operations, reductions to programs and pauses of new investments, many of which the County opposes including:

- \$450.7 million in one-time funding from the last round of the Behavioral Health Continuum Infrastructure Program;
- \$300.0 million ongoing for the Future of Public Health Initiative, including \$52.5 million in the current fiscal year;
- \$132.5 million in 2024-25 and \$207.5 million in 2025-26 for the Behavioral Health Bridge Housing Program;
- \$126.6 million in ongoing funding for CalWORKs Mental Health and Substance Abuse services;
- \$80.0 million in one-time funding for the Bringing Families Home Program;
- \$50.0 million in 2024-25 and ongoing for the processing of foster caregiver applications;
- \$47.1 million in 2024-25 and ongoing for the CalWORKs Home Visiting Program;
- \$34.8 million in 2024-25 and ongoing for the Emergency Child Care Bridge Program;
- \$18.0 million in one-time funding for health care enrollment navigation;

- \$5.5 million in 2024-25 and ongoing for the Lunch at the Library Program;
- \$2.4 million in 2024-25 and \$4.8 million in 2025-26 for the County's Fire Camp Contract; and
- \$1.75 million in 2024-25 and ongoing for the Library Services Act Program.

Since the State Budget plays an important role in funding critical programs administered by the County, the CEO Legislative Affairs and Intergovernmental Relations Branch will continue to monitor State Budget activities and advocate in support of the County's priorities with the Governor and the Legislature.

FUNDING AGREEMENT AUTHORIZATION

We recommend the Board authorize the CEO, or her designee, to execute and, if necessary, amend or terminate funding agreements totaling \$95,441,000 with LACDA for the following:

- a) Affordable Housing Development Trust Fund Notice of Funding Availability in an amount not to exceed \$65,000,000;
- b) Open Doors Program in an amount not to exceed \$19,545,000;
- c) Los Angeles County Housing Innovation Fund - Revolving Loan Fund Program in an amount not to exceed \$10,000,000;
- d) South County Public Housing Scattered Sites in an amount not to exceed \$425,000;
- e) Affirmatively Furthering Fair Housing program in an amount not to exceed \$255,000; and
- f) LACDA Homeless Coordinator in an amount not to exceed \$216,000.

We also recommend the Board authorize the Director of DEO, or her designee, to execute and, if necessary, amend or terminate funding agreements totaling \$1,482,000 with LACDA for the following:

- a) Community Policing Program in public housing sites throughout the County in an amount not to exceed \$1,007,000; and
- b) Cooperative Extension Program in an amount not to exceed \$475,000.

The Honorable Board of Supervisors
June 24, 2024
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Lastly, we recommend the Board authorize the Executive Officer of the Board to execute and, if necessary, amend or terminate a funding agreement with the Los Angeles County High School for Arts for various costs associated with the Arts Program in an amount not to exceed \$125,000.

ENVIRONMENTAL DOCUMENTATION

The recommended actions are not subject to CEQA because they are activities that are excluded from the definition of a project by section 21065 of the California Public Resources Code and sections 15378(b)(2)(4) and (5) of the State CEQA Guidelines, which apply to continuing administrative or maintenance activities such as purchases of supplies, the creation of government funding mechanisms or other government fiscal activities which do not involve any commitment to any specific project which may result in a potentially significant physical impact on the environment and/or administrative activities that will not result in direct or indirect physical changes in the environment.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Selected program changes and impacts are referenced above; all changes are detailed in the attached.

Respectfully submitted,



FESIA A. DAVENPORT
Chief Executive Officer

FAD:JMN:MRM
YR:cg

Attachments

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

GENERAL FUND AND HOSPITAL ENTERPRISE

Changes from the 2024-25 Recommended Budget

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
AGING AND DISABILITIES – ADMINISTRATION					
2024-25 Recommended Budget	138,361,000	96,872,000	12,370,000	29,119,000	592.0
1. Electronic Access Keypads: Reflects funding for the installation of electronic access keypads at community and senior centers.	23,000	--	--	23,000	--
Total Changes	23,000	0	0	23,000	0.0
2024-25 Final Changes	138,384,000	96,872,000	12,370,000	29,142,000	592.0
AGRICULTURAL COMMISSIONER/ WEIGHTS AND MEASURES					
2024-25 Recommended Budget	66,958,000	1,047,000	45,111,000	20,800,000	429.0
1. Reclassification: Reflects the Board-approved countywide reclassification of 1.0 Supervising Typist Clerk to 1.0 Senior Typist-Clerk.	--	--	--	--	--
2. Weed Hazard/Pest Management: Reflects the addition of 2.0 Weed and Pest Abatement Worker permanent items and 10.0 Weed and Pest Abatement Worker temporary items, offset by Agricultural Services revenue.	1,056,000	--	1,056,000	--	12.0
3. Administration: Reflects the addition of 1.0 Network Systems Administrator II in the Administrative Services Bureau, fully offset by Business Licenses revenue.	187,000	--	187,000	--	1.0
Total Changes	1,243,000	0	1,243,000	0	13.0
2024-25 Final Changes	68,201,000	1,047,000	46,354,000	20,800,000	442.0
ARTS AND CULTURE					
2024-25 Recommended Budget	35,948,000	71,000	15,605,000	20,272,000	52.0
1. Internship Program: Reflects an increase to maintain the program due to the County of Los Angeles minimum wage increase.	35,000	--	--	35,000	--
2. Arts Education: Reflects the addition of 1.0 Senior Program Associate, Arts and Culture position to support ongoing arts instruction services at juvenile halls and camps, fully offset by a reduction in services and supplies.	--	--	--	--	1.0
3. American Rescue Plan Act (ARPA): Reflects the reappropriation of ARPA funding for the Reopening Culture, Tourism, and Marketing Initiative.	4,904,000	--	4,904,000	--	--
Total Changes	4,939,000	0	4,904,000	35,000	1.0
2024-25 Final Changes	40,887,000	71,000	20,509,000	20,307,000	53.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
ASSESSOR					
2024-25 Recommended Budget	252,467,000	18,000	93,186,000	159,263,000	1,400.0
1. Ministerial Adjustment: Reflects a realignment of appropriation and revenue based on historical trends and an adjustment to conform to Governmental Accounting Standards Board 87.	--	--	--	--	--
Total Changes	0	0	0	0	0.0
2024-25 Final Changes	252,467,000	18,000	93,186,000	159,263,000	1,400.0
AUDITOR-CONTROLLER					
2024-25 Recommended Budget	132,340,000	73,235,000	27,590,000	31,515,000	631.0
1. eTAX: Reflects the addition of 1.0 Principal Accounting Systems Analyst and 4.0 Program Specialist III (\$1.5 million) positions and one-time funding (\$0.9 million) for the development and implementation of eTAX.	1,509,000	(854,000)	--	2,363,000	5.0
2. Cyclical Audits: Reflects one-time funding in the Audit Division to perform General Fund department cyclical audits.	--	(1,680,000)	--	1,680,000	--
3. Ministerial Adjustment: Reflects an alignment of billings for services based on historical and anticipated trends.	--	(107,000)	107,000	--	--
Total Changes	1,509,000	(2,641,000)	107,000	4,043,000	5.0
2024-25 Final Changes	133,849,000	70,594,000	27,697,000	35,558,000	636.0
AUDITOR-CONTROLLER – INTEGRATED APPLICATIONS					
2024-25 Recommended Budget	67,956,000	31,360,000	6,624,000	29,972,000	0.0
1. Enterprise Systems Maintenance: Reflects an increase in costs to maintain the eHR and eCAPS software applications and related services.	2,502,000	2,098,000	404,000	--	--
2. IT Project: Reflects one-time funding for the Data and Analytics Hub, which will act as the County's self-service portal for analyzing and reporting financial and human resources data.	1,500,000	--	--	1,500,000	--
Total Changes	4,002,000	2,098,000	404,000	1,500,000	0.0
2024-25 Final Changes	71,958,000	33,458,000	7,028,000	31,472,000	0.0
BOARD OF SUPERVISORS					
2024-25 Recommended Budget	328,676,000	22,550,000	15,103,000	291,023,000	496.0
1. Campaign Compliance Division: Reflects the addition of 1.0 Administrative Services Manager (ASM) II and 1.0 ASM I positions to continue the establishment of Campaign Compliance Division to ensure Senate Bill 1439 compliance.	433,000	--	--	433,000	2.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
2. Chief Sustainability Office: Reflects the addition of 1.0 Project Director, BOS position to support the Climate Resilience Initiative and one-time funding (\$0.2 million) for consultant support for a climate budget pilot.	462,000	--	--	462,000	1.0
3. Community Programs – Supervisorial District 1: Reflects the reversal of ongoing funding to the LA County Library due to redistricting.	521,000	--	--	521,000	--
4. Office of Child Protection: Reflects a one-time funding transfer to the Department of Public Health to support the Help Me Grow LA program.	(600,000)	--	--	(600,000)	--
5. Countywide Criminal Justice Coordinating Committee: Reflects an increase in Community Corrections Planning Grant funding to continue the support of Assembly Bill 109 program and project evaluations.	407,000	--	407,000	--	--
6. Civilian Oversight Commission (COC): Reflects the addition of 1.0 Community Services Coordinator position to support community engagement activities of the COC, fully offset by the deletion of 1.0 Senior Paralegal position and a reduction in services and supplies.	--	--	--	--	--
7. LGBTQ+ Commission: Reflects the addition of 1.0 Executive Director, LGBTQ+ position, fully offset by the deletion of 1.0 Deputy Executive Officer, BOS position, and the addition of 15.0 Youth Commissioner ordinance-only placeholder positions to support the Commission.	--	--	--	--	--
8. Ministerial Adjustment: Reflect a reduction in appropriation and revenue due the closure of the Puente Hills Landfill and the exhaustion of the trust account.	(981,000)	--	(981,000)	--	--
Total Changes	242,000	0	(574,000)	816,000	3.0
2024-25 Final Changes	328,918,000	22,550,000	14,529,000	291,839,000	499.0
CHIEF EXECUTIVE OFFICER					
2024-25 Recommended Budget	203,386,000	45,543,000	63,690,000	94,153,000	572.0
1. Empowering the Jail Closure Implementation Team (JCIT): Reflects the addition of 10.0 positions and resources to house the JCIT within the Chief Executive Office (CEO) to organize, prioritize, manage, and develop detailed written plans for the closure of Men's Central Jail per the Board motion adopted on April 9, 2024.	3,275,000	640,000	--	2,635,000	10.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
2. FY 2024-25 JCIT Carryover: Reflects a carryover of FY 2023-24 savings from JCOD into CEO to continue JCIT program efforts associated with the Board motion on April 9, 2024.	476,000	--	--	476,000	--
3. Risk Management – Privacy: Reflects the addition of 2.0 positions to oversee Health Insurance Portability and Accountability Act (HIPAA) and Privacy concerns related to data usage, breaches, policy development, training, risk exposure, and risk management.	561,000	561,000	--	--	2.0
4. Risk Management – Audit Compliance: Reflects the addition of 1.0 position to establish a new audit unit that will conduct routine audits and investigations, as well as meet highly technical functions related to HIPAA compliance, workers' compensation, liability claims programs, fraud detection, and risk mitigation.	297,000	297,000	--	--	1.0
5. Grants Adjustment: Reflects an increase in appropriation and revenue to account for the 2023 Emergency Management Performance Grant as adopted by the Board on April 9, 2024.	2,077,000	--	2,077,000	--	--
Total Changes	6,686,000	1,498,000	2,077,000	3,111,000	13.0
2024-25 Final Changes	210,072,000	47,041,000	65,767,000	97,264,000	585.0
CHILD SUPPORT SERVICES					
2024-25 Recommended Budget	232,339,000	0	225,358,000	6,981,000	1,467.0
1. Staffing: Reflects the addition of 3.0 positions, fully offset by the deletion of 6.0 vacant positions to provide support for appeal hearings and executive administration.	--	--	--	--	(3.0)
Total Changes	0	0	0	0	(3.0)
2024-25 Final Changes	232,339,000	0	225,358,000	6,981,000	1,464.0
CHILDREN AND FAMILY SERVICES – ADMINISTRATION					
2024-25 Recommended Budget	2,069,244,000	2,029,000	1,517,272,000	549,943,000	9,979.0
1. Information Technology Support Services: Reflects funding for 2.0 positions to provide information technology support.	382,000	--	382,000	--	2.0
2. Administrative Support Services: Reflects the addition of 1.0 administrative support item, offset by the deletion of 1.0 vacant budgeted position.	--	--	--	--	--
Total Changes	382,000	0	382,000	0	2.0
2024-25 Final Changes	2,069,626,000	2,029,000	1,517,654,000	549,943,000	9,981.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
CONSUMER AND BUSINESS AFFAIRS					
2024-25 Recommended Budget	38,253,000	13,581,000	7,681,000	16,991,000	177.0
1. Office of Labor Equity – Fair Chance and Fair Workweek: Reflects the addition of 3.0 Consumer and Business Affairs Representative III positions (\$0.4 million) and one-time services and supplies (\$0.4 million) to support the Office of Labor Equity.	838,000	--	--	838,000	3.0
2. Office of Immigrant Affairs: Reflects the addition of 1.0 Program Manager I position for the implementation of the Countywide Language Access Policy and to support the Office of Immigrant Affairs.	188,000	--	--	188,000	1.0
3. Office of Cannabis Management: Reflects one-time funding for staffing to continue the development and establishment of a commercial cannabis program.	1,313,000	--	--	1,313,000	--
4. Rent Registry: Reflects one-time funding for 2.0 ordinance-only Consumer and Business Affairs Representative III positions (\$0.3 million) to support the Rent Registry program and one-time services and supplies (\$0.2 million) for a consultant to provide rental market trend analysis.	542,000	--	--	542,000	--
5. Self-Help Legal Access Centers (SHLAC): Reflects one-time funding to continue to support the SHLAC program through June 2025.	3,000,000	--	--	3,000,000	--
6. American Rescue Plan Act (ARPA): Reflects one-time carryover of ARPA funds for the continuation of various services provided by the department.	2,033,000	--	1,945,000	88,000	--
7. Information Technology (IT) Position: Reflects the addition of 1.0 Student Professional Worker, IT position, fully offset by the deletion of 1.0 Student Professional Worker position and services and supplies.	--	--	--	--	--
Total Changes	7,914,000	0	1,945,000	5,969,000	4.0
2024-25 Final Changes	46,167,000	13,581,000	9,626,000	22,960,000	181.0
DISTRICT ATTORNEY					
2024-25 Recommended Budget	528,680,000	5,104,000	230,559,000	293,017,000	2,164.0
1. Cyber Crime E-Discovery: Reflects one-time carryover funding for Cyber Crime E-Discovery hardware.	70,000	--	--	70,000	--
2. Murder Resentencing Unit: Reflects carryover funding for the Murder Resentencing Unit.	2,389,000	--	--	2,389,000	8.0
Total Changes	2,459,000	0	0	2,459,000	8.0
2024-25 Final Changes	531,139,000	5,104,000	230,559,000	295,476,000	2,172.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
FIRE – LIFEGUARD					
2024-25 Recommended Budget	44,949,000	0	0	44,949,000	0.0
1. Junior Lifeguard Scholarships: Reflects funding to provide needs-based scholarships to Junior Lifeguard Program participants.	180,000	--	--	180,000	--
2. General Operations: Reflects funding pursuant to the Board-approved operating agreement.	104,000	--	--	104,000	--
Total Changes	284,000	0	0	284,000	0.0
2024-25 Final Changes	45,233,000	0	0	45,233,000	0.0
FINANCING ELEMENTS					
2024-25 Recommended Budget	80,198,000	0	10,692,446,000	(10,612,248,000)	0.0
1. Fund Balance: Reflects an increase in available fund balance needed for various programs and projects based on revised estimates.	--	--	50,910,000	(50,910,000)	--
2. Obligated Fund Balance: Reflects the use of obligated fund balance Committed for Youth Justice Reimagined and Committed for Alternatives to Incarceration for administrative support positions in the Department of Youth Development and various operations at the Justice, Care and Opportunity Department, respectively.	(3,690,000)	--	--	(3,690,000)	--
Total Changes	(3,690,000)	0	50,910,000	(54,600,000)	0.0
2024-25 Final Changes	76,508,000	0	10,743,356,000	(10,666,848,000)	0.0
GRAND JURY					
2024-25 Recommended Budget	2,134,000	0	4,000	2,130,000	5.0
1. Increase Civil and Criminal Grand Juror Daily Stipend: Reflects an increase in Juror Stipend from \$60 per day (established in 2007) to \$80 per day.	189,000	--	--	189,000	--
Total Changes	189,000	0	0	189,000	0.0
2024-25 Final Changes	2,323,000	0	4,000	2,319,000	5.0
HEALTH SERVICES					
2024-25 Recommended Budget	10,548,337,000	396,320,000	8,905,209,000	1,246,808,000	27,197.0
1. L.A. General Medical Center – Medical School Affiliation Agreement (MSAA) Adjustments: Primarily reflects a reduction in the physician services provided to L.A. General under the MSAA with the University of Southern California, which will be replaced by the net addition of 211.0 positions and other appropriation.	19,648,000	--	381,000	19,267,000	211.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
2. Integrated Correctional Health Services: Reflects an increase in contracted cleaning services for clinical areas of the jails and the addition of 5.0 positions to expedite the transfer of individuals from County jails to the State hospitals, which will support meeting the terms of a Department of Justice consent decree.	3,815,000	--	--	3,815,000	5.0
3. Office of Diversion and Re-Entry (ODR) Housing Expansion: Reflects the addition of 1.0 position and an increase primarily in contracted services, fully funded by additional Mental Health Services Act funding from the Department to Mental Health (DMH), to support an additional 70 beds as well as full implementation of 360 DMH-funded beds added last fiscal year, which will expand the ODR Housing program to 3,450 beds.	11,952,000	11,952,000	--	--	1.0
4. Housing for Health Contract Staff Conversion: Reflects an increase of 50.0 positions, fully offset by a reduction in registry expenses, to reduce dependency on contracted staff for various Housing for Health programs, including the new Interim Housing Outreach Program.	--	--	--	--	50.0
5. Martin Luther King, Jr. Outpatient Center Transition to Ambulatory Care Network: Reflects the transition of Martin Luther King, Jr. Outpatient Center from the Harbor Care South budget unit to the Ambulatory Care Network. This is primarily an administrative change to consolidate Department of Health Services clinics within the Ambulatory Care Network.	--	4,446,000	(4,446,000)	--	--
6. Capital Projects: Reflects a net increase due to the establishment of several new capital projects, primarily the elevator modernization and transfer switch projects at Olive-View UCLA Medical Center.	24,585,000	--	--	24,585,000	--
7. Other Program Changes: Reflects a net increase of 18.0 positions to support harm reduction, medical credentialing, primary care medical homes, information technology services, and various other areas.	2,294,000	--	688,000	1,606,000	18.0
8. Other Position Changes: Reflects a net increase of 3.0 positions to reduce the use of contracted dialysis services and to support various other areas.	(45,000)	--	(8,000)	(37,000)	3.0
9. Ministerial Changes: This adjustment is comprised of increases in Board-approved contracts, utilities, and charges from other County departments, as well as reductions to State and federal grants.	3,546,000	27,511,000	(29,850,000)	5,885,000	--

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
10. Fund Balance and Operating Subsidies: Reflects the use of prior-year fund balance and adjustments to the operating subsidy allocations to the hospital enterprise funds.	(110,673,000)	--	(59,367,000)	(51,306,000)	--
Total Changes	(44,878,000)	43,909,000	(92,602,000)	3,815,000	288.0
2024-25 Final Changes	10,503,459,000	440,229,000	8,812,607,000	1,250,623,000	27,485.0
HUMAN RESOURCES					
2024-25 Recommended Budget	127,843,000	79,727,000	26,033,000	22,083,000	593.0
1. Hiring Innovation: Reflects the addition of 1.0 Assistant Director, Human Resources position to serve as the County's Hiring Strategist, responsible for developmental changes, policy adjustments, training, and creating innovative solutions to hiring challenges.	416,000	362,000	54,000	--	1.0
2. Civil Service Advocacy: Reflects the addition of 1.0 Human Resources Analyst III position to represent County departments in administrative proceedings before the Civil Service Commission.	226,000	197,000	29,000	--	1.0
3. Workforce Employee Development: Reflects the addition of 1.0 Human Resources Analyst IV position to develop and provide continued oversight of a Countywide Finance Manager Academy.	260,000	226,000	34,000	--	1.0
4. Reclassification: Reflects a Board-approved position reclassification.	104,000	91,000	13,000	--	--
5. Ministerial Adjustment: Reflects the realignment of appropriation from other financing uses to services and supplies for repayment of a Quality Productivity Commission loan.	--	--	--	--	--
Total Changes	1,006,000	876,000	130,000	0	3.0
2024-25 Final Changes	128,849,000	80,603,000	26,163,000	22,083,000	596.0
INTERNAL SERVICES					
2024-25 Recommended Budget	798,639,000	610,621,000	133,183,000	54,835,000	2,154.0
1. Climate Budget: Reflects the addition of 1.0 Administrative Manager XI position to oversee and coordinate countywide efforts to reduce the County's carbon footprint and one-time funding (\$0.9 million) for consultants to conduct the Greenhouse Gas emissions inventory analysis and develop an updated public Municipal Climate Action Plan, to support the County's effort to establish a climate budget.	1,133,000	--	--	1,133,000	1.0
2. Cyber Governance and Operations Services: Reflects an increase in reimbursable funding for new cybersecurity licenses and to realign appropriation from services and supplies to other charges (\$3.3 million) to comply with Governmental Accounting Standard Board 96.	305,000	250,000	55,000	--	--

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
3. Operations Services: Reflects an increase in reimbursable funding for postage and processing fees from mail services contract, vehicle purchases, and judgment and damages, partially offset by decreases for waste and rubbish removal services, taxes and assessment for street lighting, and capital asset equipment.	4,541,000	1,475,000	3,066,000	--	--
4. Shared Services: Reflects an increase in reimbursable funding primarily for information technology services, computing-mainframe for software and licensing, lease payments for the data center, and capital asset equipment.	5,586,000	4,732,000	854,000	--	--
5. Communications and Mobility Services: Reflects an increase in reimbursable funding for additional telecommunications equipment, vehicle purchases, and lease payments for various telecom sites, partially offset by a decrease due to completion of telecom projects for the Probation Department and LA County Library.	708,000	579,000	129,000	--	--
6. Administration: Reflects an increase in funding primarily due to increased costs for services received from other County departments.	1,400,000	1,148,000	252,000	--	--
7. Customer Applications: Reflects a decrease in reimbursable funding for software licenses, partially offset by increases for training and office supplies.	(550,000)	(451,000)	(99,000)	--	--
8. Energy and Environmental Services: Reflects an increase primarily for electric vehicle (EV) charging stations funded by EV user fee revenue.	421,000	--	421,000	--	--
9. Reclassification: Reflects a Board-approved position reclassification.	--	--	--	--	--
Total Changes	13,544,000	7,733,000	4,678,000	1,133,000	1.0
2024-25 Final Changes	812,183,000	618,354,000	137,861,000	55,968,000	2,155.0
JUSTICE, CARE AND OPPORTUNITIES					
2024-25 Recommended Budget	89,032,000	11,154,000	41,915,000	35,963,000	124.0
1. Programmatic Support Positions: Reflects 2.0 positions to oversee pretrial services and site-based programs, such as Warm Landings and Community Reentry Centers, and 2.0 positions to support program data and evaluation, fully offset by Care First and Community Investment (CFI) Indirect Revenue via intrafund transfer.	1,024,000	1,024,000	--	--	4.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
2. Administrative Support Positions: Reflects 6.0 positions to provide critical administrative support in information technology, finance, and human resources, fully offset by \$0.7 million in CFCI Indirect Revenue via intrafund transfer and a realignment of \$0.4 million in services and supplies appropriation.	731,000	731,000	--	--	6.0
3. Department of Youth Development (DYD) Administration Transfer: Reflects the transfer of 9.0 administrative positions and \$2.3 million in corresponding funding to DYD that currently provides dedicated DYD support to establish a standalone administrative framework for DYD, partially offset by \$0.5 million in CFCI Indirect Revenue.	(1,840,000)	(1,840,000)	--	--	(9.0)
4. Jail Closure Implementation Team (JCIT) Transfer: Reflects the transfer of \$2.6 million in ongoing NCC to the Chief Executive Office to support JCIT operations, as directed by the Empowering the JCIT Board motion adopted on April 9, 2024.	(2,635,000)	--	--	(2,635,000)	--
5. JCIT Transfer Backfill: Reflects a transfer of \$2.6 million in ongoing NCC from the obligated fund balance Committed for Alternatives to Incarceration to backfill the transfer of JCIT funding, which supports critical administrative and programmatic operations at JCOD.	2,635,000	--	--	2,635,000	--
Total Changes	(85,000)	(85,000)	0	0	1.0
2024-25 Final Changes	88,947,000	11,069,000	41,915,000	35,963,000	125.0
LA COUNTY LIBRARY – GENERAL FUND CONTRIBUTION					
2024-25 Recommended Budget	44,507,000	0	0	44,507,000	0.0
1. One-Time Funding: Reflects an adjustment to remove funding that was provided on a one-time basis for operating costs for the Claremont (\$0.2 million) and Pico Rivera (\$0.3 million) libraries.	(521,000)	--	--	(521,000)	--
Total Changes	(521,000)	0	0	(521,000)	0.0
2024-25 Final Changes	43,986,000	0	0	43,986,000	0.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Expenditure Distribution/ IFT (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
LOS ANGELES COUNTY CAPITAL ASSET LEASING					
2024-25 Recommended Budget	22,230,000	22,230,000	0	0	0.0
1. Services and Supplies: Reflects an increase due to higher insurance premiums as a result of increases in accumulated equipment purchases financed through the Los Angeles County Capital Asset Leasing (LAC-CAL) program.	59,000	59,000	--	--	--
2. Other Charges: Reflects an increase in new equipment purchases to be financed through the LAC-CAL program.	690,000	690,000	--	--	--
Total Changes	749,000	749,000	0	0	0.0
2024-25 Final Changes	22,979,000	22,979,000	0	0	0.0
	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
MEDICAL EXAMINER					
2024-25 Recommended Budget	59,310,000	163,000	2,336,000	56,811,000	286.0
1. Opioid Settlement: Reflects Year 2 of 3 of the Board-approved Johnson & Johnson opioid settlement.	1,000,000	1,000,000	--	--	--
2. Reclassification: Reflects funding for Board-approved reclassifications.	--	--	--	--	--
3. Miscellaneous Adjustment: Reflects the deletion of 1.0 Staff Assistant II position and the addition of 1.0 Staff Assistant I position to align with Classification/Compensation's recommendation.	--	--	--	--	--
Total Changes	1,000,000	1,000,000	0	0	0.0
2024-25 Final Changes	60,310,000	1,163,000	2,336,000	56,811,000	286.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
MENTAL HEALTH					
2024-25 Recommended Budget	3,993,656,000	153,349,000	3,780,139,000	60,168,000	7,352.0
1. Mental Health Services Act (MHSA) – Previously Adopted: Reflects funding for various MHSA spending plans adopted by the Board, including: a) \$6.3 million for 109 hotel/motel rooms to provide interim housing for clients reached through the Homeless Outreach Mobile Engagement teams and the Women's Reentry program, adopted by the Board on May 21, 2024; b) \$6.0 million for the Workforce Education and Training financial incentive program to improve recruitment and retention of psychiatrists, adopted by the Board on April 9, 2024; and c) \$0.4 million to build increased capacity for reaching underserved cultural communities and promoting participation in mental health and wellness programs, adopted by the Board on May 21, 2024.	12,720,000	--	12,720,000	--	--
2. MHSA – General Program Expansions: Reflects funding for new or expanded MHSA programs, including: a) \$26.1 million for the Children's Community Care Village, an MHSA Innovations project in partnership with Kedren Health, to build and operate 24 contract-provided child/family mental health care housing units, 16 crisis residential treatment beds, 8-12 urgent care center chairs, a full spectrum of outpatient services, and mental health care coordination focused on children and their families in South Los Angeles; b) \$16.5 million for community mental health services throughout the County, specifically community family resource centers and third party-administered partnerships with community-based organizations; c) \$4.3 million for a variety of planning and information tools, resources, and training to assist the Department of Mental Health leadership, clinicians, and clients; and d) \$2.3 million for various awareness and outreach programs to promote participation in mental health and well-being activities, including stakeholder capacity building, adult and youth media campaigns, and cultural conferences.	49,159,000	--	49,159,000	--	--
3. MHSA – Partnerships with Other County Departments: Reflects services in partnership with other County departments for mental health treatment and prevention, including: a) \$12.0 million to fund expansion of intensive case management, interim housing, enriched residential care, and permanent supportive housing services provided by the Office of Diversion and Reentry; and b) \$5.0 million to fund mental health well-being projects in parks across the County in partnership with the Department of Parks and Recreation.	16,952,000	--	16,952,000	--	--

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
4. Position Adjustments: Reflects adjustments to improve the Department's operational effectiveness and support, including: a) \$2.7 million and 11.0 positions for improving clients' health access and care integration, adopted by the Board on December 19, 2023; b) \$4.2 million and 25.0 primarily clinical support positions such as medical case workers and community health workers for various programs serving patients or coordinating care at mental health clinics and in the field; c) \$2.1 million and 12.0 positions to assist in the administration of departmental operations such as quality assurance and developing documentation necessary for connecting patients to supportive services; and d) \$0.5 million and a net zero position change to more closely align classifications with assigned duties.	9,514,000	--	7,816,000	1,698,000	48.0
5. Operating Costs: Reflects miscellaneous adjustments to align the budget for services with other County departments and adjustments to revenues and expenditures to more closely reflect anticipated funding and expenditure levels, and to balance the Department's budget with available resources.	12,606,000	150,000	14,154,000	(1,698,000)	--
Total Changes	100,951,000	150,000	100,801,000	0	48.0
2024-25 Final Changes Budget	4,094,607,000	153,499,000	3,880,940,000	60,168,000	7,400.0
MILITARY AND VETERANS AFFAIRS					
2024-25 Recommended Budget	11,820,000	1,352,000	3,579,000	6,889,000	63.0
1. Cultural Competency Training Program: Reflects funding for cultural competency training on veterans needs to be provided to other County departments.	300,000	300,000	--	--	--
2. Position Reclassifications: Reflects Board-approved position reclassifications.	--	--	--	--	--
Total Changes	300,000	300,000	0	0	0.0
2024-25 Final Changes	12,120,000	1,652,000	3,579,000	6,889,000	63.0
MUSEUM OF ART					
2024-25 Recommended Budget	39,692,000	0	0	39,692,000	9.0
1. Salaries and Employee Benefits: Reflects the deletion of 1.0 Chief Deputy Director, Museum of Art position and decreases in various employee benefits, fully offset by an increase in services and supplies.	--	--	--	--	(1.0)
Total Changes	0	0	0	0	(1.0)
2024-25 Final Changes	39,692,000	0	0	39,692,000	8.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
NONDEPARTMENTAL SPECIAL ACCOUNTS					
2024-25 Recommended Budget	114,661,000	281,000	344,256,000	(229,876,000)	0.0
1. Salaries and Employee Benefits: Reflects a funding transfer for Board-approved increases in salaries and health insurance subsidies.	(50,000)	--	--	(50,000)	--
2. IT Infrastructure Fund: Reflects funding for enterprise or cross-departmental IT projects that provide a countywide benefit.	10,000,000	--	--	10,000,000	--
Total Changes	9,950,000	0	0	9,950,000	0.0
2024-25 Final Changes	124,611,000	281,000	344,256,000	(219,926,000)	0.0
PARKS AND RECREATION					
2024-25 Recommended Budget	282,950,000	1,248,000	53,563,000	228,139,000	1,563.0
1. Salaries and Employee Benefits: Primarily reflects Board-approved increases in salaries and health insurance subsidies.	52,000	--	2,000	50,000	--
2. Board-Approved Reclassifications: Reflects Board-approved reclassifications (1.0 Recreation Services Supervisor or 1.0 Regional Park Superintendent I, and 1.0 Administrative Assistant II to 1.0 Administrative Services Manager I) to meet the operational needs of the Department, fully offset by revenue.	183,000	--	183,000	--	--
3. Aquatics Program: Reflects the addition of a total of 65.0 budgeted positions (49.0 Pool Lifeguard, 12.0 Senior Pool Lifeguard, and 4.0 Pool Manager), offset by ongoing departmental revenue and one-time carryover funding to support aquatics programming.	6,974,000	--	3,833,000	3,141,000	65.0
4. Streamline Hiring Process for Aquatics Lifeguards: Reflects the addition of a total of 400.0 ordinance positions (100.0 Lake Lifeguard and 300.0 Pool Lifeguard) for Pool Lifeguard Candidate and Lake Lifeguard Candidate positions to further streamline the aquatics hiring process.	--	--	--	--	--
5. Parks After Dark Program (PAD): Reflects the addition of a total of 157.0 ordinance positions (86.0 Recreation Services Leader and 71.0 Park Aide) to meet staffing standards for PAD programming at 34 County parks.	--	--	--	--	--
6. Environment, Science, Technology, Engineering, Art and Math (ESTEAM) Camp: Reflects an increase in the overtime budget, offset by State grant revenue to fund eight-week camps at 23 park locations throughout the County.	747,000	--	747,000	--	--

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
7. Regional Park and Open Space District (RPOSD): Reflects an increase in appropriation and revenue to meet the operational needs of RPOSD.	700,000	--	700,000	--	--
8. Mental Health Services Act (MHSA) Prevention and Early Intervention Services: Reflects an increase in one-time funding from the Department of Mental Health to administer and deliver MHSA Prevention and Early Intervention services.	5,000,000	5,000,000	--	--	--
Total Changes	13,656,000	5,000,000	5,465,000	3,191,000	65.0
2024-25 Final Changes	296,606,000	6,248,000	59,028,000	231,330,000	1,628.0
PROBATION					
2024-25 Recommended Budget	1,123,237,000	5,845,000	400,472,000	716,920,000	5,518.0
1. Position Adjustments: Reflects position adjustments for the reclass action adopted by the Board on February 27, 2024, and departmental staffing needs in administration and operations, fully offset by the deletion of vacant positions.	--	--	--	--	(9.0)
Support Services	1,211,000	--	--	1,211,000	7.0
Juvenile Institutions Services	(1,211,000)	--	--	(1,211,000)	(16.0)
Field Services	--	--	--	--	--
Special Services	--	--	--	--	--
2. Governmental Accounting Standards Board (GASB) 96 – Subscription-Based Information Technology Arrangements (SBITA): Reflects a realignment of \$3.8 million in services and supplies to other charges to adhere to GASB 96-SBITA guidelines.	--	--	--	--	--
Support Services	--	--	--	--	--
Field Services	--	--	--	--	--
Special Services	--	--	--	--	--
3. Funding Certainty Grant (FCG): Reflects the FCG funds authorized by the Family First Transition Act to support and mitigate the financial shortfalls due to the State's transition from participation in the Title IV-E waiver project to implementation of the Family First Prevention Services Act. These funds will allow the Department to continue the Educational Specialists and tutoring contracts and funding for Public Health nurses.	3,500,000	--	3,500,000	--	--
Special Services	3,500,000	--	3,500,000	--	--
4. Uniform Refresh: Reflects an increase of \$1.8 million in services and supplies appropriation to fund uniform refresh for the sworn personnel, fully offset by one-time Juvenile Probation Funds (JPF) growth revenue.	1,800,000	--	1,800,000	--	--
Juvenile Institutions Services	1,800,000	--	1,800,000	--	--

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
5. Citiguard Security Services Contract: Reflects \$3.5 million in services and supplies appropriation to fund the new security services contract with Citiguard at Los Padrinos Juvenile Hall and at the Secured Youth Treatment Facility at Barry J. Nidorf Juvenile Hall, fully offset by one-time JPF growth revenue.	3,505,000	--	3,505,000	--	--
Juvenile Institutions Services	3,505,000	--	3,505,000	--	--
Total Changes	8,805,000	0	8,805,000	0	(9.0)
2024-25 Final Changes	1,132,042,000	5,845,000	409,277,000	716,920,000	5,509.0
PROVISIONAL FINANCING USES					
2024-25 Recommended Budget	1,100,878,000	0	0	1,100,878,000	0.0
1. Trial Courts: Reflects the set aside of one-time funding for Trial Courts private investigator and attorney rate increases (\$1.7 million), Professional Appointee Court Expenditure (\$2.8 million), and the Public Defense Pilot Program (\$1.7 million).	6,200,000	--	--	6,200,000	--
2. Sheriff: Reflects the set aside of one-time funding for consultant services to assess and make recommendations for the improvement of the Sheriff Department's organizational structure.	500,000	--	--	500,000	--
2. Registrar-Recorder/County Clerk (RR/CC): Reflects the transfer of funding to the RR/CC for the Ballot Processing Center (\$1.6 million) and the Voting Solutions for All People election system (\$9.0 million).	(10,607,000)	--	--	(10,607,000)	--
3. SB 1439 Campaign Compliance Office: Reflects the transfer of funding to the Board of Supervisors for the SB 1439 Campaign Compliance Office.	(433,000)	--	--	(433,000)	--
4. Fire Lifeguard: Reflects the transfer of funding to the Fire Department for costs associated with the Consumer Price Index and Junior Lifeguard Scholarships.	(269,000)	--	--	(269,000)	--
5. Aging and Disabilities: Reflects the transfer of funding to the Department of Aging and Disabilities for electronic access keypads.	(23,000)	--	--	(23,000)	--
6. Carryover: Reflects adjustments to various carryover requests included in the 2024-25 Recommended Budget.	(30,201,000)	--	--	(30,201,000)	--
Total Changes	(34,833,000)	0	0	(34,833,000)	0.0
2024-25 Final Changes	1,066,045,000	0	0	1,066,045,000	0.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
PUBLIC DEFENDER					
2024-25 Recommended Budget	327,913,000	2,412,000	40,334,000	285,167,000	1,230.0
1. MacArthur Capstone Grant: Reflects grant funding awarded by the John D. and Catherine T. MacArthur Foundation for the Alternative Diversion Pathway program to provide clients with in-court mental health evaluations and linkages, to enable programming related to mental health diversion and if needed, release from custody.	925,000	--	925,000	--	--
2. Funding Realignment – Homeless Record Clearing Project (Measure H): Reflects a net zero change in positions by deleting 2.0 vacant budgeted positions and adding 2.0 new positions to better support Measure H programming. Also includes the realignment of \$0.2 million in appropriation to fully fund the change with a net zero increase in cost.	--	--	--	--	--
3. U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention (OJJDP) Grant: Reflects grant funding awarded by the OJJDP for the Enhancing Youth Defender Services Project which supports professional development and specialized holistic youth legal defense training for attorneys at the Public Defender and Alternate Public Defender, and related community outreach.	649,000	--	649,000	--	--
4. Client Case Management System: Reflects the realignment of \$2.7 million from services and supplies to other charges to comply with Governmental Accounting Standards Board 96, Subscription Based Information Technology Arrangements.	--	--	--	--	--
5. Communications Manager Position Correction: Reflects the correction of an error inadvertently included in the 2024-25 Recommended Budget. Includes the deletion of 1.0 Communications Manager Unclassified item and the addition of 1.0 Communications Manager item.	--	--	--	--	--
Total Changes	1,574,000	0	1,574,000	0	0.0
2024-25 Final Changes	329,487,000	2,412,000	41,908,000	285,167,000	1,230.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
PUBLIC HEALTH					
2024-25 Recommended Budget	1,594,600,000	104,367,000	1,237,455,000	252,778,000	5,648.0
1. Environmental Health: Reflects a net addition of 30.0 positions to meet various programmatic and operational needs as follows: a) \$2.0 million in funding, fully offset with revenue for 15.0 positions to administer the newly adopted ordinance for rental housing habitability; b) \$1.6 million in funding for 10.0 positions, fully offset with a deletion of 1.0 position and revenue to meet operational needs in the areas of administration, community support and protection, and radiation safety; and c) \$0.9 million in funding, fully offset with revenue for 6.0 positions to administer newly adopted ordinances for compact mobile food and micro-enterprise home kitchen operations.	4,525,000	--	4,525,000	--	30.0
2. Interim Housing Outreach Program: Reflects \$9.0 million in funding from the Department of Mental Health through intrafund transfers for Substance Abuse Prevention and Control (SAPC) to provide substance abuse prevention and treatment services at interim housing sites.	8,977,000	8,977,000	--	--	--
3. Gender-Based Violence (GBV): Reflects an addition of 2.0 positions, fully offset by a realignment of appropriation for the initial implementation of the GBV program including coordination of services as well as workplan development.	--	--	--	--	2.0
4. SAPC: Reflects a net reduction of \$0.2 million in funding to realign the program's budget and meet programmatic and operational needs as follows: a) \$1.9 million in funding for 10.0 positions, fully offset with revenue to meet various operational needs; b) \$1.4 million in funding, fully offset with revenue for Board-approved reclassifications; c) a net zero change in funding for 11.0 positions, fully offset with a realignment in appropriation to enhance the Student Well-Being Centers; d) a reduction of \$2.0 million in funding and deletion of 35.0 obsolete positions, fully offset with a reduction in revenue; and e) a reduction of \$1.5 million in services and supplies appropriation and the deletion of 61.0 vacant positions, fully offset with a reduction in revenue to reflect the closure of the Antelope Valley Rehabilitation Center.	(243,000)	--	(243,000)	--	(75.0)

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
5. Grant Funding: Reflects a net increase of \$1.9 million in funding consisting of adjustments and a net zero change in budgeted positions to meet various programmatic and operational needs as follows: a) \$1.4 million in funding, fully offset with revenue to enhance services addressing the rise in sexually-transmitted disease cases; b) \$0.7 million in net funding for 4.0 positions and a reclassification of 1.0 position, fully offset with a realignment of appropriation and revenue for children services with the California Children's Service Maternal, Child and Adolescent Health programs; c) a net decrease of \$0.2 million in funding related to the deletion of 1.0 position and reduced revenue for the acute communicable diseases and oral health programs; and d) a net zero change in funding for 3.0 positions, fully offset with a deletion of 6.0 positions and a realignment of appropriation for nursing administration and the public health laboratory.	1,887,000	--	1,887,000	--	--
6. Ministerial Changes: Reflects various ministerial adjustments to properly align the Department's operating budget in meeting departmental needs primarily consisting of: a) \$1.5 million in cost-of-living adjustment-related adjustments, fully offset with a deletion of 6.0 positions, a realignment of appropriation, and increased State revenue; b) \$0.6 million in transferred funding from the Board of Supervisors for the Help Me Grow LA program to extend prevention services to youth with special health care needs; and c) various realignments of appropriation for a net zero cost to fund 2.0 positions in development and training, and facility management, as well as adjustments to costs related to other County departments.	2,146,000	--	1,546,000	600,000	(4.0)
Total Changes	17,292,000	8,977,000	7,715,000	600,000	(47.0)
2024-25 Final Changes	1,611,892,000	113,344,000	1,245,170,000	253,378,000	5,601.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
PUBLIC SOCIAL SERVICES – ADMINISTRATION					
2024-25 Recommended Budget	3,219,631,000	3,383,000	2,982,376,000	233,872,000	14,454.0
1. Department Reorganization: Reflects a request for 48.0 positions fully offset with the deletion of 48.0 vacant positions, a decrease in services and supplies appropriation, and an increase in State and federal revenues, primarily due to various Departmental reorganizations to establish: 1) an Analysis, Analytics and Customer Engagement Services division within the Bureau of Contract and Technical Services; 2) a Workforce Safety, Leave and Disability Compliance branch and Leave Management and Disability Compliance section within the Bureau of Human Resources; 3) a Bureau of Customer Service Centers; and 4) a General Services and Property Management division within the Bureau of Human Resources.	5,342,000	--	5,342,000	--	--
2. Administrative Support Staffing: Reflects the addition of 26.0 positions, fully offset with the deletion of 16.0 vacant positions, a decrease in services and supplies appropriation, and an increase in State and federal revenues.	1,455,000	--	1,455,000	--	10.0
3. Reclassification: Reflects a Board-approved reclassification of 1.0 Information Technology II position to 1.0 Administrative Services Division Manager.	16,000	--	16,000	--	--
Total Changes	6,813,000	0	6,813,000	0	10.0
2024-25 Final Changes	3,226,444,000	3,383,000	2,989,189,000	233,872,000	14,464.0
PUBLIC SOCIAL SERVICES – ASSISTANCE					
2024-25 Recommended Budget	2,835,383,000	0	2,327,669,000	507,714,000	0.0
1. Refugee Employment Program: Reflects one-time federal revenue for the Housing Assistance for Ukrainians Program.	5,000,000	--	5,000,000	--	--
2. 1991 Realignment: Reflects projected 1991 Realignment revenue growth for Social Services.	--	--	6,749,000	(6,749,000)	--
Total Changes	5,000,000	0	11,749,000	(6,749,000)	0.0
2024-25 Final Changes	2,840,383,000	0	2,339,418,000	500,965,000	0.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
PUBLIC WORKS – GENERAL FUND					
2024-25 Recommended Budget	126,929,000	537,000	82,044,000	44,348,000	0.0
1. Expanded and Expedited Encampment Clean Up Program: Reflects one-time funding for Public Works' share of the Expanded and Expedited Encampment Clean Up Program, fully offset by intrafund transfers from the Homeless and Housing Program.	12,614,000	12,614,000	--	--	--
Total Changes	12,614,000	12,614,000	0	0	0.0
2024-25 Final Changes	139,543,000	13,151,000	82,044,000	44,348,000	0.0
REGIONAL PLANNING					
2024-25 Recommended Budget	45,926,000	32,000	10,606,000	35,288,000	209.0
1. Advance Planning Division: Reflects the addition of 1.0 Senior Regional Planner in the Environmental Planning and Sustainability Section.	172,000	--	--	172,000	1.0
Total Changes	172,000	0	0	172,000	1.0
2024-25 Final Changes	46,098,000	32,000	10,606,000	35,460,000	210.0
REGISTRAR-RECORDER/COUNTY CLERK					
2024-25 Recommended Budget	268,979,000	14,000	108,087,000	160,878,000	1,171.0
1. Voting Solutions for All People (VSAP): Reflects ongoing (\$9.0 million) and one-time (\$10.8 million) funding for the VSAP election system model and its upgrade from 3.0 to 4.0 to meet Secretary of State certification requirements.	19,797,000	--	--	19,797,000	--
2. Cybersecurity – Elections: Reflects one-time funding for a cybersecurity solution to protect and prevent security threats to the County's network.	1,203,000	--	--	1,203,000	--
3. Information Technology (IT): Reflects one-time funding for various election-related IT needs, including Election Management and VSAP systems consultant support; software licenses and support; a security system for the Voting Operations Center; and servers.	2,042,000	--	--	2,042,000	--
4. Ballot Processing Center (BPC): Reflects ongoing funding (\$1.1 million) for annual lease costs and one-time funding (\$6.0 million) for tenant improvements and closed-circuit television costs for the BPC.	7,064,000	--	--	7,064,000	--

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
5. Administrative Services Division Manager (ASDM): Reflects the addition of 1.0 ASDM position to serve as Chief Language and Accessibility Officer, fully offset by the deletion of 2.0 positions and a reduction in overtime.	--	--	--	--	(1.0)
6. Reclassifications: Reflects Board-approved position reclassifications.	--	--	--	--	--
Total Changes	30,106,000	0	0	30,106,000	(1.0)
2024-25 Final Changes	299,085,000	14,000	108,087,000	190,984,000	1,170.0
SHERIFF					
2024-25 Recommended Budget	4,012,111,000	119,510,000	1,978,395,000	1,914,206,000	17,544.0
1. Los Angeles Regional Interoperable Communications Systems: Reflects one-time funding in the General Support budget for costs associated with the mobile radio replacement project.	8,300,000	--	--	8,300,000	--
<i>General Support</i>	8,300,000	--	--	8,300,000	--
2. Information Technology Security Infrastructure: Reflects one-time funding in the General Support budget for enterprise software and hardware security services.	913,000	--	--	913,000	--
<i>General Support</i>	913,000	--	--	913,000	--
3. Miscellaneous Adjustments: Reflects the transfer of 1.0 Operations Assistant III position from the Patrol budget unit, and 1.0 Deputy Sheriff position from the Administration budget unit, to the Detective budget unit to more accurately reflect operational needs.	--	--	--	--	--
<i>Patrol Clearing</i>	(179,000)	--	--	(179,000)	(1.0)
<i>Administration</i>	(253,000)	--	--	(253,000)	(1.0)
<i>Detective</i>	432,000	--	--	432,000	2.0
4. Contract Changes: Reflects net changes in positions, salaries and employee benefits, services and supplies, intrafund transfers, and revenue in various budget units primarily due to requests by contract agencies.	290,000	(35,000)	325,000	--	--
<i>Patrol Clearing</i>	--	--	--	--	--
<i>Patrol – Specialized and Unallocated</i>	112,000	--	112,000	--	--
<i>Detective</i>	(35,000)	(35,000)	--	--	--
<i>Custody</i>	213,000	--	213,000	--	--
5. Contract Changes: Reflects net changes in positions, salaries and employee benefits, services and supplies, intrafund transfers, and revenue in various budget units primarily due to requests by contract agencies.	16,575,000	--	--	16,575,000	--
<i>Patrol – Specialized and Unallocated</i>	16,575,000	--	--	16,575,000	--

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
6. Position Adjustments: Reflects the addition of 1.0 Accounting Technician II position, offset by the deletion of 1.0 Procurement Assistant I position in the Administration budget unit, and the addition of 1.0 Supervising Sheriff Station Clerk position, offset by the deletion of 1.0 Law Enforcement Technician position in the County Services budget unit, to better reflect operational needs.	--	--	--	--	--
County Services	--	--	--	--	--
Administration	--	--	--	--	--
Total Changes	26,078,000	(35,000)	325,000	25,788,000	0.0
2024-25 Final Changes	4,038,189,000	119,475,000	1,978,720,000	1,939,994,000	17,544.0
TREASURER AND TAX COLLECTOR					
2024-25 Recommended Budget	99,784,000	9,762,000	52,237,000	37,785,000	495.0
1. Collections Revenue Realignment: Reflects a reduction of 1.0 Account Clerk II and 1.0 Account Clerk I positions to partially offset revenue decline in collection activities due to the pandemic impact.	(117,000)	--	(117,000)	--	(2.0)
2. Treasury Management: Reflects funding for the implementation of a new file transfer system for the Treasury Management, fully offset by Treasury Management interest.	223,000	--	223,000	--	--
Total Changes	106,000	0	106,000	0	(2.0)
2024-25 Final Changes	99,890,000	9,762,000	52,343,000	37,785,000	493.0
TRIAL COURT OPERATIONS					
2024-25 Recommended Budget	422,048,000	0	75,260,000	346,788,000	50.0
1. Salary and Employee Benefits Increase (Revenue Offset): Reflects an increase in salary and employee benefits due to Court-approved negotiated salary increases for Collection Enhancement staff, offset by revenue in accordance with Penal Code 1463.007.	279,000	--	279,000	--	--
Total Changes	279,000	0	279,000	0	0.0
2024-25 Final Changes	422,327,000	0	75,539,000	346,788,000	50.0

GENERAL FUND AND HOSPITAL ENTERPRISE

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
YOUTH DEVELOPMENT					
2024-25 Recommended Budget	74,573,000	10,000,000	59,628,000	4,945,000	54.0
1. Administration Transfer: Reflects the transfer of 9.0 positions from the Justice, Care and Opportunities Department (JCOD) to establish a standalone administrative framework for the Department of Youth Development, fully offset by a realignment of \$1.8 million in services and supplies (S&S), which supported the cost of the positions at JCOD.	--	--	--	--	9.0
2. Additional Administrative Support: Reflects 11.0 positions in budget, fiscal, contracts, information technology, and human resources, fully offset by \$0.8 million in obligated fund balance (OFB) committed for Youth Justice Reimagined (YJR), and \$1.2 million in various indirect revenues through the realignment of existing S&S appropriation.	835,000	--	--	835,000	11.0
3. Decarceration of Girls and Gender Expansive Youth: Reflects 1.0 Youth Development Specialist to lead decarceration efforts for girls and gender expansive youth, fully offset by an increase in Care First and Community Investment (CFCI) Indirect Revenue via intrafund transfer.	220,000	220,000	--	--	1.0
4. Youth Development Networks: Reflects 1.0 Youth Development Specialist and 2.0 Youth Development Ambassadors to support existing (South Los Angeles, Antelope Valley, and East Los Angeles) and new (Long Beach and San Fernando Valley) youth development regions, fully offset by a realignment of \$0.6 million in S&S appropriation.	--	--	--	--	3.0
5. Secure Youth Treatment Facility (SYTF) Support: Reflects 1.0 Youth Development Ambassador to expand SYTF programming and services at the Probation camps and halls, fully offset by a realignment of \$0.2 million in S&S appropriation.	--	--	--	--	1.0
6. Research, Data, Policy and Training: Reflects 2.0 Youth Development Specialists and 1.0 Youth Development Ambassador to support the Department's research, data, policy, youth training, and shared learning needs; fully offset by \$0.2 million in OFB committed for YJR, a realignment of \$0.2 million in S&S appropriation, and an increase of \$0.2 million in CFCI Indirect Revenue via intrafund transfer.	423,000	203,000	--	220,000	3.0
Total Changes	1,478,000	423,000	0	1,055,000	28.0
2024-25 Final Changes	76,051,000	10,423,000	59,628,000	6,000,000	82.0
GRAND TOTAL FINAL CHANGES	197,338,000	82,566,000	117,236,000	(2,464,000)	431.0

CAPITAL PROJECTS_REFURBISHMENTS

Changes from the 2024-25 Recommended Budget

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
MEDICAL EXAMINER					
2024-25 Recommended Budget	41,305,000	0	0	41,305,000	0.0
1. Medical Examiner X-Ray Room Refurbishment: Reflects an increase in carryover funding due to lower than anticipated prior-year project expenditures.	758,000	--	--	758,000	--
Total Changes	758,000	0	0	758,000	0.0
2024-25 Final Changes	42,063,000	0	0	42,063,000	0.0
PARKS AND RECREATION					
2024-25 Recommended Budget	167,660,000	0	134,838,000	32,822,000	0.0
1. Belvedere Park Gym Electrical and Lighting System Replacement: Reflects an increase in carryover funding due to lower than anticipated prior-year project expenditures.	706,000	--	--	706,000	--
2. Frank G. Bonelli Regional Park General Improvements: Reflects an increase in carryover funding due to lower than anticipated prior-year project expenditures.	240,000	--	240,000	--	--
3. Del Valle Picnic Area Renovation and Shade Structure: Reflects an increase in carryover funding due to lower than anticipated prior-year project expenditures.	250,000	--	250,000	--	--
4. Enterprise Park Gym Heating, Ventilation, Air Conditioning System Replacement: Reflects an increase in carryover funding due to lower than anticipated prior-year project expenditures.	1,000,000	--	--	1,000,000	--
5. Normandie and 95th Street Park: Reflects an increase in carryover funding due to lower than anticipated prior-year project expenditures.	77,000	--	77,000	--	--
6. MacLaren Community Park: Reflects a decrease to accurately align American Rescue Plan Act funding.	(19,200,000)	--	(19,200,000)	--	--
7. Schabarum Park General Improvements: Reflects an increase in carryover funding due to lower than anticipated prior-year project expenditures.	248,000	--	248,000	--	--
Total Changes	(16,679,000)	0	(18,385,000)	1,706,000	0.0
2024-25 Final Changes	150,981,000	0	116,453,000	34,528,000	0.0

CAPITAL PROJECTS_REFURBISHMENTS

	Gross Appropriation (\$)	Intrafund Transfers (\$)	Revenue (\$)	Net County Cost (\$)	Budg Pos
SHERIFF					
2024-25 Recommended Budget	88,445,000	0	1,961,000	86,484,000	0.0
1. Twin Towers Correctional Health Inmate Reception Center Remodel: Reflects an increase in carryover funding due to lower than anticipated prior-year project expenditures.	1,254,000	--	1,254,000	--	--
Total Changes	1,254,000	0	1,254,000	0	0.0
2024-25 Final Changes	89,699,000	0	3,215,000	86,484,000	0.0
GRAND TOTAL FINAL CHANGES	(14,667,000)	0	(17,131,000)	2,464,000	0.0

SPECIAL REVENUE FUNDS

Changes from the 2024-25 Recommended Budget

	Financing Uses (\$)	Financing Sources (\$)	Budg Pos
INFORMATION TECHNOLOGY INFRASTRUCTURE FUND			
2024-25 Recommended Budget	10,814,000	10,814,000	0.0
1. Information Technology Infrastructure Fund: Reflects \$10.0 million in one-time funding to continue to fund projects that are enterprise or cross-departmental, and provide Board or countywide benefit.	10,000,000	10,000,000	--
Total Changes	10,000,000	10,000,000	0.0
2024-25 Final Changes	20,814,000	20,814,000	0.0
LA COUNTY LIBRARY			
2024-25 Recommended Budget	251,121,000	251,121,000	1,295.0
1. Position Adjustment: Reflects adjustments to improve the Department's operational effectiveness and support by the addition of 1.0 Librarian III to support Los Padriños library services; the addition of 1.0 Psychiatric Social Worker Consultant and 1.0 Safety and Security Specialist to support staff involved with safety and security incidents; and the addition of 3.0 Administrative Services Manager I positions to support grants, marketing, and special projects; fully offset by the deletion of 1.0 Librarian II, 1.0 Senior Secretary II, and 23.0 Library Page positions and a decrease in Services and Supplies.	--	--	(19.0)
2. One-Time Funding: Reflects an adjustment to remove funding that was provided on a one-time basis for operating costs for the Claremont (\$0.2 million) and Pico Rivera (\$0.3 million) libraries and the reduction of funding (\$0.1 million) from the Department of Public Health for the My Brother's Keeper program.	(621,000)	(621,000)	--
Total Changes	(621,000)	(621,000)	(19.0)
2024-25 Final Changes	250,500,000	250,500,000	1,276.0
MENTAL HEALTH SERVICES ACT			
2024-25 Recommended Budget	1,244,157,000	1,244,157,000	0.0
1. Mental Health Services Act (MHSA) Adjustments: Reflects a realignment among Financing Uses to align funding for MHSA services in accordance with anticipated expenditure and revenue levels. This includes an \$85.6 million increase in operating transfers out, fully offset by an \$85.6 million cancellation of obligated fund balance, for a variety of MHSA-funded services. Also includes a realignment of obligated fund balance to better reflect spending plans in future years.	85,615,000	85,615,000	--
Total Changes	85,615,000	85,615,000	0.0
2023-24 Final Changes	1,329,772,000	1,329,772,000	0.0

SPECIAL REVENUE FUNDS

	Financing Uses (\$)	Financing Sources (\$)	Budg Pos
PUBLIC HEALTH – ALCOHOL ABUSE EDUCATION AND PREVENTION FUND			
2024-25 Recommended Budget	1,066,000	1,066,000	0.0
1. Fund Reclassification: Reflects a decrease in revenue and a corresponding decrease in appropriation to zero out this fund and instead reclassify this fund as a trust fund to streamline the budget and reporting process.	(1,066,000)	(1,066,000)	--
Total Changes	(1,066,000)	(1,066,000)	0.0
2024-25 Final Changes	0	0	0.0
PUBLIC HEALTH – ALCOHOL AND DRUG FIRST OFFENDER DUI FUND			
2024-25 Recommended Budget	1,212,000	1,212,000	0.0
1. Fund Reclassification: Reflects a decrease in revenue and a corresponding decrease in appropriation to zero out this fund and instead reclassify this fund as a trust fund to streamline the budget and reporting process.	(1,212,000)	(1,212,000)	--
Total Changes	(1,212,000)	(1,212,000)	0.0
2024-25 Final Changes	0	0	0.0
PUBLIC HEALTH – ALCOHOL AND DRUG PENAL CODE FUND			
2024-25 Recommended Budget	1,000	1,000	0.0
1. Fund Reclassification: Reflects a decrease in revenue and a corresponding decrease in appropriation to zero out this fund and instead reclassify this fund as a trust fund to streamline the budget and reporting process. (3-VOTES)	(1,000)	(1,000)	--
Total Changes	(1,000)	(1,000)	0.0
2024-25 Final Changes	0	0	0.0
PUBLIC HEALTH – ALCOHOL AND DRUG PROBLEM ASSESSMENT			
2024-25 Recommended Budget	336,000	336,000	0.0
1. Fund Reclassification: Reflects a decrease in revenue and a corresponding decrease in appropriation to zero out this fund and instead reclassify this fund as a trust fund to streamline the budget and reporting process.	(336,000)	(336,000)	--
Total Changes	(336,000)	(336,000)	0.0
2024-25 Final Changes	0	0	0.0
PUBLIC HEALTH – ALCOHOL AND DRUG SECOND OFFENDER DUI FUND			
2024-25 Recommended Budget	163,000	163,000	0.0
1. Fund Reclassification: Reflects a decrease in revenue and a corresponding decrease in appropriation to zero out this fund and instead reclassify this fund as a trust fund to streamline the budget and reporting process.	(163,000)	(163,000)	--
Total Changes	(163,000)	(163,000)	0.0
2024-25 Final Changes	0	0	0.0

SPECIAL REVENUE FUNDS

	Financing Uses (\$)	Financing Sources (\$)	Budg Pos
PUBLIC HEALTH – ALCOHOL AND DRUG THIRD OFFENDER DUI FUND			
2024-25 Recommended Budget	2,000	2,000	0.0
1. Fund Reclassification: Reflects a decrease in revenue and a corresponding decrease in appropriation to zero out this fund and instead reclassify this fund as a trust fund to streamline the budget and reporting process.	(2,000)	(2,000)	--
Total Changes	(2,000)	(2,000)	0.0
2024-25 Final Changes	0	0	0.0
PUBLIC HEALTH – DRUG ABUSE EDUCATION AND PREVENTION FUND			
2024-25 Recommended Budget	5,000	5,000	0.0
1. Fund Reclassification: Reflects a decrease in revenue and a corresponding decrease in appropriation to zero out this fund and instead reclassify this fund as a trust fund to streamline the budget and reporting process.	(5,000)	(5,000)	--
Total Changes	(5,000)	(5,000)	0.0
2024-25 Final Changes	0	0	0.0
PUBLIC HEALTH – STRATHAM FUND			
2024-25 Recommended Budget	2,591,000	2,591,000	0.0
1. Fund Reclassification: Reflects a decrease in revenue and a corresponding decrease in appropriation to zero out this fund and instead reclassify this fund as a trust fund to streamline the budget and reporting process.	(2,591,000)	(2,591,000)	--
Total Changes	(2,591,000)	(2,591,000)	0.0
2024-25 Final Changes	0	0	0.0
GRAND TOTAL FINAL CHANGES	89,618,000	89,618,000	(19.0)

SPECIAL DISTRICT FUNDS

Changes from the 2024-25 Recommended Budget

	Financing Uses (\$)	Financing Sources (\$)	Budg Pos
FIRE			
2024-25 Recommended Budget	1,621,195,000	1,621,195,000	4,826.0
1. Grants: Reflects the addition and/or carryover of Board-approved grant funding.	32,327,000	32,327,000	--
<i>Executive</i>	1,540,000	1,540,000	--
<i>Operations</i>	30,787,000	30,787,000	--
2. Advanced Provider Response Unit: Reflects funding to continue the Advanced Provider Response Unit, offset by American Rescue Plan Act funding.	1,308,000	1,308,000	--
<i>Emergency Medical Services</i>	1,308,000	1,308,000	--
3. Department Operations: Reflects funding primarily to address judgments and damages, architect design services, and dispatch console maintenance.	4,444,000	31,000	--
<i>Administrative</i>	3,163,000	--	--
<i>Executive</i>	10,000	10,000	--
<i>Operations</i>	21,000	21,000	--
<i>Special Services</i>	1,250,000	--	--
4. Junior Lifeguard Scholarships: Reflects funding to provide needs-based scholarships to Junior Lifeguard Program participants.	180,000	180,000	--
<i>Lifeguard</i>	180,000	180,000	--
5. Opioid Settlement: Reflects Year 2 of 3 of the Board-approved Johnson & Johnson opioid settlement.	1,000,000	1,000,000	--
<i>Operations</i>	1,000,000	1,000,000	--
6. Lifeguard Operations: Reflects funding from the General Fund to meet the requirements of the Beach and Ocean Rescue Services agreement.	104,000	104,000	--
<i>Lifeguard</i>	104,000	104,000	--
7. Tax Revenue: Reflects increases in revenue from property taxes and special taxes based on current projections.	--	15,189,000	--
<i>Financing Elements</i>	--	15,189,000	--
8. Other Revenue: Reflects a net decrease on the latest projections for fee-for-service revenue, Assistance by Hire, and other revenue sources.	--	(15,276,000)	--
<i>Financing Elements</i>	--	1,064,000	--
<i>Health – Hazardous Materials</i>	--	18,000	--
<i>Lifeguard</i>	--	(89,000)	--
<i>Operations</i>	--	(16,304,000)	--
<i>Prevention</i>	--	(414,000)	--
<i>Special Services</i>	--	449,000	--
9. Miscellaneous Earnings: Reflects a transfer of funding set aside to offset current year expenditures.	(4,562,000)	--	--
<i>Leadership and Professional Standards</i>	(11,000)	--	--
<i>Operations</i>	(4,500,000)	--	--

SPECIAL DISTRICT FUNDS

	Financing Uses (\$)	Financing Sources (\$)	Budg Pos
<i>Special Services</i>	(51,000)	--	--
10. Reclassifications: Reflects funding for Board-approved reclassifications.	62,000	--	--
<i>Leadership and Professional Standards</i>	11,000	--	--
<i>Special Services</i>	51,000	--	--
11. Ministerial Changes: Reflects routine ministerial changes between budget units in support of department operations.	--	--	--
<i>Administrative</i>	779,000	--	--
<i>Executive</i>	464,000	--	--
<i>Emergency Medical Services</i>	43,000	--	--
<i>Leadership and Professional Standards</i>	33,000	--	--
<i>Lifeguard</i>	(120,000)	--	--
<i>Operations</i>	193,000	--	--
<i>Prevention</i>	(65,000)	--	--
<i>Special Services</i>	(1,327,000)	--	--
Total Changes	34,863,000	34,863,000	0.0
2024-25 Final Changes	1,656,058,000	1,656,058,000	4,826.0
GRAND TOTAL FINAL CHANGES	34,863,000	34,863,000	0.0

OTHER PROPRIETARY FUNDS

Changes from the 2024-25 Recommended Budget

	Financing Uses (\$)	Financing Sources (\$)	Budg Pos
PUBLIC WORKS – INTERNAL SERVICE FUND			
2024-25 Recommended Budget	1,079,511,000	1,079,511,000	4,230.0
1. Expanded and Expedited Encampment Clean-up: Reflects the addition of 24.0 ordinance positions (3.0 Road Maintenance Supervisor, 3.0 Power Equipment Operator, 3.0 Heavy Truck Driver, 6.0 Public Works Maintenance Worker, 6.0 Public Works Laborer, and 3.0 Engineering Aid III), offset by a corresponding increase in Charges for Services revenues.	3,332,000	3,332,000	--
Total Changes	3,332,000	3,332,000	0.0
2024-25 Final Changes	1,082,843,000	1,082,843,000	4,230.0
GRAND TOTAL FINAL CHANGES	1,082,843,000	1,082,843,000	4,230.0



Reform and Oversight Efforts: Los Angeles County Sheriff's Department

April through June 2024

August 28, 2024

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between April 1 and June 30, 2024, unless otherwise noted. Quarterly reports may also examine particular issues of interest. This report includes special sections on the following topics:

- An Evaluation of an ICIB and IAB Investigation into Allegations of Criminal Conduct and False Statements by a Sworn Member of the Sheriff's Department
- Attorney and Professional Visitor Access Issues for people in custody
- Out-of-Cell Time at Century Regional Detention Facility (CRDF)
- Pregnant People in Custody at Century Regional Detention Facility

During the second quarter of 2024, the Office of Inspector General also issued the following reports relating to the Sheriff's Department:

- [Review of Contracts by School Resource Deputies with Elementary and Middle School Students](#)

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. This quarter, there were four incidents in which people were shot or shot at by Sheriff's Department personnel. The Office of Inspector General's staff responded to each of these deputy-involved shootings. Three people were struck by deputies' gunfire, one fatally. The information in the following shooting summaries is based on the limited information provided by the Sheriff's Department and is preliminary in nature. While the Office of Inspector General receives information at the walk-through at the scene of the shooting, receives preliminary memoranda with summaries, and attends the Sheriff's Department Critical Incident Reviews, the statements of the deputies and witnesses are not provided until the Sheriff's Department completes its investigation. The Sheriff's Department permits the Office of Inspector General's staff limited access to monitor the ongoing investigations of deputy-involved shootings. The Sheriff's Department [maintains a page](#)

[on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.

Industry Station: Hit Shooting – Non-Fatal

On May 3, 2024, at approximately 1:17 a.m., deputies from Industry Station responded to a call for service related to a domestic disturbance in La Puente. Upon arrival deputies parked their vehicles and walked towards the suspect's wife standing outside of the residence crying and screaming. Deputies could hear the suspect arguing with his son and based on their observations updated the call classification to a priority.

As the deputies approached the suspect and attempted to speak to him, he became confrontational, bent forward, and picked up a paint roller. The deputies backed away and commanded him to "drop it," but the suspect did not comply. A deputy then sprayed the suspect in the face with oleoresin capsicum (pepper) spray. As the suspect became increasingly agitated, he appeared to position himself to throw the paint roller, while the deputies continued to command him to put it down. The suspect threw the paint roller towards the deputies, striking one deputy in the abdomen. The deputy who was struck then discharged his handgun three to four times wounding the suspect in his lower body. According to the Sheriff's Department, deputies waited to render aid until the arrival of additional units because the suspect's family members refused to obey their verbal commands. Aid was rendered, then the Fire Department transported the suspect to the hospital, where he was treated for the gunshot wound.

The deputy struck by the paint roller reported redness and soreness to his abdomen.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from body-worn cameras and a surveillance camera.

Areas for further inquiry

Only three casings identified, but the Department stated there may have been four rounds discharged. Why is there a discrepancy?

Was the shooting concurrent with the throwing of the paint roller, or did the shooting occur after the paint roller had made contact with the deputy's abdomen?

Did the deputies view the paint roller as a deadly or dangerous weapon?

Were family members or neighbors in the backdrop or line of fire?

Did deputies issue any warnings prior to firing?

Was MET contacted for assistance?

East Los Angeles Station: Non-Hit Shooting

On June 7, 2024, at approximately 10:10 a.m., deputies from the East Los Angeles Station responded to a call that an adult man was at his parents' home in violation of a restraining order. Two responding deputies contacted the suspect in an alley behind the home. The suspect refused to comply with deputy's commands and ran into the family home's rear yard. The responding deputies waited for backup and then proceeded into the rear yard, where they located the suspect and his father along a narrow, paved, side yard between the house and a cinderblock wall. The suspect held a metal folding chair and waived it as if he might strike his father. Several trash bins, plastic chairs, and other items blocked the side yard between the suspect and deputies.

The deputies formed a tactical plan in which they assigned one deputy to use a less-lethal 40mm baton launcher; another deputy to use a Taser; and another to provide a lethal force option using his department-issued firearm. The deputies approached the side yard with the deputy handling the 40mm launcher in the lead and the deputy with the firearm immediately behind. They spoke for several minutes with the suspect, who did not comply with their orders to put down the chair, although he allowed his father to leave. After several minutes, the suspect threw a barbeque grill over the trash bins at the deputies, nearly striking them. At this point, the deputy assigned to use lethal force drew his firearm and pointed it in the direction of the suspect and the deputy equipped with the 40mm launcher fired a single round from the device.

The suspect then picked up a large squeegee mounted on the end of a wooden pole, waved it about, and threw it down the side yard toward the deputies. As the squeegee sailed through the air toward the deputies, the deputy with his firearm drawn discharged a single round at the suspect but did not hit him.

Deputies continued to order the suspect to drop the chair, as they cleared items from the side yard to get to the suspect. The deputy with the 40mm launcher fired a second round toward the suspect and another deputy fired a Taser as they closed in on the suspect and took him into custody.

The suspect was taken to a local hospital and treated for a contusion to his lower left abdomen from the 40mm round. The deputies suffered no injuries.

The deputy who fired his weapon did not announce that he fired it at the time it was discharged. Only after the suspect was in custody, did the deputy indicate that he may have fired his weapon, expressing some uncertainty. The supervisor on scene ordered him to review his body-worn camera video to confirm whether he had fired.

The Department reported that IAB will investigate the incident as a non-hit shooting unless it determines that the deputy discharged his firearm accidentally.

Areas for further inquiry

Did the deputies have any information indicating that mental health issues may have played a role in the suspect's behavior?

After the suspect released his father, did the deputies on scene consider retreating to a position of safety and contacting a MET team?

Did the deputy fire accidentally or intentionally?

Did the deputy have to review the body worn camera video to determine whether he fired, or could he have just checked his service weapon?

Did the deputy follow Sheriff's Department policy and training when drawing and handling his firearm?

Did the deputies and supervisor on scene follow procedures for a non-hit shooting and timely notify IAB?

Compton Station: Hit Shooting – Fatal

On June 13, 2024, at approximately 7:46 p.m., Compton station received a call stating that the brother-in-law of the caller was firing several shots into the air and that he might be under the influence of an unspecified substance. The caller also stated that her children were inside an adjacent home, and she was fearful for their safety.

When the first deputy arrived, he spotted the suspect through a side gate and called for his surrender, but the suspect retreated into the backyard. As the first deputy awaited backup, he evacuated the family members who were still inside the adjacent building. Deputies then called for an Aero Unit, Canine Unit, and a MET team to respond to the location. A few minutes later, the suspect appeared on the roof of the building inhaling from an aerosol canister. When the Aero unit arrived, they informed the deputies below that there was a shotgun near the suspect.

While on the roof, the suspect fired several rounds and the Aero unit reported that the helicopter had been hit. Two deputies repositioned inside an adjacent house where they could see the suspect on the roof through a living room window. They called for the suspect to surrender, but he did not, at one point yelling "shoot me, shoot me." Shortly afterward, the suspect again aimed the shotgun at the hovering helicopter and the two deputies inside the house responded by firing their .223 and 9mm caliber weapons, striking the suspect.

After deploying a flashbang device and observing no response from the suspect, deputies advanced and assessed the situation safe enough for the nearby fire department to provide assistance. The suspect died at the scene. A helicopter

inspection determined that it had been hit with one pellet shot. At the conclusion of the incident, a loaded shotgun with a pistol grip and a box of ammunition were found next to the suspect. No deputies were injured.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from body-worn cameras.

Areas for further inquiry

Were all deputies who responded provided with a body-worn camera, if not, why?

Had the MET team arrived and attempted to de-escalate the situation?

Were there any attempts to de-escalate the situation?

Did Aero unit follow best practices and department policy by remaining overhead while being fired at?

Could a UAS (drone) have been deployed instead?

Did deputies follow the standard protocols and tactics involving an armed suspect on a roof?

Palmdale Station: Hit Shooting – Non-Fatal

On June 17, 2024, at around 7:52 p.m., deputies from Palmdale station received a call regarding a man wielding two knives (later described as 3-inch pocketknives) attempting to carjack three vehicles. Following the failed carjackings, the suspect proceeded towards a nearby apartment complex where, he allegedly broke the window of a ground-floor apartment.

Shortly afterward, deputies arrived at the scene, initiating a standoff with the suspect, who still held both knives and refused to surrender despite attempts by deputies to de-escalate the situation. Deputies fired 40mm rounds which failed to subdue the suspect. Subsequently, one deputy discharged two rounds from a handgun as the suspect approached them with the knives still in his hands. The suspect was struck by one round. He was transported to the hospital for medical attention and was listed in stable condition.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from body-worn cameras.

Areas for further inquiry

The shooting occurred in front of an apartment building at night, did the deputies consider evacuating residents prior to the shooting?

Since MET was on-scene at the time of the shooting, did they play a role in the de-escalation efforts?

Were other less lethal alternatives considered prior to the decision to employ lethal force?

Did deputies form a tactical plan before engaging with the suspect?

How many deputies were assigned lethal force? If more than one, why did only one deputy fire?

Was there adequate communication between deputies?

Was there a sergeant at the scene? If so, was there sufficient command and control of the incident?

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate. For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and which occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between January 1, 2024, and June 30, 2024, the District Attorney's Office issued twelve findings on deputy-involved shooting cases involving the Sheriff's Department's employees.¹

- In the March 5, 2020, non-fatal shooting of Jessa Allan Janto, the District Attorney opined in a [memorandum dated April 16, 2024](#), that the shooting by deputies Matthew Bistline, David Chavez-Cruz, Andrew De La Rosa, Jonathon Livingston, Collin Reddy, and Ryan Thompson was not unlawful.
- In the October 6, 2020, fatal shooting of Nicholas Burgos, the District Attorney opined in a [memorandum dated February 20, 2024](#), that there

¹ The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#), and the Office of Inspector General retrieves the information on District Attorney decisions from this webpage. The District Attorney's Office published the twelve memoranda listed here on its website between April 1 and June 30, 2024, although seven of the memoranda are dated prior to April 1.

was insufficient evidence Deputy Dalia Gonzalez did not act lawfully in self-defense and in defense of others when she fired her duty weapon.

- In the March 3, 2021, non-fatal shooting of Deputy Andrew Toone, the District Attorney opined in a [memorandum dated February 28, 2024](#), that the shooting was accidental and Deputy Donald McNamara is not criminally responsible.
- In the April 23, 2021, non-fatal shooting of Miguel De Los Santos, the District Attorney opined in a [memorandum dated March 29, 2024](#), that deputies Erasto Granados and Daniel Velasco acted in lawful self-defense and the defense of others when they fired their duty weapons.
- In the November 12, 2021, fatal shooting of Wendy Carolina Flores De Roque and the non-fatal shooting of Franklin Moran, the District Attorney opined in a [memorandum dated June 7, 2024](#), that the use of deadly force by Deputy Dominguez was not unlawful.
- In the December 15, 2021, non-fatal shooting of Juan Angel Marquez, the District Attorney opined in a [memorandum dated May 30, 2024](#), that the deputies Ernest Hernandez and Joshua Corrales each reasonably believed that deadly force was necessary to defend against an imminent deadly threat.
- In the March 3, 2022, fatal shooting of Edgar Ortiz, the District Attorney opined in a [memorandum dated February 12, 2024](#), that there was insufficient evidence deputies Gabriel D'Souza and Erin Herring did not reasonably believe, based on a totality of the circumstances, that deadly force was necessary to defend against a deadly threat when they fired their weapons.
- In the March 13, 2022, fatal shooting of Samuel Nunez, the District Attorney opined in a [memorandum dated May 20, 2024](#), that the District Attorney's Office cannot prove beyond a reasonable doubt that Deputy Melton acted unlawfully.
- In the August 31, 2022, fatal shooting of Agustin Flores, the District Attorney opined in a [memorandum dated May 20, 2024](#), that the deputies Jasen Tapia, Timothy Garcia, Julio Chavez-Ruiz, and Raymond Romero-Soto acted reasonably believing that deadly force was necessary to defend against an imminent deadly threat.

- In the January 26, 2023, fatal shooting of Miguel Lopez, the District Attorney opined in a [memorandum dated June 5, 2024](#), that the deputies acted reasonably believing that deadly force was necessary to defend against an imminent threat.
- In the January 31, 2023, non-fatal shooting of Mario Bustillos, the District Attorney opined in a [memorandum dated February 22, 2024](#), that the deputies Edwin Barajas, Leonel Leon, Victor Garcia, Timothy Cho, Chase Morales, and Steven Medina acted in lawful self-defense and defense of others at the time they fired their service weapons, reasonably believing, based on the totality of the circumstances, that deadly force was necessary to defend themselves and others against an imminent deadly threat.
- In the February 10, 2023, fatal shooting of Everett Byram, the District Attorney opined in a [memorandum dated March 29, 2024](#), that Deputy Blake Runge acted lawfully in self-defense and defense of others when he fired his weapon.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has fourteen shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a June 19, 2023, shooting in the jurisdiction of Walnut Station. For further information as to that shooting, please refer to the Office of Inspector General's report. The oldest case that the Bureau has open is a 2022 shooting in the city of Compton, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent one deputy-involved shooting case to the District Attorney's Office for filing consideration.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.² As of the

² Gov't Code § 12525.3(b).

end of the second quarter, the DOJ [is investigating](#) three shootings involving deputies from the Sheriff's Department, the oldest of which occurred in February 2022. During the last quarter, the DOJ [issued no written reports](#) regarding shootings involving Sheriff's Department deputies.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.³

The Sheriff's Department reports that ICIB has 79 active cases. This quarter, the ICIB reports sending one case to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 29 cases from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting or use of force, IAB reviews the evidence to determine whether Sheriff's Department personnel violated any policies during the incident.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

This quarter, the Sheriff's Department reported opening 143 new administrative investigations. Of these 143 cases, 40 were assigned to IAB, 77 were designated as unit-level investigations, and 26 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 152 cases were closed by IAB or

³ Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

at the unit level. There are 526 pending administrative investigations, of which 320 are assigned to IAB and the remaining 206 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between April 1 and June 30, 2024, the Civil Service Commission issued final decisions in three cases involving Sheriff's Department employees.⁴

Employee Position	Date of Department action	Case number	Department actions	Date of Civil Service Hearing	Civil Service decision
Deputy Sheriff	5-13-15	15-185	Discharge	4-10-24	Commission sustained discharge, but Superior Court ordered reinstatement
Custody Assistant	12-9-21	21-251	Discharge	4-24-24	Commission overruled the Department and imposed a 30-day Suspension
Deputy Sheriff	10-6-21	21-212	Discharge	5-22-24	Commission did not sustain the Department's decision to discharge

Two cases concerned sworn peace officers of the rank of deputy and one concerned a custody assistant. In all three cases, the Sheriff's Department had discharged the employee. In one case, the Civil Service Commission sustained the deputy's discharge, but the deputy sought review in the Superior Court, which overturned the discharge and ordered the deputy reinstated on grounds that the Department had not imposed discipline within the one-year statute of limitations required by the Public Safety Officers Procedural Bill of Rights Act, Govt. Code § 3304(d). Another case overruled the Department's decision to discharge and imposed a 30-day suspension. In the last case, the Commission did not sustain the Department's discharge.

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) nine times between April 1 and June 30, 2024, as summarized in the chart below.

DATE	OPERATION TYPE	LOCATION	SUMMARY
4-29-24	Barricaded Suspect	Whittier	SEB K9 services assisting Norwalk station with barricaded suspect. UAS utilized to monitor location. Suspect Surrendered.

⁴ The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings posted on the County's website](#) for commission publications.

5-12-24	Search and Rescue	Monrovia Peak	SEB responded to location regarding a barricaded suspect. UAS used to view interior of location. Suspect surrendered.
5-13-24	Barricaded Suspect	Los Angeles	SEB personnel served a high-risk search warrant related to a murder investigation. UAS used to search attic space for suspect.
5-17-24	High Risk Tactical Operations	Compton	UAS used to observe train rail tracks bordered by freeway. High risk area off limits to pedestrian danger.
5-22-24	Search and Rescue	Malibu	SEB personnel assisted Montrose Search and Rescue with a missing hiker. Hiker not located.
5-26-24	High Risk Tactical Operations	Compton	UAS used to assist SEB with a barricaded suspect who used a sharp object to assault deputies. UAS used to locate suspect inside location and monitor while arrest team took suspect into custody.
6-15-24	High Risk Tactical Operations	Compton	SEB personnel serving arrest warrant for murder suspect. UAS used to search interior and attic for suspect.
6-22-24	High Risk Tactical Operations	Palmdale	SEB personnel responded for inspection and removal of potential blast hazard. UAS used to gather information on two unstable and over-pressured heavy equipment tires.
6-24-24	High Risk Tactical Operations	Palmdale	SEB personnel responded for inspection and removal of potential blast hazard. UAS used to gather information on two unstable and over-pressured heavy equipment tires.

Evaluation of an ICIB and IAB Investigation into Allegations of Criminal Conduct and False Statements by a Sworn Member of the Sheriff's Department.

The Office of Inspector General reviewed ICIB and IAB investigations into an allegation that a sworn member of the Sheriff's Department engaged in illegal gambling activity. The review found that neither ICIB nor IAB followed up on significant investigative leads uncovered during the ICIB investigation, including evidence that the subject may have been receiving large amounts of money from an unknown person in connection with gambling. Neither investigation examined the deputy's financial or business dealings to determine if the deputy was engaged in activities that violated criminal laws or County or Sheriff's Department policies. Although the deputy made statements during the IAB investigation that were inconsistent with evidence gathered during surveillance of the deputy, the Department chose not to pursue an investigation into whether those statements were intentionally false. In response to Office of Inspector General inquiries, the current administration explained the decision not to pursue an investigation into possible false statements on grounds that the passage of time may explain the deputy's failure to recall certain events. The length of the ICIB investigation along with the failure to investigate the deputy's financial records made it difficult to prove that the deputy's statements to IAB that were inconsistent with evidence gathered during surveillance of the deputy were false. In previous reports, the Office of Inspector General identified

issues with the Department's failure to conduct thorough investigations, investigatory delays that may lead to memories fading, the loss of evidence, leaving a lack of sufficient time for follow-up interviews before the expiration of the one-year Peace Officer Bill of Rights statute of limitations and neglecting to impose discipline on sworn personnel for making false statements during misconduct investigations.⁵

In March 2021, ICIB began investigating a complaint to the Sheriff's Department alleging that a sworn member of the Department was hosting illegal high-stakes poker events. ICIB investigated for approximately **two years** before concluding that they lacked evidence to file criminal charges.⁶ In June 2023, ICIB closed its investigation without submitting the case to the District Attorney's Office and referred the matter to IAB for investigation into possible administrative policy violations. In April 2024, IAB completed its investigation, based on which the Sheriff's Department found the allegations "unresolved."

During the course of the ICIB investigation, investigators overheard a conversation at a casino between the subject deputy and an unidentified male who discussed wiring the subject a monthly five-figure sum of money and mentioned a player cheating at the poker events. The conversation ended with the unidentified male asking the subject to send him wire instructions to send the deputy a five-figure sum of money.

The ICIB and IAB case files reviewed by the Office of Inspector General indicate that neither ICIB nor IAB made any efforts to identify and interview the man talking about the wire transfer with the subject deputy. The investigators did not request surveillance recordings from the casino where the deputy and the man had the conversation. Nor did ICIB or IAB make any attempt to determine whether the deputy received a wire transfer consistent with that described by the man, or any unexplained large transfers of money and, if so, what services the subject provided for those payments. County rules require

⁵ See Los Angeles County Office of Inspector General, [Los Angeles County Sheriff's Department: Review and Analysis of Misconduct Investigations and Disciplinary Process](#) (Feb. 2021).

⁶ The Sheriff's Department did not submit the case to the District Attorney's Office and relied upon its own determination that criminal activity could not be proven based on the ICIB investigation. There are multiple advantages in submitting criminal cases to the District Attorney for filing consideration. One, of course, is that the District Attorney's office, in its independent review of the case, may determine that it justifies filing. The District Attorney's office may also suggest areas for further investigation, including recommending securing a search warrant or suggestions for additional investigation to support the statement of probable cause to obtain a search warrant, or can initiate a grand jury investigation to gather additional evidence on its own. Finally, submitting the case to the District Attorney's office provides the prosecution with information regarding the subject deputy for inclusion in a *Brady* database to comply with the constitutional requirement that potentially exculpatory information be provided to defendants in criminal cases.

that employees inform the County of outside employment activities, including conducting a personal business, yet the investigation does not state whether the investigators even checked if the subject disclosed any outside employment. ICIB investigators do not appear to have obtained any search warrants during their investigations to investigate the subject's finances to corroborate the sums discussed.⁷ Nor was the deputy asked to voluntarily provide financial records to ICIB or IAB investigators.⁸ Neither ICIB nor IAB investigators provided any explanation in the case files reviewed by the Office of Inspector General as to why they did not attempt to further investigate the lead generated by the Department's own investigation.

In March 2024, the IAB interviewed the subject on two separate occasions. During the interviews, IAB investigators asked the subject about the conversation with the unidentified man, and the subject denied that the conversation took place, contradicting the evidence in the Department's possession. Under the Department's Manual of Policy and Procedures (MPP), "false statements and any other form of dishonesty during an official Department internal investigation or inquiry shall, absent extenuating

⁷ The Department has stated to the Office of Inspector General that ICIB investigators did not believe there was sufficient evidence to support probable cause to obtain a search warrant. The Office of Inspector General disagrees with this assessment.

⁸ If the subject had failed to comply with such a request in the IAB investigation, they would potentially face punishment under the Sheriff's Department's Manual of Policy and Procedures (MPP) § 3-01/040.76. Under this section, employees of the Department "shall not take any action that could interfere with, delay, obstruct, distort or unduly influence any investigation." While employees of the Sheriff's Department are required to cooperate in a criminal investigation as stated in MPP § 3-01/040.85, employees may assert their rights under the Fourth and Fifth Amendment of the United States Constitution and discipline could not be imposed for a valid assertion of a constitutional right. The assertion of a constitutional right during an IAB investigation, once ordered to answer, may be considered to be a failure to cooperate and an employee may be disciplined, up to and including discharge from the Sheriff's Department. See MPP § 3-01/040.75, which states, "[f]ailure or refusal to make statements when ordered during Department internal investigations constitutes insubordination and shall, absent extenuating circumstances, result in discharge." While Government Code § 3308 states that a public safety officer shall not be required or requested to disclose income or sources of income in a personnel action, there is an exception when the information "tends to indicate a conflict of interest with respect to the performance of his official duties." There is no published case on what constitutes a "conflict of interest with respect to the performance of his official duties." In one court decision, on an *ex parte* application for a temporary restraining order in Los Angeles County, a court ordered that deputies not be compelled to answer financial questions and could not be punished for failing to answer **but allowed the questions to be asked of the deputies**. See *Khounthavong, et al. v. County of Los Angeles*, Los Angeles Superior Court Case No. BC603263. Engaging in illegal gambling activities while employed as and therefore performing one's official duties as a sheriff's deputy is arguably a conflict of interest as intended by the statute. Section 3308 applies only to personnel actions and would not prevent ICIB from inquiring into the subject's financial records as part of its criminal investigation, nor from including the results of that investigation in its file for IAB to review.

circumstances, result in discharge.”⁹ But the Department never initiated an administrative investigation into the subject’s possibly false statements because it concluded at the outset that the deputy’s failure to recall certain events could be explained by the passage of time. Had the Department actually conducted a thorough, evidence-based investigation, it might have gathered sufficient evidence to determine whether or not the deputy’s statements to IAB investigators were false.¹⁰

The Sheriff’s Department ultimately found that the allegation was “unresolved,” and as a result, the deputy was not disciplined. As of this writing, the subject remains on duty with the Department. The Department’s handling of the ICIB and IAB investigations here exhibit the issues identified previously by the Office of Inspector General, that investigations of employees are not always evidence-based, thorough, or timely. These problems increase the possibility that misconduct goes unpunished.

Semi-Annual Report on Implementation of the Family Assistance Program

The Los Angeles County Board of Supervisors [established the Family Assistance Program](#) (Family Assistance), first in 2019 as a one-year pilot that it later made permanent, with the aim of improving compassionate communication and providing trauma-informed support to families of those who died following a fatal use of force by a Sheriff’s Department employee or while in the custody of the Sheriff’s Department. The Office of Inspector General reports semi-annually on Family Assistance in its quarterly reports on the Sheriff’s Department.

Family Assistance Status

On February 8, 2024, the administration of Family Assistance officially transitioned from the Department of Mental Health (DMH) to the Office of Violence Prevention (OVP)

⁹ [MPP § 3-01/040.75](#), *Dishonesty/Failure to Make Statements And/Or Making False Statements During Departmental Internal Investigations*.

¹⁰ The Department stated to the Office of Inspector General that due to the passage of time between the October 2021, conversation and the March 2024, IAB interview of the subject, “it was deemed reasonable that the subject may have forgotten aspects of visits to gambling establishments [they] frequented after this significant period of time.”

within the Department of Public Health, pursuant to the plan to make Family Assistance permanent as recommended to the Board in 2022.¹¹

As previously reported, the Chief Executive Office approved four positions requested by DPH in the FY 2023-2024 budget to support Family Assistance. OVP reports that it filled the Clinical Social Worker Supervisor II position on September 1, 2023, and the Clinical Social Worker position on March 22, 2024. OVP continues to work in collaboration with the Department of Medical Examiner (DME) to fill the two Psychiatric Social Worker II (PSWII) positions, both of which will be assigned to work on-site with the DME.¹²

OVP reports that it has prepared a draft Memorandum of Understanding (MOU) outlining the terms of the agreement, funding provisions, and the respective duties and responsibilities of DPH, OVP, and DME. OVP reports that the draft MOU has been submitted to DME for review and will likely require modifications. OVP reports that it anticipates meeting with the DME to further clarify roles and responsibilities regarding next-of-kin identification and death notifications, managing communications with mortuaries/funeral homes, and the process for impacted families to claim decedents' personal effects and property.

In March 2024, OVP formed a multidisciplinary work group that meets monthly to discuss program design and implementation, protocols, eligibility criteria, and reviews cases. The work group includes representatives from the Sheriff's Department, DME, the Office of Inspector General, the Sheriff Civilian Oversight Commission (COC), Los Angeles County District Attorney Office, DMH, Los Angeles County Correctional Health Services, and Los Angeles Office of the County Counsel.

Family Assistance Service Data

OVP reports that from January 1, 2024, to June 30, 2024, OVP was notified of 21 incidents where an individual died following a fatal use of force by a Sheriff's Department employee or while in the custody of the Sheriff's Department. OVP successfully contacted 20 families. Of those, all 20 families accepted services and assistance from OVP Family Assistance Advocates. OVP distributed burial expenses to

¹¹ See [*Office of Inspector General's Semi-Annual Report on Implementation of the Family Assistance Program and Report Back on Permanent Support for Families Affected by Los Angeles County Sheriff's Department: Identifying Sustainable Funding for and Streamlining the Family Assistance Program \(Item No.14, Agenda of July 9, 2019 and Item No. 9, Agenda of October 19, 2021\)*](#) (Feb. 22, 2022).

¹² The Clinical Social Worker Supervisor II position was originally classified as Mental Health Clinical Supervisor and the Clinical Social Worker position was originally classified as PSWII.

14 families, with expenses ranging from \$1,393 to \$7,500, totaling approximately \$68,785 for the period.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracing and Documenting Taser Use

On October 3, 2023, the Board of Supervisors directed the Sheriff's Department to revise its Taser use policies to incorporate best practices from other law enforcement agencies, ensure compliance with State and Federal legal standards, and consider recommendations by other law enforcement and advocacy groups.¹³

The Board of Supervisors also directed the Office of Inspector General to include in its quarterly reports to the Board an "[u]pdate on the status of the LASD's adoption of an updated Taser policy, the status of training personnel on the updated Taser policy, and deputy compliance with updated policies, once adopted, consistent with LASD trainings until full compliance;" and "[d]ocumentation and tracking on the Department's Taser use, including those that result in serious injury or death, in patrol and custody."

Updated Taser Policy

In its previous quarterly report, the Office of Inspector General reported that the Sheriff's Department had not completed bargaining with labor associations and had not finalized a revised policy on Taser use. The Department did not finalize a policy during this reporting period. However, on July 11, 2024, shortly after the reporting period ended, the Sheriff's Department provided the Office of Inspector General with a finalized version of the updated Taser policy. The Office of Inspector General will review the language of the updated policy in its next quarterly report to the Board in accordance with the Board's directive and to examine how the Department addressed Office of Inspector General comments on its draft Taser policy, including the clarity of its standards for authorized Taser use, the potential for use against passive resistance, the policy provisions limiting multiple applications of Tasers, and the extent to which the policy adequately conveyed the potential risks of Taser use.

Documenting and Tracking Taser Use

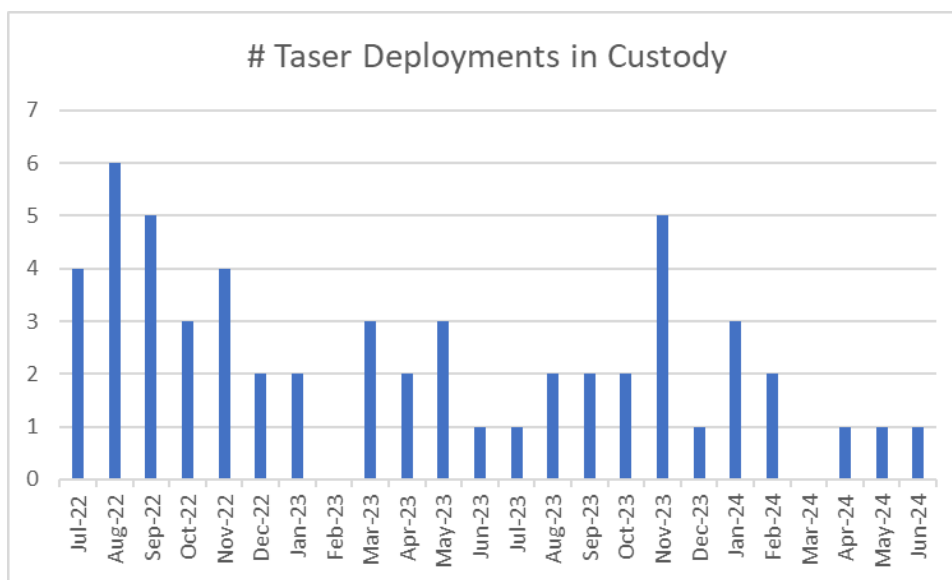
In May 2024, the Sheriff's Department launched a [web dashboard reporting Taser usage](#) after April 1, 2024, by patrol station or facility, date, and subject description. Beginning in July 2024, the Department began including in that data the "Result of the

¹³ [Transparency, Accountability, and Oversight of Los Angeles Sheriff's Department's Taser Use Policy](#), Agenda No. 15 (Oct. 3, 2023).

Use of Force” (i.e., whether the use resulted in serious injury or death) for all incidents that occurred on or after July 1, 2024.

Taser Use in Custody

The following chart reflects the number of use-of-force incidents in custodial settings over the past two years in which deputies employed a Taser, according to the *Monthly Force Synopsis* that the Sheriff’s Department produces and provides to the Office of Inspector General each month:



CUSTODY DIVISION

Attorney and Professional Visitor Access Issues

The Office of Inspector General received several complaints of jail visitation staff refusing to allow people in custody to meet with members of their criminal defense team in attorney visit areas, despite valid court orders directing such access.¹⁴

¹⁴ Some attorneys who spoke with Office of Inspector General staff advised that they will at times preemptively obtain a court order directing access to their clients in an effort to avoid being denied access.

The Sheriff's Department jail facilities have dedicated visiting areas for attorneys and professional visitors, such as social workers, paralegals, law enforcement officers, and private investigators, to meet with people in custody. Each facility is responsible for developing and implementing policies for providing attorneys and professional visitors with reasonable access to people in custody, which, as discussed below, has resulted in inconsistencies between the policies of the facilities.¹⁵ Depending on the facility, the Department requires certain types of professional visitors to obtain a court order to meet with a person in custody in the attorney visiting areas. The Department also requires attorneys and professional visitors who wish to meet face-to-face with a person in custody without a physical barrier separating them to obtain a court order.¹⁶ Legal and professional representatives may submit court orders to a facility's legal unit for prior approval or present the court order to visitation staff upon arrival to the visit area. Visitation staff work closely with their respective facility's legal unit to validate visitors' credentials and process court orders.

In August 2022, an attorney complained to the Office of Inspector General that visitation staff at Twin Towers Correctional Facility (TTCF) refused to allow him to meet with his client in a private visiting room. The attorney reported that he presented TTCF visitation staff with a valid court order to meet confidentially with his client, and that visitation staff wrote "not possible" on the court order in black marker, ostensibly due to the Tower 2 elevators being inoperable.¹⁷

In September 2023, an attorney complained that Sheriff's Department staff refused to allow a member of her legal team to meet with a client at Men's Central Jail (MCJ) in the attorney visiting area, despite a valid court order signed by a judge directing that the legal team, including an investigator, be granted visits with their client to assist with legal representation.

In November 2023, a legal clinic complained that, although it had obtained a court order to have a licensed social worker conduct a social history assessment of the client who was housed at MCJ, visitation staff denied the social worker access to meet confidentially with the client in an attorney visiting room on grounds that the social worker was not employed by the County. Office of Inspector General staff spoke with Custody Division personnel regarding this incident, who stated that MCJ staff did not

¹⁵ See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-10/030.00, [Attorney Room Visits](#).

¹⁶ *Id.*

¹⁷ The attorney visiting area in Tower 2 can be accessed via either stairs or via the elevators for Tower 1, and the Department did not explain why the attorney could not use these alternatives.

comply with the court order partly due to staff training issues. However, the Department had denied the clinic's legal team court-ordered access to clients on prior occasions as well. The clinic obtained a court order granting a law student access to interview a client housed at MCJ. The supervising attorney accompanied the law student and presented the court order to visitation staff. Visitation staff refused to comply with the court order on the basis that the law student was not certified as required by Department policy and that Department policy superseded the court order.¹⁸ The court order did not require that the law student be certified to access the client.

The Office of Inspector General reviewed unit orders related to accessing attorney visit areas from MCJ and TTCF and noted several concerns:¹⁹

No clear directive to comply with court orders. The unit orders fail to emphasize the importance of ensuring that the Department adhere to court orders. California Penal Code section 166(4) provides that “[w]illful disobedience of the terms, as written, of a process or court order or out-of-state court order, lawfully issued by a court” constitutes a misdemeanor. Yet, it appears as though some Department visitation staff are unaware that non-compliance with court orders may constitute a criminal offense, and Department policy does not outline the legal significance of court orders.

MCJ's unit order instructs visitation staff that when visitors bring in court orders, “Legal Staff shall be contacted for approval to comply with the order” or “[i]n their absence, the Watch Sergeant or Watch Commander shall be contacted.”²⁰ Requiring approval in order to comply with a court order suggests that the default course of action is non-compliance. This raises serious concerns given that adhering to court orders is mandatory. In contrast, TTCF's unit order requires that visitation staff notify either a supervisor or, in their absence, the watch commander, for verification, logging, and processing.

No time frame for complying with court orders. MCJ's unit order also lacks a time frame for visitation staff to process court orders. In contrast, TTCF Unit Order # Unit

¹⁸ The State Bar of California's Practical Training of Law Students Program certifies law students to provide legal services permitted by rule 9.42(d) of the California Rules of Court under the supervision of an attorney. The program is also governed by Title 3, Division 1, Chapter 1 of the Rules of the State Bar.

¹⁹ The Office of Inspector General reviewed the following unit orders: (1) Men's Central Jail Unit Order 5-15-041, [Attorney Room Procedures](#), (2) Men's Central Jail Unit Order 4-03-020, *Procedures for Handling Court Orders*, (3) Twin Towers Correctional Facility Unit Order 5-15-020, *Attorney and Other Professional Priority Visits*, and (4) Twin Towers Correctional Facility Unit Order 4-08-010, [Court Orders](#).

²⁰ Men's Central Jail Unit Order 5-15-041, [Attorney Room Procedures](#).

Order #: 5-15-020, *Attorney and Other Professional Priority Visits*, provides, “[w]hen an attorney, or other professional, presents TTCF Visiting staff with a court order, the deputy personnel shall *immediately* [emphasis added] notify the Visiting bonus deputy, who shall forward a copy of the court order to the TTCF Legal Unit for verification, logging, and processing. If the Visiting bonus deputy is not available and the court order is of an exigent nature, the handling deputy shall forward the order to the on-duty watch commander” The lack of timeframe in MCJ’s unit order may impact the facility staff from processing court orders as expeditiously as possible.

Inconsistent practices on attorney and professional visitation between jail facilities. In addition to the inconsistencies noted above regarding the handling of court orders, TTCF’s unit order provides that a certified law student need not be under the direct, physical supervision of the attorney in order to use an attorney visit room. MCJ’s unit order prohibits a certified law student from using an attorney visit room unless accompanied by an attorney. TTCF’s unit order allows for private paralegals to access the attorney visiting area with a valid court order, while MCJ’s unit order prohibits private paralegals from accessing the attorney visiting area. TTCF’s unit order does not establish procedures for defense expert visits, while MCJ’s unit order allows defense experts to access the attorney visit areas with a valid court order. The lack of continuity between the types of professional visitors that are able to access each facility creates confusion for legal counsel and other professional visitors.

Inadequate documentation of refused attorney and professional visits. The unit orders do not require visitation staff to log instances where the Department denies attorneys, attorney representatives, and other professional visitors access to attorney visiting areas or refuses to comply with a court order’s directions on the terms for a meeting. Documenting such instances will allow for periodic audits to ensure that all policies and procedures outlined in the unit orders are followed consistently.

During conversations with defense attorneys regarding the challenges with accessing their clients in TTCF and MCJ, it became apparent to Office of Inspector General staff that attorneys and other professional visitors seeking to meet with clients lacked sufficient clear information about the Sheriff’s Department’s policies and procedures for such visits. Office of Inspector General staff reviewed the Sheriff’s Department’s website and found only fragmented information about MCJ’s attorney visiting area. The [website](#) does not provide clear guidance for attorney representatives or other professional visitors seeking to meet with clients in the attorney visiting area of each facility, nor does it indicate the required identification, credentials, and documentation that the Department requires from professional visitors.

The Sixth Amendment to the United States Constitution guarantees that a criminal defendant shall “have the Assistance of Counsel for his defense.”²¹ California Courts have recognized that incarcerated people have a constitutional right to “confidentially confer with counsel” and “have contact visits with counsel as a part of their right to meaningful access to the courts.”²² Impairing a detained criminal defendant’s ability to access their legal team interferes with the right to counsel. California Courts have also made clear that “[attorney visitation] policies will not be upheld if they unnecessarily abridge the defendant’s meaningful access to his attorney and the courts.”²³ Furthermore, California state regulations require that jail facilities “develop written policies and procedures to ensure inmates have access to the court and to legal counsel.”²⁴ The Sheriff’s Department’s inconsistent policies and practices that impose barriers on legal counsel seeking access to their clients likely fail to comply with this regulation and to pass constitutional muster.

To address these problems, the Office of Inspector General recommends the following:

- The Sheriff’s Department should develop agency-wide policies related to attorney and professional visits to ensure consistency across all facilities including the types of visitors who qualify to access the attorney visit areas and the materials they may bring into the visit areas, as well as the identification, credentials, and documentation each visitor must present. Unit orders should be limited to addressing facility-specific needs.
- The Sheriff’s Department should revise its policies on visitation to clearly instruct its staff to honor all court orders providing criminal defendants in custody access to members of their legal team, including experts and professionals, and create a process for visitation staff to quickly resolve questions about court orders regarding legal team access. The policy should expressly instruct staff that defendants representing themselves in propria persona (“pro per”) should be afforded access to any legal experts or investigators, or professionals necessary for their defense.

²¹ U.S. Const., Amend. VI.

²² *County of Nevada v. Superior Court of Nevada County and Jacob Michael Siegfried* (2015) 236 Cal.App.4th 1001; see also *In re Rider* (1920) 50 Cal. App. 797, 799.

²³ *Ching v. Lewis* (9th Cir. 1990) 895 F.2d 608, 609.

²⁴ [Cal. Code Regs., tit. 15 § 1068 \(2024\)](#).

- The Sheriff's Department should train visitation staff on verifying, processing, and logging routine court orders for expeditious processing.
- The Sheriff's Department should require that visitation staff log all instances in which they deny a visitor's request to access the attorney visiting area. Staff should document the visitor and the person in custody, the visitor's basis for claiming a right to access the attorney visiting area, and their reason denying access. Staff should also preserve any supporting documentation or court orders presented by the visitor or person in custody. The Sheriff's Department should periodically audit the log to ensure that staff are adhering to policies and procedures.
- The Sheriff's Department should post comprehensive information regarding professional visits on its website. The information should include the types of professional visitors who are allowed into the attorney visiting area of each facility, as well as the required identification, credentials, and documentation that professional visitors must present. There should be links to policies and unit orders of the Sheriff's Department relating to attorney visits and relating to visits by court-appointed investigators and experts for persons who are represented by counsel and for persons who are pro per. The material should also include contact information for each facility's attorney visit area and designated legal unit.

Out-of-Cell Time at Century Regional Detention Facility (CRDF)

The Office of Inspector General has received recent complaints from people housed in general population units at CRDF that restrictions on out-of-cell time have created conditions of confinement similar to those in isolation, raising concerns about compliance with Sheriff's Department policy and CRDF unit orders.

California regulations establish standards for detention and correctional facilities in Title 15 of the California Code of Regulations (Title 15), which require that county jail facilities allow people in custody "a minimum of 10 hours of out of cell time [per week]."²⁵ Although Sheriff's Department policy requires only that staff comply with Title 15

²⁵ [Cal. Code Regs., tit. 15, § 1065 \(2024\)](#). Under Title 15, "out-of-cell time" means "time spent outside of the sleeping area, where an individual has the opportunity to exercise or participate in recreation." "Recreation" means "the individual's ability to choose from activities that occupy the attention and offer the opportunity for relaxation and may include reading, games, socialization, entertainment, education, and programs." "Exercise" means "the opportunity for physical exertion." [Id. § 1006](#).

standards,²⁶ CRDF established a unit order that sets a higher standard by requiring that people in custody “be allotted a minimum of two (2) hours per day of out-of-cell time” amounting to 14 hours of out-of-cell time per week.²⁷ CRDF’s unit order further states that, “[u]nless an educational class, religious service, or a self-help group (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) has been scheduled for the day room, all inmates shall be allowed out of their cells to use the telephones, vending machines, showers, outdoor recreation area, television, or to socialize with the other inmates housed in the same housing module.”²⁸ Sheriff’s Department policy and the CRDF’s unit order both require staff record out-of-cell-time in the electronic Uniform Daily Activity Log (e-UDAL).²⁹

The Office of Inspector General spoke with people in custody and Sheriff’s Department personnel about their respective concerns with out-of-cell time and conducted an evaluation of out-of-cell time in a general population housing module for a two-week period from June 9 to 22, 2024. A review of e-UDAL and closed-circuit television (CCTV) video revealed inconsistencies in out-of-cell time at CRDF across three areas: amount of time out of cell, number of times out of cell, and time of day out of cell. The review also raised concerns about line personnel’s broad discretion to restrict out-of-cell time and inaccurate and inconsistent documentation.

Insufficient out-of-cell time. In the two-week period reviewed by the Office of Inspector General, CRDF staff failed to provide several people in custody a minimum of two hours per day of out-of-cell time on at least three days, violating CRDF Unit Order 5-23-090.³⁰ Staff also failed to document in the e-UDAL the reason for not providing the minimum required out-of-cell time. On those days, CRDF staff confined several people in this general population module to their cells for approximately 23 hours a day, mirroring conditions in restrictive housing and discipline units. Research shows isolation

²⁶ See Custody Division Manual, [§ 5-13/115.00, Out of Cell Time](#).

²⁷ See Custody Division Unit Orders, [5-23-090, Inmate Out-of-Cell Time](#).

²⁸ Custody Division Unit Order, [5-23-090, Inmate Out-of-Cell Time](#).

²⁹ Custody Division Manual, [§ 5-13/115.00, Out of Cell Time](#) (“All out of cell time shall be recorded in the electronic Uniform Daily Activity Log (e-UDAL).”); [CRDF Unit Order 5-23-090](#) (“All permitted out-of-cell activities shall be recorded in the electronic Uniform Daily Activity Log (e-UDAL).”).

³⁰ Data obtained from e-UDAL entries and CCTV footage for June 10, 11, and 15, 2024.

can detrimentally impact the psychological and physiological wellbeing of people in custody and recommends that carceral institutions limit the use of isolation housing.³¹

Inconsistent amounts and schedule of out-of-cell time. The review also detailed that, on multiple dates, custody personnel allowed people out of their cell for varying amounts of time and on different shifts. For example, on June 12, custody personnel provided the lower tier of the module about three hours of out-of-cell time on the AM shift in comparison to approximately two hours of out-of-cell time for the upper tier on the PM shift. On June 21 everyone in the module was allowed out of their cell for the same amount of time but were allowed out on different shifts. People in custody have reported to Office of Inspector General staff that inconsistent out-of-cell access limits their ability to connect with people outside of custody via telephone, particularly school-aged children who can only be reached in the afternoon, and attorneys, who can often only be reached earlier in the day.

People in custody have also reported that inconsistent out-of-cell access and parity issues have contributed to perceptions of favoritism. On at least one date within the review period, June 10, custody personnel allowed one quarter of the module out of their cells at a time. Entries in e-UDAL and CCTV footage show that line staff split the lower tier into two groups and allowed them out of their cell separately for approximately an hour and half each on the morning shift. Contrary to an entry in e-UDAL, CCTV footage reveals staff did not allow any group from the upper tier out on the morning shift. On the afternoon shift, staff allowed the entire upper tier out for approximately three hours and 45 minutes. In sum, the review indicated that the Sheriff's Department allowed one quarter of the module out of their cells for nearly four hours, while they limited out-of-cell time for everyone else to approximately one and a half hours. These inconsistencies tended to average out somewhat over time – for example, over June 9 through June 15, out-of-cell time for people in the upper tier had about 16 to 16.5 hours out-of-cell time, and people in the lower tier had about 17.25 hours. Although there were significant inconsistencies on some days, and there did not seem to be any pattern that suggested CRDF staff followed a schedule or deliberately attempted to make up time lost on days with more time on following days, out-of-cell time for people in the module varied over the week by only about 6%. The difference in out-of-cell time between different people over time seems less problematic than the Department's failure on several days to provide the minimum out-of-cell time required by the unit order

Insufficient justification for restricting out-of-cell time. The review additionally showed that line personnel had broad discretion to restrict programming time without

³¹ Kayla James & Elena Vanko, [Evidence Brief: The Impacts of Solitary Confinement](#), Vera Institute (April 2021).

clearly articulating a security management concern. In one instance, staff cut short programming, noting, “10:35 Program upper tier start; 12:00 Upper tier program ended due to be[ing] loud and not listening to custody personnel when told multiple times to keep the peace[.]” This e-UDAL entry raises concerns about what actions and behaviors constitute legitimate security concerns that justify restricting out-of-cell access. The Office of Inspector General recommends that the Sheriff’s Department prohibit custody personnel from limiting out-of-cell time for behaviors and actions that amount to minor disruptions and hold staff accountable for any violations. To do so, the Department must have clear standards governing line staff’s ability to limit out-of-cell time. Decisions to lock down inmates must carry a significant and clear relationship to safety and security and, as the unit order requires, should be documented clearly and thoroughly in the e-UDAL. As the unit order affords staff broad discretion to lockdown people in custody for perceived or potential safety and security reasons, the order should more clearly require staff to document notifications about safety and security concerns to supervisors, including articulating safety concerns as opposed to unruly behavior that does not rise to the level of a safety concern, in the e-UDAL. CRDF leadership should regularly review out-of-cell time and hold floor sergeants accountable for failing to ensure all modules under their supervision meet the minimum requirements for out-of-cell time required under the unit order.

Inconsistent practices in documenting out-of-cell time. The Office of Inspector General’s review further revealed inaccuracies and inconsistencies with out-of-cell time documentation. In most cases, CRDF personnel logged out-of-cell time under the “Activity Tracking” section of the e-UDAL, selecting a combination of activities such as “Indoor Rec,” “Outdoor Rec,” “Showers,” and/or “Telephones.” But some personnel logged out-of-cell time as a comment under the “Additional Information” section of the e-UDAL.³² Neither CRDF’s unit order nor Sheriff’s Department policy clearly specifies where in e-UDAL out-of-cell time should be logged, creating confusion among custody personnel and resulting in inconsistent documentation.³³ The Office of Inspector General recommends that the Sheriff’s Department clarify policies governing e-UDAL entries to ensure that staff log out-of-cell time consistently.

³² Custody personnel logged out-of-cell time under the “Activity Tracking” section of the e-UDAL on twelve of the days reviewed and logged out-of-cell time as a comment under the “Additional Information” section of the e-UDAL on the two other days.

³³ [CRDF Unit Order 5-29-090](#) includes a note directing that “Each module officer shall document the time of day the cell lights were turned on and off under the “Additional Information” section in the e-UDAL.” A similar note does not exist specifying where in the e-UDAL out-of-cell time should be documented.

Inaccurate documentation of out-of-cell time. The review also raised concerns about the integrity of the Sheriff's Department's data on out-of-cell time. CCTV footage revealed that on three days during the two-week period,³⁴ when custody personnel documented not providing some people in custody any out-of-cell time, the people in question were in fact allowed out of their cells, but custody personnel failed to log the activity in the e-UDAL.³⁵ Other entries in the e-UDAL significantly overstate the amount of time staff allowed people out of their cells. For instance, entries for June 21, 2024, indicate the upper tier was allowed out on the morning shift for 4 hours and 10 minutes, and the entire module was allowed out on the afternoon shift for 4 hours and 10 minutes. However, CCTV footage revealed that each tier was allowed out for approximately 4 hours and 10 minutes, respectively. The upper tier was only allowed out on the morning shift, while the lower tier was only allowed out on the afternoon shift.³⁶ Such inaccurate documentation of out-of-cell time, whether intentional or not, casts doubt on the reliability of Department data.

The Office of Inspector General reported these issues to CRDF leadership in writing and meetings.³⁷ After Office of Inspector General staff emailed CRDF leadership complaints from people in custody related to out-of-cell time, Office of Inspector General staff met with CRDF leadership to discuss possible solutions. CRDF leadership reiterated the expectation that all people in custody housed in general population modules be out of cell at the same time for as much time as possible unless there is an exception to the order. CRDF leadership explained that past attempts to address noncompliance with the Department's expectation and unit order related to out-of-cell time failed to produce sustained compliance.

³⁴ e-UDAL entries for Module 3800 indicate the upper tier was not allowed any out-of-cell time on June 9, the lower tier was not allowed any out-of-cell time on June 11, and the lower tier was not allowed any out-of-cell time on June 17.

³⁵ For example, in Module 3800, on June 9, no staff documented out-of-cell time on the morning shift, but CCTV footage reveals that the upper tier was allowed out of their cells for approximately two and a half hours. Similarly, on June 11, e-UDAL entries reflect no documented out-of-cell time for the afternoon shift, but CCTV footage shows that staff allowed the lower tier out of their cells on the afternoon shift for approximately two and a half hours.

³⁶ e-UDAL entries misrepresent that on June 21, everyone in Module 3800 was allowed out-of-cell time together on the PM shift from 15:10 to 19:20. CCTV reveals the upper tier was allowed out for approximately 4 hours and 10 minutes (from 9:20 to 13:30) (AM shift) and lower tier was also allowed out for about 4 hours and 10 minutes (from 15:10 to 19:20) (PM shift).

³⁷ Office of Inspector General staff members emailed CRDF leadership on June 10, June 11, and July 9, 2024; reported issues to CRDF leadership in person on June 10, 2024; and met with CRDF leadership on June 25, 2024.

On July 23, 2024, CRDF leadership shared with Office of Inspector General staff an out-of-cell time directive that was sent to all CRDF personnel. The directive requires that module staff allow people in moderate-observation and general population housing to program one tier at a time on the morning and afternoon shifts, respectively, and that they be offered a minimum of three hours out of their cell on each shift for a total of six hours per day. Deviation from the schedule requires the approval of the on-duty watch commander and should be documented in the e-UDAL. Module personnel are also required to document programming refusals, significant information and unusual activity related to out-of-cell time and a range of other activities in the e-UDAL. The directive also calls for the early morning Title 15 Safety Check Sergeant to conduct daily audits of the e-UDAL to ensure documentation accuracy, and log findings. CRDF leadership report that the policies and procedures in the directive will remain in effect until further notice. The Office of Inspector General recognizes that, by significantly increasing requirements for out-of-cell time, documentation, and auditing, the new directive represents significant progress. CRDF leadership recognizes that its unit order must also be revised to reflect these changes. In revising the unit order, transparency and accountability will be key to achieving compliance with Sheriff's Department policy. The Department must avoid vague and permissive language in unit orders or policy revisions. Supervisorial staff must regularly monitor out-of-cell time through direct supervision and compliance audits to ensure both that staff accurately document out-of-cell time and that they consistently provide out-of-cell time according to policy. Where audits reveal inaccuracies in documentation, supervisors must address those inaccuracies with staff to ensure future compliance. To the extent this monitoring shows failure to adhere to policies or unit orders, the Department must hold staff accountable.

Pregnant People in Custody at Century Regional Detention Facility (CRDF)

Over the past several months, the Office of Inspector General has received complaints from pregnant people in custody and their loved ones regarding prenatal diets and access to bottled water, unstructured out-of-cell time for large muscle exercise, and issues with the use of restraints.

The care of incarcerated pregnant and post-partum people poses significant challenges. In addition to the issues faced by many justice-involved people — complex histories of trauma, poor nutrition, substance use, mental illness, chronic medical conditions, low socioeconomic status, and limited social support systems — the stressors of carceral

settings increase risks of miscarriage, premature birth, cesarean section, or complex birth for pregnant people in custody.³⁸

CRDF is the main housing location for incarcerated females within Los Angeles County jail system. The Office of Inspector General monitors gender responsive and reproductive justice issues at CRDF, including access to care for pregnant and post-partum people, focusing on issues including the provision of bottled water and prenatal diets, access to unstructured out-of-cell time for large muscle exercise, labor and delivery, visitation with newborns, and release to community programs. The Office of Inspector General previously addressed this issue in a 2018 report, [Services and Programs Offered to Pregnant Prisoners and Mothers](#) and have revisited the issue in its quarterly [report to the Board](#) on reform and oversight for the first quarter of 2022.

From April 1 to June 30, 2024, the Sheriff's Department reported housing a total of 74 pregnant people in custody at CRDF in various modules throughout the facility based on classification status. Office of Inspector General staff interviewed 32 pregnant people in custody during this timeframe.³⁹

Bottled Water and Prenatal Diets

Prior to 2018, the Sheriff's Department did not provide bottled water to pregnant people in custody and required them to purchase it themselves or drink from facility water fountains and sinks in their cells. While the Office of Inspector General was preparing its 2018 report, the Sheriff's Department began providing four 16.9 oz. bottles of water per day with prenatal diets. In November 2021, the Office of Inspector General and the Sybil Brand Commission notified CRDF leadership that several pregnant people in custody complained that bottled water was missing from their meals and that the four bottles provided were often insufficient. In response, CRDF began providing each pregnant person with six bottles of water per day (two bottles distributed at each meal), enough to meet the recommended daily water intake for pregnant people.⁴⁰

³⁸ Susan Hatters Friedman, Aimee Kaempf, and Sarah Kauffman, [The Realities of Pregnancy and Mothering While Incarcerated](#), J. Am. Acad. Psych. & L. Online (May 2020).

³⁹ Of the 74 pregnant people identified by Correctional Health Services, 35 were released prior to Office of Inspector General staff outreach and the remaining 7 refused to be interviewed, had false positive pregnancy tests, or had early term miscarriages. The Office of Inspector General does not have the information regarding how many of the 74 persons identified as pregnant upon intake at IRC continue with the pregnancy. All 74 are classified as pregnant in this report consistent with the Sheriff's Department assigned that classification.

⁴⁰ American College of Obstetricians and Gynecologists [Nutrition During Pregnancy FAQ](#) (June 2023).

All pregnant persons interviewed by Office of Inspector General staff reported receiving their appropriate prenatal diet and six bottles of water per day. Some of the pregnant people interviewed reported that they received extra bottles of water if they requested them, while others reported that Department staff expressed reluctance in providing extra bottles of water absent written directives. CRDF leadership reports that they are in the process of revising unit orders to ensure that all pregnant people receive extra bottles of water upon request. CRDF leadership additionally reported to the Office of Inspector General on May 29, 2024, that the Sheriff's Department had purchased and received point-of-use water filters that were pending installation in all CRDF living modules. At the time of this report, only two living modules have had the filters installed.

Unstructured Out-of-cell Time for Large Muscle Exercise

In pregnancy, physical inactivity and excessive weight gain are recognized as independent risk factors for maternal obesity, gestational diabetes, and other complications.⁴¹ The U.S. Department of Health and Human Services recommends at least 150 minutes of moderate intensity aerobic activity per week during pregnancy and the postpartum period.⁴²

As discussed in the previous section, California regulations require that county jail facilities allow people in custody a minimum of 10 hours of out-of-cell time each week for exercise.⁴³ In addition, CRDF offers pregnant people an additional 45 minutes for large muscle exercise through dedicated timeslots to walk in the day room or the recreation room within their housing module.⁴⁴ Although the Sheriff's Department reports offering opportunities for this additional large muscle exercise once daily on alternating AM/PM shifts (e.g., Monday 7 a.m., Tuesday, 7 p.m., Wednesday 7 a.m., etc.), several pregnant people reported having to choose between sleep or large muscle exercise in the morning, as the program was conducted as early as 7:00 a.m. and often

⁴¹ Committee on Obstetric Practice, American College of Obstetricians and Gynecologists, [Committee Opinion No. 804: Physical Activity and Exercise During Pregnancy and Postpartum Period](#) (Apr. 2020).

⁴² U.S. Department of Health and Human Services. [Physical Activity Guidelines for Americans, 2nd ed.](#) (2018), at p.80.

⁴³ [Cal. Code Regs., tit. 15, § 1065 \(2024\)](#). Under Title 15, “out-of-cell time” means “time spent outside of the sleeping area, where an individual has the opportunity to exercise or participate in recreation.” “Recreation” means “the individual's ability to choose from activities that occupy the attention and offer the opportunity for relaxation and may include reading, games, socialization, entertainment, education, and programs.” “Exercise” means “the opportunity for physical exertion.” [Id. § 1006](#).

⁴⁴ CRDF Unit Order [5-23-090 Inmate Out-of-Cell Time](#).

prior to breakfast.⁴⁵ The Sheriff's Department reported when pregnant people refused to participate in large muscle exercise in the morning, they have to wait until the following evening to be offered large muscle exercise again, exceeding 24 hours from the initial offering. Pregnant people housed in discipline reported to the Office of Inspector General that they often were unable to participate in large muscle exercise altogether.

The Office of Inspector General analyzed entries made in e-UDAL to determine whether Sheriff's Department staff appropriately documented opportunities for large muscle exercise. The analysis showed inconsistencies in documentation during this reporting period. Only 66% of the modules that housed pregnant people documented offering large muscle exercise. Several pregnant persons reported that although they may have refused the morning large muscle exercise, some staff would allow them to walk later in the same day. However, staff did not document these accommodations.

The Office of Inspector General recommends that the Sheriff's Department offer pregnant people the opportunity to participate in large muscle exercise after breakfast is served on the AM shift or offer opportunities twice daily to ensure that pregnant persons receive the opportunity to meet their exercise needs. In addition, the Department should take steps to ensure they offer pregnant people housed in discipline or restrictive housing modules the opportunity for large muscle exercise. The Office of Inspector General also recommends that CRDF leadership audit e-UDAL entries to ensure that module staff accurately document the large muscle exercise provided to pregnant people in custody.

Release of pregnant persons from custody

The Office of Inspector General previously reported on efforts by the Sheriff's Department and the Department of Health Services Correctional Health Services (CHS) to limit the number of pregnant people confined in its facilities by supporting diversion to community-based services.⁴⁶ The Department cites several reasons related to the criminal charges or procedural status of each person's criminal case that preclude pregnant people from release. The Department also cites barriers to timely placement and release outside of its control, such as rigid placement criteria for many community-based organizations. The Department reports that from April 1 through June 30, 2024,

⁴⁵ Proper sleep also promotes mental and physical health, and women often face greater difficulty sleeping during pregnancy. See [What You Should Know About Sleep](#) and [Insomnia](#), U.S. Department of Health and Human Services, Office of Women's Health.

⁴⁶ Los Angeles County Office of Inspector General, [Reform and Oversight Efforts – Los Angeles County Sheriff's Department – October to December 2021](#).

35 pregnant persons were released. Of those persons released, approximately 40% were diverted from custody through the Office of Diversion and Re-entry or other community-based rehabilitative programs; approximately 55% were released by courts on bond or following full adjudication of their criminal cases, and; approximately 5% were transferred to other jurisdictions.

Labor and Delivery

The Office of Inspector General interviewed three people housed at CRDF who delivered their babies at the hospital and remained in custody postpartum. All three reported that the Sheriff's Department provided them with time to bond with their newborn babies before returning to jail. The Sheriff's Department recognizes parent and child bonding during the initial hour following birth, commonly referred as "The Golden Hour."⁴⁷ During this time, the person in custody is able to engage in skin-to-skin contact with the newborn infant, which increases emotional bonding between mother, baby and loved ones present for the birth. By providing this dedicated time, newborn babies are provided the opportunity to benefit from the initial contact with their mother. Additionally, CHS policy states that, upon return to CRDF, all post-partum people are screened to ensure that they are provided mental health services as appropriate, to assist with the separation from their child.

During this reporting period, one person in custody experienced a miscarriage and subsequent stillbirth delivery at Los Angeles General Medical Center (LAGMC). Although the person experienced the miscarriage while at CRDF, she opted to have a delayed stillbirth delivery so that she could make necessary funeral arrangements for her infant. The Office of Inspector General reviewed patient care in response to the event and noted CHS provided adequate trauma-informed support services including chaplain and mental health services, both while the individual was notified of the miscarriage and again upon her subsequent return to LAGMC for delivery of her stillborn infant. The person reported to Office of Inspector General staff that she experienced significant emotional duress while undergoing medical treatment, and that she did not perceive Sheriff's Department staff to be "compassionate." The Sheriff's Department reported that, due to patient confidentiality concerns, non-medical staff would not be aware of the pregnancy complications that people in custody experience. The Office of Inspector General recognizes the importance of patient confidentiality for people in custody. But CHS and the Sheriff's Department should take steps to ensure that confidentiality does not pose a barrier to pregnant people (or other people with

⁴⁷ Neczypor J.L., Holley S.L., *Providing Evidence-Based Care During the Golden Hour* (Dec. 2017) 21 Nursing for Women's Health, vol. 6, pp. 462-472.

medical needs) receiving appropriate care and support. The Office of Inspector General recommends that deputies working directly with pregnant people in custody receive proper training on trauma-informed practices to best supervise the pregnant and post-partum population, as they pose higher risks for behavioral concerns stemming from emotional trauma related to their pregnancy. Both the Department and CHS should inform pregnant people that deputies will not know about even the most significant medical facts related to their pregnancy unless the person informs them directly or provides written consent to CHS to release information.

In-Custody Deaths

Between April 1 and June 30, 2024, eight people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for six deaths: five deaths were natural, and one death was accidental. For the remaining two deaths, the DME findings remain deferred.⁴⁸ Three people died at Twin Towers Correctional Facility (TTCF), one died at North County Correctional Center (NCCF), one died at Century Regional Detention Facility (CRDF), one died at Lancaster Station Jail, and two died at hospitals where they had been transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a [dedicated page on Inmate In-Custody Deaths on its website](#).⁴⁹

Office of Inspector General staff attended the Custody Services Division (CSD) Administrative Death Reviews for each of the eight in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Two people of the people who died this quarter were housed in CRDF pod 1400 immediately prior to their deaths. CRDF 1400 is an intake pod for individuals who

⁴⁸ In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion, the Sheriff's Department and Correctional Health Services (CHS) use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parentheses.

⁴⁹ [Penal Code § 10008](#) requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

require further medical or mental health evaluation before they are assigned to permanent housing — including people undergoing drug and alcohol detox, the sudden cessation of drugs or alcohol that can lead to withdrawal in a habitual user. In the past two years, four people in custody have been housed in this module immediately prior to their deaths. In contrast, no one has died in the drug and alcohol detox pod at IRC. The Office of Inspector General recommends that the Sheriff's Department review the four deaths and protocols in the module in order to identify any changes, additional safeguards or other corrective action needed to ensure that the health and safety of people housed in CRDF 1400.

Date of Death: April 5, 2024

*Custodial Status: Sentenced.*⁵⁰

Custody personnel at TTCF Correctional Treatment Center (CTC) found an unresponsive person on the floor of their cell. CHS staff and paramedics rendered emergency aid and CHS staff administered three doses of Narcan. The person died at the scene. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death as ischemic heart disease.

Date of Death: April 9, 2024

Custodial Status: Pre-trial.

Custody personnel conducting Title 15 safety checks at TTCF found an unresponsive person on the floor of his cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering three doses of Narcan. The person died at the scene. A review of the person's incarceration records revealed that he was transported to TTCF from a dorm in MCJ two days before he died. Closed Circuit Television (CCTV) from the dorm at MCJ showed that, immediately before the person was transported to TTCF, he was on the floor of the dorm in different positions, seemingly unable to rise, for approximately 22 hours. The video additionally showed that during hourly Title 15 safety checks people in custody appeared to wave their arms to get assistance from the staff member conducting the check, who walked to the individual and appeared to speak to him briefly before leaving. Staff did not transport the person to TTCF for a higher level of care until after he had defecated on himself. Areas of concern include the quality of Title 15 safety checks at MCJ, the quality of Title 15 safety checks at TTCF, custody personnel's emergency response, and CHS staff's

⁵⁰ For purposes of custodial status, "Pre-trial" indicates that the person is in custody awaiting arraignment, hearing, or trial. "Convicted, Pre-sentencing" indicates that the person is being held in custody based on a conviction, pending sentencing, on at least some charges, even if they are in pre-trial proceedings on other charges. "Sentenced" indicates that the person is being held on the basis of a sentence on at least some charges, even if they are in pre-trial proceedings on other charges.

medical and mental health intake assessments. Preliminary manner of death: Natural. The DME website reflects that the manner of death was natural, and the cause of death is pulmonary embolism and phlebothrombosis.⁵¹

Date of Death: April 10, 2024

Custodial Status: Pre-trial.

Custody personnel conducting Title 15 safety checks at NCCF found an unresponsive person on their bunk. Sheriff's Department staff, CHS personnel, and paramedics rendered emergency aid, including administering three doses of Narcan. The person died at the scene. Areas of concern include custody personnel's emergency response and the failure to renew prescription medication.⁵² Preliminary manner of death: Accident (Overdose). The DME website reflects the manner of death was accidental, and the cause of death is due to combined effects of methamphetamine and heroin.

Date of Death: April 26, 2024

Custodial Status: Pre-trial.

During a routine detox assessment at CRDF, nursing staff found an individual unresponsive in her cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering three doses of Narcan. The person died at the scene. Areas of concern include the quality of the detox assessment, why the individual was housed in a cell rather than in the dayroom as required under detox housing protocol, custody personnel's emergency response, and the quality of Title 15 safety checks. Preliminary cause of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: May 14, 2024

Custodial Status: Pre-trial.

Three days after being booked into custody at CRDF and being placed into the detox

⁵¹ In response to a draft of this report, the Sheriff's Department provided the following response regarding this in-custody death: "Custody Services Division conducted an inquiry into both the frequency and quality of the safety checks. The results of the inquiry revealed the Title 15 checks were in compliance, with the exception of one late check. There was no concern for the quality of the checks. Title 15 personnel did check on and speak to the inmate on several occasions before he was transferred to Twin Towers Correctional Facility (TTCF). Although it is true that he was on the floor for several hours, the inmate was sitting and lying down during different times. He never requested medical assistance or appeared to be in distress. After he defecated on himself, a Behavioral Observation and Mental Health Referral form was completed, and he was transferred to TTCF for a higher-level of care. Additionally, the Department, thus far, has found no indication that other people in custody attempted to summon help for the decedent and were ignored."

⁵² While the expired medication was not reported as a contributing factor in the death, it should still be addressed in the Sheriff's Department's corrective action plan.

unit in module 1400, a person experienced a medical emergency and was transported to St. Francis Medical Center. She returned from the hospital to CRDF and was again placed in module 1400. Seven hours after her return, custody personnel at CRDF discovered her unresponsive on her bunk and notified nursing staff of a health emergency. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering three doses of Narcan. Paramedics transported the person back to St. Francis Medical Center, where she was pronounced dead the next day. Areas of concern include an inquiry regarding the provider's plan of care and the quality of the Title 15 Safety Checks. Preliminary cause of death was unknown. The DME website reflects the manner of death as natural, and the cause of death was anoxic encephalopathy and cardiopulmonary arrest.

Date of Death: May 30, 2024

Custodial Status: Pre-trial.

On May 28, 2024, a person in custody with a pre-existing medical condition was transported from CTC to Los Angeles General Medical Center (LAGMC) for medical evaluation. On May 30, 2024, the hospital staff transitioned the person to comfort care, and he was pronounced dead. Preliminary cause of death: Natural. The DME website currently reflects the manner as natural and the cause of death as multiple organ failure and metastatic stomach cancer.

Date of Death: June 5, 2024

Custodial Status: Pending probation violation hearing.

Custody personnel conducting Title 15 safety checks at Lancaster Station Jail found an unresponsive person in his cell. Custody personnel and paramedics rendered emergency aid, including custody personnel administering two doses of Narcan. The person died at the scene. Areas of concern include custody personnel's emergency response. Preliminary cause of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: June 20, 2024

Custodial Status: Pre-trial.

Custody personnel conducting Title 15 safety checks at TTCF found a person in medical distress on the floor of his cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering five doses of Narcan. The person died at the scene. Areas of concern include the quality of Title 15 safety checks and custody personnel's emergency response. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death is pulmonary embolism.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff's Department to "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the Office of Inspector General," and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections." The Board also directed the Office of Inspector General to report quarterly on the Sheriff's Department's progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody deaths.

Of the eight people who died in the care and custody of the Sheriff's Department between April 1 and June 30, 2024, the medical examiner's final reports, including toxicology assessments, confirm that one person died due to an overdose. Toxicology results remain pending for two of the eight deaths and may indicate additional overdose deaths once completed.

Tracking Narcotics Intervention Efforts

The Board's motion directed that the Sheriff's Department "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions." To increase drug detection efforts, the Department must analyze data on how often it performs different interventions and when the use of the intervention resulted in the detection and seizure of narcotics. Data would allow the Department to properly evaluate what interventions are most effective at detecting narcotics, and target drug detection efforts accordingly. The Department reports that it does not presently track narcotics detection in a format that allows data to be analyzed.

According to the Sheriff's Department, custody personnel enter all narcotic seizures into the Los Angeles Regional Crime Information System (LARCIS), a database generally used to track narcotics seizures for criminal prosecution. Although LARCIS contains records of narcotics seized in the jails, LARCIS does not track the scope or duration of drug detection efforts, which would be necessary to evaluate the effectiveness of drug detection methods. Moreover, the only place Sheriff's Department personnel can enter the drug detection intervention used to discover the narcotic into LARCIS is in the narrative, so that the Department cannot search LARCIS for seizures by detection intervention and would have to manually review each entry to compile data on narcotics seized by type of intervention. The Department reports that such a review would be so

labor-intensive as to be impractical and that it therefore cannot compile the data to analyze seizures by drug detection mechanism.

However, the Sheriff's Department tracks a majority of narcotics detection efforts in multiple Department databases, as set forth in the table below. The Department reports that, because efforts are tracked in separate databases, it cannot compile data into a single dataset for analysis. Additionally, as the Office of Inspector General [reported last quarter](#), the Sheriff's Department does not require that staff report all narcotics intervention efforts and, even when information is tracked, the Department does not impose specific requirements on data tracking, resulting in inconsistent and unreliable data on narcotics detection efforts.

Narcotics Detection Mechanism	Department Database Where Data is Tracked
Body Scanner	Electronic Line Operations Tracking System (e-LOTS)
Contraband Watch	e-LOTS
Mail Searches	Not tracked
Dorm Searches	e-LOTS, Watch Commander Log
Cell Searches	Custody Automated Reporting and Tracking System (CARTS)
K9 Assisted Searches	K9 Log, Watch Commander Log
Staff Searches	Individual Facility Staff Search Logs, Watch Commander Log
Visiting	e-LOTS, Watch Commander Log
Off-Grounds Recovery (i.e., hospital, inmate worker outside maintenance, etc.)	Not tracked

The Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General has previously recommended that the Department examine ways to comply with the Board's directive by improving reporting requirements for staff and compiling data on detection interventions and seizures using existing technologies. The

Department reports that it currently does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in LARCIS to evaluate the efficacy of drug detection intervention.

Improving Searches of Staff and Civilians

The Board's second directive required that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails]." The Department previously reported its current policy grants the Department broad authority to search staff and civilians entering the jails, so that no changes to existing Department policy are required to implement more comprehensive searches. The Department previously reported that it planned to implement more frequent unannounced and randomized staff searches beginning in May 2024.⁵³

All jail facilities reported conducting unannounced searches during the previous quarter, beginning in May as planned, though the comprehensiveness of the searches varied across facilities. Prior to May 2024, the K9 handling team sent a briefing to jail leadership stating that they would be available upon request to assist facilities in conducting searches, and almost all facilities reported utilizing K9 units to supplement their search efforts in the second quarter. All 13 K9s are trained to detect narcotics (including fentanyl) and alcohol. Two K9s are cross trained to detect electronics and cellular phones. Each time the Department deployed K9 units to assist facility staff and civilian searches, the K9 searched Department staff, civilians, and property entering the facility.

Office of the Inspector General staff met with each facility's leadership to inquire about each facility's search efforts from April 1 through June 30, 2024, and detail what each reported about their efforts and challenges below.

⁵³ This report uses the term "staff search" to mean the search of all staff and civilians entering the facility during a single shift change for Sheriff's Department personnel at a facility. Such search would entail searching Sheriff's Department personnel and CHS workers.

Facility	# Staff Searches	# Staff Searches with K9	Minimum Search Requirement	Search Conducted Inside Security	Search Evasion Concerns	Where Searches are Logged
MCJ	Not Tracked	7	Yes	No	Yes	Watch Commander Log
TTCF	Not Tracked	1	Yes	Yes	Yes	Watch Commander Log
IRC	Not Tracked	2	Yes	Yes	Yes	Watch Commander Log
CRDF	Not Tracked	1	Yes	No	Yes	Watch Commander Log
NCCF	15	5	Yes	Yes	No	Watch Commander Log
PDC-North	19	0	No	Yes	Yes	Watch Commander Log & Staff Search Log
PDC-South	28	4	Yes	Yes	No	Staff Search Log

Men's Central Jail

MCJ tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. MCJ staff report that they cannot extract search information entered in the Watch Commander Log and so cannot provide data on how many staff searches have been conducted between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with K9 assistance and reported that the K9 assisted with staff searches seven times at MCJ between April 1 and June 30, 2024. MCJ assigns sergeants to conduct staff searches on a randomized schedule. MCJ leadership attempts to conduct staff searches as frequently as possible but requires that at least one search be conducted one time per week for each of the three shifts.⁵⁴ MCJ conducted three staff searches with K9 assistance prior to the Sheriff's Department directive requiring that facilities begin staff searches in May 2024.

MCJ provides lockers outside security for staff to store items that are prohibited in jail facilities, such as cell phones and department-issued firearms. MCJ conducts staff

⁵⁴ Custody facilities, like many units across the Sheriff's Department, schedule staff to work in three shifts: a morning or "AM" shift, an afternoon to evening or "PM" shift, and a night to early morning or "EM" shift.

searches outside security, directly in front of the sole secured entrance to the jail. Because people in custody housed at MCJ regularly walk through the facility to engage in programming and receive medical care, it is difficult for MCJ to conduct searches inside security. Yet because staff can observe searches being conducted before they enter security, they may anticipate, evade, or alert others of a search. Any employees with contraband could observe the search prior to entering the facility and simply return to their cars to leave the contraband and then bring contraband into the facility another day or after the search ended.

MCJ staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. Since commencing staff searches, MCJ has not seized any contraband.

Twin Towers Correctional Facility

TTCF tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. TTCF staff report that they cannot extract search information from the Watch Commander Log and therefore cannot provide data on how many staff searches have been conducted between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with a K9 and reported that the K9 assisted with staff searches one time at TTCF between April 1 and June 30, 2024. TTCF conducts searches on a randomized schedule but requires that at least one search be conducted one time per week during each of the three shifts. When introducing staff searches in May 2024, the TTCF facility captain conducted staff searches alongside the sergeants tasked with conducting staff searches.

TTCF provides lockers outside security for staff to store items that are prohibited in jail facilities. TTCF conducts staff searches inside security at staff check-in, but in an area visible from outside security. Because staff can see when searches are being conducted before they enter the facility, they may anticipate, evade, or alert others of a search.

TTCF staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. Since commencing staff searches, TTCF has identified several CHS workers bringing cell phones into the facility, in violation of policy. TTCF reports that when staff are identified attempting to bring electronic devices in the facility, the facility informs CHS leadership and the staff member is instructed to contain the electronic device outside of security. The Sheriff's Department did not report that any additional action was taken as far as employee discipline.

Inmate Reception Center

IRC tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. IRC staff report that they cannot extract search information from the Watch Commander Log and therefore cannot provide data on how many staff searches have been conducted between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with a K9 and reported that the K9 assisted with staff searches two times at IRC between April 1 and June 30, 2024. Staff searches are conducted by sergeants. IRC conducts searches on a randomized schedule but requires that at least one search be conducted one time per week per shift.

IRC provides lockers outside security for staff to store items that are prohibited in jail facilities. IRC conducts staff searches inside security at staff check-in, but in an area that is observable from outside security. Because staff can observe when searches are being conducted, they may anticipate, evade, or alert others of a search. More concerning, IRC's porous layout poses a severe barrier to searches, as IRC is connected to both MCJ and TTCF and has three unstaffed exits. Thus, while staff subject to search at other facilities may be able to evade searches by exiting the facility through a secured entry, staff at IRC are able to evade searches by walking to MCJ or TTCF, exiting the facility through a secured entry, or exiting the facility through one of three unstaffed exits. IRC staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. Since commencing staff searches, IRC has identified several CHS workers bringing cell phones into the facility, in violation of policy. IRC reports that, when staff are identified attempting to bring electronic devices in the facility, the staff member is instructed to contain the electronic device outside of security. The Sheriff's Department did not report that any additional action was taken as far as employee discipline.

Century Regional Detention Facility

CRDF tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. CRDF staff report that they cannot extract search information from the Watch Commander Log and therefore cannot provide data on how many staff searches have been conducted between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with a K9 and reported that the K9 assisted with staff searches one time at CRDF between April 1 and June 30, 2024. Staff searches are conducted by sergeants, and CRDF conducts searches on a randomized schedule but requires that at least one search be conducted one time per

week per shift. CRDF set up check points to enforce the clear bag policy prior to the Sheriff's Department directive requiring that facilities begin staff searches in May 2024.

CRDF provides lockers outside security for staff to store items that are prohibited in jail facilities. CRDF conducts staff searches outside security, and CRDF leadership uses whiteboards to notify staff of searches while they are happening. Because staff are provided notice of searches and able to observe when searches are being conducted, they may anticipate, evade, or alert others of a search. Prior to introducing staff searches, CRDF leadership distributed a briefing directing the sergeants conducting searches to not detain staff who attempt to evade searches.

CRDF staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. Since commencing staff searches, CRDF has identified several CHS workers bringing cell phones into the facility, in violation of policy. CRDF reports that, when staff are identified attempting to bring electronic devices in the facility, a note is created in the facility Watch Commander log and the staff member is instructed to contain the electronic device outside of security. The Sheriff's Department did not report that any additional action was taken as far as employee discipline.

North County Correctional Facility

NCCF tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. . However, NCCF is in the process of working with Sheriff's Department information technology staff to develop a mechanism to track staff searches and was therefore able to report that the facility has conducted 30 staff searches between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with a K9 and reported that the K9 assisted with staff searches four times at NCCF between April 1 and June 30, 2024. Staff searches are conducted by sergeants. NCCF conducts searches on a randomized schedule but requires that at least one search be conducted one time per week per shift.

NCCF provides lockers outside security for staff to store items that are prohibited in jail facilities. NCCF staff conducts staff searches inside security at the sole staff check-in station. Because the searches are not observable from outside security, staff cannot anticipate, evade, or alert others of a search.

NCCF staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. When NCCF searching sergeants detect staff attempting to bring non-transparent bags through the facility, searching sergeants provide clear trash bags for staff to transport their belongings. NCCF reports that it has not detected contraband as a result of the searches.

Pitchess Detention Center North

Between April 1, 2024, and June 30, 2024, PDC North conducted 19 staff searches and zero staff searches with K9 assistance. Sergeants are responsible for conducting the searches, but, unlike all other facilities, PDC North does not have a schedule determining when searches should occur. Despite receiving communications from Sheriff's Department executives requiring that each facility begin conducting comprehensive staff searches in May 2024, PDC North did not complete a search until June 11, 2024, the day before Office of Inspector General staff met with PDC North leadership about staff searches.

PDC North leadership reported that their facility layout presents challenges to conducting searches. Specifically, the facility's administrative building located within security where staff can use lockers to store items generally prohibited in jail facilities, such as cell phones and department-issued firearms. Staff work modules are located across from the administrative building. Due to this design, facility leadership determined that staff searches must be conducted in open areas outside of each module so that staff were able to secure their belongings in the administrative building. The facility lacks a hard boundary between secured and unsecured areas, so that staff can anticipate and evade searches.

PDC North reported that the search consisted of enforcing clear bag policies. PDC North leadership stated that the sergeants tasked with conducting searches did not inspect or remove items inside bags because PDC leadership could not locate a table. PDC North leadership has since procured tables to allow sergeants to more thoroughly search staff property entering the jail. During the meeting with Office of Inspector General staff, PDC staff incorrectly reported that they did not have authority to search CHS workers entering the facility. Approximately five weeks after meeting with Office of Inspector General staff, PDC North reported that CHS staff were subject to search.

PDC North leadership reported that they had not detected any contraband as a result of the search. Searches conducted at PDC North are logged both in the facility Watch Commander log and in a Staff Search log.

PDC North leadership articulated resistance to deploying staff searches, stating that they were concerned that the searches may make staff "feel like criminals."

Pitchess Detention Center South

Between April 1 and June 30, 2024, PDC South conducted 28 staff searches and 4 staff searches with K9 assistance. Staff searches are conducted by sergeants. PDC South conducts searches on a randomized schedule but requires that at least one search be conducted one time per week per shift. PDC South leadership reported that the facility

consistently conducted searches prior to the Sheriff's Department directive requiring that facilities begin staff searches in May 2024.

PDC South provides lockers outside security for staff to store items that are prohibited in jail facilities. PDC South adjusted the location of its check-in point so that staff would already be inside security when searched, which prevents staff from anticipating, evading, or alerting others of a search. PDC South leadership stated that it has issued progressive discipline consistently and without exception for staff who bring prohibited items (specifically cell phones) through security. PDC South leadership reported that progressive discipline has effectively deterred staff bringing prohibited items into the jail, as PDC South has not seized any contraband since they began tracking searches in 2024.

PDC South also reported implementing strategies to improve staff transparency and morale. For example, PDC South provided additional refrigerators and microwaves to deter staff from bringing coolers and large lunch containers which can obstruct visual bag searches. In addition to enforcing clear bag policies, sergeants use a ruler to dig through and inspect items inside clear bags. PDC South has relied on the support of K9 units and require that the K9s sniff staff and property entering the facility. However, PDC South leadership stated that it would not allow K9s to search staff meals due to sanitation concerns about K9s sniffing food. While there may be some basis for these concerns, the exception for food creates an obvious vulnerability that staff could easily exploit: in 2010, a Sheriff's Department deputy attempted to smuggle heroin concealed in a burrito into a jail.⁵⁵ Searches conducted at PDC South are logged both in the facility Watch Commander log and in a customized Staff Search log.

Office of Inspector General Findings

Sheriff's Department leadership has reported that technological assistance, including the purchase and deployment of body scanners and X-ray machines, would supplement the Department's efforts to detect staff bringing contraband into the jails. Several facility leaders reported that, because staff searches presently occur during shift change, staff may still leave the facility during their shift and bring contraband into the facility when searches are not being conducted. Thus, these facility leaders recommended that the Sheriff's Department employ a fulltime security officer to search staff at each facility entrance/exit.

⁵⁵ Robert Faturechi and Jack Leonard, [*Heroin in a burrito allegedly smuggled by L.A. County deputy into courthouse jail*](#), Los Angeles Times (Jan. 12, 2012).

Despite the Sheriff's Department's limited resources, all facilities should at least follow the efforts made by PDC South's leadership in conducting staff searches. Specifically, the Office of Inspector General recommends that each jail conducts searches at a single checkpoint inside security that entering staff cannot observe from outside security, that jail leadership issues progressive discipline to staff who bring contraband into the jails, and that each facility develop and use a staff search tracker to record data on the number of staff searches conducted and contraband detected as a result of the search, since the Department reports it cannot extract data for analysis from Watch Commander logs.

Status of Progress on Recommendations and Board Directives

The Office of Inspector General collaborated on a report with the Chief Executive Office, [Chief Executive Office's report Enhancing Illegal Drug Detection in the Jails and Courts](#). As mentioned in the CEO's report, the Office of Inspector General's top priority to prevent overdose deaths is to reduce the jail population to a manageable level that allows for adequate care and supervision of inmates. While the population is lower than it has been historically, facility conditions and staff levels are insufficient to provide the type of care needed to prevent most or all overdose deaths.

The Office of the Inspector General previously reported on the status of the proposals made by the Sheriff's Department and referenced in both the CEO's report and the Board's motion. There has been no change in the status of any of those proposals.

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the second quarter of 2024, Office of Inspector General personnel completed 197 site visits, totaling 446 monitoring hours, at CRDF, IRC, LACMC, MCJ, Pitchess Detention Center (PDC) North, PDC South, PDC East, NCCF, TTCF and station jails located in Palmdale, Lancaster, and East Los Angeles.⁵⁶

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 171 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 247 monitoring hours related to uses of force, in-custody deaths, COVID-19 policies and protocols, Prison Rape Elimination Act (PREA) audits, and general conditions of confinement.

⁵⁶ These figures include site visits and meetings related to monitoring for compliance with the Prison Rape Elimination Act ("PREA").

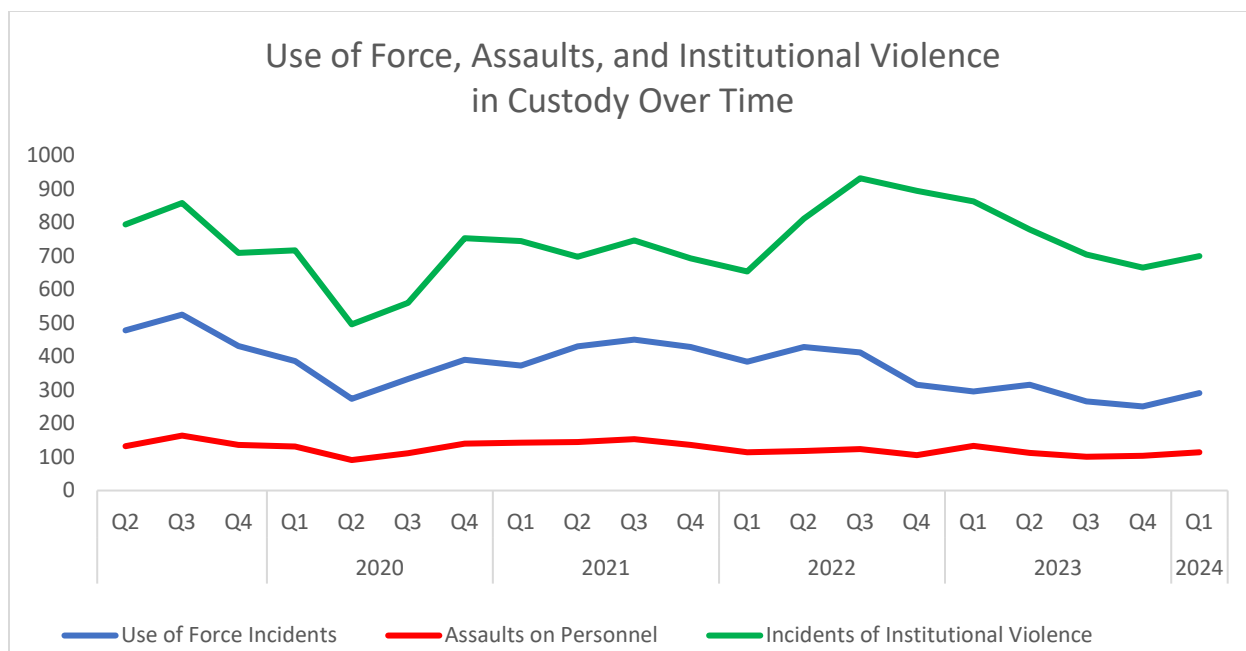
Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.⁵⁷ The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people in its custody.⁵⁸

		Use of Force Incidents	Assaults on Personnel	Incidents of Institutional Violence
2019	2 nd Quarter	478	132	794
	3 rd Quarter	525	164	858
	4 th Quarter	431	136	709
2020	1 st Quarter	386	131	717
	2 nd Quarter	274	91	496
	3 rd Quarter	333	111	560
	4 th Quarter	390	140	753
2021	1 st Quarter	373	143	745
	2 nd Quarter	430	145	698
	3 rd Quarter	450	153	746
	4 th Quarter	428	136	693
2022	1 st Quarter	384	114	654
	2 nd Quarter	428	118	811
	3 rd Quarter	412	124	932
	4 th Quarter	316	106	894
2023	1 st Quarter	296	133	863
	2 nd Quarter	316	112	779
	3 rd Quarter	266	101	704
	4 th Quarter	251	104	665
2024	1 st Quarter	291	114	700

⁵⁷ Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

⁵⁸ The reports go through the quarter of 2024 because the Sheriff's Department has not yet verified the accuracy of reports for the second quarter of 2024. The Department in early 2024 noted corrected information for assaults on personnel and incidents of institutional violence for the first quarter of 2022, which is reflected here and which differs from uncorrected information reported in quarterly reports for 2022 and 2023.



HANDLING OF GRIEVANCES AND COMMENTS

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received 390 new complaints in the second quarter of 2024 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

Of these grievances, 365 related to conditions of confinement within the Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	173
Personnel Issues	39
Classification	31
Living Condition	25
Food	21
Transportation	17
Property	9
Mail	7

Bedding	6
Education	6
Showers	5
Telephones	4
Visiting	4
Commissary	1
Other	17
Total	365

Twenty-five complaints related to civilian contacts with Department personnel by persons who were not in custody, as shown in the chart below:

Complaint/Incident Classification	Totals
Personnel	
Improper Detention	4
Improper Tactics	3
Harassment	3
Off Duty Conduct	3
Criminal Conduct	2
Dishonesty	2
Discourtesy	1
Neglect of Duty	1
Force	1
Service	
Policy Procedures	1
Response Time	1
Other	3
Total	25

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 83 iPads installed in jail facilities: 46 at TTCF; 12 at MCJ; and 25 at CRDF. During the second quarter there were 6 new installations and iPad replacements. The Department had 68 iPads reconnected during this period.

The Sheriff's Department continues to experience malfunctioning iPads and have identified power source problems as the major cause. To rectify this issue, the

Department reports that Facility Services Bureau is currently working to install dedicated data drops and power supply for the iPads. The Department also reports that outdated equipment also contributes to the problem. Custody Support Services Bureau – Correctional Innovative Technology Unit (CITU) recently acquired two new MacBooks to use to reconfigure and program the iPads. The new MacBooks are currently being prepared and programmed by Data Systems Bureau. With the MacBooks, the Department reports CITU can update applications for outdated iPads. The Department states that CITU is also monitoring the Wi-Fi connectivity issues and exploring alternative solutions to assist with strengthening the Wi-Fi signal.

As [previously reported](#), the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in custody.⁵⁹ The Sheriff's Department reports that between April 1 and June 30, 2024, no one in custody had been placed on restrictive filing and it therefore did not reject any grievances under this policy.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.⁶⁰ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and

⁵⁹ See Los Angeles County Sheriff's Department, Custody Division Manual, [§ 8-04/050.00, Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges](#).

⁶⁰ See Los Angeles County Sheriff's Department, MPP, [§ 3-04/010.00, Department Service Reviews](#).

- **Personnel Complaint:** an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.⁶¹

The following chart lists the number and types of comments reported for each station or unit.⁶²

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
ADM : CENTRAL PATROL ADM HQ	0	1	0
ADM : DETECTIVE DIV HQ	1	0	0
ADM : PROF STANDARDS ADM HQ	1	0	0
AER : AERO BUREAU	1	1	0
ALD : ALTADENA STN	1	1	0
CCS : COMMUNITY COLLEGE BUREAU	3	0	0
CEN : CENTURY STN	4	2	1
CER : CERRITOS STN	2	1	0
CMB : CIVIL MANAGEMENT BUREAU	5	4	3
CNT : COURT SERVICES CENTRAL	2	1	2
COM : COMPTON STN	1	8	3
CRD : CENTURY REG DETEN FAC	1	1	0
CRV : CRESCENTA VALLEY STN	10	4	0
CSB : COUNTY SERVICES BUREAU	4	4	1
CSN : CARSON STN	13	6	3
DSB : DATA SYSTEMS BUREAU	1	0	0
ELA : EAST LA STN	6	2	0
EOB : EMERGENCY OPER BUREAU	2	0	0
EST : COURT SERVICES EAST	0	1	0
FCC : FRAUD & CYBER CRIMES BUREAU	2	0	0
HDQ : SPECIAL OPERATIONS DIV HQ	1	0	0
IND : INDUSTRY STN	2	4	0
IRC : INMATE RECEPTION CENTER	1	0	0

⁶¹ It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

⁶² The chart reflects data from the Sheriff's Department Performance Recording and Monitoring System current as of July 1, 2024.

ISB : INMATE SERVICES BUREAU	0	1	1
LCS : LANCASTER STN	5	21	3
LKD : LAKEWOOD STN	8	8	5
LMT : LOMITA STN	4	1	0
MAR : MARINA DEL REY STN	6	2	1
MCB : MAJOR CRIMES BUREAU	2	1	1
MCJ : MEN'S CENTRAL JAIL	2	2	1
MLH : MALIBU/LOST HILLS STN	10	8	2
NCF : NORTH CO. CORRECTL FAC	0	2	0
NO : PITCHESS NORTH FACILITY	0	1	1
NWK : NORWALK REGIONAL STN	5	5	0
OCP : OFFICE OF CONSTITUTIONAL POLICING HQ	0	1	0
OSS : OPERATION SAFE STREETS BUREAU	1	1	0
PAD : PARKS & COUNTY SRVS ADM HQ	0	1	0
PER : PERSONNEL ADMIN	0	1	0
PKB : PARKS BUREAU	1	1	0
PLM : PALMDALE STN	7	23	8
PRV : PICO RIVERA STN	1	0	1
RMB : RISK MANAGEMENT BUREAU	0	2	0
SCV : SANTA CLARITA VALLEY STN	11	7	1
SDM : SAN DIMAS STN	9	1	0
SLA : SOUTH LOS ANGELES STATION	0	5	1
SSB : SCIENTIFIC SERV BUREAU	1	0	0
SVB : SPECIAL VICTIMS BUREAU	1	0	0
TB : TRAINING BUREAU	1	0	0
TEM : TEMPLE CITY STN	4	0	1
TSB : TRANSIT SERVICES BUREAU	3	3	3
TT : TWIN TOWERS	0	1	0
WAL : WALNUT/SAN DIMAS STN	1	1	1
WHD : WEST HOLLYWOOD STN	11	14	0
WST : COURT SERVICES WEST	1	7	0
Total :	159	162	44



Reform and Oversight Efforts: Los Angeles County Sheriff's Department

July through September 2024

Issued December 4, 2024

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between July 1 and September 30, 2024, unless otherwise noted. Quarterly reports may also examine particular issues of interest. This report includes special sections on the following topics:

- Use of Facial Recognition Technology in Photograph Arrays
- Deputy-Involved Shooting at Harbor-UCLA Medical Center
- Office of Inspector General's Outstanding Requests to the Sheriff's Department
- Jail Overcrowding

During the third quarter of 2024, the Office of Inspector General also issued the following reports relating to the Sheriff's Department:

- [Eleventh Report Back on Implementing Body-Worn Cameras in Los Angeles County](#)
- [Report Back on the Sheriff's Department's Compliance with the Prison Rape Elimination Act](#)
- [Fourth Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421](#)

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. During this quarter, there were seven incidents in which people were shot or shot at by Sheriff's Department personnel. The Office of Inspector General staff responded to each of these deputy-involved shootings. Five people were struck by deputies' gunfire, three fatally. The information in the following shooting summaries is based on the limited information provided by the Sheriff's Department and is preliminary in nature. While the Office of Inspector General

receives information at the walk-through at the scene of the shooting, receives preliminary memoranda with summaries, and attends the Sheriff's Department Critical Incident Reviews, the statements of the deputies and witnesses are not provided until the Sheriff's Department completes its investigation. The Sheriff's Department permits the Office of Inspector General's staff limited access to monitor the ongoing investigations of deputy-involved shootings. The Sheriff's Department also [maintains a page on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.

East Los Angeles Station: Hit Shooting – Non-Fatal

On July 2, 2024, at approximately 1:16 p.m., deputies from the East Los Angeles Station identified a stolen vehicle traveling in the City of Commerce. The deputies pursued the stolen vehicle until it stopped in a residential back alley. The driver and rear passenger jumped out of the vehicle and ran eastbound into the residential neighborhood. The deputies stayed with the stolen vehicle where they located and detained a third suspect seated in the front passenger seat. The deputies did not engage in a foot pursuit of the other suspects, but instead requested additional deputies to respond and established a containment of the area.

Approximately two hours later, deputies were alerted by a resident who believed one of the suspects was hiding at a nearby home, possibly on one of the rooftops. A Sheriff's Department helicopter eventually located the vehicle's driver hiding on the roof under an overhang. Deputies deployed a flash bang on the roof, and the suspect surrendered.

At approximately 4:00 p.m., a resident approached two deputies who were standing by the stolen vehicle and said they had seen an individual running near some homes down the street. The deputies drove a short way to the area where this suspect was reportedly seen. As they neared the suspect on the sidewalk by a parked truck, the passenger deputy got out and ran around the car to approach the subject on the sidewalk while the other deputy continued in the car around the parked truck. The suspect raised his hands while holding a firearm in his right hand. The deputy fired approximately five rounds, two of which struck the suspect. The other deputy did not witness the shooting as he was still in the patrol vehicle. The suspect was transported to the hospital in critical condition and survived. The Sheriff's Department located a loaded revolver at the scene of the shooting. The Department later determined that two of the suspects in the stolen vehicle, including the one shot, are juveniles.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from body-worn cameras and nearby surveillance cameras. Both deputies activated their body-worn cameras only after the shooting occurred, so that the shooting was

captured on the cameras' one-minute buffer period, which records only video without audio for the minute preceding the activation.

Areas for further inquiry:

Why did the deputies fail to activate their body-worn cameras until after the shooting?

Did the deputies form a tactical plan for pursuing the suspect in the residential area?

Did the deputies issue instructions or give the suspect an opportunity to surrender before closing in on the suspect?

What was the shooting backdrop?

East Los Angeles Station: Hit Shooting – Fatal

On July 10, 2024, East Los Angeles Station deputies conducted a high-risk traffic stop on a car-jacking suspect.¹ The suspect was the only occupant in the car. The suspect initially stopped, but then backed into the front of the deputies' patrol vehicle and drove away. The deputies began a vehicle pursuit, following the suspect onto the 710 freeway. After the suspect exited the freeway, the deputies conducted a second felony traffic stop. The suspect again stopped but then again backed into the front end of the deputies' vehicle and proceeded onto the I-10 freeway. The deputies conducted a third felony traffic stop after the suspect exited the freeway, but once again the suspect stopped and backed into the patrol car. The pursuit continued through traffic on Vermont Avenue until the suspect became boxed in by cars stopped at an intersection, drove up onto the sidewalk, and hit a light pole. A pursuing deputy came to a stop against the suspect's rear bumper, pinning it against the light pole. A video of this incident from a news helicopter shows the suspect's wheels spinning and smoking as he tried to back away from the light pole. As the wheels on the car stop spinning the suspect sticks his left hand and head out of the driver's window. Deputies appear to advance, and the video shows deputies shooting through the car's rear window into the passenger compartment. From the video, it appears several deputies each fired multiple times at the suspect.² The suspect sustained multiple gunshot wounds to the upper torso. He was treated by Los Angeles Fire Department and transported to the hospital, where he subsequently died from his injuries. No weapon was recovered at the scene.

¹ In a high-risk stop, a deputy with reason to believe the occupant of a stopped vehicle may be dangerous conduct the stop with guns drawn.

² Because this shooting resulted in the death of an unarmed civilian, the California Department of Justice conducts the investigation, rather than the Sheriff's Department's Homicide Bureau, and some information remains unknown to the Sheriff's Department and the Office of Inspector General.

The California Department of Justice (DOJ) took over the investigation of this incident as a shooting by law enforcement resulting in the death of an unarmed civilian.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from the deputy's body-worn cameras and a news helicopter.

Areas for further inquiry:

What prompted the deputies to shoot?

Prior to approaching the suspect's vehicle, did deputies form a tactical plan for the approach consistent with Departmental policy and training?

Was there a sufficiently clear backdrop when the deputies opened fire?

Was contagious fire a factor in this shooting?

West Hollywood Station: Hit Shooting – Fatal

On July 20, 2024, at approximately 5:00 p.m., deputies patrolling near Santa Monica Boulevard in the City of West Hollywood were flagged down by witnesses reporting that a white man had just robbed a nearby convenience store. Deputies responded to the scene and located a suspect matching the description at a nearby intersection. As deputies attempted to arrest him, the suspect fled on foot. During the brief foot pursuit, deputies observed a knife in the suspect's right hand and yelled at him to stop and drop the knife.

After a brief chase, the suspect turned to face the closest deputy, while still holding the knife. In response, deputies fired approximately 11 rounds, striking the suspect multiple times. Paramedics arrived on scene shortly thereafter and transported the suspect to the hospital, where he was later pronounced dead.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from the deputy's body-worn cameras.

Areas for further inquiry:

Did the deputies' tactics in engaging in a foot pursuit with a suspect carrying a knife comport with Department training?

Did the deputies consider the backdrop of the residential area prior to the shooting?

Did the deputy consider less-lethal force options before resorting to lethal force? Did the deputy warn the subject deadly force would be used if he did not drop the knife?

Did each of the 11 rounds fired comply with the Department's policy for use of deadly force?

Lakewood Station: Hit Shooting – Non-Fatal

On August 3, 2024, at 9:35 a.m., deputies from the Lakewood Sheriff's Station received a call for service in which the caller stated that he was in his vehicle following a person armed with a knife who the caller observed walking around a shopping center in the city of Lakewood. The dispatcher remained on the phone with the caller, and the caller at some point advised the dispatcher that the suspect turned to confront him and attempted to slash at him, but he was in his vehicle and not injured. Deputies arrived at the scene and immediately attempted to detain the suspect at gunpoint. The suspect screamed at the deputies to shoot him, while holding a knife in each hand. During the incident an aero bureau helicopter arrived to monitor the scene and assist with coordinating the responding deputies. The suspect advanced towards the deputies, one of whom employed a Taser that was ineffective at stopping the suspect's advance. The deputies continued to retreat as the suspect advanced, screaming he wanted to be shot. When the suspect was within 6 feet of the deputies still armed with both knives, each of the deputies opened fire, firing a total of five rounds, and striking the suspect multiple times. Deputies provided medical assistance until paramedics arrived and transported the suspect to the hospital for treatment. Investigators recovered two knives at the scene.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from the deputy's body-worn cameras.

Areas for further inquiry:

Should the deputies have attempted to use additional less-lethal options or de-escalation tactics after the one application of the Taser proved ineffective?

Should dispatch have advised the caller to stop following the armed suspect?

Lakewood Station: Hit Shooting – Fatal

On August 4, 2024, at 9:04 p.m., Lakewood Station received a call for service indicating a family disturbance between a father and son in the City of Paramount. Three deputies arrived and saw the father in the driveway bleeding from a head wound, which he reported resulted from his adult son punching him. The father and mother escorted the deputies around to a rear patio of the house. As they approached a door to the house, the son emerged from it, pulled a pair of scissors from his pocket, and moved quickly towards the deputies and his parents. One deputy employed a Taser, but it did not prove effective. Two deputies fired their guns, striking the suspect. Deputies began rendering medical aid, but the suspect died at the scene. Investigators recovered a pair of office scissors from the scene.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from the deputy's body-worn cameras.

Areas for further inquiry:

Did the deputies have any information relating to potential mental health issues?

Operation Safe Streets: Non-Hit Shooting – Non-Fatal

On August 20, 2024, at approximately 1:45 p.m., deputies with the Operation Safe Streets Gang Surveillance Unit were conducting surveillance in the parking lot of a hotel located in the city of La Mirada. The deputies were trying to apprehend a suspect who was wanted for a homicide. The deputies saw the suspect and a female exit the hotel and enter his parked car. The deputies then executed a tactical plan using a "Vehicle Containment Technique." During the attempted apprehension, a deputy in an unmarked car saw the suspect, who was still inside of his car, point a firearm at him. The deputy exited the unmarked car and fired twelve shots at the suspect's car. Neither the suspect nor the passenger was struck by the gunfire. The suspect suffered minor lacerations to his arms and surrendered shortly after. The suspect was treated at a local hospital for his injury and released into the custody of the Sheriff's Department. A loaded semi-automatic firearm was recovered from the front driver's side of the suspect's car. The deputy did not activate his body worn camera until after the shooting, but the camera captured the shooting without audio in its one-minute buffer period.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from the deputies' body-worn cameras.

Areas for further inquiry:

Were the tactics used by the apprehension team in accordance with Department policy and best practices?

Did the deputies have any information that the suspect might be armed?

Why didn't the deputy activate his body worn camera before engaging in the planned tactical operation to apprehend the suspect?

Compton Station: Non-Hit Shooting – Non-Fatal

On September 30, 2024, at 12:20 p.m., deputies from the Compton Sheriff's Station responded to a domestic violence call involving a male suspect attempting to stab his wife in the City of Compton. When deputies arrived, the wife told them that her husband had attempted to stab her and fled the location on foot armed with a knife and possibly a firearm. A description of the suspect was broadcast, and two other deputies nearby located a suspect matching the description. The suspect fled, and the deputies pursued

him on foot. During the foot pursuit the suspect fired two rounds at the deputies, and one deputy fired two rounds in return. Neither the deputies nor the suspect was struck by the gunfire. The suspect continued to flee through an adjacent property and onto a different street. The deputies terminated the foot pursuit at that point and established a containment area. Additional deputies and a sergeant encountered the suspect and arrested him without any further incident. After the arrest, a resident of a nearby building told deputies that they saw the suspect change clothes outside of their apartment and directed deputies to the location where a firearm and clothes matching the suspect's attire during the foot pursuit were found. Both deputies involved in the foot pursuit had their body-worn cameras activated.

Areas for further inquiry:

Did deputies formulate a tactical plan before engaging with a suspect who was reportedly armed with a knife and possibly a gun?

Did the deputy who fired consider the backdrop before firing in a residential area?

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.³ For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and which occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

³ In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. See [A.B. 1506 \(McCarty 2020\)](#) (codified at [Govt. Code § 12525.3](#)). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*. Until the law took effect in 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet.

Between July 1 and September 30, 2024, the District Attorney's Office issued seven findings on deputy-involved shooting cases involving the Sheriff's Department's employees.⁴

- In the February 23, 2022, non-fatal shooting of Adrian Romero and J.M., the District Attorney opined [in a memorandum dated July 9, 2024](#), that Deputies Sergio Campos, Damien Guerrero, and Justin Perez initially acted in self-defense at the time they fired their service weapons, and that it could not be proved that Deputy Guerrero acted unlawfully when he continued to fire his service weapon at the sedan driven by Adrian Romero.
- In the December 21, 2022, fatal shooting of Fernando Fierro, the District Attorney opined [in a memorandum dated July 18, 2024](#), that evidence supports that the use of deadly force was necessary when Deputy Robert Mass fired his duty weapon.
- In the April 29, 2021, fatal shooting of Alfredo Aceves, the District Attorney opined [in a memorandum dated August 20, 2024](#), that the deputy acted in lawful self-defense and defense of others at the time he fired his weapon.
- In the October 3, 2021, fatal shooting of Christopher Mosco, the District Attorney opined [in a memorandum dated September 19, 2024](#), that Deputies Rudy Hernandez and Tyler Wheatcroft acted in lawful self-defense.
- In the August 16, 2022, non-fatal shooting of Rafael Salazar, the District Attorney opined [in a memorandum dated September 19, 2024](#), that Deputies Jaime Gallegos and Carlos Gomez acted in a lawful self-defense at the time they fired their service weapons.
- In the September 22, 2021, non-fatal shooting of Julio King, the District Attorney opined [in a memorandum dated September 24, 2024](#), that Detective Jeremy Edwards and Deputy Jesus Chamorro acted in a lawful self-defense at the time they fired their weapons.
- In the November 21, 2021, fatal shooting of John Holenbeck, the District Attorney opined [in a memorandum dated September 26, 2024](#), that deputies

⁴ The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#). The Office of Inspector General retrieves the information on District Attorney decisions from this webpage.

Christopher Carmona and Alfonse Valenzuela acted in lawful self-defense when they used deadly force.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has ten shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a February 23, 2024, shooting in the jurisdiction of Palmdale Station. For further information as to that shooting, please refer to the Office of Inspector General's report [Reform and Oversight Effort: Los Angeles Sheriff's Department, January to March 2024](#). The oldest case that the Bureau has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent seven deputy-involved-shooting cases to the District Attorney's Office for filing consideration.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.⁵ The DOJ [is currently investigating](#) four shootings involving deputies from the Sheriff's Department, the oldest of which occurred in February 2022. During the last quarter, the DOJ [issued no written reports](#) regarding shootings involving Sheriff's Department deputies.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.⁶

⁵ Gov't Code § 12525.3(b).

⁶ Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

The Sheriff's Department reports that ICIB has 77 active cases. This quarter, the ICIB reports sending three cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 26 cases from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 117 new administrative investigations. Of these 117 cases, 35 were assigned to IAB, 55 were designated as unit-level investigations, and 27 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 132 cases were closed by IAB or at the unit level. There are 500 pending administrative investigations, of which 318 are assigned to IAB and the remaining 182 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between July 1 and September 30, 2024, the Civil Service Commission issued final decisions in three cases involving Sheriff's Department employees.⁷ In all three, the Commission sustained the Department's discipline.

⁷ The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings posted on the County's website](#) for commission publications.

All of these cases concerned sworn peace officers of the rank of deputy. All three cases sustained Sheriff's Department decisions to discharge a sworn employee, while one case only partially sustained the Department regarding allegations of a tattoo that were not proven.

Employee Position	Date of Department action	Case number	Department actions	Date of Civil Service Hearing	Civil Service decision
Deputy Sheriff	8-6-21	21-173	Discharge	7-3-24	Sustained the Department's decision.
Deputy Sheriff	10-1-20	20-137	Discharge	7-17-24	Sustained the Petitioner/Employee's claims in part, that the allegations regarding the tattoo were not proven but sustained Department's the final decision to discharge.
Deputy Sheriff	5-17-21	21-129	Discharge	8-28-24	Sustained the Department's decision.

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) 13 times between July 1 and September 30, 2024, as summarized in the chart below, which reflects data from the Sheriff's Department [Transparency page](#) as of October 8, 2024.

DATE	OPERATION TYPE	LOCATION	SUMMARY
7-2-24	High-Risk Tactical Operations	Rowland Heights	SEB personnel responded at the request of patrol personnel for technology support. UAS was used to observe a person who was believed to have died by suicide.
7-29-24	Barricaded Suspect	La Puente	SEB personnel responded to an armed barricaded suspect. UAS used to visually clear the location and locate the suspect.
8-22-24	High-Risk Tactical Operations	Rosemead	SEB responded to assist Major Crimes with high-risk tactical operation. UAS used to visually clear the location for possible suspects.
8-26-24	High-Risk Tactical Operations	Los Angeles	SEB personnel responded to assist East Los Angeles Station with high-risk tactical operation. UAS was used to visually clear the location for possible suspects.
8-31-24	High-Risk Tactical Operations	Palmdale	SEB personnel responded to assist Palmdale Station with high-risk tactical operation. UAS was used to visually clear the location for possible suspects.
9-1-24	High-Risk Tactical Operations	Rancho Palos Verdes	SEB personnel responded to assist Lomita Station with a high-risk tactical operation. UAS was used to detect urban and rural fire danger in a landslide area that could impact live power lines servicing a residential area.
9-5-24	High-Risk Tactical Operations	Rancho Palos Verdes	SEB personnel responded to assist Lomita Station with a high-risk tactical operation. UAS was used to detect urban and rural fire danger in a landslide area that could impact live power lines servicing a residential area.
9-16-24	Search and Rescue	Rancho Palos Verdes	Lost Hills Station responded to search an area where a caller indicated a vehicle drove over a cliff. UAS was used to search the area and rescue the occupants of the vehicle.
9-17-24	High-Risk Tactical Operations	Rancho Palos Verdes	SEB personnel assisted Lomita Station to deploy a UAS to detect urban and rural fire danger in a landslide area.
9-19-24	High-Risk Tactical Operations	Rancho Palos Verdes	SEB personnel assisted Lomita Station. UAS was used to detect urban and rural fire danger in a landslide area.
9-24-24	High-Risk Tactical Operations	Rancho Palos Verdes	SEB personnel assisted Lomita Station. UAS was used to detect urban and rural fire danger in a landslide area.
9-25-24	High-Risk Tactical Operations	Compton	SEB personnel assisted Homicide Bureau with a barricaded suspect. UAS was used to locate a suspect inside a residence.
9-26-24	High-Risk Tactical Operations	Rosemead	SEB personnel assisted Major Crimes Bureau. UAS was used to locate suspects inside a structure.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracing and Documenting Taser Use

Updated Taser Policy Implementation Status

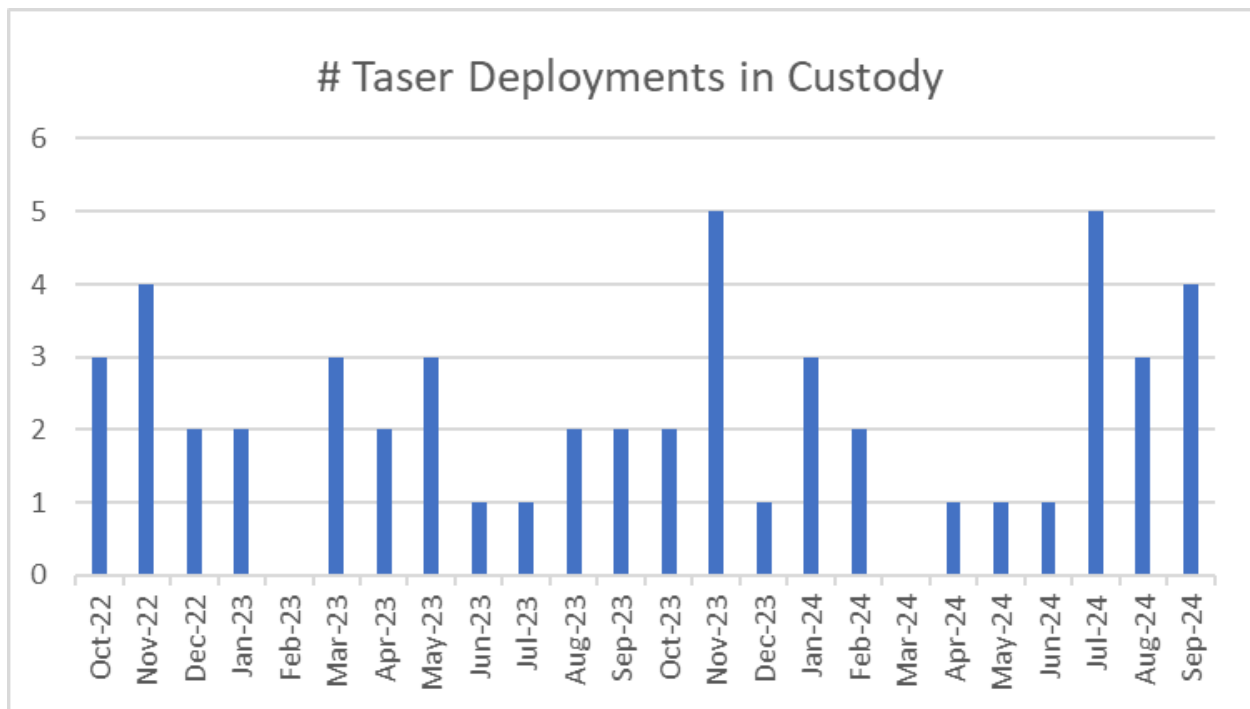
On October 3, 2023, the Board of Supervisors passed a [motion](#) instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The

motion directs the Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.

The Office of Inspector General reviewed a draft of the Conducted Energy Weapon (CEW) policy and provided the Department with comments in July 2023, before the meet and confer process with labor. On July 23, 2024, the Department provided the Board with the finalized version of its new CEW policy, published under Manual of Policy and Procedures (MPP) sections 5-06/045.00 through 5-06/045.14 (collectively, the new CEW policy). Because the revised policy necessitates a detailed analysis, the Office of Inspector General will issue a separate report, titled *Report on the Sheriff's Department's Taser Policy, Training, and Usage* for this quarter. Future reporting on the Sheriff's Department's Taser usage will be included in our quarterly reporting as directed.

Taser Use in Custody

The following chart reflects the number of use-of-force incidents in custodial settings over the past two years in which deputies employed a Taser, according to the *Monthly Force Synopsis* that the Sheriff's Department produces and provides to the Office of Inspector General each month:



Use of Facial Recognition Technology in Photograph Arrays

The use of facial recognition technology (FRT) by law enforcement agencies raises significant concerns about privacy, civil liberties, accuracy, and bias. While proponents assert that FRT enhances public safety by aiding law enforcement in the investigation and prevention of crimes, critics warn of dangers to privacy and civil liberties, racial inaccuracies resulting in misidentifications, bias, and the potential for abuse. Public opinion on the use of FRT by law enforcement varies. A [2022 Pew Research Center report](#) found that 46% of surveyed U.S. adults believed widespread use of facial recognition technology by police was a good idea for society, while 27% thought it would be bad, and 66% believed that police would use facial recognition more in Black and Hispanic neighborhoods. The U.S. Government Accountability Office noted that “civil rights advocates have cautioned that an over-reliance on facial recognition technology in criminal investigations could lead to the arrest and prosecution of innocent people, particularly those of certain ages and racial and ethnic backgrounds.”⁸ The potential disproportionate impact of FRT on communities of color is particularly troubling within the historical context of over-policing and discrimination within these communities.

Most of the concerns around FRT arise from false identifications that could lead to wrongful arrests and prosecutions, especially since FRT error rates have varied across racial backgrounds and skin tones. A 2018 study analyzed the results of FRT software from leading companies on 1270 unique faces and found significant gender and skin-type bias in classification.⁹ A 2022 study by the Pew Research Center also found that some facial recognition algorithms exhibited higher error rates when identifying women and people with darker skin tones.¹⁰ More recent evaluations of FRT, however, indicate that the top facial recognition algorithms have achieved higher levels of accuracy but reference applications other than suspect identification, such as airline passenger identification during boarding processes, including across different demographic

⁸ U.S. Government Accountability Office (2024) [Facial Recognition Technology: Federal Law Enforcement Agency Efforts Related to Civil Rights and Training](#).

⁹ Joy Buolamwini and Timnit Gebru, [Gender Shades: Intersectional Accuracy Disparities in Commercial Gender Classification](#), Proceedings of Machine Learning Research, 81: 1-15, 2018.

¹⁰ Lee Rainie, Cary Funk, Monica Anderson and Alec Tyson, [AI and Human Enhancement: Americans’ Openness Is tempered by a Range of Concerns](#), Pew Research Center (2022).

groups.¹¹ Even with improved accuracy, the routine use of FRT by law enforcement will result in false identifications. Law enforcement policy must account for the inevitable false matches.

The Los Angeles County Regional Identification System (LACRIS) provides Facial Recognition services to the Sheriff's Department using a database made up exclusively of mugshot photographs.¹² Mugshots are typically high-quality, frontal images taken in controlled conditions and are the best format for FRT use.¹³

A recent [New York Times article](#) reported on a cautionary tale, in which the Detroit Police Department wrongfully arrested three people based on false FRT matches. One of these people, Robert Williams, was arrested for a 2018 theft from a store in downtown Detroit. Investigators obtained an image of the suspect from surveillance camera footage, and facial recognition software identified a driver's license photo of Mr. Williams, listing him ninth on a list of 243 potential matches. The person running the search determined that Mr. Williams was the best match. Detroit Police Department investigators then inserted his picture into a photo lineup and showed it to the security

¹¹ [NIST Evaluates Face Recognition Software's Accuracy for Flight Boarding](#), Nat'l Inst. of Standards and Tech. (July 13, 2021). The Security Industry Association (SIA) reviewed NIST data and concluded that the top 100 facial recognition algorithms are over 99.5% accurate across various demographic groups, including Black males and White males. Jake Parker, [What Science Really Says About Facial Recognition Accuracy and Bias Concerns](#), Security Industry Assn. (July 23, 2022).

¹² See *Facial Recognition Software* section in [Reform and Oversight Efforts: Los Angeles County Sheriff's Department October to December 2020](#), for an in-depth discussion of LACRIS. LACRIS is a hybrid organization staffed by Sheriff's Department employees working in partnership with the California Department of Justice to provide law enforcement agencies with training and assistance in obtaining Criminal Offender Record Information. The LACRIS image database does not use Department of Motor Vehicle photographs or any social media or surveillance camera photographs. An employee enters a "probe" image into the LACRIS Facial Recognition System, which then compares the probe image with photographs in the mugshot database. The LACRIS Facial Recognition System uses comparison algorithms that have been tested by NIST for accuracy. All agencies that use the LACRIS Facial Recognition System must implement policies consistent with state requirements. LACRIS representatives also conduct random audits to ensure that all investigators who use the LACRIS Facial Recognition System have been trained and authorized by LACRIS.

¹³ Chris Burt, [Paravision joins podium for mugshot and webcam biometric accuracy in NIST facial recognition testing](#), Biometric Update (Mar. 26, 2020). Images taken in controlled environments (e.g., passport photos, mugshots) typically result in higher accuracy rates than those captured in uncontrolled settings (e.g., surveillance cameras, webcam images). Patrick Grother, Mei Ngan, Kayee Hanaoka, [Face Recognition Vendor Test \(FRVT\)](#), Natl. Inst. of Standards and Tech. (2019). When comparing high-quality mugshots against a database of 1.6 million templates, NIST found that 45 out of 105 tested algorithms achieved over 99% accuracy. Gabrielle Shea, [Face Recognition Technology Accuracy and Performance](#), Bipartisan Policy Center (May 24, 2023).

contractor who provided surveillance video. The security contractor, who did not witness the actual crime and only watched the theft via the surveillance footage, identified Mr. Williams. Based on this identification, the Detroit Police Department obtained a warrant and arrested Mr. Williams for the theft. Subsequent investigation revealed that Mr. Williams was at work when the theft occurred, and prosecutors eventually dismissed the case against him.

The case against Mr. Williams demonstrates how gaps in FRT policy, in conjunction with poor investigative practices, can result in the arrest of an innocent person. The FRT system determined that Mr. Williams highly resembled the person on the surveillance camera footage, based on its algorithm's assessment of millions of drivers' license photos. The eyewitness unsurprisingly identified him based on that physical similarity to the security video, essentially providing a human stamp on the computerized algorithm's match without any meaningful independent evidence of Mr. Williams' involvement. Mr. Williams sued the City of Detroit, and as part of the civil settlement of his case, the Detroit Police Department adopted a new rule that prohibits faces of people identified by facial recognition technology being shown to an eyewitness in a photo lineup unless other evidence links the person to the crime.

Unfortunately, Sheriff's Department policy, as written, may allow investigators to place a person's face in a photo array solely based on a facial recognition match. The Department's [Use of Facial Recognition](#) policy (MPP 5-08/100.20) states that FRT matches are considered "investigative leads only" and "shall not be used as the sole basis for an arrest or identification of a suspect." However, as currently written, nothing in the Sheriff's Department's facial recognition policy prevents an investigator from placing a person's face in a photo array solely based on a facial recognition match. While this may not be the Sheriff's Department's investigative practice, the Office of Inspector General strongly recommends that the Department revise the Use of Facial Recognition policy to state explicitly that the face of a person identified by FRT cannot be shown to an eyewitness in a photo array unless investigators have discovered other evidence that links that person to the crime.

Deputy-Involved Shooting at Harbor-UCLA Medical Center

Background

On October 6, 2020, a Sheriff's Department deputy fatally shot a patient (the Patient) at Harbor-UCLA Medical Center (HUMC).¹⁴ Last quarter, the Los Angeles County District

¹⁴ While the Patient was shot on October 6, 2020, he did not die from his wounds until November 1, 2020.

Attorney's Office posted on its website a [memorandum dated February 20, 2024](#), summarizing its review of the Sheriff's Department's investigation and opining that there was insufficient evidence to file charges against the deputy. The conclusion of the criminal investigation now allows the Office of Inspector General to report on the findings of our investigation. Given the length of time it took to conclude the criminal investigation, we focus mostly on our recommendations.

Summary of Deputy-Involved Shooting

The Patient had been admitted for a psychological evaluation under Welfare and Institutions Code section 5150 and was being treated for self-inflicted wounds. At the time of this incident, the Patient was in a recovery room on the same floor where two Sheriff's Department deputies were working their regular patrol shift by providing armed security for a hospitalized deputy who was recovering from an unrelated incident, in a room nearby to the Patient.

While there were varying accounts of the events leading up to the shooting, all the witnesses agree that the Patient was acting erratically prior to the shooting and that he was in possession of a large metal hospital care device, which he used to smash a window and a computer station prior to proceeding down the hallway to the room with the hospitalized deputy. When the Patient reached the deputy's recovery room, he broke the window to the room, and one of the deputies providing security fired her service firearm nine times at the Patient. The deputy was not equipped with a Taser but did have oleoresin capicum (OC) spray available for use.

Sheriff's Department Training

Prior to the shooting, multiple hospital staff members reacted to the Patient's actions by calling for a Code Gold, an internal hospital alert that initiates a response from a team of personnel specially trained in de-escalation and restraint of agitated patients. Members of the Code Gold team have gone through a certification and training program.

Sheriff's deputies assigned to the HUMC do not go through this certification and training program.

The Sheriff's Department Manual of Policy and Procedures provides no written policy related to protocol for deputies assigned to County hospital facilities either permanently or temporarily as part of a security detail, nor does the Sheriff's Department provide specialized training for deputies assigned to the hospital on a permanent basis.

According to the information provided by the Sheriff's Department, deputies, sergeants, and lieutenants assigned to a contract hospital have completed the Sheriff's Basic Academy, Patrol School, and are current with their Police Officers Standards and

Training (POST) certification by completing 24-hours of Advanced Officer Training (AOT) in perishable skills that are applicable to their position and rank every two years. In addition, deputies throughout the Department attend de-escalation scenario training through a virtual based platform. While the Sheriff's Department conducts specialized de-escalation training for its Mental Health Evaluation Team deputies and conducts crisis intervention skills training, known as ROAR (Respond, Observe, Assess, React) neither of these trainings are required for deputies assigned to HUMC.

When assigned to a contract hospital, all deputies receive a detailed hospital orientation manual and an orientation to the physical layout of the facility. Deputies attend a daily briefing that includes any known problem patients and new directives handed down by the hospital administrators. There is no de-escalation training provided to deputies that is specific to a hospital setting.

Less-Lethal Weapons

Like custodial facilities that prohibit firearms because of the risks posed if the weapons are taken from the deputies, HUMC hospital policy prohibits firearms in psychiatric units for similar reasons. Using less-lethal weapons instead of firearms lowers the risk of deadly outcomes. The deputy involved in the shooting had OC spray but did not have any other less-lethal weapons available.

Recommendations

1. Policy and Procedure:
 - a. The Sheriff's Department should draft policies specific to deputies assigned to HUMC, and any other county medical facilities, on both permanent and temporary assignments, that include policies on interactions with hospital staff, including who is in command during a Code Gold or similar emergency situation.
2. Training:
 - a. Sheriff's Department staff assigned to HUMC should receive Code Gold training and certification.
 - b. Sheriff's Department personnel assigned to the hospital should receive MET training and ROAR training.
 - c. Deputies should also:

- i. Be trained by certified instructors in the handling of patients exhibiting violent behavior and de-escalation techniques specific to a hospital setting.
 - ii. Be trained by hospital risk management on hospital response protocols to violent patients, mental health intervention, and an active shooter.
 - iii. Be trained by hospital risk management on the protocols to activate the hospital's emergency response teams.
 - iv. Be trained by certified instructors on critical decision-making in a hospital setting, e.g., intervention techniques, consideration when using force, etc.
 - v. Receive training specific on responding to people with mentally illness.
 - d. Deputies who are permanently assigned to the hospital should be responsible for providing patient security for deputies and persons in custody at HUMC. The Sheriff's Department should no longer assign temporary security details to deputies from patrol stations or other Sheriff's Department divisions who lack the proper MET and Code Gold training.
3. Deputies assigned to HUMC should have on their person a Taser, baton, and OC Spray.
 4. Deputies assigned to HUMC should have on their person a portable radio tuned to the assigned radio frequency of hospital security or the dedicated law enforcement agency assigned to that hospital.
 5. Firearm lock boxes should be installed on each floor of HUMC, and law enforcement personnel should be required to place their firearms in the lockbox as they would when entering a jail facility. This practice would comply with hospital policy prohibiting firearms in psychiatric units and be consistent with the prohibition of firearms in custodial facilities, which involve risks similar to a psychiatric ward in a hospital setting.

6. Sheriff's Department personnel temporarily assigned to the hospital should be familiar with the Code Gold Team and its policies and protocols.¹⁵
7. HUMC should consider banning firearms in all areas of the hospital but allowing the use of less-lethal weapons (i.e., bean bag guns, Tasers, or OC spray).

Office of Inspector General's Outstanding Requests to the Sheriff's Department

Several issues relating to the Sheriff's Department response to Office of Inspector General requests over the past quarter merit reporting to the public, as they potentially reflect on the Department's willingness to allow this office to perform the functions mandated by state law and County ordinance.

Monitoring the Meet-and-Confer Process on Policies Related to Law Enforcement Gangs

The first issue concerns factually inaccurate representations the Sheriff's Department made regarding Office of Inspector General's efforts to monitor the development of policies related to law enforcement gangs. The development of the Department's policy on law enforcement gangs has been an issue of primary importance to the public, the Board, the Civilian Oversight Commission (COC), and this office.

Penal Code section 13670(b), enacted in 2021, requires every law enforcement agency in the state to "maintain a policy that prohibits participation in a law enforcement gang and that makes violation of that policy grounds for termination." As this office has previously reported, although the statute took effect in January 2022, the prior Sheriff's administration did not revise its policies to comply with the law.¹⁶

After Sheriff Luna took office in December 2022, the Sheriff's Department developed a draft policy on law enforcement gangs that not only satisfied the requirements of state law, but also followed recommendations to prohibit secret and exclusive subgroups made by the COC in its Special Counsel report on deputy gangs and cliques and by the RAND Corporation in a study of subgroups in the Sheriff's Department commissioned

¹⁵ The absences of deputies assigned permanently to HUMC may require deputies to be temporarily assigned to fill in.

¹⁶ Los Angeles County Office of Inspector General, [Los Angeles County Sheriff's Department's Legal Compliance: Deputy Gangs](#) (Feb. 26, 2024).

by the County.¹⁷ The Sheriff's Department presented the draft policy to the Office of Inspector General for review in June 2023 and stated by email that the policy conformed to the COC's input. The Office of Inspector General provided comments on the draft policy, and the Department represented that those comments would be considered as it revised the draft policy to take to negotiations with labor associations representing the Department's peace officer employees. These negotiations are commonly referred to as the meet-and-confer process.

When the Sheriff's Department released the final version of the negotiated policy, [Manual of Policy and Procedure \(MPP\) section 3-01/050.82](#), on September 18, 2024, the policy differed substantially from the draft policy presented to the Office of Inspector General the year before. The final policy no longer contained provisions on subgroups as recommended by RAND and the COC but had been curtailed to the bare minimum requirements of state law on law enforcement gangs and hate groups using language nearly identical to state statutes.¹⁸ The Sheriff publicly stated that he intended to continue negotiating on additional policy provisions relating to subgroups.

The Sheriff's Department provided the Office of Inspector General with the final policy the same day it released it to the public. The next day, on September 19, 2024, the Office of Inspector General sent an email to the Sheriff's Department expressing concern over not being permitted to monitor the meet-and-confer process on the law enforcement gang policies. The email also pointed out that the Office of Inspector General had requested all policies be provided to us during the drafting/revision process before the policy drafts were presented to the employee unions.

In response, Sheriff Luna sent [a fourteen page letter dated September 24, 2024](#), that, among other things, stated that despite the Office of Inspector General's broad authority to access confidential documents and meetings, it might not be entitled to monitor the

¹⁷ Samuel Peterson, Dionne Barnes-Proby, Kathryn E. Bouskill, Lois M. Davis, Matthew L. Mizel, Beverly A. Weidmer, Isabel Leamon, Alexandra Mendoza-Graf, Matt Strawn, Joshua Snoke, and Thomas Edward Goode, [Understanding Subgroups Within the Los Angeles County Sheriff's Department: Community and Department Perceptions with Recommendations for Change](#), RAND Corporation, at 187 (2021); Los Angeles County Civilian Oversight Commission, [Report and Recommendations of the Special Counsel to Sheriff Civilian Oversight Commission Regarding Deputy Gangs and Deputy Cliques in the Los Angeles County Sheriff's Department](#), 46-47 (Feb. 2023).

¹⁸ Penal Code §§ [13670](#), [13680 et seq.](#)

meet-and-confer process.¹⁹ The letter set forth a number of complaints about the manner in which the Office of Inspector General communicates, attempting to and shift blame for failing to respond to information requests back onto the Inspector General.

Among these complaints, the letter included the inaccurate factual claim that the Inspector General never requested to monitor the meet-and-confer process either privately or publicly. The letter states:

[w]e have found no record that the OIG requested to attend any of the negotiations relating to this policy during the last 14 months. Further, at no point during public COC meetings where I specifically referenced the ongoing meet and confer process did [the inspector general] or anyone from your office express concern that you were excluded from the process.

Presumably, if you actually sought to attend the negotiations, you or a representative of your office would have raised this issue to me or voiced your objection publicly at a COC meeting. You did not.

The Sheriff may not recall the request made by the Inspector General directly to him in person. Other communications through third parties may not have been communicated. However, contrary to the allegations in the letter, Office of Inspector General staff raised their concerns at being prevented from monitoring the meet-and-confer process in more than one public forum, including at least one recorded COC meeting on June 20, 2024.²⁰ There, the Chief Deputy Inspector General stated, in regard to the meet-and-confer process, “we are not permitted to be there,” that the office had been “shut out” of

¹⁹ The County Code establishing the Office of Inspector General defines its purview to include “matters relevant to the policies, procedures, practices, and operations of the Sheriff’s and Probation departments.” [L.A. Cnty. Code § 6.44.190\(A\)](#). To accomplish that purpose, the Code provides that the Office of Inspector General (OIG) “shall have access to all Departments’ information; documents; materials; facilities; and meetings, reviews, and other proceedings necessary to carry out [our] duties.” *Id.* In particular, the Code charges the OIG with “[m]onitoring the Departments’ operations” and states that “[a]s part of this function, the OIG may attend meetings, reviews, and proceedings regarding the Departments’ ... operations ... unless the OIG’s presence would obstruct an ongoing criminal investigation.” *Id.* [§ 6.44.190\(F\)\(1\)](#). The Code specifically contemplates access to confidential information and directs that “[t]he confidentiality of peace officer personnel records, juvenile records, medical and mental health records, protected health information, and all other privileged or confidential information received by the OIG in connection with the discharge of the OIG’s duties shall be safeguarded and maintained by the OIG as required by law and as necessary to maintain any applicable privileges or the confidentiality of the information.” [Id. \[§ 6.44.190\\(J\\)\]\(#\).](#)

²⁰ See Video Recording, [June 20, 2024, Meeting of the Civilian Oversight Commission](#) (beginning at 1:14).

the meet-and-confer process and not “invited in.” The Chief Deputy explained at some length that the Office of Inspector General should monitor the negotiations in order to report publicly whether the negotiations were proceeding in good faith and in a timely manner, and because the presence of the office would likely push the process along. The Sheriff was present at the outset of the meeting and reported to COC on Department operations. Either he or members of his command staff, including an Assistant Sheriff, were present during the remainder of the meeting, including the exchange on monitoring the meet-and-confer process.²¹

Request for Policy Drafts and Revisions

The September 19 email renewing the request to monitor negotiations also reiterated a request for all policy drafts and revisions, which the Office of Inspector General had previously made both in person and by email. On July 11, 2023, Office of Inspector General staff requested that the Sheriff’s Department provide our office the initial draft policy with sufficient time to review, emphasized the need for us to review not just the initial drafts, but “any revisions made by the Sheriff’s Department based on input from OIG or other entities at least five days prior to the policies being provided to [peace officer] unions so we have an opportunity to raise any continuing concerns.”

Since the time of the July 11, 2023, email, the Office of Inspector General has commented on the lack of dialogue on policy revisions, which also evidences our ongoing requests for all revisions. At the [July 18, 2024, COC meeting](#), the Chief Deputy commented (at 1:19 in the recording) that the Sheriff’s Department provides initial drafts of policies but does not engage in a dialogue or explain why suggested revisions are or are not incorporated.

We continue to request all revisions to draft policies including all policies related to law enforcement gangs. The September 19 email specifically requested revisions to the drafts of the Grooming and Dress Standards policy, the Unit Stations and Logo policy, and the Deputy Cliques/Secret Subgroups/Secret Societies policy. Although the Department provided those policies in summer 2023, negotiated on the law enforcement gang policy for months, and substantially altered the language of that policy in the final, approved draft, the Sheriff’s Department reported that “the operative copies remain the copies that were previously provided to you.”

²¹ [Government Code section 25303](#) provides for the Board of Supervisors to ensure that the Sheriff discharges their duties, and the Board has designated the COC to assist in this pursuant to [Government Code section 25303.7](#). [Los Angeles County Code 3.79.070](#) requires that the sheriff or a senior ranking member of the sheriff’s department not only attend COC meetings but “participate.”

In response to a validation draft of this report, the Sheriff's Department provided a series of emails dating from September 13 to 18, 2024, relating to the approval and release of the final policy on deputy gangs. The Department stated that its lack of timely response was an oversight and not intended to ignore the request.²² But the emails it provided reveal that the Department and employee labor associations reached an agreement on final policy language on September 13, 2024, five days before the public release of the policy. The email included the draft of that version which should have been provided to the Office of Inspector General. Furthermore, the Department's failure to provide the Office of Inspector General even with the final version of the policy, approved by labor associations, in advance of its public release demonstrates a failure to collaborate.

The Sheriff's September 24 letter is the latest in a series of attacks on the Office of Inspector General's requests and reporting as somehow unreasonable and without supporting evidence. For instance, in a letter dated February 15, 2024, the Sheriff stated that the Office of Inspector General's report on its Risk Management Bureau were not "supported by evidence or objective evaluation" and that much of the report is "speculative, unfair, and irresponsible."²³ In a letter dated April 3, 2024, the Sheriff accused the Inspector General's office of issuing "scathing reports" that result in media coverage that suggests "law enforcement's 'flouting' of oversight" and asserted that Office of Inspector General reporting "create[s] divisions between the Department and oversight, fuel[s] distrust in the community, and increase[s] frustration in the Department."

These complaints do not identify any factual deficiencies in Office of Inspector General reporting. Honesty and transparency are the cornerstones of building community trust, and independent reporting conveys to the community accurate information about Sheriff's Department operations and a "second opinion" about the legality and wisdom

²² This claim is difficult to accept given the protocols the Sheriff has put in place that regularly restrict and delay oversight access to information and the fact that the Department did not retract its attack but rather asked that it be publicized in response to receiving contradictory evidence. The recent failure to respond to a COC request, an Office of Inspector General request, and ultimately an Office of Inspector General subpoena in advance of a recent COC hearing, followed by public release of information *after* the hearing, are another example of such lack of transparency. See Keri Blakinger, [Ex-homicide investigator said to give Nazi-like salute during training](#), L.A. Times (Nov. 27, 2024).

²³ The Office of Inspector General learned as a result of inquiry related to footnote 22 that the Sheriff's Department's Risk Management Bureau, a division of its Office of Constitutional Policing, received an allegation in May 2023 that the Department had unlawfully conducted electronic surveillance of attorney-client communications at the Office of Inspector General but did not convey the information to this office and seems to have conducted no criminal investigation.

of those operations. Substituting criticism of the Office of Inspector General for factual analysis continues an unfortunate practice from the previous administration denying valid reporting on unlawful conduct of the Sheriff's Department.

The September 24 letter also stated that the Sheriff forwarded the Office of Inspector General's request to monitor the negotiations with the labor unions to County Counsel for analysis, and that it was "await[ing] County Counsel's assessment" of the Office of Inspector General's request for each draft of proposed revisions to the policy exchanged by the County and deputy labor associations during the meet and confer process. More than two months later, the Office of Inspector General has still received no communication regarding either request.

Outstanding Requests for Information and Subpoenas

In addition to making factual misrepresentations about requests, the Sheriff's Department failed to respond timely to two significant requests for information and one subpoena that followed.

On September 18, 2024, the Office of Inspector General made an email request for the date that the Sheriff's Department employee unions and the Sheriff's Department reached an agreement on the law enforcement gang policy and for all communications that contain a draft of the policy or discussed the draft policy from the date of the agreement to the date of the email. Only after the Office of Inspector General provided the Department a validation draft of this report that noted we had not received any of this information did the Department on November 18, 2024 state that its failure to respond earlier was an oversight and provide responsive emails.

On August 27, 2024, the Office of Inspector General sent a request for documents relating to investigations by the Sheriff's Department Public Integrity Unit. At least two of the requests were for documents that had already been compiled by the Sheriff's Department one set which was to provide to the Attorney General and one set that was compiled and sent in response to a Public Records Act (PRA) request by a journalist. On September 23, 2024, we received documents responsive to one of the nineteen categories of documents requested, which was the set of documents that had been compiled for the PRA response.

Some of the materials sought in the August 27 request were to assist the COC in conducting its October 11, 2024, hearing questioning two detectives assigned to its Public Integrity Unit. Because the Sheriff's Department had not provided the remaining documents, the Office of Inspector General issued and served a subpoena duces tecum on October 1, 2024, mirroring the August 27 requests and adding requests to cover an

answered request for documents made to the Sheriff's Department by the COC for SB 1421 information for the detectives being questioned.

The subpoena provided for production of the requested categories of documents within ten days. While the Sheriff's Department acknowledged receipt of the subpoena, it made no further communication on the matter during the ten days. The service of the subpoena may have sped up the production of documents, as the Department informed Office of Inspector staff on October 8 that more documents would be forthcoming that week and on October 10 provided documents responding to eight categories. The Department provided responsive documents to eight more categories between October 16 and November 6 — after the October 11 response date for the subpoena and after the COC hearing. On November 6, over two months after the initial request, the Department told the Office of Inspector General that the last two requests would lead to voluminous responses or could not be searched as requested, and asked whether the Office of Inspector General wanted the complete, voluminous production or to modify the search. Yet the Department's failure to provide a timely response — whether producing documents, an objecting, or a promising to provide the documents — either to the initial August 27 request for documents or within the 10-day deadline set by the subpoena — deprived the COC of documents and information relevant to its October 11 hearing. While any of these options might be justified as a response, to the absence of a response to the subpoena might fairly be described as “flouting” oversight.

CUSTODY DIVISION

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide humane conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.²⁴

²⁴ See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.²⁵ According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of September 30, 2024, the total population of people in custody in the Los Angeles County jails was 12,094.

The table below show that the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center East (PDC East), Pitchess Detention Center North (PDC North), Pitchess Detention Center South (PDC South), and North County Correctional Facility (NCCF) on the last day of the previous four quarters. On these dates, three facilities (MCJ, PDC North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity. The number of people in custody at six of the facilities (MCJ, TTCF, CRDF, PDC East, PDC North, and NCCF) on September 30, 2024, exceeded the number of people in custody at these facilities on December 31, 2023.

Facility	BSCC Capacity	Facility Count			
		12/31/23	3/31/24	6/30/24	9/30/2024
MCJ	3512	3530	3551	3572	3698
TTCF	2432	2230	2156	2378	2378
CRDF	1708	1269	1269	1255	1371
PDC East	926	16	14	12	20
PDC North	830	1124	1187	1286	1276
PDC South	782	661	674	663	633
NCCF	2214	2717	2923	2775	2718

²⁵ The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the pandemic, understaffing, or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

As the chart indicates, PDC East is well under its rated capacity. The Sheriff's Department should explain why it under-utilizes that facility while operating other facilities over their BSCC rated capacities.²⁶

In-Custody Deaths

Between July 1 and September 30, 2024, eight people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for six deaths: three deaths were natural, one death was a suicide, one death was a homicide, and one death was an accident. For the remaining two deaths, the DME findings remain deferred.²⁷ Three people died at MCJ, two people died at TTCF, one died at Inmate Reception Center (IRC), and two died at hospitals after being transported there from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a [dedicated page on Inmate In-Custody Deaths on its website](#).²⁸

²⁶ CRDF also operates well below its rated capacity, that facility does not house males and so cannot readily take up excess capacity from other facilities.

²⁷ In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and Correctional Health Services use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

²⁸ [Penal Code § 10008](#) requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews for each of the eight in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of Death: July 11, 2024

*Custodial Status: Pre-trial.*²⁹

Custody staff at IRC found an unresponsive person with a ligature around his neck under a module stairwell. Sheriff's Department staff, Correctional Health Services (CHS) staff and paramedics rendered emergency aid but did not administer Narcan. The person died at the scene. Areas of concern include the quality and timeliness of Title 15 safety checks, facility staff placing beds under stairwells, custody staff's emergency response, custody staff and CHS staff not administering Narcan, and the person being moved from the IRC Clinic to IRC overflow housing without being cleared by medical staff. Preliminary manner of death: Suicide. The DME currently reflects the manner of death as suicide, and the cause of death as hanging.

Date of Death: July 21, 2024

Custodial Status: Sentenced.

A person in custody at TTCF alerted custody staff of a "man down" who was unresponsive on his assigned bunk. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include custody staff allowing tenting to obstruct their direct observation within the module,³⁰ custody staff's emergency response, and cameras at TTCF being non-operational at the time of the death.³¹ Preliminary cause of death: Unknown. The DME website currently reflects the manner of death as natural, and the cause of death as ischemic heart disease and atherosclerotic coronary artery disease.

²⁹ For the purposes of custodial status, "Pre-trial" indicates that the person is in custody awaiting arraignment, hearing, or trial. "Convicted, Pre-sentencing" indicates that the person is being held in custody based on a conviction, pending sentencing, on at least some charges, even if they are in pre-trial proceedings on other charges. "Sentenced" indicates that the person is being held on the basis of a sentence on at least some charges, even if they are in pre-trial proceedings on other charges.

³⁰ Tenting is when a visual obstruction is created by placing clothing, linens, towels, papers, or other items in such a way as to obstruct the view into the cell, dormitory, or bunk. Department policy requires employees to remove such obstructions for the safety of persons in custody and staff. See [CDM 4-11/030.00 Inmate Safety Checks](#).

³¹ The Corrective Action Plan formulated in the Administrative Death Review also identified that this person did not receive a follow-up appointment with CHS on an issue that appears unrelated to this person's cause of death.

Date of Death: July 22, 2024

Custodial Status: Pre-trial.

A person in custody at MCJ alerted custody staff of a “man down” who was unresponsive on a mattress on the floor of a Moderate Observation Housing (MOH) dorm. CHS staff, and paramedics rendered emergency aid, and CHS staff administered two doses of Narcan. The person, who presented with rigor mortis, was pronounced dead at the scene. Areas of concern include the quality of Title 15 safety checks, custody staff’s emergency response, and whether custody staff adhered to Department policy while clearing wristband count. Preliminary cause of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Throughout the administrative death review process, Office of Inspector General staff raised that it reviewed deaths that occurred in MCJ dorms in the preceding two years and determined that many of the Corrective Action Plans (CAPs) that the Department had committed to were not implemented. The areas of concerns noted in this particular case are areas addressed by these CAPs.

Date of Death: July 25, 2024

Custodial Status: Pre-trial.

On July 18, 2024, a person in custody with a pre-existing medical condition was transported from Correctional Treatment Center (CTC) to Good Samaritan Hospital for a higher level of care. On July 25, 2024, the hospital staff transitioned the person to comfort care, and he died. Preliminary cause of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death as anoxic encephalopathy, septic shock, and consequences of urosepsis.

Date of Death: August 11, 2024

Custodial Status: Convicted, Pre-sentenced.

Custody staff were alerted to a “man down” in a dorm at MCJ. Sheriff’s Department staff, CHS staff, and paramedics rendered emergency aid, and CHS staff administered one dose of Narcan. The person was pronounced dead at the scene. Areas of concern include the quality of Title 15 safety checks, custody staff not coordinating bio-hazard cleanup, custody staff allowing tenting to obstruct their direct observation within the module, whether custody staff adhered to Department policy while clearing wristband count, and custody staff’s delay in making death notifications. Preliminary cause of death: Homicide. The DME website currently reflects the manner of death as homicide, and the cause of death as multiple sharp force injuries.

Date of Death: August 13, 2024

Custodial Status: Convicted, Pre-sentenced.

A person in custody at MCJ alerted custody staff of a “man down” inside a medical dorm. CHS staff and paramedics rendered emergency aid, and custody staff and CHS staff administered three doses of Narcan. The person died at the scene. Areas of concern include the quality of Title 15 safety checks, custody staff’s emergency response, and whether custody staff and CHS staff adhered to policy governing pill call no-shows.³² Preliminary cause of death: Unknown. The DME website currently reflects the manner of death as accident, and the cause of death as effects of oxycodone and hydrocodone.

Date of Death: August 27, 2024

Custodial Status: Pre-trial.

People in custody at NCCF alerted custody staff of a “man down” inside a general population dorm. Sheriff’s Department staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered five doses of Narcan. Paramedics transported the person to Henry Mayo Newhall Hospital, where he died the same day. Areas of concern include CHS not placing orders for the person to receive a follow-up health care appointment, CHS not referring the person to a drug-rehabilitation program, and the two-minute delay in custody staff and CHS staff learning of the man down and rendering emergency aid. Preliminary cause of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: August 29, 2024

Custodial Status: Pre-trial.

Custody staff conducting Title 15 safety checks at TTCF found an unresponsive person in his cell. Sheriff’s Department staff, CHS staff, and paramedics rendered emergency aid, and custody staff administered three doses of Narcan. The person died at the scene. Areas of concern include the emergency response. Preliminary cause of death: Unknown. The DME website currently reflects the manner of death as natural, and the cause of death as atherosclerotic and hypertensive cardiovascular disease.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff’s Department to “[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide

³² Pill call is the process through which CHS staff administer medication to persons in custody. A pill-call no-show is when a person who has prescribed medication does not appear after pill call is announced. [See CDM 5-03/050.00 Access to Health Care](#), which details the pill-call process.

information to the Office of Inspector General,” and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections.” The Board also directed the Office of Inspector General to report quarterly on the Sheriff’s Department’s progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody overdose deaths.

Of the eight people who died in the care and custody of the Sheriff’s Department between July 1 and September 30, 2024, the medical examiner’s final reports, including toxicology assessments, confirm that none of the people died due to an overdose. Toxicology results remain pending for three of the eight deaths and may indicate additional overdose deaths once completed.

Tracking Narcotics Intervention Efforts

The Board’s motion directed that the Sheriff’s Department “[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions.” The Department has made no new efforts to improve tracking of narcotics recovery since the Office of Inspector General’s last quarterly report. As described in previous reports, the Sheriff’s Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in LARCIS to evaluate the efficacy of drug detection intervention. Instead, the Department takes the position that constructing an all-encompassing jail management data system would best support the Department’s efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Department examine ways to comply with the Board’s directive by improving reporting requirements for staff and compiling data on detection interventions and seizures using existing technologies.

Improving Searches of Staff and Civilians

The Board’s second directive required that the Sheriff’s Department “[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails].” The Department previously reported its current policy grants the Department broad authority to search staff and civilians entering the jails, so that no changes to existing Department policy are required to implement more comprehensive searches. The Department previously reported that it

implemented more frequent unannounced and randomized staff searches beginning in May 2024.⁶⁰

All jail facilities reported conducting unannounced searches during the previous quarter, beginning in May as planned, though the comprehensiveness of the searches varied across facilities. The table below details the staff searching practices at all facilities from July 1 to September 30, 2024.

In the [previous quarter's report](#), the Office of Inspector General recommended that "each facility develop and use a staff search tracker to record data on the number of staff searches conducted and contraband detected as a result of the search, since the Department reports it cannot extract data for analysis from Watch Commander logs." In response, the Department's Custody Support Services Correctional Innovation Technology Unit changed the Watch Commander Log to allow facilities to track and report data showing the number of staff searches that facilities conduct, effectively adding a separate tracking mechanism to an existing database to accurately track and report on staff searches.

Facility	# Staff Searches		# Staff Searches with K9		Minimum Search Requirement	Search Conducted Inside Security	Search Evasion Concerns	Where Searches Logged
	Q3	Q2	Q3	Q2				
MCJ	106	Not Tracked	41	7	Yes	No	Yes	Watch Commander Log
TTCF	11	Not Tracked	9	1	Yes	Yes	Yes	Watch Commander Log
IRC	10	Not Tracked	6	2	Yes	Yes	Yes	Watch Commander Log
CRDF	4	Not Tracked	7	1	Yes	No	Yes	Watch Commander Log
NCCF	144	15	12	5	Yes	Yes	No	Staff Search Log
PDC-North	75	19	3	0	No	Yes	Yes	Watch Commander Log & Staff Search Log
PDC-South	39	28	11	4	Yes	Yes	No	Staff Search Log

Substance Use Disorder Treatment

As the largest jail system in the country, Los Angeles County jails house a significant number of people with substance use disorders (SUDs).³³ Research indicates that a majority of incarcerated people suffer SUDs, and that providing comprehensive SUD treatment for people in custody reduces security management concerns in custodial settings and is critical to “reducing overall crime and other drug-related societal burdens.”³⁴ Treating SUDs during incarceration can also lead to “major reductions in recidivism.”³⁵

The accepted standard of care for treating SUDs is to use medications to manage withdrawal symptoms and psychological cravings in combination with behavioral therapy to address the underlying disorder — an approach known as Medication Assisted Treatment (MAT).³⁶ Evidence strongly demonstrates that MAT increases the likelihood of successful treatment for people with opioid use disorders (OUD) and alcohol use disorders.³⁷ Research also suggests that, when utilized in correctional settings, MAT confers the same treatment benefits as it does in community settings, while concurrently reducing criminal behaviors and recidivism.³⁸

Correctional Health Services (CHS) provides medications to address withdrawal symptoms and cravings for opioid and alcohol use disorders through MAT program and psychoeducation services through its Substance Treatment and Re-entry Transition (START) program, for people in custody in Los Angeles County jails who meet the

³³ Vera Institute of Justice, [Care first L.A.: Tracking jail decarceration](#), October 9, 2024.

³⁴ National Institute on Drug Abuse, [Fewer than half of U.S. jails provide life-saving medications for opiate use disorder](#), September 24, 2024 (nearly two-thirds of people incarcerated nationally meet diagnostic criteria for substance dependence or abuse); Frank S. Pearson, and Douglas S. Lipton(1999) [A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse](#), *Prison J.* , 79:384–410; National Institute on Drug Abuse (June 2020) [Criminal justice drug facts](#); see also J. Tsai and X. Gu (2019) [Utilization of addiction treatment among U.S. adults with history of incarceration and substance use disorders](#), *Addiction Science & Clinical Practice* 14, 9.

³⁵ American Psychological Association, [Inmate drug abuse treatment slows prison’s revolving door](#), March 23, 2004.

³⁶ Substance Abuse and Mental Health Services Administration, [Medication-Assisted Treatment](#), 2016; Office of the Surgeon General. [Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health](#), US Dept of Health and Human Services, 2016.

³⁷ National Sheriff’s Association and National Commission on Correctional Health Care, [Jail-based medication-assisted treatment: Promising practices, guidelines, and resources for the field](#), October 2018.

³⁸ *Id.*

clinical criteria for SUD. Although “medication assisted treatment” in medical literature generally refers to the use of medications in combination with behavioral therapies, CHS’s MAT program focuses on the provision of medications, while it addresses the behavioral component with psychoeducation services through its START program. CHS allows qualifying people in custody to participate in these programs independently: they can receive medications through their MAT program to address withdrawal symptoms without receiving psychoeducational services through START, they can participate in START without receiving medications, or they can participate in MAT and START simultaneously to receive psychoeducational services supported by medication.

Provision of SUD Medications in Custody

CHS implemented its MAT program in 2021, supported by a \$25 million investment by the Los Angeles County Department of Health Services. The MAT team consists of 4 clinical pharmacists, 15 nurses, and 1 supervising nurse. Since its inception, the MAT program has treated approximately 7,300 people.

CHS identifies potential participants in MAT in several ways. First, CHS identifies individuals with opioid and alcohol SUDs entering the Inmate Reception Center (IRC) as the most at risk and prioritizes providing immediate treatment to these individuals. CHS also offers MAT treatment to people in custody who have received Narcan intranasal interventions, those with court orders to participate in MAT, and those who request treatment through a medical provider during a routine medical visit or by using a Health Service Request (HSR) form. Upon placement on the MAT program, CHS provides patients with the medication sublingual Suboxone in pill form and monitors them for adverse effects.

After seven days of sublingual Suboxone treatment, CHS transitions patients to one of two forms of long-acting injectable medications, Brixadi or Sublocade. Like the oral medication Suboxone, Brixadi and Sublocade are forms of buprenorphine, a medication that lessens the effects of opioid withdrawal, reduces opioid cravings, and blocks the ability of opioids to cause an effect.³⁹ Sublocade is injected into a patient’s abdomen and lasts approximately four to five weeks, but causes a visible mass in the patient’s abdomen that may indicate that a person is receiving OUD treatment. Another injectable option, Brixadi, can be injected into a patient’s arm or abdomen and does not cause a visible mass on the patient’s body. Although Brixadi is more cost-effective and may allow patients to more easily keep their OUD treatment confidential, it is less potent and so may not be the most effective option for a patient requiring treatment for heavy opioid

³⁹ Substance Abuse and Mental Health Services Administration, [Buprenorphine quick start guide](#), Accessed October 14, 2024.

use. CHS reports that providing two treatment options both preserves health equity by providing access to treatment choices that would be available in the community and also allows CHS to use the medication most appropriate for the individual's patient care. CHS began providing Suboxone in 2022, and as of October 1, 2024, reports that it has administered 19,467 doses to treat 5,647 people in custody. CHS began using Brixadi for treatment in 2023 and has administered 2,982 doses to treat 1,652 people in custody.

Using the long-acting injectable form of these medications has two advantages over the oral form. First, it avoids an illicit drug trade in the oral medications. CHS and the Sheriff's Department both report oral Suboxone has become a commodity in Los Angeles jails with a reported value of \$2,000 per dose because people in custody perceive oral Suboxone as a safe way to continue using narcotics in custody. Second, the long-acting injectable requires less resources from CHS nursing staff, who must observe persons administered the oral form of Suboxone for 5 to 10 minutes following each daily oral dose to ensure that they do not suffer from adverse effects. Because of these advantages, using long acting injectables is the optimal method of treatment in jail settings.

CHS reports that it is working to offer another drug, Methadone, as a treatment option. Methadone is an effective treatment option for opioid addiction that is more widely used in noncustodial community settings. Some people taken into custody may be receiving Methadone treatment at the time of their arrest. Unfortunately, federal regulations for prescribing, administering, and storing Methadone make its use in a custody setting difficult, and CHS does not currently offer it as a treatment option, meaning these persons receiving Methadone treatment in the community must stop when they are taken into custody. In an effort to have Methadone as an available treatment option, especially for those already taking it, CHS is working to attain the licensure necessary to administer Methadone as a SUD treatment option in jail facilities.

After the close of the quarter, CHS executives reported that due to a reduction in the Department's MAT budget, people in custody who had initially rejected MAT services at jail intake or voluntarily opted out of the MAT program are now being placed on a waitlist to begin or resume MAT treatment. Office of Inspector General staff received complaints from people in custody and community stakeholders about access to the MAT program. One person in custody reported receiving their initial dose of sublingual Suboxone but then being placed on a waitlist for access to the injectable medication, with a delay possibly causing a relapse if drugs are accessible and uncomfortable withdrawal symptoms. Another person in custody who recently overdosed reported that they had not been able to access MAT services.

In response to an inquiry from the Office of Inspector General regarding the two cases outlined above, a CHS staff member reported that the Department exceeded its MAT budget for the quarter of the fiscal year by nearly \$300,000, that there are approximately two to three hundred people in custody waiting to receive MAT, and that it was not known when CHS will be able to provide treatment to people on the waitlist.

Because MAT is regarded in the scientific community as the standard of care for both treating OUD and preventing opioid related overdose and deaths, the Office of Inspector General recommends that CHS continue to provide MAT services and ensure continued maintenance of medication to all people in custody who meet the diagnostic criteria and request enrollment in the program, and that the County ensure that CHS has sufficient funding to do so.

Substance Treatment and Re-entry Transition (START) Program

CHS's START Program is an 8-to-10-week program, consisting of 24 group counseling sessions, 4 individual counseling sessions, and case management for people in custody who are transitioning to the community. CHS utilizes two community providers, Los Angeles Center for Alcohol and Drug Abuse (LACADA) and Prototypes to provide START programming within the jails, both of which employ certified SUD counselors to administer the program.⁴⁰ In the first two quarters of 2024, approximately 2,883 people in custody were enrolled in the START program and approximately 447 people in custody completed it. As of September 2024, approximately 300 people in-custody were on the waitlist to enroll in the START program.

Limited Individualized Counseling. CHS has stated that the START program is not a clinical treatment program, but a psychoeducational and peer support program. Unlike many community-based MAT programs that utilize more extensive individual counseling, CHS limits participants in the START program to four individual sessions with SUD counselors. Because SUD counselors do not provide robust individual counseling and case management, their function in the START program is to provide “care coordination” instead of intensive substance-use counseling.

People in custody have reported that participating in individual sessions with a SUD counselor is integral for their recovery, and that the jail environment often impedes

⁴⁰ LACADA provides START services to people in custody at Twin Towers Correctional Facility, Men’s Central Jail, North County Correctional Facility, Pitchess Detention Center-North, and Pitchess Detention Center South, and Prototypes provides START services to people in custody at Century Regional Detention Facility. START is offered to people housed in general population (GP), moderate observation housing (MOH), Forensic Inpatient Stepdown (FIP-Stepdown), Accommodating Disability Dorms, Veteran Dorms, and LGBTQ+ dorms.

openly participating in START groups. Sheriff's Department staff have echoed this concern, explaining that a jail is not a safe place for a person to exhibit vulnerabilities through group counseling sessions. Although SUD counselors are certified by the State of California to provide individualized therapy in the community, CHS has stated that it "cannot translate [individualized] community practices in [Los Angeles County Jails]." CHS describes the model for the START program as offering psycho-educational services, not SUD treatment or full scope one-on-one treatment, a choice that CHS made because it can serve more individuals in groups than it would be able to serve in more robust individualized treatment.

Space and Staffing Limitations. The Sheriff's Department reports that its goal is to designate housing modules for people enrolled in the START Program to create a therapeutic environment for people in SUD recovery. Presently, there are designated START modules at MCJ, PDC South, and NCCF. At issuance of this report, people in custody housed in a START dorm at MCJ were moved out of the dorm to create additional MOH housing, eliminating the therapeutic living environment and posing significant barriers to START program participation. CHS concurs that a lack of space is an impediment to expand the program and to provide more individual sessions and that it would also need more CHS staff to administer the START program, including more SUD counselors, and more Sheriff's Department staff to provide escorts and supervision. Another barrier to implementing more robust START program is the preference for hiring SUD counselors with lived experience, who are credible and trusted messengers. Some counselors with this lived experience are not passing the Sheriff's Department stringent background checks and CHS recommends that the Department implement a less stringent background check process for SUD counselors similar to the background check process used by California Department of Corrections and Rehabilitation (CDCR) facilities. We note that reducing the jail population would allow the Sheriff's Department to provide treatment to a greater number of persons remaining in custody as additional housing modules could be designated for START.

Security classification limitations. While non-sworn custody assistants can provide escorts and security for people with a security classification below level 8, sworn deputies are required to escort persons with a higher classification level. In order for CHS to expand START programming services to people in higher security levels, additional sworn deputies would need to be hired. CHS reports that people in custody who are security levels 8 and above are the population who request START Program placement the most frequently, and their inability to provide START services to this population is a "glaring gap" in their care model.

To ameliorate these concerns, CHS is looking to expand telehealth services to provide START Program services virtually. First, CHS intends to provide telehealth START

Services to populations with classifications that disqualify START participation at MCJ, TTCF, and CRDF (to ensure health equity amongst the male and female populations).

Second, CHS intends to expand the START group model with a large monitor to provide START Programming off-peak hours and on weekends to provide START services to more people.

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the third quarter of 2024, Office of Inspector General personnel completed 164 site visits, totaling 493 monitoring hours, at IRC, CRDF, IRC, LAGMC, MCJ, Pitchess Detention Center North, PDC South, NCCF, and TTCF and station jails located in Santa Clarita, Lancaster, Lynwood, Norwalk, and Pico Rivera.⁴¹

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 138 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 257 monitoring hours related to uses of force, in-custody deaths, COVID-19 policies and protocols, Prison Rape Elimination Act (PREA) compliance, and general conditions of confinement.

Use-of-Force Incidents in Custody

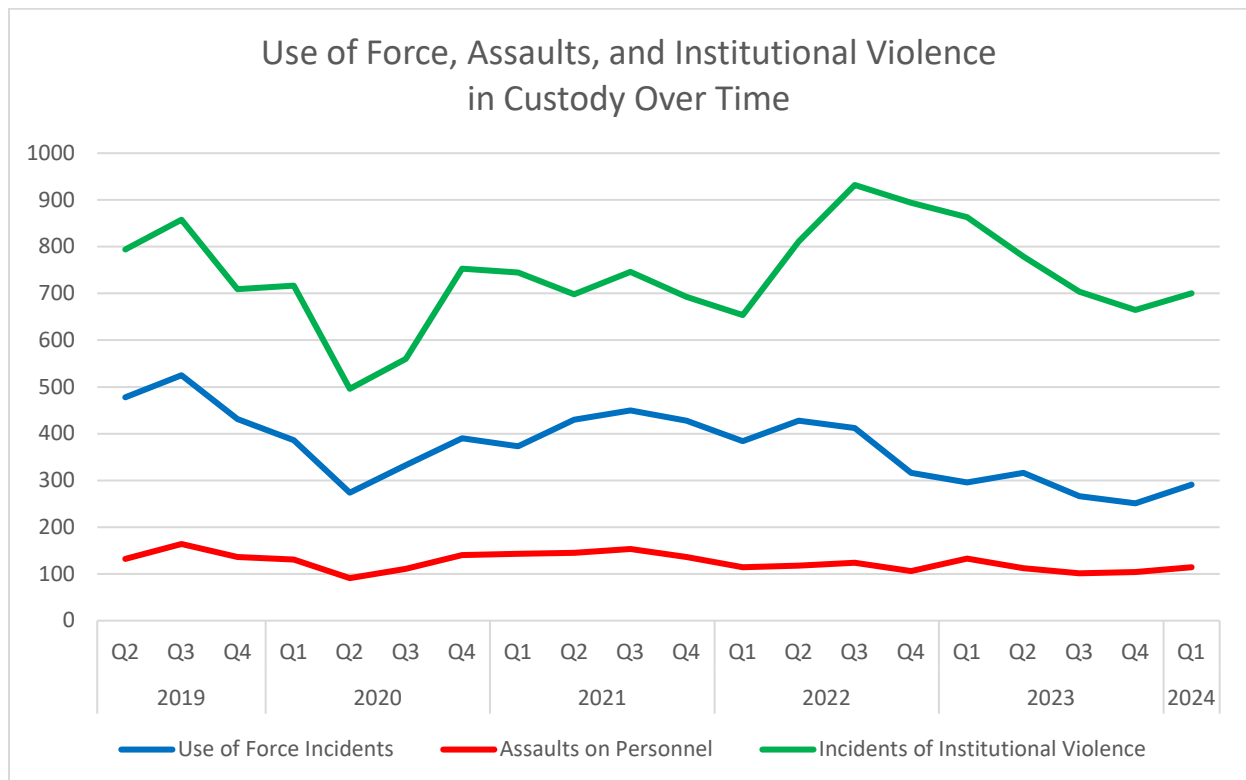
The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.⁴² The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people in its custody.⁴³

⁴¹ These figures include site visits and meetings related to monitoring for compliance with the Prison Rape Elimination Act ("PREA").

⁴² Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

⁴³ The reports go through the fourth quarter of 2023 because the Sheriff's Department has not yet verified the accuracy of reports for the first quarter of 2024. In reviewing this report, the Department noted corrected information for assaults on personnel and incidents of institutional violence for the first quarter of 2022, which is reflected here, and which differs from uncorrected information reported in previous quarterly reports.

		Use of Force Incidents	Assaults on Personnel	Incidents of Institutional Violence
2019	2 nd Quarter	478	132	794
	3 rd Quarter	525	164	858
	4 th Quarter	431	136	709
2020	1 st Quarter	386	131	717
	2 nd Quarter	274	91	496
	3 rd Quarter	333	111	560
	4 th Quarter	390	140	753
2021	1 st Quarter	373	143	745
	2 nd Quarter	430	145	698
	3 rd Quarter	450	153	746
	4 th Quarter	428	136	693
2022	1 st Quarter	384	114	654
	2 nd Quarter	428	118	811
	3 rd Quarter	412	124	932
	4 th Quarter	316	106	894
2023	1 st Quarter	296	133	863
	2 nd Quarter	316	112	779
	3 rd Quarter	266	101	704
	4 th Quarter	251	104	665
2024	1st Quarter	291	114	700



HANDLING OF GRIEVANCES AND COMMENTS

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received three hundred and sixteen new complaints in the third quarter of 2024 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

Grievances/Incident Classification	Totals
Medical	117
Personnel Issues	29
Transportation	22
Living Condition	22
Mental Health	20
Classification	17
Food	15
Visiting	11
Dental	9
Bedding	5
Mail	3
Education	2
Showers	2
Commissary	2
Property	2
Telephones	1
Other	12
Total	291

Twenty-five complaints were related to civilian contacts with Department personnel by persons who were not in custody, as shown in the chart below:

Complaint/Incident Classification	Totals
Personnel	
Harassment	4
Improper Tactics	3
Improper Detention	3
Off Duty Conduct	2
Force	2
Dishonesty	2
Neglect of Duty	2
Discourtesy	1
Service	
Policy Procedures	3
Response Time	1
Other	2
Total	25

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 77 iPads installed in jail facilities: 40 at TTCF; 12 at MCJ; and 25 at CRDF. During the third quarter there were no new installations and 12 iPads reconnected. Six iPads were found to be damaged at TTCF and were removed for safety concerns. There were 978 automated responses provided to people in custody using the iPad application to request information.

The Sheriff's Department continues to experience malfunctioning iPads and have identified power source problems as the major cause. Facility Services Bureau (FSB) was able to install a dedicated power source to limited areas within MCJ and TTCF. The Department found that the Wi-Fi connection was weak and inconsistent and is working on improving the connection, with expected progress in November. Additionally, newer MacBooks were purchased in order to reconfigure and program the iPads, but technical issues continue due to necessary software and program updates. The Sheriff's Department reports it continues to work on fixing these technical problems.

As [previously reported](#), the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in

custody.⁴⁴ The Sheriff's Department reports that between July 1 and September 30, 2024, no one in custody had been placed on restrictive filing and it therefore did not reject any grievances under this policy.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.⁴⁵ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.⁴⁶

The following chart lists the number and types of comments reported for each station or unit.⁴⁷

⁴⁴ See Los Angeles County Sheriff's Department, Custody Division Manual, § 8-04/050.00, [Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges](#).

⁴⁵ See [Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, Department Service Reviews](#).

⁴⁶ It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

⁴⁷ The chart reflects data from the Sheriff's Department Performance Recording and Monitoring System current as of January 9, 2024.

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
ADM: NORTH PATROL ADM HQ	0	0	1
AER: AERO BUREAU	0	1	0
ALD: ALTADENA STN	2	1	0
ASH: OFFICE OF THE ASST SHF I	0	1	0
CAF: COMM & FLEET MGMT BUR	1	0	0
CCS: COMMUNITY COLLEGE BUREAU	3	0	1
CEN: CENTURY STN	2	9	3
CER: CERRITOS STN	6	2	1
CMB: CIVIL MANAGEMENT BUREAU	12	3	4
CNT: COURT SERVICES CENTRAL	1	4	0
COM: COMPTON STN	5	8	1
CPB: COMMUNITY PARTNERSHIP BUREAU	0	1	0
CRD: CENTURY REG DETEN FAC	2	0	0
CRV: CRESCENTA VALLEY STN	15	4	1
CSB: COUNTY SERVICES BUREAU	6	1	1
CSN: CARSON STN	3	5	3
DSB: DATA SYSTEMS BUREAU	1	0	0
ELA: EAST LA STN	2	3	1
EOB: EMERGENCY OPER BUREAU	1	0	0
EST: COURT SERVICES EAST	0	5	1
HOM: HOMICIDE BUREAU	0	1	1
IND: INDUSTRY STN	3	5	2
LCS: LANCASTER STN	12	27	5
LKD: LAKEWOOD STN	2	7	2
LMT: LOMITA STN	4	4	0
MAR: MARINA DEL REY STN	4	1	3
MCB: MAJOR CRIMES BUREAU	4	0	0
MCJ: MEN'S CENTRAL JAIL	0	1	0

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
MLH: MALIBU/LOST HILLS STN	12	5	4
MTL: METROLINK	0	2	0
NCF: NORTH CO. CORRECTL FAC	1	0	0
NO: PITCHESS NORTH FACILITY	0	1	0
NWK: NORWALK REGIONAL STN	1	1	0
OCP: OFFICE OF CONSTITUTIONAL POLICING HQ	0	1	0
OJC: DOJ COMPLIANCE UNIT	0	1	0
OSS: OPERATION SAFE STREETS BUREAU	3	6	1
PER: PERSONNEL ADMIN	0	1	1
PKB: PARKS BUREAU	1	1	0
PLM: PALMDALE STN	18	30	1
PRV: PICO RIVERA STN	4	2	3
SCV: SANTA CLARITA VALLEY STN	18	7	1
SDM: SAN DIMAS STN	6	1	0
SIB: SHERIFF INFORMATION BUREAU	2	0	0
SLA: SOUTH LOS ANGELES STATION	2	9	0
SVB: SPECIAL VICTIMS BUREAU	1	2	1
TEM: TEMPLE CITY STN	6	4	3
TSB: TRANSIT SERVICES BUREAU	0	1	2
WAL: WALNUT/SAN DIMAS STN	3	7	1
WHD: WEST HOLLYWOOD STN	4	11	3
WST: COURT SERVICES WEST	0	3	1
Total:	173	190	53



OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

ROBERT G. LUNA, SHERIFF



December 9, 2024

Max Huntsman, Inspector General
Los Angeles County Office of the Inspector General
312 South Hill Street, Third Floor
Los Angeles, California 90013

Dear Mr. Huntsman:

**LOS ANGELES COUNTY SHERIFF'S DEPARTMENT'S
RESPONSE TO THE OFFICE OF INSPECTOR GENERAL'S
QUARTERLY REPORT ON REFORM AND OVERSIGHT EFFORTS**

The Los Angeles County Sheriff's Department (Department) is in receipt of the Office of Inspector General's (OIG) report dated December 4, 2024, entitled "Reform and Oversight Efforts: Los Angeles County Sheriff's Department." Thank you for the opportunity to provide a written response, which we understand will be included in the online version of the report.

While the Department takes issue with the characterization of a few items listed in the report, this response will focus on limited issues of the most concern to the Department.

First, the Department disagrees with the characterization of the Department's responses to subpoenas and information requests. This is of particular concern because the Department has undertaken considerable efforts to ensure information is provided to its oversight bodies. This effort reflects the Sheriff's commitment to cooperation and collaboration with the OIG and all of its oversight bodies. As a result, the Department works diligently to respond in a thorough and timely manner to OIG requests while also managing the delays in production often caused by the limitations of both technology and resources. As you are aware, the Department is faced with significant staffing shortages which, combined with a number of complex requests for information, have resulted in some production delays. While delays happen,

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we endeavor to keep our oversight bodies informed about the status of their requests.

With respect to some of the specific requests for information listed in the Quarterly Report, upon receipt of the OIG's August 7, 2024, request, the Department began its due diligence search for responsive records. The confidential nature and scope of the requests required consultation with internal and external stakeholders, including Data Systems Bureau, County Counsel, and the California Department of Justice. During this process, the Department remained in contact with the OIG and requested clarification, as needed, to assist in the accurate and complete fulfillment of the request. On August 30, 2024, for example, the OIG provided a written response to a phone call initiated by the Department on the previous day for clarification. Per the Department's request, the OIG provided explicit timeframes for some of the requested items in order to better facilitate the timely production of documents.

Furthermore, after the OIG served the subpoena dated October 1st, the Department notified the Chief Deputy Inspector General, via an October 8th text message, that some of the documents previously requested but also included in the subpoena, would be sent later that week. The Chief Deputy Inspector General acknowledged the text. On October 10, 2024, responsive documents for eight requested items were fulfilled. Between October 16, 2024, and November 6, 2024, responsive documents for all but two items listed in the August 7th request (and reiterated in the October 1st subpoena) were fulfilled.

On November 6, 2024, the Department advised the OIG that the electronic requests for the two remaining requests were either voluminous or not searchable/obtainable as requested. As a result, the Department inquired whether the OIG was open to a modification in the search terms or instead wanted the complete, voluminous production responsive to the original request (of approximately 650,000 items). On November 13, 2024, the OIG advised that they did not have a suggested modification *yet*, implying that it would provide additional instructions. Later, on December 3, 2024, the OIG provided an alternative request to address the two outstanding matters. The Department is currently working on the revised request.

The information above is provided to describe the facts surrounding the production of the requested material and to demonstrate that the Department, even with large requests such as this, has made a concerted effort to provide

the requested material. While the Department did not count every page provided in response to the OIG request, we estimate that the Department produced several thousand pages of material and over 11,000 emails. We do not believe that this effort, even though time consuming, reflects any disregard for oversight. To the contrary, considerable time and effort was placed into this matter.

Similarly, the Department has dedicated considerable resources to responding to the COC requests for information. In 2023, the Department completed 72 COC requests for information producing over 1,500 pages of material. Thus far in 2024, the Department has completed 59 requests for information out of the 68 requests that the COC has submitted. The outstanding requests are either pending production or involve confidential information that is the subject of discussions with legal counsel. The Department remains committed to continuing its production of all lawfully permitted material, to ensure transparency and accountability.

Finally, on a separate matter, in one footnote in the report, there is a reference to an allegation received by the Department in May 2023 regarding "unlawfully conducted electronic surveillance." Obviously, this is a serious allegation. It is worth noting that this allegation was also alleged in a civil complaint filed against the Department and was one of many allegations asserted in a larger public lawsuit. While that allegation has been dismissed by the Superior Court Judge presiding over the case, the lawsuit remains active, and this allegation could be revisited in this case. As a result, the Department believes it should refrain from public comments about those allegations at this time. However, the Department is evaluating all allegations made and will take all appropriate actions if wrongdoing is uncovered.

Sincerely,

ROBERT G. LUNA, SHERIFF


APRIL TARDY
UNDERSHERIFF



Reform and Oversight Efforts: Los Angeles County Sheriff's Department

October through December 2024

Issued February 26, 2025

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between October 1 and December 31, 2024, unless otherwise noted. Quarterly reports may also examine particular issues of interest. This report includes special sections on the following topics:

- Revisions to the Sheriff's Department's Use of Force Policy
- Sheriff's Department's Adoption of Civilian Oversight Commission Recommendations on Deputy Gang Policy
- Letter to a Journalist Threatening Litigation

During the fourth quarter of 2024, the Office of Inspector General also issued the following reports relating to the Sheriff's Department:

- [Report Back on Proper Maintenance and Accounting for All Cameras in the Los Angeles County Jails, Court Holding Tanks, and Patrol Station Lockups](#)
- [Report on the Sheriff's Department's Taser Policy, Training, and Usage](#)

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. During this quarter, there were two incidents in which people were shot or shot at by Sheriff's Department personnel. The Office of Inspector General staff responded to each of these deputy-involved shootings. Two people were struck by deputies' gunfire, one fatally. The information in the following shooting summaries is based on the limited information provided by the Sheriff's Department and is preliminary in nature. While the Office of Inspector General receives information at the walk-through at the scene of the shooting, receives preliminary memoranda with summaries, and attends the Sheriff's Department Critical Incident Reviews, the statements of the deputies and witnesses are not provided until the Sheriff's Department completes its investigation. The Sheriff's Department permits the Office of Inspector General's staff limited access to monitor the ongoing

investigations of deputy-involved shootings. The Sheriff's Department also [maintains a page on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.

Santa Clarita Station: Hit-Shooting – Non-Fatal

On October 11, 2024, at approximately 12:10 p.m., deputies from the Santa Clarita Station responded to a radio call regarding a domestic dispute with shots fired on Sloan Canyon Road. A deputy arrived at the scene and saw the suspect, a 43-year-old Hispanic man holding a handgun and struggling with a woman next to a white Lexus SUV. The man turned toward the deputy with the gun in his hand, and the deputy fired one round striking the suspect in the head. The man fell to the ground, and the deputy placed him in handcuffs and called for backup. Los Angeles County Fire Department paramedics arrived, treated the man, and transported him to the hospital for non-life-threatening injuries.

No other deputies were involved in this incident. The suspect's 6-year-old son was seated in the SUV during the incident and was not injured. Investigators recovered two loaded handguns at the scene as well as what appeared to be a spent shell casing.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from the deputy's body-worn camera.

Areas for further inquiry:

Did deputies provide any medical aid prior to the arrival of the paramedics? Did the deputies un-cuff the suspect when medical aid was being rendered?

East Los Angeles Station: Hit-Shooting – Fatal

On December 10, 2024, at approximately 12:55 p.m., deputies from the East Los Angeles Station responded to a report of a man with a gun at a convenience store on Olympic Boulevard in East Los Angeles. The reporting party stated that the subject was inside the store when they observed what they believed was a handgun in his waistband, but the subject was not causing a disturbance.

Three deputies responded in two marked patrol cars. Before the deputies arrived, the subject reportedly purchased goods and left the store, at which point the clerk locked the doors to keep him from re-entering.

Although all three of the deputies were equipped with body-worn cameras (BWCs), none of them activated the devices before the shooting. Two of the deputies activated their BWCs shortly after the shooting, capturing one minute of video of the shooting without audio for the automatic buffer period programmed in the BWCs. Both those

deputies were positioned behind their patrol car doors for cover, and the vehicles' doors, windshield pillars, and windshields obscure the view of the subject during part or the entire interaction. And because the BWC video does not contain audio, it does not reveal any of the deputies' communications with or commands to the subject. Surveillance cameras for the convenience store also captured the shooting without audio.

According to the deputies' accounts and the available video, upon arriving, they pulled into the store's parking lot and contacted the suspect, a 24-year-old White man wearing over-the-ear headphones, who was standing at the closed entrance of the store, gesturing at the clerk with his back to the parking lot. The deputies reportedly saw the gun in his waistband as they pulled up. Security footage from the store shows the subject with a gun visible in his rear waistband. The deputies got out of their patrol cars and, using the doors for cover, reportedly commanded him to put his hands up. Initially, he complied, but then began shifting a phone and card he was holding from hand to hand, gesturing, dropping his hands, and pacing to one side. He then removed the handgun from his waistband, holding its handle between his thumb and fingertips so that it dangled upside-down while he gestured at it with the other hand. Deputies reportedly told him to drop it, but he shifted it, so he held the handle in his palm. Three deputies then fired a total of 13 rounds at the man, striking him numerous times.

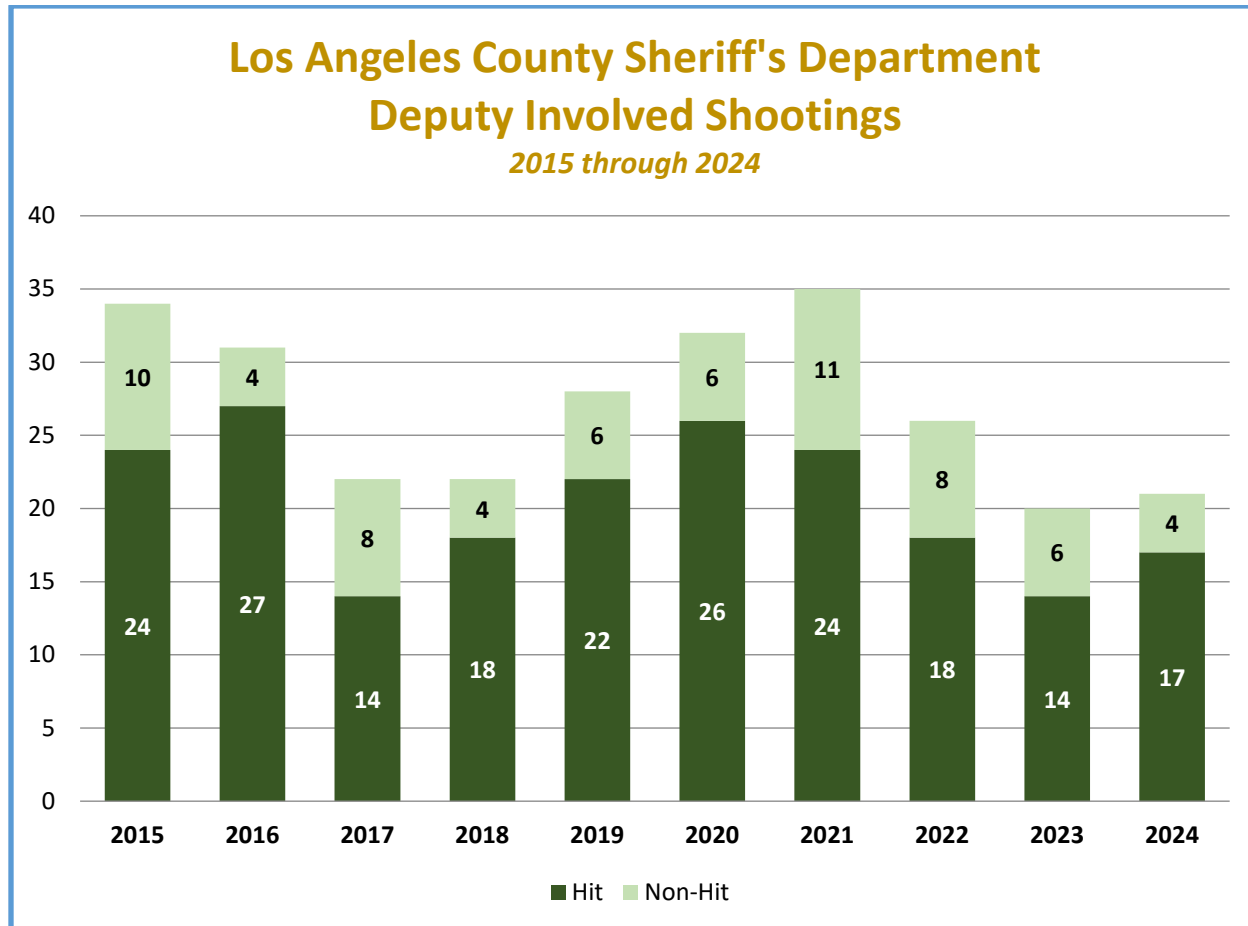
The deputies approached the subject and moved him away from the handgun and then rendered aid. Los Angeles County Fire Department paramedics transported the man to the hospital where he was pronounced dead. A replica semi-automatic firearm, later determined to be a BB gun, was retrieved at the scene.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from the deputies' body-worn cameras and from the convenience store's surveillance cameras.

Areas for further inquiry:

Did the deputies formulate a plan prior to arriving at the location? Were the tactics used consistent with best practices? What commands did the deputies give the deputies? Was there any attempt to de-escalate the situation? Were the number of rounds fired excessive? Did the deputies activate their body-worn cameras in compliance with Sheriff's Department policy?

Comparison to Prior Years



District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.¹ For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and which occurred in the County of Los Angeles to the

¹ In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. See [A.B. 1506 \(McCarty 2020\)](#) (codified at [Govt. Code § 12525.3](#)). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*. Until the law took effect in 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet.

Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between October 1 and December 31, 2024, the District Attorney's Office issued 11 findings on deputy-involved shooting cases involving the Sheriff's Department's employees.²

- In the January 27, 2024, non-fatal shooting of Jerald Hardcastle, the District Attorney opined in a [memorandum dated October 16, 2024](#), that the deputies Daniel Rodriguez, Juan Cruz, Richard Simms and Aaron Agajanian acted in lawful self-defense when they fired their weapons and that deadly force was necessary to defend against an imminent deadly threat.
- In the December 18, 2021, non-fatal shooting of Nicholas Hernandez, the District Attorney opined in a [memorandum dated October 17, 2024](#), that the deputies Jeremy Licona and Aaron Agajanian acted in lawful self-defense when they fired their weapons reasonably believing, based on the totality of the circumstances, that deadly force was necessary to defend against an imminent deadly threat.
- In the September 23, 2021, fatal shooting of Barry Ross, the District Attorney opined in a [memorandum dated October 21, 2024](#), Deputy Trevor Moore acted in lawful self-defense at the time his weapon was fired.
- In the November 26, 2022, non-fatal shooting of Bridget Blaney, the District Attorney opined in a [memorandum dated November 6, 2024](#), that Deputy Ernesto Valencia acted in lawful self-defense at the time his weapon was fired.
- In the October 6, 2010, fatal shooting of Marco Vazquez, Jr. and the non-fatal shooting of Christopher Vazquez, the District Attorney opined in a [memorandum issued November 10, 2024](#), that there is insufficient evidence to prove that Sergeant Vincent Cisneros, and deputies Patricia Miramontes and Gregory Nickell did not act in lawful self-defense at the time they fired their weapons.
- In the September 4, 2023, fatal shooting of Robert Bryant Boozer, the District Attorney opined in a [memorandum issued November 13, 2024](#), that Deputy Bobby Olivares acted in lawful self-defense when he fired his weapon,

² The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#). The Office of Inspector General retrieves the information on District Attorney decisions from this webpage. As of the writing of this report, District Attorney decisions through November 27, 2024, were posted.

reasonably believing, in the totality of the circumstances, that deadly force was necessary to defend against an imminent deadly threat.

- In the October 5, 2021, fatal shooting of Jesse Medrano, the District Attorney opined in a [memorandum issued November 13, 2024](#), that deputies Chase Morales and Jorge Fajardo, along with California Highway Patrol officers, that the evidence supports a reasonable belief by the deputies and officers, that the use of deadly force was necessary in self-defense when they each fired their duty weapon.
- In the December 16, 2019, fatal shooting of Jorge Serrano, the District Attorney opined in a [memorandum issued November 14, 2024](#), that deputies Nikolis Perez and Kevin Thompson acted in lawful self-defense and defense of another when they used deadly force against Jorge Serrano.
- In the November 12, 2021, non-fatal shooting of Manuel Fidel Chavez, the District Attorney opined in a [memorandum issued November 19, 2024](#), that the evidence establishes that the use of deadly force by deputies Estevan Perez, Matthew Doud and Michael Thompson, was in lawful defense of themselves and others.
- In the February 15, 2022, fatal shooting of Stephanie Browne, the District Attorney opined in a [memorandum issued November 26 2024](#), that insufficient evidence exists to prove beyond a reasonable doubt that deputies Michael Thompson and Luis Valle did not act in lawful self-defense when they each fired their duty weapon.
- In the June 6, 2019, fatal shooting of Ryan Twyman, the District Attorney opined in a [memorandum issued November 27, 2024](#), that there is insufficient evidence to prove beyond a reasonable doubt that deputy Christopher Muse did not act in a lawful self-defense when he used deadly force against Ryan Twyman.³

³ The other deputy involved in the shooting, Deputy Andrew Lyons, fired his handgun at the vehicle driven by Mr. Twyman while the vehicle was still moving. Deputy Lyons then retrieved a Department-issued semiautomatic assault rifle and resumed firing at the vehicle after it stopped. The District Attorney filed criminal charges against Deputy Lyons. In return for a plea to one felony count of assault with a semiautomatic firearm and one count of assault under color of authority, Deputy Lyons was placed on probation for 2 years with a 30-day jail sentence . In addition to his sentence, Deputy Lyons surrendered his POST certification and as a result is no longer certified as a peace officer in California. See the District Attorney's press release of January 12, 2024: [District Attorney Gascón Announces Conviction of Sheriff's Deputy in Fatal On-Duty Shooting](#).

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has 11 shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a May 3, 2024, shooting in the jurisdiction of Industry Station. For further information as to that shooting, please refer to the Office of Inspector General's report [*Reform and Oversight Effort: Los Angeles Sheriff's Department, April through June 2024*](#). The oldest case that the Homicide Bureau has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent one deputy-involved-shooting case to the District Attorney's Office for filing consideration.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.⁴ The DOJ [*is currently investigating*](#) four shootings involving deputies from the Sheriff's Department, the oldest of which occurred in February 2022. During the last quarter, the DOJ [*issued no written reports*](#) regarding shootings involving Sheriff's Department deputies.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.⁵

The Sheriff's Department reports that ICIB has 74 active cases. This quarter, ICIB reports sending no cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 21 cases from ICIB for filing. The oldest open

⁴ Gov't Code § 12525.3(b).

⁵ Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 113 new administrative investigations. Of these 113 cases, 37 were assigned to IAB, 57 were designated as unit-level investigations, and 19 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 99 cases were closed by IAB or at the unit level. There are 487 pending administrative investigations, of which 329 are assigned to IAB and the remaining 158 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between October 1 and December 31, 2024, the Civil Service Commission issued final decisions in two cases involving Sheriff's Department employees.⁶ In both cases, the Civil Service Commission sustained the Department's discipline.

One of these cases concerned a custody assistant and the other concerned a sworn peace officer at the rank of deputy. Both cases sustained Sheriff's Department decisions to discharge a custody assistant and suspend the sworn employee.

⁶ The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings posted on the County's website](#) for commission publications.

Employee Position	Date of Department action	Case number	Department actions	Date of Civil Service Hearing	Civil Service decision
Custody Assistant	1-4-22	22-10	Discharge	10-9-24	Sustained the Department's decision.
Deputy Sheriff	2-6-23	23-28	10-day suspension	7-17-24	Sustained the Department's decision

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) 24 times between October 1 and December 31, 2024, as summarized in the chart below, which reflects data from the Sheriff's Department [Transparency page](#) as of January 16, 2025.⁷

DATE	OPERATION TYPE	LOCATION	SUMMARY
10-2-24	High-Risk Tactical Operations	Malibu	UAS used to assist with a high-risk tactical operation to search for a felony suspect in the area along the coastline.
10-5-24	Search and Rescue	Agoura Hills	UAS used to search for a missing person.
10-6-24	Barricaded Suspect Operation	Palmdale	SEB responded to assist Palmdale station a barricaded suspect operation. UAS used to locate an armed suspect inside a residence.
10-11-24	High-Risk Tactical Operations	Calabasas	Malibu/Lost Hills station conducted a high-risk tactical operation to search for an elderly female believed to be injured on a large residential property owned by an armed man. UAS was used to provide overwatch for deputy personnel.
10-18-24	High-Risk Tactical Operations	Topanga	Malibu/Lost Hills station conducted a high-risk tactical operation to search for a suspect of assault with a deadly weapon. UAS was used to provide overwatch for deputy personnel.
10-25-24	High-Risk Warrant Service	Baldwin Park	SEB personnel serving arrest warrant for armed suspect. UAS was used to search interior of location prior to entry.
10-29-24	Search and Rescue	Sierra Madre	SEB personnel responded to assist Search and Rescue Team to search for a missing hiker. UAS used to search for missing hiker. Unable to locate hiker.
10-30-24	High-Risk Tactical Operations	East Los Angeles	SEB personnel deployed to assist Sheriffs Response Team. UAS used to assist to locate persons assaulting deputy personnel with explosives.

⁷ [MPP5-09/570.10 - Unmanned Aircraft System Procedures](#) requires that the Special Enforcement Bureau (SEB) unit commander notify the executive director of the COC of an authorized or unauthorized UAS use within 48 hours of deployment. In checking for such notifications from the Department, the COC executive director found a notification from December 2023. The Office of Inspector General is inquiring as to whether the Department is regularly notifying the COC as required by the MPP and also requested supporting documentation for UAS deployments to search for a felony suspect.

11-7-24	High-Risk Tactical Operations	Calabasas	Malibu/Lost Hills Station personnel deployed UAS regarding calls of illegal shooting or transformers blowing in high fire danger, red flag wind area. UAS unable to located source of noise and no fire danger observed.
11-10-24	Search and Rescue	Topanga	Malibu/Lost Hills Station personnel deployed UAS regarding to search for possible human remains over a cliffside. UAS unable to locate any human remains. Source of odor determined to be a dead animal.
11-17-24	Explosive Ordinance Detection	Santa Monica	SEB personnel deployed UAS to visually inspect interior and exterior of home. SEB used UAS technology to identify and observe destructive devices. UAS used to identify devices construction for render safe procedures.
11-23-24	High-Risk Operations	Agoura Hills	Malibu/Lost Hills Station personnel conduct search for a felony suspect. UAS used to assist search.
11-29-24	High-Risk Operations	Malibu	Malibu/Lost Hills Station personnel conduct search for a felony suspect. UAS used to assist search.
11-30-24	Barricaded Suspect Operation	East Los Angeles	SEB conduct search for felony suspect. UAS used to assist search.
12-3-24	Search and Rescue	Calabasas	Malibu/Lost Hills Station personnel used UAS to check for occupants of a vehicle located over a cliff. No persons located or seen within the vehicle.
12-10-24	High-Risk Tactical Operation	Cerritos	SEB personnel assisted Cerritos station to locate an armed and barricaded suspect. UAS used to locate the suspect.
12-17-24	High-Risk Tactical Operation	Malibu	Malibu/Lost Hills Station personnel used UAS to conduct a search for reported fire and smoke during a high wind event. Hot spots of fire reported to fire personnel.
12-18-24	Barricaded Suspect Operation	Carson	SEB personnel responded to location regarding a barricaded suspect. UAS used to view interior and suspect location.
12-21-24	Search and Rescue	Malibu	Malibu/Lost Hills Station personnel used UAS to check several vehicles over the cliff side for occupants. No persons found inside vehicles.
12-23-24	High-Risk felony suspect containment	Hidden Hills	Malibu/Lost Hills Station personnel used UAS to search for a felony suspect. One suspect detained.
12-23-24	Search and Rescue	Malibu	Malibu/Lost Hills Station personnel used UAS to search for a critical missing adult. Missing person located.
12-24-24	Search and Rescue	Agoura Hills	Malibu/Lost Hills Station personnel used UAS to search for a critical missing adult. Missing person unable to be located.
12-27-24	High-Risk Operation	Calabasas	Malibu/Lost Hills Station personnel used UAS to search for a felony suspect.
12-30-24	Search and Rescue	Westlake Village	Malibu/Lost Hills Station personnel conduct search and rescue for a missing hiker. UAS used to search for missing hiker.

Semi-Annual Report on Implementation of the Family Assistance Program

The Los Angeles County Board of Supervisors [established the Family Assistance Program](#) (Family Assistance), first in 2019 as a one-year pilot that it later made permanent, with the aim of improving compassionate communication and providing trauma-informed support to families of those who died following a fatal use of force by a

Sheriff's Department employee or while in the custody of the Sheriff's Department. The Office of Inspector General reports semi-annually on Family Assistance in its quarterly reports on the Sheriff's Department.

Family Assistance Status

On February 8, 2024, the administration of Family Assistance officially transitioned from the Department of Mental Health (DMH) to the Office of Violence Prevention (OVP) within the Department of Public Health (DPH), pursuant to the plan to make Family Assistance permanent as recommended to the Board in 2022.⁸ DPH reported to the Board on the OVP Family Assistance Program in its report dated January 21, 2025, [Permanent Funding and Implementation of the Family Assistance Program](#). OVP has a webpage with an [overview of Family Assistance](#) with links to the Family Assistance [brochure in English](#) and [in Spanish](#) and to the [Family Assistance Application Form](#).

OVP reports that OVP and the Los Angeles County Medical Examiner (DME) finalized a draft Memorandum of Understanding (MOU) that outlines the roles and responsibilities of the two Psychiatric Social Workers (PSW) IIs that will be housed at DME including the process for next-of-kin notifications and the process for families to claim the decedent's personal effects and property. The MOU is currently being processed by DPH - Contracts and Grants Division. Once the MOU between OVP and DME is executed, the PSW IIs will begin working onsite at the DME.

In March 2024, OVP formed a multidisciplinary work group that meets monthly to discuss program design and implementation, protocols, eligibility criteria, and reviews cases. The work group includes representatives from the Sheriff's Department, DME, the Office of Inspector General, the Sheriff Civilian Oversight Commission (COC), Los Angeles County District Attorney Office, DMH, Los Angeles County Correctional Health Services, and Los Angeles Office of the County Counsel. In collaboration with the workgroup partners, OVP drafted Family Assistance protocols, which are expected to be approved in February 2025.

Family Assistance Service Data

[OVP reports](#) that from July 1 to December 31, 2024, OVP was notified of 25 families who experienced the death of a loved one through a fatal use of force by a Sheriff's

⁸ See [Office of Inspector General's Semi-Annual Report on Implementation of the Family Assistance Program and Report Back on Permanent Support for Families Affected by Los Angeles County Sheriff's Department: Identifying Sustainable Funding for and Streamlining the Family Assistance Program \(Item No.14, Agenda of July 9, 2019 and Item No. 9, Agenda of October 19, 2021\)](#) (Feb. 22, 2022).

Department employee or while in their loved one was in the custody of the Sheriff's Department. Out of these 25 deaths, 20 individuals lost their lives while in custody at a LASD facility. The remaining 5 individuals died due to a fatal use of force. OVP engaged with 23 families and provided at least some Family Assistance services. The remaining 2 families did not respond to multiple outreach efforts to provide them assistance. OVP distributed burial expenses to 13 families, with expenses ranging from \$1,391 to \$7,500, totaling approximately \$80,335. for the period. In its [report](#), DPH notes that families sometimes incur burial and other expenses that may be covered by the program in an amount greater than the \$7,500 maximum. The DPH report recommends aligning the burial expense limit with the state's California Victims of Crime Compensation limit as they were prior to the state increasing the limit in 2022, with the limit now \$12,818.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracing and Documenting Taser Use

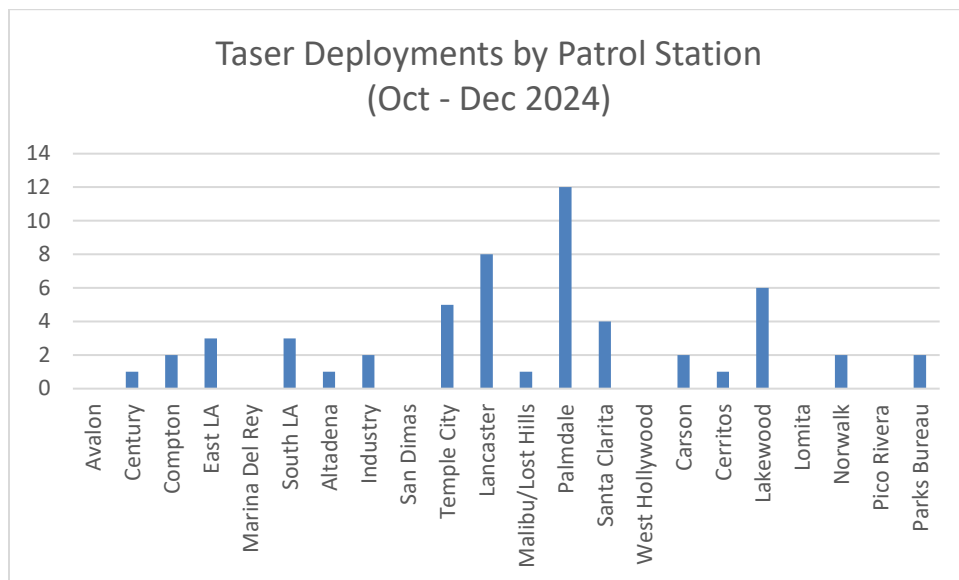
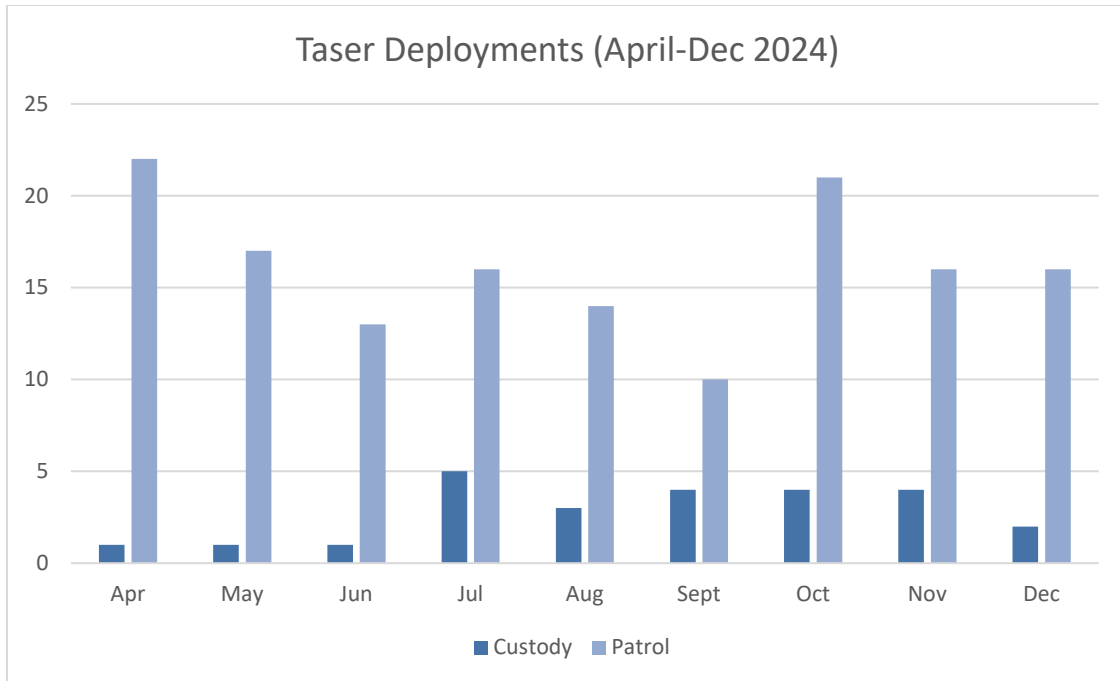
Status of Taser Policy Implementation and Training

On October 3, 2023, the Board of Supervisors passed a [motion](#) instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The motion directs the Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.

On December 16, 2024, the Office of Inspector General published a detailed analysis of the policy titled [Report on the Sheriff's Department's Taser Policy, Training, and Usage](#). As set forth in that report, the Sheriff's Department purchased 3,197 Taser 10s and conducted its first Taser 10 training class on July 17, 2024. As of the end of December 2024, approximately 1,400 deputies and sergeants in the Patrol Division had attended the 8-hour training course for the Taser 10 and been equipped with Taser 10s; approximately 1,200 of the 1,400 employees trained attended the course during the fourth quarter of 2024.

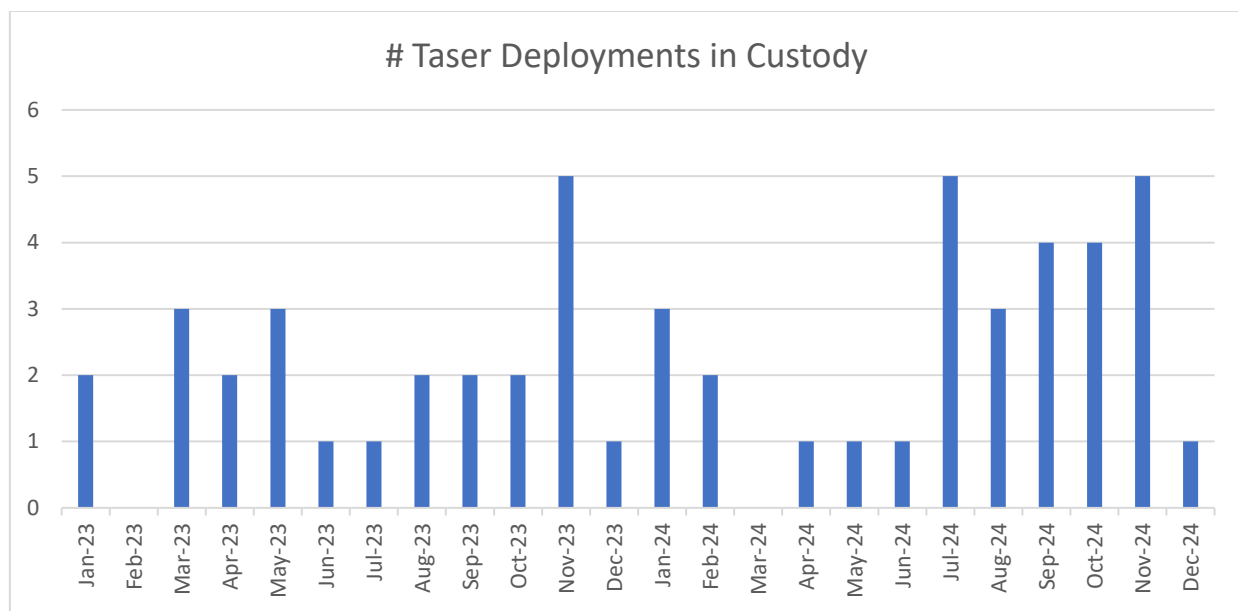
Tracking Taser Use

In May 2024, the Sheriff's Department launched a [web dashboard reporting Taser usage](#) after April 1, 2024, by patrol station or facility, date, and subject description. Beginning in July 2024, the Department began including in that data the "Result of the Use of Force" (i.e., whether the use resulted in serious injury or death) for all incidents that occurred on or after July 1, 2024.



Taser Use in Custody

The following chart reflects the number of use-of-force incidents in custodial settings over the past two years in which deputies employed a Taser, according to the *Monthly Force Synopsis* that the Sheriff's Department produces and provides to the Office of Inspector General each month:



Review of Sheriff's Department's Internal Audits

The Office of Inspector General's office reviews audit work plans and completed audits performed by the Sheriff's Department's Audit and Accountability Bureau (AAB). Going forward, the Office of Inspector General will provide a broad overview of the audits reviewed during the quarter focusing on the information that is of the greatest public interest. Links to each audit on the [Sheriff's Department webpage](#) are provided for access to specifics including the auditing period and sample size. During the fourth quarter of 2024, the Office of Inspector General reviewed 11 audits and one audit work plan:⁹

- [Inmate Welfare Fund \(IWF\) Audit – Financial Programs Bureau](#) (2023-10-A): an assessment of the policies and procedures for adherence to internal controls, County rules, and best practices for procurement and expenditures. The audit makes appropriate recommendations to ensure that policies are regularly updated, and staff are trained to ensure adherence to internal controls. The audit did not cover the use of funds for inmate welfare, which is of greater concern to the County given that the IWF is funded by revenue from jail commissary sales

⁹ Audits are not reviewed until after the Sheriff's Department completes the audit. Thus, the Office of Inspector General review may not correspond to the quarter in which the audit is dated.

as noted in the Board motion of July 9, 2024.¹⁰ The Office of Inspector General report, [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#) discusses the relationship between commissary pricing and IWF funding.

- [Body-Worn Camera Audit – Lakewood Sheriff's Station](#) (2024-4-A): an assessment of the use of body-worn cameras (BWC) including requirements for training, activation, recording, and proper data entry for BWC exemptions. The audit found 100% compliance with training, 87% compliance with proper activation, 80% compliance with continuous recording, 86% compliance with proper entry of video content information, 82% compliance with proper entry of video retention, 97% compliance with timeliness in uploading video recordings, 81% compliance with proper identification of video for non-investigative/non-enforcement contacts and 65% compliance with proper use of notations for clearances not requiring a BWC recording. The audit found 0% compliance for documenting the reason for delayed BWC activation and for documenting incomplete video recordings. Because the audit only analyzed a randomized sample of BWC recordings, the data analyzed in the audit did not include instances where the deputy entirely failed to activate the BWC when required to do so under Departmental policy, resulting in the absence of any recording at all.¹¹ Additionally, the audit does not cover the required supervisory review of BWC activation compliance, a necessary tool for improving compliance. While the audit makes appropriate recommendations, they are limited to corrective action at Lakewood station and did not make any departmentwide recommendations.
- [Stops and Detentions Performance Audits Part II – Supervisory Review and Deputy's Daily Worksheet](#) (2024-7-A): an assessment of the process and controls for supervisory reviews of Deputy's Daily Worksheets (DDWS) and the implementation of recommendations made by the Antelope Valley Monitoring Team (MT or monitoring team) based on a September 2023 audit by the

¹⁰ See Board motion dated July 9, 2024, [People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#).

¹¹ The audit identified a total of 4,773 BWC recordings. However, Office of Inspector General inspectors noted that the Department's BWC Dashboard, which also tracks recordings, tallied 5,658 recordings for the audit period. Additionally, the BWC Dashboard indicated a total of 154 calls/observations that required BWC video but did not contain any BWC recording.

monitoring team.¹² The Departmental audit found a lack of established processes and controls to ensure all DDWS Log Compliance checks were submitted, that the stations lack effective DDWS log review processes and controls for weekly reviews by sergeants, a failure of watch deputies and sergeants to thoroughly review the logs, and a failure to direct the deputies to correct errors. Additionally, AV unit orders were insufficient for the stations to track repeated DDWS log errors and the 15-day unit order requirement to document DDWS log reviews did not align with the CAD system's 7-day and 10-day time windows. The audit concluded that this lack of processes increased the *risk of inadequate and inaccurate data in the CAD system*, which the auditors determined increased the risk of inappropriate decision making.¹³ The audit makes recommendations to improve processes to enhance the Antelope Valley (AV) stations operations and also includes the status of adopting the monitoring team's recommendations in its audit along with corrective action to fully implement the monitoring team's recommendations.

- [Public Complaints Audit Part I – Assessment of Availability and Acceptance of Complaint Information](#) (2024-23-A): an assessment of availability and acceptance of complaint information for the AV stations. To evaluate the complaint process at the AV stations, the auditors submitted 2 email complaints, 6 certified mail-in complaints, and 23 telephone complaints.¹⁴ The audit accessed the availability of complaint materials at each station, each of which was found to be in 100% compliance, and the acceptance of public complaints, for which there were areas of noncompliance. For mail-in complaints, the combined AV station compliance total was 67%, for email complaints it was 100%, for the Department 800 number it was 86%, for the AV stations compliance with calls being transferred without delay it was 81% and for supervisor's willingness to accept

¹²The monitoring team is the monitor for a settlement agreement by the Sheriff's Department with the United States Department of Justice covering the two Antelope Valley stations, Lancaster and Palmdale. For information on the AV Settlement Agreement, see [Monitoring of the Antelope Valley Settlement Agreement](#) to review the agreement and to access related documents. The September 2023 MT audit is [Antelope Valley Monitoring Team – First Stops and Bias-Free Policing Audit](#) (September 2023)

¹³ CAD stands for Computer-Aided Dispatch.

¹⁴ The 2 email complaints were submitted through the LASD.org website, the 6 mail-in complaints were sent to both the AV stations and the Professional Standards Bureau (PSD), and the 23 telephone complaints were made to the AV stations and the Sheriff's Information Bureau.

the complaint it was 79%.¹⁵ While the audit noted some glitches with the usability of the online complaint forms in Spanish, steps were taken to fix the problems and reported in the audit. The audit report makes appropriate recommendations for corrective action. While the auditors submitted complaints in English and Spanish only, the report recommends responding to complainants in the same language as the complaint.

- [Public Complaints Audit Part III Investigation and Management Review and Oversight of Public Complaints](#) – (2024-25-A): an assessment of investigations of complaints, management review, and oversight procedures for complaints at the AV stations. The audit reviewed Watch Commander Service Comment Reports (WCSCR or complaints) for the AV stations. The audit looked at complaints submitted during the first quarter of 2024, that were to be completed by the date the data was extracted. For both the AV stations, this was a total of 29 complaints. For the Palmdale station, 22% of the complaints were completed timely, for the Lancaster 0% of the complaints were completed. Specific sub-objectives for the handling of complaint investigations are noted in the audit, with some of Palmdale's achieving compliance rates of 100% for seven of the sub-objectives but falling below the metrics required by the AV Settlement Agreement for the remaining sub-objectives. Because Lancaster did not complete any of the investigations, the compliance rate was 0%. The audit makes detailed recommendations toward achieving compliance with the AV Settlement Agreement.
- [Stops and Detentions Audit Part I – Backseat Detentions \(2024-10-A\)](#): an assessment of explanations for backseat detentions to civilians and documentation of reasons for the backseat detentions. The audit found that the AV stations failed to meet the compliance metrics for the two metrics measured: (1) explanation of backseat detentions to civilians (40%) and (2) backseat detentions documentation and articulation (70%).¹⁶ The settlement agreement

¹⁵ The breakdown for each station may be found in the link to the audit in this report. It is noteworthy that for mail-in complaints Lancaster was 100% complaint and Palmdale was at 50% compliance. The compliance rate for the complaints received by PSD was also only 50%. While a Spanish language complaint was received and handled properly, the mail-in complaint in English was not responded to by Lancaster or PSD. Additionally, PSD submitted the complaint to the Lancaster station captain four days beyond the required timeframe.

¹⁶ Backseat detentions are when a subject is placed in the backseat of a patrol vehicle. The percentage of backseat detentions in compliance for each metric are noted here for the AV stations combined. For a breakdown of each station, the audit may be accessed through the Sheriff's Department's Transparency page for audits or following the link to the audit in this report.

requires 90% compliance. Along with other recommendations, the audit makes recommendations to include an MDC/CAD function to allow deputies to digitally attest that they explained the reason for the backseat detention and to require adherence to the Sheriff's Department [Body Worn Camera \(BWC\) policy](#) requiring continuous video coverage of the entire interaction with a subject.

- [Stops and Detentions Audit Part V- Initiations of Stops and Detentions – Parole/Probation Searches](#) (2024-15-A): an assessment of stops and detentions by AV deputies focused evaluating the treatment of individuals searched based on their parole/probation status. The audit does not evaluate whether the stops were legally justified, nor does it examine whether racial or ethnic disparities existed in the stops and detentions. While the audit found 80-90% compliance in the combined AV totals for all but one sub-objective, there was notably only 50% compliance at both AV stations in an objective that included the reason for the stop,¹⁷ now a legal requirement in California. While BWC activation was among the metrics in the 80-90%, the rate of compliance with this metric should be closer to the 100% metric required by the AV Settlement Agreement. The audit does not assess supervisors' roles in identifying, addressing, or preventing noncompliance. An evaluation of supervisory practices, particularly during the Daily Stop Audits, is recommended. Finally, the audit fails to identify patterns on noncompliance by specific deputies, units, or shifts, if any, which could identify systemic issues, including ineffective leadership or training. The audit includes recommendations to increase compliance rates.
- [Stops and Detentions Audit Part III – Backseat Detentions – Domestic Violence Related](#) (2024-28-A): an assessment of backseat detentions related to domestic violence calls for service at the AV stations. The audit found 63% compliance for the two AV stations in explaining the backseat detentions to the subjects and 66% compliance for both stations for documenting the backseat detention. The audit does not identify systemic reasons for noncompliance or inability to achieve the required 90% metric required by the AV Settlement Agreement. The audit omits any analysis of racial or ethnic demographic patterns in backseat detentions. Additionally, there is some inconsistency in the audit with regard to finding justification for two backseat detentions with similarities to two other

¹⁷Objective 1(b) of this audit also assessed whether deputies introduced themselves in addition to providing the reason for the stop. A failure in this objective indicated that the deputy either did not introduce themselves, did not state the reason for the stop, or both. When considered separately, compliance with stating the reason for the stop was 80% at the Palmdale station and 100% at the Lancaster station.

backseat detentions that were found to be unnecessary. The audit includes recommendations to increase compliance rates.

- [Use of Force Audit Part I – De-escalation and Use of Force Assessment](#) (2024-18-A): an assessment on de-escalation and uses of force at the AV stations. The 100% compliance rate is somewhat surprising as there have been notable recordings of uses of force by AV deputies that evidence a lack of de-escalation and force that is not proportional.¹⁸ The Office of Inspector General notes that the sample size chosen is small and that the exclusion of Category 3 uses of force, which are the most serious, and the conclusions that may be drawn from it are therefore limited. The audit found recurring failures in management oversight, such as delayed notifications to IAB, incomplete documentation, and inaccuracies in reports. The audit also did not analyze whether there were any racial or ethnic disparities related to uses of force.
- [Use of Force Audit Part III – Use of Force Training](#) (2024-22-A): an assessment of use-of-force training at the Antelope AV stations that included compliance with mandated use-of-force training.¹⁹ The audit found a combined compliance rate for both stations to be 30% for annual Force Training, 5% for annual Supervisors Use of Force Investigations Refresher Training, and 50% for biennial Deputy Tactics and Survival Training (TAS). Notably, at Palmdale station, **none** of the 10 randomly selected personnel completed the annual training for use of force or for supervisors and only 40% completed the TAS training. The audit does not discuss reasons for the lack of compliance with training requirements and does not discuss the availability of training. There are no meaningful recommendations in the audit to increase the compliance rate.
- [Stops and Detentions Audit – Initiation of Stops and Detentions – Consent Searches](#) (2024-29-A): an assessment of initiated stops and detentions with an evaluation of policy compliance for consent searches of persons and vehicles by AV station deputies. While most of the sub-objectives that were the subject of the audit had compliance rates between 80-100% combined for the AV stations, the

¹⁸ See, for example the following videos: [New video shows what sparked the controversial arrest in the Antelope Valley, 12/14/2024 LASD DUI Stop](#), and video embedded in the Los Angeles Times article by Keri Blakinger and James Queally, [Body-cam footage shows Palmdale Sheriff's deputy punching a woman holding her baby](#) (July 12, 2023).

¹⁹ The audit included data from the AV monitoring team's audit regarding adherence to policies prohibiting interference with photographing or recording law enforcement activities. This portion of the audit is not summarized in this report as the audit was not conducted by the Sheriff's Department.

combined compliance rate for articulation and documentation of the consent search was 45% for the two stations combined. Also noteworthy is the 82% compliance rate for the category on consent search request and response, which falls short of the AV Settlement Agreement compliance metric of 95%. In addition to other recommendations, the auditors recommend that Daily Stop Audits should continue so that supervisors regularly review BWC recordings with deputies to ensure proper introductions to the subjects of stops and that deputies are stating the reason for the stop as soon as practicable. In two of the Lancaster stop reviews, the deputies did not receive consent for the search of the subject, despite being classified as a “Consent” search. In one vehicle search classified as consent, the deputy did not clearly phrase his request to conduct a consent search of the vehicle. The Office of Inspector General recommended policy changes for consent searches in its report: [*Reform and Oversight Efforts: Los Angeles County Sheriff’s Department October to December 2020*](#) in the section titled, *Consent Search Policy*.

- Stops and Detentions Audit Work Plan East Patrol Division (2024-42-A): A work plan for an audit on stops and detentions in East Patrol Division: The Office of Inspector General reviewed the audit work plan and provided comments to the Sheriff’s Department.

Letter to a Journalist Threatening Litigation

On December 12, 2024, the Red State, an online political blog, published an opinion article, [*EXCLUSIVE: LA County Sheriff Threatens Investigative Journalist With Lawfare Over X Post*](#).²⁰ The article discussed a [*December 11, 2024 letter*](#) sent by an attorney for Sheriff Luna to online journalist CeCe Woods threatening her with a defamation action for a [*November 10, 2024 post on X*](#) that said:

NEW: Rumors have been heavily circulating throughout @LASDHQ and @LBPD that @LACoSheriff could potentially step down as the head of the largest sheriff’s department in the country due to health concerns (multiple sources say Parkinson’s disease).

A link to the letter was available through the RedState article. The Office of Inspector General requested a copy of the letter from Sheriff Luna to confirm its accuracy. While a member of the Sheriff’s command staff referred us to the copy of the letter on RedState,

²⁰ The Library of Congress summarizes the RedState as “an American conservative political blog. (*RedState*. United States, 2006. Web Archive. <https://www.loc.gov/item/lcwaN0007962/>.)

to date the Sheriff has declined to provide us with the letter, instead asking the Office of Inspector General to provide the Sheriff with the reason for requesting the letter. In the email requesting the explanation for our request, a representative of the Sheriff stated that the “letter was sent privately.”

As the Office of Inspector General explained in response, we requested the letter as it is a matter of public concern that the Sheriff retained an attorney to threaten litigation against a journalist for publishing a statement about a public official’s health. The Sheriff potentially stepping down for health reasons concerns his fitness for duty as a public official and is therefore not a private matter. In fact, the letter refers to Sheriff Luna in his official capacity in the very first sentence thereby acknowledging that the matter is not private. Additionally, on page 3 of the letter in the last paragraph, states, “[y]ou knew that the Statement could cause substantial damages to a public official,” further acknowledging that the statement in the post does not refer to a private matter, but rather one of public interest based on the Sheriff’s position as an elected public official.

The Office of Inspector General previously reported on instances when Sheriff Villanueva sought to infringe the rights of journalists under the First Amendment of the United States Constitution. The letter sent by Sheriff Luna’s attorney attempts to do the same: chill reporting and public discussion on whether the Sheriff is fulfilling the duties of his office. Two Inspector General reports discuss efforts to chill the conduct of journalists: [Report Back on Unlawful Conduct of Los Angeles County Sheriff’s Department](#), which includes discussions of the treatment of three journalists in the section titled, *Conduct Suppressing the Exercise of First Amendment Rights* and [Reform and Oversight Efforts: Los Angeles County Sheriff’s Department - October to December 2023](#), specifically the section *Inaccurate and Biased Analysis of First Amendment Violations against a Reporter*. In addition to the Inspector General’s reports, the Los Angeles Times reported on Sheriff Villanueva’s efforts to chill negative reporting on him, with the most egregious example being a purported investigation of Alene Tchekmedyan, a reporter for the paper, as reported in its article of April 27, 2022, [Villanueva backs off investigation of Times reporter who revealed cover-up](#). The article references Sheriff Villanueva’s press conference the previous day during which he posted a photograph of Ms. Tchekmedyan and told the press that all parties who acted upon a leaked investigation of a use of force were subjects of an investigation into a criminal leak. Sheriff Luna ran against former Sheriff Villanueva on a platform of transparency and reform and efforts to chill free speech are contrary to such goals.

Finally, the letter to Ms. Woods fails to specifically state the standard for prevailing on defamation case against a public official. Statements that there are rumors that a Sheriff may step down due to health concerns are clearly statements about a public official and are a matter of public interest. While there are passing references in the letter to maliciousness and recklessness, a public official must prove that there was actual

malice in the statement made, yet that standard is not acknowledged in the letter to Ms. Woods. Actual malice means that the statement was made “with knowledge that it was false or with reckless disregard of whether it was false or not.” (See *New York Times Co. v. Sullivan* (1964) 376 U.S. 254, 280.) And for the Sheriff to prevail on a summary judgment motion, actual malice must be proven by clear and convincing evidence. (See *Jackson v. Paramount Pictures Corp.* (1998) 68 Cal. App. 4th 10, 27.) Actual malice is only based upon the attitude of the person making the statement toward the truth or falsity of the material published, not on the person’s attitude toward the public official. (*Jackson v. Paramount Pictures Corp.* at pages 31-32.) The letter to Ms. Woods is devoid of any evidence that Ms. Woods knew the rumors to be untrue or acted with reckless disregard for the truth. Quite the contrary, some persons replying to the post also mentioned these rumors. Most notably, on November 12, 2024, Keri Blakinger of the Los Angeles Times posted a reply:

Yeah, I’d concur this was circulating pretty widely!²¹

While there were some replies denying that the rumors were true, on the same day as her post, an article authored by Ms. Blakinger appeared in the Los Angeles Times, [Will L.A. County’s sheriff run for reelection in 2026? Absolutely Robert Luna says](#). The article repeats the rumors and references that Sheriff Luna and his representative acknowledged the existence of such rumors. The article refers to union leaders being “peppered with these horrible rumors” for at least a week. In the article, Ms. Blakinger again described the rumors as widespread.

As far as we are aware, no such letter was sent to Ms. Blakinger or the Los Angeles Times, supporting Ms. Woods and Ms. Blakinger’s statements that the Sheriff’s health was a widespread topic of conversation, suggesting that Ms. Woods did not know the information was actually false or acting with reckless disregard of its truth. While certainly repeating rumors may be the subject of a defamation action when the person repeating the rumors knows them to be false or acts with reckless disregard for the truth, the fact that the others had heard these same rumors suggest that Ms. Woods did not act with actual malice as required for the Sheriff to prevail in a lawsuit for defamation. Given the high standard for a public official to prevail on a claim for defamation, sending such a letter to a lone online journalist appears to be an attempt to inhibit her right to free speech.

²¹ The X post by Ms. Blakinger is accessible through the RedState article.

CUSTODY DIVISION

Jail Overcrowding

Overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide humane conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.²²

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.²³ According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of December 31, 2024, the total population of people in custody in the Los Angeles County jails was 11,846.

The table below show that the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center East (PDC East), Pitchess Detention Center North (PDC North), Pitchess Detention Center South (PDC South), and North County Correctional Facility (NCCF) on the last day of the previous four quarters. On these dates, three facilities (MCJ, PDC North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity. The number of people in custody at four of the facilities (MCJ, TTCF, CRDF, and PDC North) on December 31, 2024, exceeded the number of people in custody at these facilities on March 31, 2024.

²² See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

²³ The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the pandemic, understaffing, or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

Facility	BSCC Capacity	Facility Count			
		3/31/24	6/30/24	9/30/2024	12/31/2024
MCJ	3512	3551	3572	3698	3850
TTCF	2432	2156	2378	2378	2350
CRDF	1708	1269	1255	1371	1341
PDC East	926	14	12	20	10
PDC North	830	1187	1286	1276	1221
PDC South	782	674	663	633	462
NCCF	2214	2923	2775	2718	2612

As the chart indicates, PDC East is well under its rated capacity. The Sheriff's Department should explain why it under-utilizes that facility while operating other facilities over their BSCC rated capacities.²⁴

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a [motion](#) requesting the Sheriff's Department and directing the Office of Inspector General, Sybil Brand Commission, and the Sheriff Civilian Oversight Commission to review and report back on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation, and directing the Office of Inspector General to include status on the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice.

In January 2025, the Office of Inspector General issued its [Report Back On Dignity and Health For People Who Are Incarcerated: Ensuring Accessibility to Menstrual Products in the Los Angeles County Jails, Patrol Lockups and Court Holding Tanks](#). The Office of Inspector General will include updates on the availability and accessibility of menstrual products for people in the custody of the Sheriff's Department in its next quarterly report.

Commissary Prices

On July 9, 2024, the Board passed a [motion](#) directing the Sheriff's Department to report back on measures taken to ensure commissary prices for people in the Los Angeles

²⁴ CRDF also operates well below its rated capacity, that facility does not house males and so cannot readily take up excess capacity from other facilities.

County Jails, especially for food, drinks, and hygiene items, are not excessive but remain on par with prices for grocers and retailers. On February 6, 2025, the Office of Inspector General issued its [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#).

In-Custody Deaths

Between October 1 and December 31, 2024, nine people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for four deaths: one natural, one suicide, one accident, and one homicide. Currently, there is no public autopsy record for one death which occurred at a hospital, for which the hospital ruled the preliminary cause of death as natural. For the remaining four deaths, the DME findings remain deferred.²⁵ Three people died at MCJ, one person died at TTCF, one person died at Inmate Reception Center (IRC), one person died at Century Regional Detention Facility (CRDF), and three people died at hospitals after being transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a [dedicated page on Inmate In-Custody Deaths on its website](#).²⁶

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews for each of the nine in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

²⁵ In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and Correctional Health Services use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

²⁶ [Penal Code § 10008](#) requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

Date of Death: October 8, 2024

*Custodial Status: Pre-trial.*²⁷

Custody staff at IRC found multiple people, including the decedent, unresponsive in a Courtline²⁸ holding tank. Custody staff, Correctional Health Services (CHS) staff and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include the quality of Title 15 safety checks, lack of policy and procedures for multiple people in distress, and not searching people in custody prior to being transported to IRC for Courtline.

Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: October 24, 2024

Custodial Status: Pre-trial.

Custody staff and CHS staff at MCJ found a person in a multi-person cell unresponsive during pill call. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include changing mental health level of care during a discipline review process, lack of adequate referral process to Addiction Medicine Services (AMS), and the Department's handling of medical refusals. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: October 30, 2024

Custodial Status: Sentenced.

Custody staff at MCJ were alerted to a "man down" and found a person unresponsive in a multi-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered five doses of Narcan. The person died at the scene. Areas of concern include lack of adequate referral process to AMS.

Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as accident, and the cause of death as effects of fentanyl and heroin.

²⁷ For the purposes of custodial status, "Pre-trial" indicates that the person is in custody awaiting arraignment, hearing, or trial. "Convicted, Pre-sentencing" indicates that the person is being held in custody based on a conviction, pending sentencing, on at least some charges, even if they are in pre-trial proceedings on other charges. "Sentenced" indicates that the person is being held on the basis of a sentence on at least some charges, even if they are in pre-trial proceedings on other charges.

²⁸ Courtline is the holding area where persons going to court are held prior to being transported to court and where they are held upon their return before being transferred to their assigned housing location.

Date of Death: November 10, 2024

Custodial Status: Pre-trial.

On October 29, 2024, custody staff at TTCF found a person exhibiting signs of distress during a Title 15 safety check. The person was transported to Los Angeles General Medical Center (LAGMC) for a higher level of care. On November 10, 2024, the person died at the hospital while receiving medical treatment. Areas of concern include the mental health evaluation following Behavioral Observation and Mental Health Referral reports, custody staff using force on the person (while he was restrained) prior to transporting him to the hospital, and lack of adequate referral process to AMS.

Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as suicide, and the cause of death as sequelae of swallowing foreign objects.²⁹

Date of Death: December 4, 2024

Custodial Status: Sentenced.

A person in custody at MCJ alerted custody staff to a “man down” in his two-person cell. Custody staff found the person in custody unresponsive on the floor. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered three doses of Narcan. The person died at the scene. Areas of concern include quality and timeliness of Title 15 safety checks, pill call procedures, and supervision of trustees.³⁰ Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as homicide, and the cause of death as asphyxiation and ligature strangulation.

Date of Death: December 10, 2024

Custodial Status: Pre-Trial.

A person in custody at CRDF alerted custody staff of a “man down” inside her two-person cell. Custody staff, CHS staff and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include whether custody staff’s emergency response aligned with training and policies. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

²⁹ As used here, “sequelae” means a consequence or result.

³⁰ The Sheriff’s Department assigns work to some of the people in custody in its facilities. See, e.g., Los Angeles County Sheriff’s Department, [Custody Division Manual \(CDM\), § 5-01/025.00](#), Housing Area Inmate Workers. These workers are commonly referred to as trustees.

Date of Death: December 17, 2024

Custodial Status: Sentenced.

On December 16, 2024, a person in custody who was exhibiting signs of distress was transported from North County Correctional Facility (NCCF) to Henry Mayo Newhall Hospital for a higher level of care. On December 17, 2024, the hospital staff reported his respiratory status decompensated. Despite efforts by hospital staff, the person died. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death as sepsis, bilateral pneumonia, and influenza A infection.

Date of Death: December 26, 2024

Custodial Status: Sentenced.

People in custody at TTCF alerted custody staff of a “man down” in the dayroom. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered six doses of Narcan. The person was pronounced dead at the scene. Preliminary manner of death: Deferred. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: December 27, 2024

Custodial Status: Pre-Trial.

On December 23, 2024, a person in custody with a pre-existing medical condition was transported from MCJ to DaVita Burbank Dialysis Center for routine care. On the same day, he was transferred to Providence St. Joseph Medical Center for a higher level of care. On December 27, 2024, the hospital staff transitioned the person to comfort care, and he died. The preliminary manner of death according to the hospital is natural, due to intracerebral hemorrhage. The DME website currently does not have a public record for this death.

Other Death

On December 24, 2024, Lakewood Station deputies responded to a business disturbance call and detained the suspect. During the investigation, the suspect suffered a medical emergency. Deputies rendered emergency aid and administered Narcan. Paramedics responded and pronounced the person dead at the scene. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff's Department to “[c]ollect and track data outlining narcotics recovery in county

jail facilities to evaluate the efficacy of drug detection interventions and provide information to the Office of Inspector General,” and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections.” The Board also directed the Office of Inspector General to report quarterly on the Sheriff’s Department’s progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody overdose deaths.

Of the nine people who died in the care and custody of the Sheriff’s Department between September 30 and December 31, 2024, the medical examiner’s final reports, including toxicology assessments, confirm that one person died due to an overdose. Toxicology results remain pending for five of the nine deaths and may indicate additional overdose deaths once completed.

Tracking Narcotics Intervention Efforts

The Department has made no new efforts to improve tracking of narcotics recovery since the Office of Inspector General’s last quarterly report. As described in previous reports, the Sheriff’s Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Department takes the position that constructing an all-encompassing jail management data system would best support the Department’s efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Department examine ways to comply with the Board’s directive by improving reporting requirements for staff and compiling data on detection interventions and seizures using existing technologies.

Improving Searches of Staff and Civilians

The Board’s second directive required that the Sheriff’s Department “[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails].” The Department previously reported its current policy grants the Department broad authority to search staff and civilians entering the jails, so that no changes to existing Department policy are required to implement more comprehensive searches. The Department previously reported that it implemented more frequent unannounced and randomized staff searches beginning in May 2024.⁶⁰

All jail facilities reported conducting unannounced searches during the previous quarter, beginning in May 2024 as planned, though the comprehensiveness of the searches varied across facilities. The table below details the staff searching practices at all facilities from September 30 to December 31, 2024.³¹

Facility	# Staff Searches			# Staff Searches with K9			Minimum Search Req't	Search Inside Security	Search Evasion Concerns	Where Searches Logged
	Q4	Q3	Q2	Q4	Q3	Q2				
MCJ	166	106	-	40	41	7	Yes	No	Yes	Watch Commander Log
TTCF	8	11	-	8	9	1	Yes	Yes	Yes	Watch Commander Log
IRC	20	10	-	0	6	2	Yes	Yes	Yes	Watch Commander Log
CRDF	4	4	-	5	7	1	Yes	No	Yes	Watch Commander Log
NCCF	111	148	156	4	12	5	Yes	Yes	No	Inconsistent
PDC-North	37	75	19	4	3	0	No	Yes	Yes	Watch Commander Log & Staff Search Log
PDC-South	39	39	28	8	11	4	Yes	Yes	No	Staff Search Log

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the fourth quarter of 2024, Office of Inspector General personnel completed 133 site visits, totaling 357 monitoring hours, at IRC, CRDF, MCJ, Pitchess Detention Center North, PDC South, NCCF, and TTCF.

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 113 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 168 monitoring hours related to uses of

³¹ Office of Inspector General staff identified discrepancies between 2024 data provided by NCCF and the previously submitted data for the second and third quarters of 2024. NCCF staff attribute the variance to the lack of a formal process and rotating personnel unfamiliar with logging staff searches, but also report that the facility has implemented a new system to address the issue.

force, in-custody deaths, COVID-19 policies and protocols, Prison Rape Elimination Act (PREA) compliance, and general conditions of confinement.

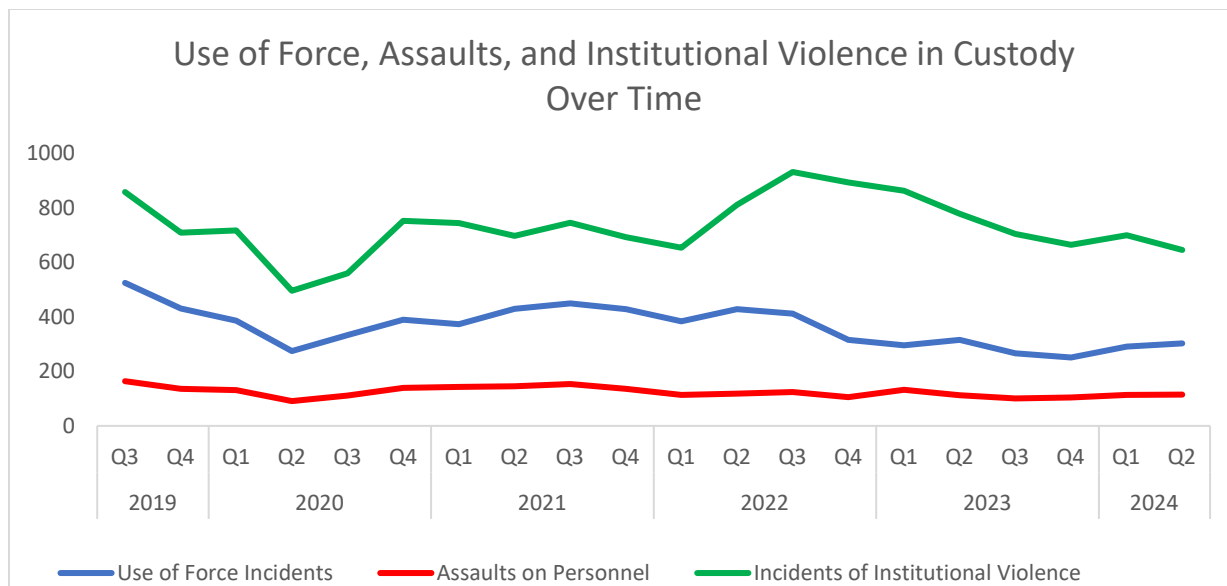
Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.³² The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people in its custody.³³

		Use of Force Incidents	Assaults on Personnel	Incidents of Institutional Violence
2019	3 rd Quarter	525	164	858
	4 th Quarter	431	136	709
2020	1 st Quarter	386	131	717
	2 nd Quarter	274	91	496
	3 rd Quarter	333	111	560
	4 th Quarter	390	140	753
2021	1 st Quarter	373	143	745
	2 nd Quarter	430	145	698
	3 rd Quarter	450	153	746
	4 th Quarter	428	136	693
2022	1 st Quarter	384	114	654
	2 nd Quarter	428	118	811
	3 rd Quarter	412	124	932
	4 th Quarter	316	106	894
2023	1 st Quarter	296	133	863
	2 nd Quarter	316	112	779
	3 rd Quarter	266	101	704
	4 th Quarter	251	104	665
2024	1 st Quarter	291	114	700
	2 nd Quarter	303	115	646

³² Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

³³ The reports go through the fourth quarter of 2023 because the Sheriff's Department has not yet verified the accuracy of reports for the first quarter of 2024. In reviewing this report, the Department noted corrected information for assaults on personnel and incidents of institutional violence for the first quarter of 2022, which is reflected here, and which differs from uncorrected information reported in previous quarterly reports.



HANDLING OF GRIEVANCES AND COMMENTS

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received 260 new complaints in the fourth quarter of 2024 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

Of these grievances, 239 related to conditions of confinement within the Department’s custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	97
Personnel Issues	29
Classification	22
Mental Health	19
Living Condition	14
Dental	9
Transportation	7
Food	5
Education	5
Property	5
Mail	2
Bedding	2
Showers	2
Commissary	2
Telephones	2
Visiting	2
Other	15
Total	239

Twenty-one complaints related to civilian contacts with Department personnel by persons who were not in custody, as shown in the chart below:

Complaint/Incident Classification	Totals
Personnel	
Harassment	1
Improper Tactics	3
Improper Detention	2
Off Duty Conduct	1
Force	2
Alleged Criminal Conduct	1
Neglect of Duty	3
Service	
Policy Procedures	1
Traffic Citation	2
Response Time	4
Other	1
Total	21

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 77 iPads installed in jail facilities: 40 at TTCF; 12 at MCJ; and 25 at CRDF. During the fourth quarter there were no new installations or iPad replacements. There were 99,441 automated responses provided to people in custody using the iPad application to request information.

The Sheriff's Department continues to experience malfunctioning iPads and have identified power source problems as the major cause. Facility Services Bureau (FSB) was able to install a dedicated power source to limited areas within MCJ and TTCF. The Department found that the Wi-Fi connection was weak and inconsistent. The Department reports that after further discussions with FSB, it was decided that direct power and data sources would yield better results if installed simultaneously. FSB started the project at TTCF in early September and is still pending completion. Custody Support Services Bureau – Correctional Innovative Technology Unity (CITU) acquired two new MacBooks to assist with reconfiguring and programming the iPads. Apple administrator problems have resurfaced preventing the completion of necessary software and program updates. The Department states that once the FSB project is completed at TTCF, the reconfiguring and programming of the iPads will be readdressed.

As [previously reported](#), the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in custody.³⁴ The Sheriff's Department reports that between October 1 and December 31, 2024, no one in custody had been placed on restrictive filing and it therefore did not reject any grievances under this policy.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

³⁴ See Los Angeles County Sheriff's Department, Custody Division Manual, § 8-04/050.00, [Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges](#).

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.³⁵ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.³⁶

The following chart lists the number and types of comments reported for each station or unit.³⁷

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
ADM: NORTH PATROL ADM HQ	0	0	1
AER: AERO BUREAU	0	1	0
ALD: ALTADENA STN	2	1	0
ASH: OFFICE OF THE ASST SHF I	0	1	0
CAF: COMM & FLEET MGMT BUR	1	0	0
CCS: COMMUNITY COLLEGE BUREAU	3	0	1
CEN: CENTURY STN	2	9	3
CER: CERRITOS STN	6	2	1
CMB: CIVIL MANAGEMENT BUREAU	12	3	4

³⁵ See [Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, Department Service Reviews.](#)

³⁶ It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

³⁷ The chart reflects data from the Sheriff's Department Performance Recording and Monitoring System current as of January 13, 2025.

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
CNT: COURT SERVICES CENTRAL	1	4	0
COM: COMPTON STN	5	8	1
CPB: COMMUNITY PARTNERSHIP BUREAU	0	1	0
CRD: CENTURY REG DETEN FAC	2	0	0
CRV: CRESCENTA VALLEY STN	15	4	1
CSB: COUNTY SERVICES BUREAU	6	1	1
CSN: CARSON STN	3	5	3
DSB: DATA SYSTEMS BUREAU	1	0	0
ELA: EAST LA STN	2	3	1
EOB: EMERGENCY OPER BUREAU	1	0	0
EST: COURT SERVICES EAST	0	5	1
HOM: HOMICIDE BUREAU	0	1	1
IND: INDUSTRY STN	3	5	2
LCS: LANCASTER STN	12	27	5
LKD: LAKEWOOD STN	2	7	2
LMT: LOMITA STN	4	4	0
MAR: MARINA DEL REY STN	4	1	3
MCB: MAJOR CRIMES BUREAU	4	0	0
MCJ: MEN'S CENTRAL JAIL	0	1	0
MLH: MALIBU/LOST HILLS STN	12	5	4
MTL: METROLINK	0	2	0
NCF: NORTH CO. CORRECTL FAC	1	0	0
NO: PITCHESS NORTH FACILITY	0	1	0
NWK: NORWALK REGIONAL STN	1	1	0
OCP: OFFICE OF CONSTITUTIONAL POLICING HQ	0	1	0
OJC: DOJ COMPLIANCE UNIT	0	1	0
OSS: OPERATION SAFE STREETS BUREAU	3	6	1
PER: PERSONNEL ADMIN	0	1	1
PKB: PARKS BUREAU	1	1	0
PLM: PALMDALE STN	18	30	1
PRV: PICO RIVERA STN	4	2	3
SCV: SANTA CLARITA VALLEY STN	18	7	1

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
SDM: SAN DIMAS STN	6	1	0
SIB: SHERIFF INFORMATION BUREAU	2	0	0
SLA: SOUTH LOS ANGELES STATION	2	9	0
SVB: SPECIAL VICTIMS BUREAU	1	2	1
TEM: TEMPLE CITY STN	6	4	3
TSB: TRANSIT SERVICES BUREAU	0	1	2
WAL: WALNUT/SAN DIMAS STN	3	7	1
WHD: WEST HOLLYWOOD STN	4	11	3
WST: COURT SERVICES WEST	0	3	1
Total:	173	190	53



Reform and Oversight Efforts: Los Angeles County Sheriff's Department

January through March 2025

Issued May 27, 2025

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between January 1 and March 31, 2025, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- Failure to Exercise Due Diligence in Obtaining a Search Warrant
- Sheriff's Department's Policies for Cooperating with Federal Immigration Authorities

During the first quarter of 2025, the Office of Inspector General issued the following reports relating to the Sheriff's Department:

- [Twelfth Report Back on Implementing Body-Worn Cameras in Los Angeles County](#)
- [Report Back on People Over Profit – Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#)
- [Fifth Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421](#)
- [Report Back on Ensuring Accessibility to Menstrual Products in the Los Angeles County Jails, Patrol Lockups, and Court Holding Tanks](#)

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. During this quarter, there were four incidents in which people were shot or shot at by Sheriff's Department personnel. Three people were fatally struck by deputies' gunfire. The Office of Inspector General staff responded to each of these deputy-involved shootings. The information in the following shooting summaries is based on the limited information provided by the Sheriff's Department and is preliminary in nature. While the Office of Inspector General receives information at the walk-through at the scene of the shooting, receives

preliminary memoranda with summaries, and attends the Sheriff's Department Critical Incident Reviews, the statements of the deputies and witnesses are not provided until the Sheriff's Department completes its investigation. The Sheriff's Department permits the Office of Inspector General's staff limited access to monitor the ongoing investigations of deputy-involved shootings. The Sheriff's Department also [maintains a page on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.

Temple Station: Non-Hit Shooting – Non-Fatal

On January 5, 2025, at approximately 12:48 p.m., deputies from Temple Station responded to a report of an assault with a deadly weapon, a firearm, that occurred on Garvey Avenue in the city of Rosemead. A deputy, who was accompanied by a 16-year-old Explorer ride-along, arrived at the scene and observed the suspect, a 53-year-old Hispanic man. As the deputy exited his vehicle, the suspect turned toward him and raised the firearm with his left hand. In response, the deputy fired one round, missing the suspect. The suspect subsequently dropped the firearm and assisting deputies took him into custody. A loaded firearm was recovered from the scene. The deputy who shot at the suspect failed to activate his body-worn camera prior to or during the incident. This deputy-involved shooting is not listed on the Los Angeles County Sheriff's Department website because only the deputy-involved shootings that result in injury or death are reported there.

Areas for Further Inquiry

Why did the deputy fail to activate his body-worn camera in violation of Sheriff's department policy? Should deputies with Explorer or other ride-alongs be the primary responding unit to this type of call and if so, how can they best be protected? What was the backdrop of the shooting? Were there any bystanders in the line of fire?

Century Station: Hit Shooting – Fatal

On January 21, 2025, at approximately 1:29 a.m., deputies from Century Station received a call for service regarding a domestic disturbance on 77th Place in the City of Los Angeles. The caller reported that her boyfriend was sending her threatening messages and knocking on her window.

When deputies arrived and contacted the victim, they saw the suspect, a 45-year-old Hispanic man, about two blocks north of the location. As they approached the suspect, he opened fire on the deputies, striking their patrol vehicle multiple times. The deputies returned fire, and the suspect fled north about half a block with the deputies in foot pursuit, when a second deputy-involved shooting took place.

Following the second exchange, the suspect continued fleeing another half block and then entered a white Toyota Sienna minivan, at which point a third deputy-involved shooting occurred. Deputies gave repeated commands to the suspect, to exit the vehicle but received no response. An armored vehicle was deployed, and additional commands were issued, but the suspect remained unresponsive.

Deputies then approached the minivan, opened the door, and removed the suspect. Deputies, along with Los Angeles Fire Department personnel staged nearby, provided medical aid, but the suspect was pronounced dead at the scene. A firearm was recovered. A total of 39 rounds were fired by deputy personnel. No deputies were injured.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with video from body-worn cameras and a surveillance camera.

Areas for Further Inquiry

Was the initial contact consistent with training and best practices? Was the foot pursuit conducted in compliance with Sheriff's Department policy and training? What specific imminent threat to the deputies or others was present during the second and third shootings that justified using deadly force? Did the suspect receive timely medical aid?

Lakewood Station: Hit – Fatal

On January 30, 2025, at approximately 12:15 a.m., a deputy was seated in his patrol vehicle parked in a row of unoccupied patrol vehicles outside of the Paramount substation when he heard a loud banging noise. As he drove forward to investigate the noise, the deputy saw a 34-year-old Hispanic man, holding a machete repeatedly striking an unoccupied parked patrol car. The deputy exited his vehicle and ordered the suspect to stop and drop the machete, but the suspect pointed the machete in his direction and began walking towards him. The deputy again ordered the suspect to drop the machete and get on the ground, but the suspect continued walking towards him. When the suspect got to within 15-20 feet of the deputy still holding the machete, the deputy fired 5 rounds, hitting the suspect multiple times.

Once assisting deputies arrived, they approached the suspect and rendered first aid. Los Angeles County Fire Department personnel responded to the location and the suspect was pronounced deceased at the scene. A machete, approximately, 24" in length, was recovered at the scene. The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with body-worn camera video.

Areas for Further Inquiry

Did the deputy consider a tactical retreat thus creating time and distance from the suspect?

Temple Station: Hit Shooting – Fatal

On February 26, 2025, at approximately 6:00 p.m., Temple Station deputies responded to a call reporting an arson in progress on Scott Street in the city of Rosemead. The call included information that the suspect, a 56-year-old Asian woman, ignited an unknown item and threw it towards a neighbor. The patrol deputies and deputies on the Mental Evaluation Team (MET), who also responded, set up a containment and made multiple unsuccessful attempts to contact the suspect by cell phone and the public announcement system to convince the suspect to exit her residence and surrender. The Special Enforcement Bureau (SEB) was contacted but declined to respond to the scene given the circumstances of the call and the information communicated to SEB regarding the suspect.¹ A Crisis Negotiation Team was not called to the scene, but MET deputies are cross trained in crisis negotiations. While the deputies on scene were attempting to contact the suspect, Temple Station detectives prepared a search warrant and received judicial authorization to execute the warrant at the suspect's home.

On February 27, 2025, shortly before 12:30 a.m., the Sheriff's Department requested that the suspect open the door for the deputies to execute the warrant. The suspect remained barricaded inside the home and did not respond to that request. The warrant team's tactical plan assigned at least two deputies to use any necessary non-lethal force, and one deputy was assigned to use lethal force in the event such force became necessary to ensure the safety of the deputies or the public. The warrant team forced entry into the home.

¹ In response to reviewing a draft of this report, the Sheriff's Department noted: *On February 26, 2025, the on-call SEB Duty Lieutenant received information that Temple Station was possibly dealing with an arson suspect. Being proactive, the SEB Duty Lieutenant contacted the Temple Station Watch Commander and dispatched an Arson/Explosives Detective to assist with the investigation. The detective determined the elements of arson were not present in that call for service. The SEB Duty Lieutenant continued to consult with the Temple Station Watch Commander regarding the circumstances. According to the Department Manual of Policy and Procedures 5-06/110.05, a barricaded suspect is defined as a person who is armed or reasonably believed to be armed with a weapon, explosive, or other destructive device, who occupies a fortified location and resists apprehension violently or by threat of violence. In this case, although the suspect refused to exit her residence, there was no information at the time indicating she was armed, had made threats of violence toward law enforcement, or had fortified the location in a manner that would elevate the situation to meet the criteria for SEB deployment. Based on the totality of circumstances and the information available SEB determined the incident did not meet the deployment criteria outlined in policy.*

Upon entering the room occupied by the suspect, the deputies saw that the suspect had a meat cleaver in one hand and a spray bottle in the other. One of the deputies ordered the suspect to drop the weapon but she did not drop the cleaver. The deputy assigned to use the less-lethal 40 mm foam baton rounds, fired several rounds at the suspect. The rounds had minimal effect, even though the rounds hit her on the right thigh and the center mass of her chest. After being hit by the 40 mm rounds, the suspect moved the cleaver to her right hand and raised it above her shoulder, with the cleaver aimed in the direction of the deputies. At the time, the suspect was less than 5 feet away from the deputies. The deputy assigned to use lethal force fired three rounds at the suspect from his department issued firearm, striking her in the upper torso. Deputies immediately rendered aid, followed by medical assistance from Los Angeles County Fire Department personnel, who were standing by to assist. The suspect was transported to the hospital, where medical staff pronounced her dead. A meat cleaver was recovered from the scene.

Personnel from the Office of Inspector General, IAB, and other LASD units were denied access to the shooting scene. The explanation later given by the Homicide Bureau was that due to the size and layout of the scene, investigators were concerned about the preservation of evidence. Representatives from the District Attorney's Office were permitted entry to the scene. Office of Inspector General staff and IAB personnel should be provided with the same access as District Attorney personnel²

The Sheriff's Department posted a [Critical Incident Review](#) of this incident on its website.

Areas for Further Inquiry:

Was all the information known by the Temple Station communicated to SEB? Should SEB have responded?

² In response to reviewing a draft of this report, the Sheriff's Department noted: *Access to the residence at the shooting scene was restricted due to concerns about evidence preservation in the tight and complex layout. As a result, the Office of Inspector General, Internal Affairs Bureau, and other LASD units were denied entry. However, the Los Angeles County District Attorney's Office was allowed access due to its independent investigative role. JSID's presence was essential for conducting an impartial review of the evidence, as they later determine whether the deputy's use of force was legally justified. Accordingly, their access was necessary and immediate to ensure an independent prosecutorial review, which differs in scope and purpose from internal oversight or administrative investigations.* (This explanation is more disturbing than the exclusion as it demonstrates careful disregard for state law providing for Inspectors General to conduct independent investigations and requiring local law enforcement to cooperate in those investigations. See Government Code sections 25303 and 25303.7 and Penal Code section 13510.8(b)(8)).

Other Shooting

West Hollywood Station: Discharge of Duty Weapon by Suspect – Non-Fatal

On March 29, 2025, at approximately 5:57 p.m., deputies from West Hollywood Station received a domestic violence call. Two single-deputy units were dispatched to the scene and were talking with the victim when they observed the suspect, a 24-year-old Black man across the street. The deputies immediately returned to their patrol vehicles and proceeded to the suspect's location to effectuate an arrest.

While the suspect initially complied with the deputies' instructions, reports indicate that he resisted when one of the deputies attempted to handcuff him. During the altercation, it was alleged that the suspect gained control of the deputy's firearm, which was in its holster, resulting in a discharge. The round struck the suspect, who was subsequently transported to the hospital for treatment of non-life-threatening injuries. Both deputies involved had their body-worn cameras activated at the time of the incident.

Based on interviews of the deputies, the suspect, and video evidence, the Sheriff's Department has determined that this was ***not*** a deputy-involved shooting. The Los Angeles County District Attorney's filed several charges against the suspect including domestic violence, assault, resisting arrest, and taking a firearm from a peace officer. The incident is included in this report due to the media attention garnered at the time.

Areas for Further Inquiry:

How was the suspect able to remove the deputy's gun from his holster?

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.³ For those shootings it investigates, the Homicide Bureau submits the

³ In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. See [A.B. 1506 \(McCarty 2020\)](#) (codified at [Govt. Code § 12525.3](#)). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*. Until the law took effect in 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet.

completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and which occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between January 1 and March 31, 2025, the District Attorney's Office issued one finding on deputy-involved shooting cases involving the Sheriff's Department's employees.⁴

- In the September 4, 2023, non-fatal shooting of Eduardo Villasenor, the District Attorney opined in a [memorandum dated January 29, 2025](#), that Deputy Inzunza reasonably believed that deadly force was necessary to defend against an imminent threat of death or serious bodily injury to himself or others.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.⁵ The DOJ through its Police Practices Section (PPS) [is currently investigating](#) one shooting involving deputies from the Sheriff's Department that occurred in July 2024. During the first quarter of 2025, the DOJ [issued two written reports](#) regarding shootings involving Sheriff's Department deputies.

In addition to determining whether criminal charges should be filed, PPS uses the review process to identify recommendations to modify policies and practices that may reduce the likelihood that officers use deadly force, as well as recommendations to address any other deficiency or concern related to the officers' conduct or the agency's response.

- In its report on the [February 17, 2022 deputy-involved fatal shooting of Pedro Morales Lopez](#), the DOJ opined that the evidence showed that detectives actually and reasonably believed that deadly force was necessary against an imminent threat of death or serious bodily injury to the detectives and others by the actions of defendant Andre M. Mora and that the shooting death of

⁴ The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#). The Office of Inspector General retrieves the information on District Attorney decisions from this webpage. The one shooting referenced in this section is the only decision posted by the District Attorney's Office since the Office of Inspector General's report for the fourth quarter of 2024.

⁵ Gov't Code § 12525.3(b).

Mr. Lopez was inadvertent. As such, there was insufficient evidence to support a criminal prosecution.

- The written report includes the following PPS recommendation:

- **Recommendation One: Body-Worn Cameras Equipment and Policy:**

- The report recommends that the Sheriff's Department issue body-worn cameras (BWCs) to all deputies, including plain clothes deputies, noting that 40 out of 58 counties provide policies for the use of BWCS by plain clothes or non-uniformed deputies. The report also recommends that the Sheriff's Department develop policies on the circumstances in which deputies who are in plain clothes or otherwise not in uniform can and must activate BWCs.⁶
- In its report on the [January 11, 2023 deputy-involved fatal shooting of Christopher Lee](#), the DOJ opined that the evidence showed that the shooting deputy objectively and reasonably believed that the threat of death or great bodily injury was imminent and that she fired her weapon in self-defense. As such, there was insufficient evidence to support a criminal prosecution

- The written report includes the following PPS recommendations:

- **Recommendation One: De-Escalation Policy and Training**

- That the Sheriff's Department expand its de-escalation policy to promote officer safety so that it includes specific guidelines, definition, and examples of potential de-escalation techniques, including a variety of tactics and strategies covering an array of circumstances.
- In addition, that the Sheriff's Department provide its deputies with improved training on de-escalation tactics, techniques, skill, strategies, and approaches for safely and effectively addressing situations without use of force whenever possible. Training should focus on tactical decision-making

⁶ In response to reviewing a draft of this report, the Sheriff's Department noted: *The Department is currently engaged with labor unions (ALADS and PPOA) regarding the use and policies for BWCs for specialized units. This policy will include the Department's Detective Division, which includes plain clothes deputies.*

skills and addressing situations in ways that may minimize the need to use force and/or the amount of severity of force to be used when feasible.

- **Recommendation Two: Policy and Training regarding Identifying and Responding to Individuals with Mental Health Conditions**
 - That Sheriff's Department policies provide deputies with effective guidance and training regarding how to identify people with a mental health condition by considering several factors, including: (1) self-reporting, (2) information provided by witnesses, (3) the agency's and justice system's previous knowledge of the individual, or (4) an officer's direct observations.
 - That the Sheriff's Department provide deputies with effective training on how to interact with people who have mental health conditions, and procedures to follow during these encounters. Deputies should know when and how to contact MET and any other resources available. Strengthening and maintaining deputies' training in this area will instill these core skills in a deputy's practice, which will support safer interactions for all involved.
- **Recommendation Three: Training regarding Conduct following an Officer-Involved Shooting**
 - That the Sheriff's Department provide refresher training on deputy requirements and responsibilities after an officer-involved shooting.
 - That deputies are made to fully understand that they are not to discuss the matter with any member or person other than a supervisor in the very limited manner proscribed by Sheriff's Department policy, or other authorized personnel like the Homicide Bureau Investigator, or the DOJ's Division of Law Enforcement.
 - PPS recommends that LASD provide refresher training on the importance of preserving evidence, and place greater emphasis on preserving evidence in the future.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has nine shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a May 3, 2024, shooting in the jurisdiction of Industry Station. For further information as to that shooting, please refer to the Office of Inspector General's report [Reform and Oversight Efforts: Los Angeles Sheriff's Department – April through June 2024](#). The oldest case that the Homicide Bureau has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent four deputy-involved-shooting cases to the District Attorney's Office for filing consideration.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.⁷

The Sheriff's Department reports that ICIB has 77 active cases. This quarter, ICIB reports sending 10 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 29 cases previously sent from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

⁷ Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 133 new administrative investigations. Of these 133 cases, 42 were assigned to IAB, 55 were designated as unit-level investigations, and 36 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 108 cases were closed by IAB or at the unit level. There are 475 pending administrative investigations, of which 333 are assigned to IAB and the remaining 142 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between January 1 and March 31, 2025, the Civil Service Commission issued final decisions in two cases involving Sheriff's Department employees.⁸ In both cases, the Civil Service Commission sustained the Department's discipline.

One case concerned a sworn peace officer of the rank of deputy or higher and one case concerned a law enforcement technician. Both cases sustained Sheriff's Department decisions, one to discharge a sworn employee, and the other sustained a suspension of 25-days.

Employee Position	Date of Department action	Case number	Department actions	Date Final Decision was adopted	Civil Service decision
Deputy Sheriff	1-23-23	23-32	Discharge	1-22-25	Sustained the Department's decision.
Law Enforcement Technician	7-11-22	22-122	25-day suspension	2-19-25	Sustained the Department's decision

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) 29 times between January 1 and March 31, 2025, as summarized in the

⁸ The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings posted on the County's website](#) for commission publications.

chart below, which reflects data from the Sheriff's Department [Transparency page](#) as of 4-8-25.⁹

DATE	OPERATION TYPE	LOCATION	SUMMARY
1/14/2025	High Risk Tactical Operation	Los Angeles	SEB personnel assisted South Los Angeles Station. The UAS used to locate an armed and barricaded suspect.
1/16/2025	Scene Documentation for Fire-Related Incident	Eaton Fire Burn Area	SEB personnel used UAS to document the scene for investigation purposes.
1/17/2025	Scene Documentation for Fire-Related Incident	Eaton Fire Burn Area	SEB personnel used UAS to document the scene for investigation purposes.
1/24/2025	High Risk Tactical Operation	Lancaster	SEB personnel used UAS to assist Lancaster Station to locate a suspect.
1/27/2025	Search and Rescue	Wrightwood	SEB personnel assisted Homicide Bureau with a critical missing person. The UAS was used but unable to locate the person.
1/28/2025	Search and Rescue	Wrightwood	SEB personnel assisted Homicide Bureau with a critical missing person. Missing person located by airship.
2/5/25	Search and Rescue	Malibu Lost Hills Station	Malibu Lost Hills Station personnel used UAS to search for missing person. Missing person located.
2/5/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/6/2025	Search and Rescue	Malibu	Malibu Lost Hills Station personnel used UAS to search for missing person. Missing person located.
2/6/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/7/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for theft prevention mission.
2/7/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/8/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for theft prevention mission.
2/8/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/9/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/10/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for theft prevention mission.
2/11/2025	Search and Rescue	Malibu	Malibu Lost Hills Station personnel used UAS to search for missing hiker. Hiker located.
2/11/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for theft prevention mission.
2/12/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.

⁹ [MPP5-09/570.10 - Unmanned Aircraft System Procedures](#) requires that the Special Enforcement Bureau (SEB) unit commander notify the executive director of the COC of an authorized or unauthorized UAS use within 48 hours of deployment. In the Office of Inspector General's report for the fourth quarter of 2024, we noted that the COC executive director had not received any notifications since December 2023. In response to our report, the Sheriff's Department determined that it had not been sending the notifications to the COC. Notifications have since resumed and now also include a notification to the Chief Deputy for the Office of Inspector General. The Office of Inspector General requested additional information for instances in which a UAS was used to locate a suspect. To date, that information has not been provided.

DATE	OPERATION TYPE	LOCATION	SUMMARY
2/14/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/14/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for disaster assessment of mud slide area.
2/20/2025	High Risk Theft Prevention	Calabasas	Malibu Lost Hills Station used UAS to search of the area for multiple suspects. Suspects not located.
2/26/2025	Search and Rescue	Glendora	SEB personnel used UAS in a search and rescue operation for a missing person. Person not located.
2/28/2025	Search and Rescue	Malibu	Malibu Lost Hills Station personnel used UAS on a Search and Rescue operation. Person not located.
3/3/2025	Barricaded Suspect	Norwalk	SEB personnel used UAS to locate an armed and barricaded suspect inside the location. Suspect located.
3/7/2025	Barricaded Suspect	Gardena	SEB personnel used UAS to locate an armed and barricaded suspect inside the location. Suspect located.
3/10/2025	Barricaded Suspect	Los Angeles	SEB personnel used UAS to locate an armed and barricaded suspect inside the location. Suspect located.
3/11/2025	Barricaded Suspect	Los Angeles	SEB personnel used UAS to locate an armed and barricaded suspect inside the location. The suspect was not located.
3/17/2025	High Risk Theft Prevention	Malibu	Malibu Lost Hills Station personnel used UAS for theft prevention mission for possible suspects from an unoccupied vehicle. No suspects located.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracking and Documenting Taser Use

Status of Taser Policy Implementation and Training

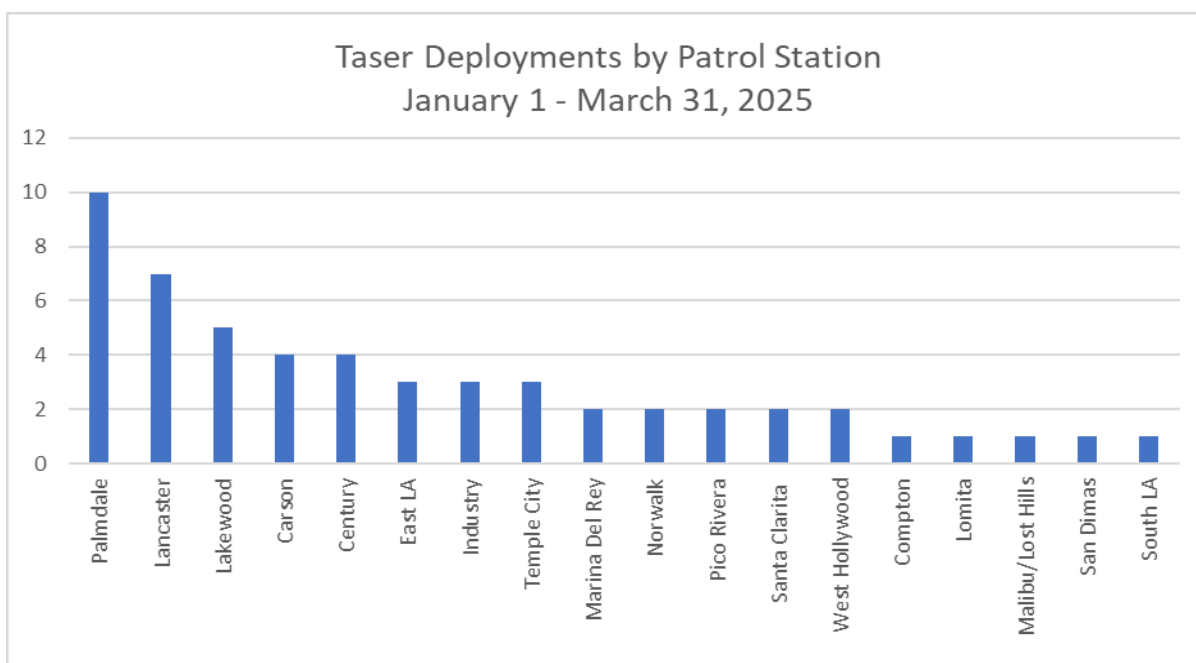
On October 3, 2023, the Board of Supervisors (Board) passed a [motion](#) instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The motion directs the Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.¹⁰

¹⁰ On December 16, 2024, the Office of Inspector General published a detailed analysis of the policy titled Report on the Sheriff's Department's Taser Policy, Training, and Usage. As set forth in that report, the Sheriff's Department purchased 3,197 Taser 10s and conducted its first Taser 10 training class on July 17, 2024. As of the end of December 2024, approximately 1,400 deputies and sergeants in the Patrol Division had attended the 8-hour training course for the Taser 10 and been equipped with Taser 10s; approximately 1,200 of the 1,400 employees trained attended the course during the fourth quarter of 2024.

Tracking Taser Use

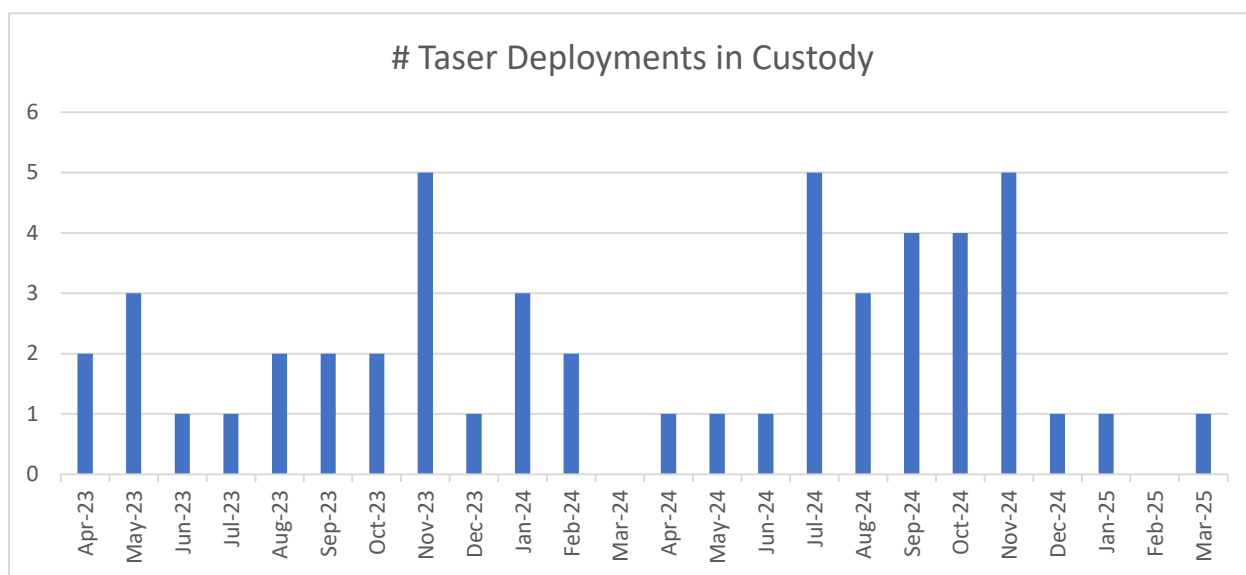
In May 2024, the Sheriff's Department launched a [web dashboard reporting Taser usage](#) occurring on or after April 1, 2024, by patrol station or facility, date, and subject description. Beginning in July 2024, the Department began including in that data the "Result of the Use of Force" (i.e., whether the use resulted in serious injury or death) for all incidents that occurred on or after July 1, 2024.

The following chart reflects the number of Taser Deployments by station between January 1 through March 31, 2025.



Taser Use in Custody

The following chart reflects the number of use-of-force incidents in custodial settings over the past two years in which deputies employed a Taser, according to the *Monthly Force Synopsis* that the Sheriff's Department produces and provides to the Office of Inspector General each month:



Failure to Exercise Due Diligence in Obtaining a Search Warrant

Unreasonable Search and Seizure at a Home Where the Suspect No Longer Resided

In May 2022, Norwalk Station Operation Safe Streets (OSS) detectives prepared a search warrant for a home where a suspect named in their warrant no longer resided.¹¹ At the time of the suspect's arrest, there was evidence that the suspect was living in his vehicle, including that the suspect told the arresting deputies that he was homeless and lived in the car in which he was arrested. Later review supported the conclusion that had the detectives exercised due diligence, including reading the incident report, they likely would have discovered that the suspect did not reside at the address for which the search warrant was sought and issued, and the home had new occupants.¹²

Despite learning that the detectives did not exercise due diligence in confirming the suspect's address and that the checklist for the search warrant was missing the

¹¹ According to the Sheriff's Department's [About Us page for OSS](#), the unit is "responsible for providing suppression, intelligence and expert investigation against criminal street gangs." The OSS Detail description includes that it "investigates high grade felonies of targeted gangs" and "[p]articipates in street gang suppression efforts within assigned OSS team areas."

¹² The terms incident report and arrest report refer to the report detailing the stop and arrest of the suspect and are used interchangeably.

requisite review by a sergeant and a lieutenant, the Sheriff's Department failed to initiate any internal investigation into the actions of the detectives who obtained the search warrant to determine whether any policy violations occurred. Such actions are necessary when formulating corrective actions to avoid the same or similar mistakes in the future.

The Office of Inspector General reviewed the [Claims Board Recommendation](#) for a settlement in the amount of \$200,000 for a federal civil rights lawsuit brought by the residents of the home against the County and the Sheriff's Department alleging an unreasonable search and seizure at their home. The Claims Board Recommendation includes a case summary and a summary corrective action plan. In addition to reviewing the Claims Board documents, we requested and reviewed the search warrant for the plaintiffs' home and the reports relating to the arrest of a suspect who was the subject of the search warrant.

Summary of Suspect's Arrest and Preparation of Search Warrant

On May 18, 2022, at approximately 7:30 p.m., Norwalk Station deputies arrested a suspect for possessing body armor following a vehicle stop. Evidence recovered from the suspect's car led deputies to suspect him of trafficking methamphetamine. The incident report stated that the suspect "appeared as if he was living out of the vehicle, due to having a lot of personal living items inside." Body-worn camera video recorded the suspect telling deputies he was homeless and currently living in his car. However, the arrest report listed a residential address in the city of Norwalk as the suspect's residence.

Detectives from the Operation Safe Streets Bureau drafted a search warrant for the Norwalk residence. To verify the suspect's address as noted in the arrest report, they relied on outdated information from the Department of Motor Vehicles (last updated in 2021) and an address the suspect previously provided to the Department of Probation. The Sheriff's Department reported that at the time, both the incident report and the body-worn video from the arrest, which included the suspect's statements about being homeless and living out of the car, were not yet available for review. No explanation as to why the detectives didn't wait for the information from the arrest to be available was given.

According to a search warrant checklist prepared by the Department's Records and Identification Bureau, the detectives did not take additional steps to confirm the suspect's residence. They failed to check postal or utility records, recent parking tickets, or conduct surveillance of the home before drafting the warrant, all of which are common steps employed by law enforcement officers prior to requesting judicial

authorization for a search warrant. There is also no indication that the detectives made any attempt to speak with the arresting deputies to determine if they had additional information as to the suspect's address, a reasonable step given that the detectives did not review the incident report. The checklist has a place for a signature for Sergeant Review of the warrant prior to Judicial signing for accuracy and nexus, and a place for Lieutenant review prior to service. There is no signature by a sergeant, or a lieutenant as appears to be required.¹³

Execution of Search Warrant

As a result of the failures to conduct a diligent investigation into the suspect's address, the detectives did not discover that the suspect no longer lived at the location specified in the search warrant, as he stated to the arresting deputies at the time of arrest, and that a family with a young child had moved in. Deputies had no evidence linking the family living in the residence to the suspect, or to any illegal activity.

Deputies executed the search warrant at approximately 2:00 a.m. on May 19, 2022, less than eight hours after the suspect's arrest. Body-worn camera video shows the search team breaking down the door and escorting the couple from their home. The couple told deputies they had lived at the residence for about six months and did not know the suspect. The pregnant mother informed deputies that her young child, described in the summary corrective action plan as a baby, was still inside; the detective did bring the child from the house to the mother. After speaking with the couple, deputies chose not to search the home and left the scene.

¹³ In response to reviewing a draft of this report, the Sheriff's Department provided a criminal history for the suspect that shows the date generated as 9/26/23, which is more than a year after the execution of the warrant. The Department also noted that the subject provided this address at the time of booking. From a review of the documents, it cannot be determined that the suspect gave this address. It is true that this address is noted on the booking form, but it is not known whether the suspect provided this information, or the arresting officers used the last known address on the suspect's criminal history or some other source, such as a driver's license. The Department further noted, based on the criminal history printout from September of 2023, that (1) *Probation had last verified the address on 4/25/2022 (less than one month prior to the incident);* (2) *CCHRS still showed the same address on 7/6/2022 (less than two months after the date of the incident);* (3) *DMV records were not updated with a new address until 9/11/2023;* and (4) *Detectives are required to use three nexuses to an address, and four were used for the warrant in this case.* One of the four nexuses used was that the suspect gave that address without noting that the suspect also stated he was living in his car.

Sheriff's Department Review of the Search Warrant Preparation and Execution

Following the lawsuit by the residents of the home, the Sheriff's Department reviewed the process of obtaining and executing the search warrant. In the recommended corrective actions, the memo notes that:

This incident was thoroughly reviewed by representatives from Operation Safe Streets Bureau. The review concluded the Detectives were working within the guidelines of what is expected from personnel assigned to Operations Safe Streets Bureau and the Los Angeles County Sheriff's Department.

While the recommended corrective action stated that the detectives worked within Department guidelines and expectations, the plan goes on to note:

In the days following the incident, all teams at Operation Safe Streets Bureau were briefed on the importance of finding a solid nexus to a location for a search warrant using at least three current sources.

These two statements are at odds with each other. If the detectives operated within Sheriff's Department guidelines, there would be no reason to brief personnel on the importance of using at least three current sources for a suspect's nexus to a location, a process that the detectives may not have undertaken, as the checklist does not indicate whether the records checked showed a nexus between the suspect and the search warrant location.¹⁴ Ensuring that there is a nexus is likely the reason for the requirement on the checklist that a sergeant sign off not only as to the accuracy of the warrant but also the suspect's nexus to the location and that a lieutenant review and sign off on the warrant prior to service. The checklist for this search warrant lacks both the required signatures. There is no mention in the summary corrective action plan that the checklist lacked the required review. The failure of the detectives to obtain the requisite approval alone, even absent their other failures, should have resulted in an administrative review. An administrative review was warranted, as was a summary corrective action plan that acknowledged the failures of the detectives.

The summary corrective action plan also fails to address any reason for rushing to search the location such that there was not time to wait for the completion of the

¹⁴ As noted in a previous footnote, the Sheriff's Department reports the detectives used four nexuses to link the suspect with the address.

incident report for the detectives to review. Absent an imminent threat to law enforcement officers or public safety, a review of the incident report should be a minimum requirement for detectives to affirm under oath the information in an application for a search warrant. The Office of Inspector General recommends that the Sheriff's Department emphasize that the affiants for a search warrant application sufficiently evaluate all available information rather than rely on an arbitrary number of nexus points as sufficient.

Sheriff's Department's Policies for Cooperating with Federal Immigration Authorities

Background

On January 20, 2025, President Donald Trump issued the proclamation titled *Guaranteeing the States Protection Against Invasion* with its stated goal of "suspending the physical entry of aliens involved in an invasion into the United States across the southern border until I [the President] determine that the invasion has concluded."¹⁵ On January 23, 2025, the Acting Secretary of the Department of Homeland Security followed that directive with an order *Finding of Mass Influx of Aliens* in which the Acting Secretary declared that under Title 28 of the Code of Federal Regulations, he can "request assistance from a State or local government in the administration of the immigration laws of the United States" to enforce the President's orders.¹⁶

Even before the issuing of the proclamation and order, the Board passed a motion, [*Increasing Support for Los Angeles County Immigrants*](#), in November 2024, after President Trump's election. The motion includes an affirmation that all County departments will comply with the California Values Act, which "ensures that no local resources are used to assist federal immigration enforcement." In the months since these directives went into effect, local and state officials and immigration advocates continue to express concerns over the possibility that the federal government will enlist local law enforcement to assist with enforcement of federal immigration laws.

The Office of Inspector General reached out to the Sheriff's Department to inquire as to the status of its policies on immigration-related issues and whether any policy revisions

¹⁵ [United States President, *Proclamation Guaranteeing the States Protection Against Invasion, 2025, Proclamation 10888 of January 20, 2025*, Federal Registrar 90 FR 8333.](#)

¹⁶ [United States Acting Secretary of Homeland Security, *Finding of Mass Influx of Aliens, January 29, 2025, Federal Registrar 90 FR 8399*](#). The *Finding* was set to expire on March 29, 2025. The Secretary of Homeland Security extended the *Finding* on March 21, 2025, and it is set to expire 180 days from that date.

are anticipated in response to the federal government directives or possible requests for assistance with immigration enforcement. The Department's representatives stated they are engaging in regular discussions with County Counsel to make sure they are following the appropriate local, state, and federal laws and regulations. As of this report, the Department informed us that it has not changed any of its existing policies or practices relating to immigration enforcement. Recently, the Department re-briefed its personnel on several of the Department's immigration policies to remind personnel how they should conduct themselves in these matters.

Immigration and Custom Enforcement Agents in Custody Facilities

In 2017, under President Trump's first term, the Los Angeles County Board of Supervisors requested the Office of Inspector General to review, analyze, and make recommendations regarding Sheriff's Department policies as they relate to immigration issues. From 2017 to 2020, the Office of Inspector General issued several reports on the matter.¹⁷ By 2020, the Department had made significant changes to its level of cooperation with ICE. In 2018, Immigration and Custom Enforcement (ICE) agents were physically present and had access to custodial facilities; by 2020, the Department had not only removed ICE from its facilities but also stopped notifying ICE about when inmates were about to be released.

In the years since, the Department has continued to receive ICE detainees.¹⁸ The Sheriff's Department's Custody Division Manual, section 4-06/005.05, *Immigration and Customs Detainer Notification*, explicitly forbids ICE agents from having access to any custodial facilities or station jails to conduct civil immigration enforcement. The policy includes that "[t]he Department shall not transfer inmates into the custody of the United States Immigration and Customs Enforcement (ICE) based solely on a civil immigration detainer." ICE must have a judicial order or criminal warrant before the Department will release an inmate into ICE custody. If an inmate posts a bail or bond, and has an ICE detainer, the detainer will not be used as a reason to refuse the bond or bail or delay the

¹⁷ See [Immigration: Public Safety and Public Trust](#) (October 2017); [First Report Back on the Sheriff's Department's Adherence to Policies Regarding Cooperation with Immigration Authorities](#) (June 2018); [Second Report Back – Sheriff's Adherence to Policies Regarding Cooperation with Immigration Authorities](#) (November 2018); [Inspector General's Monitoring of Los Angeles County Sheriff's Department's Cooperation with Immigration Authorities](#) (February 2019); and [Report Back on Truth Act Forum – LASD Inmate Locator System and Public Access to Inmate Release Information](#) (December 2019).

¹⁸ A detainer is a request from ICE asking federal, state or local law enforcement agencies to do one of two things: to alert ICE before the agency releases an individual, or a request that the agency hold the individual for up to 48 hours beyond the time they would be released to give the Department of Homeland Security time to assume custody of the individual.

release of the inmate. If the Department receives an ICE detainer for an inmate, the inmate will be given a copy of that detainer and verbally notified about the Department's policy concerning transfer to ICE custody.

The Department generally receives two types of ICE detainers, *I-247 A* and *I-247 G*. *I-247 G* are detainers requesting for advance notification of release of a person, and *I-247 A* are titled *Immigration Detainer – Notice of Action*, which requires the Department to hold the individual so ICE can take the person directly from Sheriff's Department custody into ICE custody. As to the *I-247 G* detainers, the Department does not process those but keeps the requests for statistical purposes. For *I-247 A* detainers, these are served on the subject person and recorded and tracked for statistical purposes only. The Department emphasized that regardless of which detainer it receives, it makes no notification to ICE. On its [website](#), the Department publishes the number of ICE requests it receives, and the number of inmates it transfers to ICE. For the year-to-date, as of April 11, 2025, the Department had received 163 ICE detainers. The Department reports it has transferred no inmates to ICE pursuant to a civil detainer.¹⁹

Immigration Inquiries

The Department's Manual of Policies and Procedure, section 5-09/271.00, *Immigration Inquiries and Notifications*, states Department personnel are prohibited from inquiring about anyone's immigration status, this includes persons who are being investigated for criminal activity, unless that information is absolutely necessary for the investigation.²⁰ The Department also prohibits asking witnesses and victims about their place of birth, unless it is again necessary to investigate the crime.²¹ During the booking and fingerprinting process, the Department is required to ask arrestees about their place of

¹⁹ SB 54, or as it is commonly known, the *California Values Act* limits the cooperation between local law enforcement agencies and ICE. Under its provision, local law enforcement can only transfer inmates to ICE custody if the inmates have committed one of the delineated crimes. Qualifying crimes include if the inmate has committed a serious and/or violent felony under state law, is on the Sex and/or Arson Registry, or if has a judicial criminal warrant for violating federal criminal immigration law.

²⁰ This language mirrors the language found in SB 54.

²¹ [Field Operations Support Services Newsletter, 18-06 Immigration Policies, Protocols, and Procedures](#), Los Angeles Sheriff's Department.

birth and country of citizenship as the Live Scan digital fingerprinting system requires the information and is governed by rules that are outside the Department's control.²²

The Los Angeles County Regional Identification System (LACRIS) oversees the Live Scan and manages the identification of individuals booked in Los Angeles County. LACRIS requires information as to the booked suspect's place of birth and citizenship. LACRIS needs this information because the California Department of Justice requires that all Live Scans include such details. The California Department of Justice forwards this information to the Federal Bureau of Investigation.

Additionally, United States' treaties with foreign countries require the Sheriff's Department to obtain information regarding an arrestee's place of birth and citizenship. Under the terms of the treaties, the United States is required to notify foreign countries when a foreign national from a country has been detained or arrested in the United States. For these reasons, the Sheriff's Department requires that an arrestee provide place of birth and citizenship information during the Live Scan fingerprinting process.

Outstanding Requests to the Sheriff's Department

The Office of Inspector General made the following requests for information to the Sheriff's Department for which responses are still outstanding:

- A February 7, 2025 request for additional information on the deployment of Unmanned Aircraft System (UAS) to search for suspects, including any crime reports, investigatory reports, and warrants relating to the UAS deployment.
- An April 10, 2025 request for the number of deputies investigated by the Sheriff's Department for possible violations of MPP section 3-01/050.82 and the number of deputies investigated by the Sheriff's Department for possible violations of MPP section 3-01/050.83.

²² Recently, the Los Angeles Times published an [article](#) stating the Los Angeles Police Department (LAPD) "has also stopped its previous practice of recording a suspect's place of birth during fingerprinting and uploading that info to an FBI database, which immigration authorities can access." The Office of Inspector General sought to corroborate this information, as it appeared to contradict the Sheriff's Department's position that it was required to ask a suspect about their place of birth during the booking process. We reached out to LAPD's Office of Inspector General, who directed us to LAPD's recent February 2025 [report](#) to the Los Angeles Board of Police Commissioners. In the report, under the section titled "2025 Los Angeles Police Department Federal Immigration Enforcement Frequently Asked Question," it states, "[a]n officer, however, may ask for and record an individual's place of birth if the person is arrested for a criminal offense. This is required to process the arrestee for a criminal offense, comply with consular notification requirements, investigate a crime, or otherwise comply with the law." This practice is identical to the above-described practices of the Sheriff's Department, and contradictory to the quote an unnamed source provided to the Los Angeles Times.

- An April 18, 2025 request for additional materials responsive to a subpoena duces tecum that included request for all documents and information relating to any Sheriff's Department surveillance of any County oversight officials; this follow up request was made after it came to the OIG's attention that surveillance of a County oversight official was conducted but information relating to that surveillance, including notes and an audio digital tape of an interview, were not provided. The subpoena duces tecum was served on October 1, 2024.

CUSTODY DIVISION

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide humane conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.²³

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.²⁴ According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of March 31, 2025, the total population of people in custody in the Los Angeles County jails was 12,255. As of December 31, 2024, the total population of people in custody in the Los Angeles County jails was 11,846.

The table below shows the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center – East (PDC-East), Pitchess Detention Center – North (PDC-North), Pitchess Detention Center – South (PDC-South), and North County Correctional Facility

²³ See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

²⁴ The total rated capacity is determined by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the pandemic, understaffing, or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

(NCCF) on the last day of the previous four quarters. On these dates, three facilities (MCJ, PDC-North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity.

Facility	BSCC Capacity	Facility Count			
		6/30/24	9/30/24	12/31/2024	3/31/2025
MCJ	3512	3572	3698	3850	3793
TTCF	2432	2378	2378	2350	2314
CRDF	1708	1255	1371	1341	1418
PDC-East	926	12	20	10	11
PDC-North	830	1286	1276	1221	1286
PDC-South	782	663	633	462	423
NCCF	2214	2775	2718	2612	3010

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a [motion](#) requesting the Sheriff's Department and directing the Office of Inspector General, Sybil Brand Commission, and the Sheriff Civilian Oversight Commission to review and report back on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation, and directing the Office of Inspector General to include status on the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice.²⁵

The Board also requested that the Sheriff's Department collaborate with Correctional Health Services (CHS) to develop a policy that would ensure accessibility and availability of menstrual products for incarcerated individuals with mental health needs. In its initial [report back](#) to the Board, staff from the Office of Inspector General determined that the Sheriff's Department and CHS had taken measures to ensure that

²⁵ See [Pen. Code, § 4023.5\(a\)](#). ("A person confined in a local detention facility shall be allowed to continue to use materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the incarcerated person."); [Cal. Code Regs., tit 15, § 1265](#). ("Each menstruating person shall be provided with sanitary napkins, panty liners, and tampons as requested with no maximum allowance."); Los Angeles County Sheriff's Department, Custody Division Manual, [§ 6-15/010.00 Inmate Clothing, Bedding, and Personal Hygiene](#). ("All menstruating inmates shall have ready access to sanitary napkins, panty liners, and tampons."); Los Angeles County Sheriff's Department, Custody Division Unit Orders, [§ 5-16-040 Distribution of Personal Care Items](#). ("Each menstruating inmate housed at CRDF shall be provided with sanitary napkins, panty liners, and tampons. All feminine hygiene products shall be readily available in a common space within each module or pod setting."); [Pen. Code, § 3409\(a\)](#). ("A person incarcerated...who menstruates or experiences uterine or vaginal bleeding shall, without needing to request, have ready access to, and be allowed to use, materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the person.").

menstrual products were accessible and available for individuals in high observation housing²⁶ units, including those under suicide precautions.

In March and April 2025, Office of Inspector General staff re-examined the availability and accessibility of menstrual products in high observation housing units, including the Forensic Inpatient (FIP) Stepdown program housing units, at Century Regional Detention Facility (CRDF).²⁷ This inquiry included a review of Sheriff's Department policies, and conversations with CRDF leadership, custody and CHS personnel, and people in custody.

Restrictions on property. In high observation housing units, where people require a higher level of mental health care and may have property restrictions due to mental health conditions, custody personnel report providing menstrual products as requested and needed. As previously reported, while there is no general restriction on menstrual products for people in custody who have mental health conditions, in certain circumstances limitations on products may be necessary for certain individuals, such as those under suicide precautions, to ensure their own safety.

Property restrictions apply to all individuals newly placed in high observation housing or those under suicide precautions.²⁸ Department policy requires a mental health professional conduct a clinical assessment within 24 hours of initial placement, and as needed thereafter, to determine whether property restrictions are still required.²⁹ When restrictions are imposed, an "Allowable Inmate Property" sign listing allowable property is generated and placed on the incarcerated individual's cell door.³⁰ A mental health clinician will update or reaffirm any restrictions following each subsequent evaluation and notify custody personnel, who are responsible for replacing any new or updated signs and for providing individuals with their allowable property.

²⁶ See Los Angeles County Sheriff's Department, Custody Division Manual, [§ 5-01/050.10, Housing for Mentally Ill Inmates](#). ("Level of Care P3 - Significant impairment. Generally requires high observation housing (HOH) in jail with mental health supervision.")

²⁷ Staff from the Office of Inspector General visited modules 1200 (comprised of two high observation housing units and two FIP Stepdown program housing units), 1300 (comprised of four FIP Stepdown program housing units), and 2200, 2300, and 2400 (comprised of four high observation housing units, respectively).

²⁸ See Custody Division Manual, [§ 5-01/050.15, Property Restrictions for Mentally Ill Inmates](#). ("Upon initial placement in High Observation Housing (HOH), except when transferred directly from Forensic Inpatient (FIP), inmates shall be provided only suicide-resistant blankets, gowns, and approved mattresses, unless otherwise specified, as determined and documented by a Jail Mental Health Services (JMHS) clinician.")

²⁹ Custody Division Manual, [§ 5-01/050.15, Property Restrictions for Mentally Ill Inmates](#). ("Within 24 hours of initial placement in HOH, a clinician will make recommendations regarding allowable property based upon an individual clinical assessment (Refer to JMHS policy 70.7 Suicide Prevention).")

³⁰ Custody Division Manual, [§ 5-01/050.15, Property Restrictions for Mentally Ill Inmates](#).

The Sheriff's Department's policy on allowable property includes sanitary napkins, tampons, and panty liners.³¹ Custody personnel report it is highly uncommon for individuals in high observation housing to have restrictions on menstrual products. Even those under suicide precautions are generally allowed to have menstrual products unless the items present a specific risk of self-harm. Restrictions are determined on a case-by-case basis. For example, tampons may be restricted for an individual who has previously attempted to ingest them. Similarly, pads may be restricted for someone who has used them to obstruct custody or CHS personnel's view into their cell.

Accessing menstrual products. In high observation housing units, custody personnel manage the distribution of menstrual products by either handling this task themselves or assigning it to incarcerated workers also known as "trustees." In the FIP Stepdown program housing units, this responsibility is assigned to Mental Health Assistants.³²

All high observation housing units, except for the FIP Stepdown program housing units, have clear plastic bags filled with menstrual products tied to stair railings in common areas on the upper and lower tiers. As previously reported, individuals in these units do not have access to the common areas for most of the day and are generally cuffed when they leave their cell – for example, when they are escorted to shower or when they are escorted to the day room, where they remain handcuffed. As a result, they generally must request menstrual products. Those in the FIP Stepdown program housing units have access to the common areas for longer periods of time and are uncuffed. In these housing units, menstrual products are readily available and accessible in cardboard boxes set out in common areas.

Types and amounts of menstrual products supplied. The supply of tampons and sanitary pads provided in common areas was ample and consistent across high observation housing units and the FIP Stepdown program housing units. While the supply of panty liners varied by housing unit, every unit had at least some inventory. Custody personnel and trustees report that requests for panty liners are infrequent, but they ensure availability by putting out a supply and maintaining an inventory in supply closets.

People in high observation housing units continue to report varying experiences regarding the availability and accessibility of menstrual products. Those who have encountered issues have identified problems such as being instructed to wait and

³¹ See Los Angeles County Sheriff's Department, Custody Division Manual, [§ 5-06/010.10, Allowable Inmate Property - Female Inmates](#).

³² The FIP Stepdown program in the Los Angeles County Jails employs "volunteer, specially-trained, Mental Health Assistants who are incarcerated and live in the modules and care for and mentor patients and assist them in acclimating to the less restrictive environment in the modules." See Board motion, [Supporting the Expansion of FIP Stepdown and HOH Dorm Units in the Los Angeles County Jails](#) (June 27, 2023).

experiencing delays in receiving products. Custody personnel in turn point to operational constraints, and report providing an ample supply of products when distributed to the person to alleviate potential future delays.

Suicide prevention gowns. While the Department does not have a blanket prohibition on providing menstrual products to individuals under suicide precautions, those who are required to wear suicide prevention gowns are unable to affix pads to the existing gowns.³³

With input from CHS, CRDF leadership decided to purchase [suicide prevention jumpsuits](#) with a middle lining that would allow menstruating people under suicide precautions to affix pads to the jumpsuit. Following procurement, the facility will pilot the distribution of the jumpsuits to evaluate their use prior to full implementation and before developing or updating existing policy. Piloting the distribution of the suicide prevention jumpsuits will involve briefing custody personnel and assessing any operational challenges that may arise.

Recommendations. As reported in the Office of Inspector General's initial [report back](#) to the Board, the Sheriff's Department and CHS have not yet developed a policy or updated existing policy to address the accessibility and availability of menstrual products for people with mental health needs. The Office of Inspector General continues to recommend that until such a policy change is implemented, the Sheriff's Department and CHS should document the protocols currently in place for providing menstrual products to this population, and additionally, the protocols for providing suicide prevention jumpsuits to those who need them.³⁴ When a policy is developed or updated, the Department should make it clear that menstrual products are not automatically restricted for those who are placed in high observation housing units or under suicide precautions. The protocols and policy should ensure the dignity of menstruating individuals in custody while also maintaining facility security and the safety of the people in custody.

³³ See Los Angeles County Sheriff's Department, Custody Division Manual, [§ 5-01/050.00 Handling of Suicidal Inmates](#).

³⁴ Currently, CHS informs custody personnel of those who require a suicide prevention gown, and custody personnel are responsible for helping the individual change into the gown.

Commissary Prices

On July 9, 2024, the Board passed a [motion](#) directing the Sheriff's Department to report back on measures taken to ensure commissary prices for people in the Los Angeles County Jails, especially for food, drinks, and hygiene items, are not excessive but remain comparable with prices for groceries and other retail outlets.

In January 2024 the County prepared a [Request for Proposals for Inmate and Commissary and Vending Services](#) (RFP No. 525-SH). The timetable in the RFP provided that proposals were due on May 10, 2024. The RFP was on presented at the [Public Safety Cluster Agenda Review on May 14, 2025](#). The only proposal submitted was from the current vendor, Keefe Commissary Network, LLC.

In-Custody Deaths

Between January 1 and March 31, 2025, 15 people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for 11 deaths: five natural, five accident, and one suicide. For the remaining four deaths, the DME findings remain deferred.³⁵ Four people died at MCJ, one person died at CRDF, one died at the transportation compound, and nine people died at hospitals after being transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a [dedicated page on Inmate In-Custody Deaths on its website](#).³⁶

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews for each of the 15 in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

³⁵ In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and Correctional Health Services use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

³⁶ [Penal Code § 10008](#) requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

Date of Death: January 10, 2025

*Custodial Status: Sentenced.*³⁷

People in custody alerted Court Services Transportation Bureau (CSTB) staff to multiple “man downs” on a transportation bus in the CSTB secured bus compound. Custody staff, CHS staff, and paramedics rendered emergency aid to three individuals. Custody staff and CHS staff administered six doses of Narcan to one person. This person died at the scene. Areas of concern include not searching people in custody prior to being transported to the IRC for Courtline, placement and maintenance of the Automated External Defibrillators (AEDs), custody staff not escorting medical staff to the scene as is common practice, and lack of access to Addiction Medicine Services (AMS) for people with heightened security levels. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as an accident, and the cause of death as heroin toxicity.

Date of Death: January 14, 2025

Custodial Status: Sentenced

Custody staff at MCJ were alerted to a “man down” and found a person unresponsive in a multi-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered six doses of Narcan. The person died at the scene. Areas of concern include the availability of Narcan in the housing unit, and staff failing to adhere to wristband count procedures. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as an accident, and the cause of death as combined effects of methamphetamine and fentanyl.

Date of Death: January 15, 2025

Custodial Status: Sentenced

Custody staff at MCJ found a person in a single-person cell unresponsive during a Title 15 safety check. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered five doses of Narcan. The person died at the scene. The preliminary cause of death according to the hospital is urine positive for methamphetamine, an enlarged heart, and left ventricular hypertrophy. The DME website currently reflects the manner of death as an accident, and the cause of death as fentanyl and methamphetamine toxicity.

³⁷ For the purposes of custodial status, “Pre-trial” indicates that the person is in custody awaiting arraignment, hearing, or trial. “Convicted, Pre-sentencing” indicates that the person is being held in custody based on a conviction, pending sentencing, on at least some charges, even if they are in pre-trial proceedings on other charges. “Sentenced” indicates that the person is being held on the basis of a sentence on at least some charges, even if they are in pre-trial proceedings on other charges.

Date of Death: January 19, 2025

Custodial Status: Pre-trial

Custody staff at TTCF found a person in a single-person cell unresponsive during a Title 15 safety check. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered three doses of Narcan. The person was transported to Los Angeles General Medical Center (LAGMC) for a higher level of care. Despite efforts by hospital staff, the person died. Areas of concern include the use of the handheld radios during medical emergencies, the handcuffing of incarcerated individuals experiencing a medical emergency, and limited direct line of sight resulting from the custody staff workstation layout. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as natural, and the cause of death as dilated cardiomyopathy.

Date of Death: January 21, 2025

Custodial Status: Pre-trial

On January 20, 2025, a person in custody who was exhibiting signs of distress was transported from the Inmate Reception Center (IRC) to LAGMC for a higher level of care. On January 21, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include the quality and timeliness of Title 15 safety checks. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as an accident, and the cause of death is methamphetamine toxicity.

Date of Death: January 27, 2025

Custodial Status: Pre-trial

CHS staff at CRDF found a person in a two-person cell unresponsive during a mental health check. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff administered three doses of Narcan. The person died at the scene. Areas of concern include the quality of Title 15 safety checks and an inoperable cell light. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as an accident, and the cause of death is effects of methamphetamine.

Date of Death: February 2, 2025

Custodial Status: Sentenced

On February 2, 2025, a person in custody was found unresponsive in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid. The person died at the scene. Areas of concern include the quality of Title 15 safety checks, a delay in rendering emergency aid, and inadequate mental health follow-up. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as suicide, and the cause of death as sharp force injuries of neck.

Date of Death: February 13, 2025

Custodial Status: Sentenced

On January 11, 2025, a person in custody who was exhibiting signs of distress was transported from the Correctional Treatment Center (CTC) to White Memorial Medical Center for a higher level of care. Despite efforts by hospital staff, the person died. The preliminary cause of death according to the hospital is cardiopulmonary arrest due to congestive heart failure and pneumonia. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: February 19, 2025

Custodial Status: Pre-trial

On February 3, 2025, a person in custody was transferred from the CTC to LAGMC for a higher level of care. On February 19, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include follow-up medical care, adherence to procedures for hospital returnees, and appropriateness of medical care. The preliminary cause of death according to the hospital is respiratory failure, due to pneumonia and septic shock. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: March 9, 2025

Custodial Status: Pre-trial

On March 3, 2025, a person in custody who was exhibiting signs of distress was transported from MCJ to LAGMC for a higher level of care. On March 9, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include the quality of Title 15 safety checks, missed court proceedings due to transportation issues, and CHS staff did not communicate Narcan deployment to custody staff. The preliminary cause of death according to the hospital is cardiac arrest due to kidney failure due to diabetes mellitus. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: March 18, 2025

Custodial Status: Pre-trial

On March 12, 2025, a person in custody was transferred from the CTC to LAGMC for a higher level of care. On March 18, 2025, the person died while receiving medical treatment. The preliminary cause of death according to the hospital is cardiopulmonary arrest due to myxedema coma. The DME website currently reflects the manner of death as natural, and the cause of death as hypertensive atherosclerotic cardiovascular disease.

Date of Death: March 21, 2025

Custodial Status: Sentenced

On February 14, 2025, a person in custody was transported from the CTC to LAGMC for a medical appointment. On March 21, 2025, the person died at the hospital while receiving medical treatment. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death as metastatic biliary adenocarcinoma.

Date of Death: March 30, 2025

Custodial Status: Pre-trial

On March 30, 2025, custody staff at MCJ found a person unresponsive in a single-person cell during a Title 15 safety check. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as natural, and the cause of death as pneumonia.

Date of Death: March 30, 2025

Custodial Status: Sentenced

On March 14, 2025, a person in custody was transported from MCJ to LAGMC due to complications from a possible overdose. On March 30, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include the arresting agency's handling of healthcare issues, missed mental health follow-up appointments, not conducting a dorm search following a possible overdose, and failure to document critical incident in electronic Uniform Daily Activity Log. The preliminary cause of death according to the hospital is renal failure due to septic shock. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: March 30, 2025

Custodial Status: Pre-trial

On March 16, 2025, a person in custody was transported from MCJ to LAGMC for a higher level of care. On March 30, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include a missed medical appointment due to wheelchair transportation issues. The DME website currently reflects the manner of death as natural, and the cause of death as lung cancer.

Other Death

On March 11, 2025, Santa Clarita Valley Station deputies responded to a business disturbance call and placed the suspect under arrest. Upon arrival at the hospital for medical clearance, the suspect suffered a medical emergency. Despite efforts by

hospital staff, the person died. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff's Department to "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the Office of Inspector General," and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections." The Board also directed the Office of Inspector General to report quarterly on the Sheriff's Department's progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody overdose deaths.

Of the 15 people who died in the care and custody of the Sheriff's Department between January 1 and March 31, 2025, the medical examiner's final reports, including toxicology assessments, confirm that five people died due to an accidental overdose. Toxicology results remain pending for four of the 15 deaths and may indicate additional overdose deaths once completed.

Tracking Narcotics Intervention Efforts

Since the Office of Inspector General's last quarterly report, all jail facilities reported searching random people in custody prior to transporting them to court line at the Inmate Reception Center (IRC).³⁸ The Sheriff's Department decided not to implement a division-wide search plan. Instead, the Sheriff's Department left the decision to search people prior to transport to court line to the discretion of each jail facility. Thus, this practice varies across jail facilities.³⁹ As described in previous reports, the Sheriff's Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to

³⁸ Court line is the holding area where people going to court are held prior to being transported and where they are held upon their return before going back to their assigned housing location.

³⁹ Men's Central Jail is the only facility that has created a search plan. The plan outlines a monthly schedule of designated housing locations where randomly selected people are supposed to be searched prior to being transported to court line.

evaluate the efficacy of drug detection intervention. Instead, the Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Sheriff's Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Sheriff's Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

Improving Searches of Staff and Civilians

The Board's second directive required that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails]." The Sheriff's Department previously reported that its current policy grants the Sheriff's Department broad authority to search staff and civilians entering the jails, so that no changes to existing policy are required to implement more comprehensive searches. The Sheriff's Department previously reported that it implemented more frequent unannounced and randomized staff searches beginning in May 2024.

Despite the policy granting broad authority to search staff and civilians and the Board's motion supporting searches "beyond visual inspections," the Sheriff's Department does not employ body searches via body-scanner or pat-down. All searches of staff and civilians entering the jail are visual: deputies look inside see-through backpacks and cases.

The comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table below details the staff-search practices at all jail facilities from January 1 to March 31, 2025. The data regarding the number of staff searches and searches with K9 illustrated in the table was supplied by Custody Support Services Bureau (CSSB). CSSB extracted the data on staff and contractor searches from the Custody Watch Commander's Log on April 3, 2025. The Office of Inspector General was unable to verify the data provided by CSSB without additional information.

	Number of Staff Searches	Number of Staff Searches with K9	Monthly Minimum Search Requirement ⁴⁰	Search Inside Security	Search Evasion Concerns	Where Searches Logged
Facility	Q1	Q1				
MCJ	116	22	Unable to Determine ⁴¹	No	Yes	Watch Commander Log
TTCF	77	6	No ⁴²	Yes	Yes	Watch Commander Log
IRC	27	2	Unable to Determine ⁴³	No	Yes	Watch Commander Log
CRDF	21	2	No ⁴⁴	No	Yes	Watch Commander Log
NCCF	116	7	No ⁴⁵	Yes	Yes	Watch Commander Log
PDC-North	35	2	Unable to Determine ⁴⁶	Yes	Yes	Watch Commander Log
PDC-South	38	4	Yes ⁴⁷	Yes	Yes	Watch Commander Log

⁴⁰ Each jail facility's unit order regarding staff searches was used to determine whether it met its minimum search requirement by month. Where the unit order is silent regarding the minimum search requirement, the OIG was unable to determine if the requirement was met. Also, the jail facility must meet the minimum search requirement during each of the three months in the quarter in order to be in compliance.

⁴¹ Los Angeles County Sheriff's Department, Custody Division Unit Orders, [§ 3-08-021 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁴² TTCF did not meet its minimum search requirement in January. Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-08-010 Security of Personal Property](#). ("Watch commander shall ensure a minimum of two random searches are conducted each week of persons entering the secured area during their assigned shift").

⁴³ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 5-23/006.00 Security and Searches of Person Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁴⁴ CRDF did not meet its minimum search requirement in January and March 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-01-090 Searches of sworn Personnel, Custody Assistants, Professional Staff and their personal property-Approved by CSS 3/11/2024 ("The searches shall be conducted a minimum of once per week, per shift. [unit order obtained via email message]).

⁴⁵ NCCF did not meet its minimum search requirement for January 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 07-145/10 Personal Property Searches](#). ("A minimum of four (4) random searches per shift per week of any personnel and/or official visitors shall be conducted at the discretion of the watch sergeant.").

⁴⁶ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-06-010 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁴⁷ Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-02-080 Searches of Sworn Personnel, Custody Assistants, Professional Staff and Their Property on the Facility. ("The searches shall be conducted at a minimum of once per week, per shift.")

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the first quarter of 2025, Office of Inspector General personnel completed 122 site visits, totaling 361 monitoring hours, at IRC, TTCF, CRDF, MCJ, Pitchess Detention Center North, PDC South, and NCCF.

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 143 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 155 monitoring hours related to uses of force, in-custody deaths, COVID-19 policies and protocols, Prison Rape Elimination Act (PREA) compliance, and general conditions of confinement.

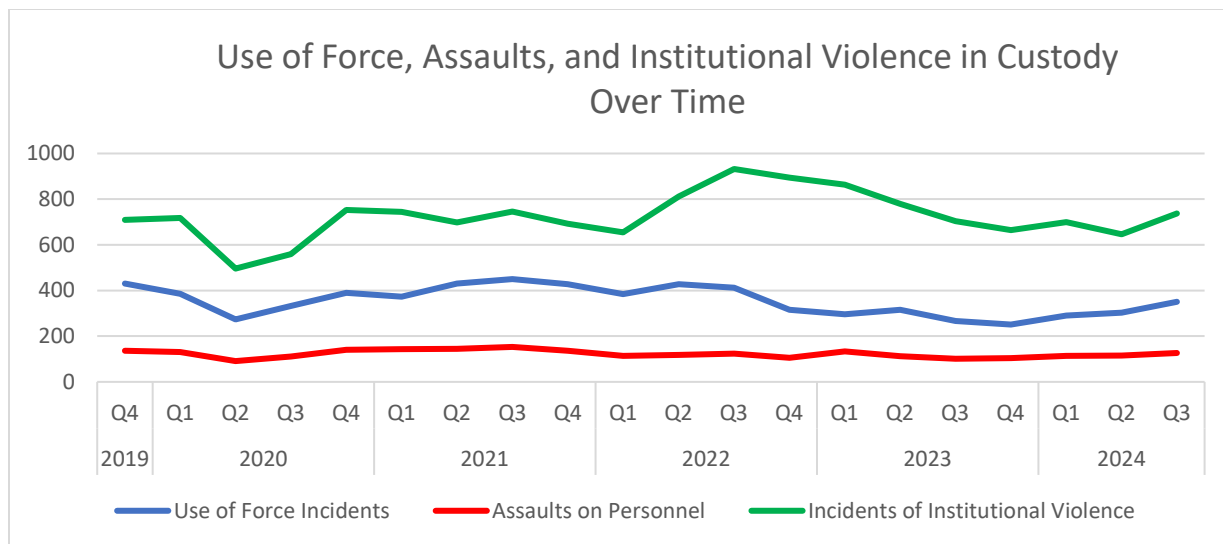
Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.⁴⁸ The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people in its custody.⁴⁹

		Use of Force Incidents	Assaults on Personnel	Incidents of Institutional Violence
2019	4 th Quarter	431	136	709
2020	1 st Quarter	386	131	717
	2 nd Quarter	274	91	496
	3 rd Quarter	333	111	560
	4 th Quarter	390	140	753
2021	1 st Quarter	373	143	745
	2 nd Quarter	430	145	698
	3 rd Quarter	450	153	746
	4 th Quarter	428	136	693
2022	1 st Quarter	384	114	654
	2 nd Quarter	428	118	811
	3 rd Quarter	412	124	932
	4 th Quarter	316	106	894
2023	1 st Quarter	296	133	863
	2 nd Quarter	316	112	779
	3 rd Quarter	266	101	704
	4 th Quarter	251	104	665
2024	1 st Quarter	291	114	700
	2 nd Quarter	303	115	646
	3 rd Quarter	350	127	737

⁴⁸ Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

⁴⁹ This chart includes only those quarters for which the data has been verified for accuracy by the Sheriff's Department. When data is adjusted by the Department, this chart is updated for previous quarters with the new information.



HANDLING OF GRIEVANCES AND COMMENTS

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received two hundred and fifteen new complaints in the first quarter of 2025 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

One hundred and ninety-six of these grievances were related to conditions of confinement within the Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	91
Personnel Issues	16
Living Condition	12
Food	11
Mail	8
Classification	7
Transportation	7
Property	5
Dental	5

Bedding	5
Showers	5
Education	4
Commissary	3
Mental Health	1
Telephones	1
Visiting	1
Other	14
Total	196

Nineteen complaints were related to civilian contacts with Department personnel by persons who were not in custody, as shown in the chart below:

Complaint/Incident Classification	Totals
Personnel	
Discourtesy	5
Improper Tactics	4
Neglect of Duty	2
Off Duty Conduct	2
Force	1
Service	
Policy Procedures	2
Traffic Citation	1
Response Time	1
Other	1
Total	19

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 77 iPads installed in jail facilities: 40 at TTCF; 12 at MCJ; and 25 at CRDF. During the first quarter there were no new installations or iPad replacements. There were 134,431 automated responses provided to people in custody using the iPad application to request information.

The Sheriff's Department continues to experience malfunctioning iPads and has identified power source problems as the major cause. Facility Services Bureau (FSB) was able to install a dedicated power source to limited areas within MCJ and TTCF. The Department found that the Wi-Fi connection was weak and inconsistent. The Department reports that after further discussions with FSB, it was decided that direct

power and data sources would yield better results if installed simultaneously. FSB started the project at TTCF in early September and is still pending completion. Custody Support Services Bureau – Correctional Innovative Technology Unity (CITU) acquired two new MacBooks to assist with reconfiguring and programming the iPads. Apple administrator problems have resurfaced preventing the completion of necessary software and program updates. The Department states that once the FSB project is completed at TTCF, the reconfiguring and programming of the iPads will be readdressed.

As [previously reported](#), the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in custody.⁵⁰ The Sheriff's Department reports that between January 1 and March 31, 2025, no one in custody had been placed on restrictive filing and it therefore did not reject any grievances under this policy.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.⁵¹ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and

⁵⁰ See Los Angeles County Sheriff's Department, Custody Division Manual, § 8-04/050.00, [Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges](#).

⁵¹ See [Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, Department Service Reviews](#).

- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.⁵²

The following chart lists the number and types of comments reported for each station or unit.⁵³

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
ADM : GEN POPL ADM HQ	0	1	0
AER : AERO BUREAU	0	0	1
ALD : ALTADENA STN	2	1	1
AVA : AVALON STN	0	1	0
CAF : COMM & FLEET MGMT BUR	1	0	0
CEN : CENTURY STN	3	8	4
CER : CERRITOS STN	3	2	2
CIS : CUSTODY INVESTIGATIVE SERVICES	0	1	0
CMB : CIVIL MANAGEMENT BUREAU	4	2	1
CNT : COURT SERVICES CENTRAL	1	3	1
COM : COMPTON STN	0	6	2
CRD : CENTURY REG DETEN FAC	1	0	0
CRV : CRESCENTA VALLEY STN	1	2	0
CSB : COUNTY SERVICES BUREAU	1	2	0
CSN : CARSON STN	1	6	2
CST : COURT SERVICES TRANSPORTATION	0	2	0
ELA : EAST LA STN	4	2	0
EOB : EMERGENCY OPER BUREAU	4	0	0
EST : COURT SERVICES EAST	0	3	0
FS : FISCAL ADMIN	0	1	0
HOM : HOMICIDE BUREAU	1	0	1
IND : INDUSTRY STN	5	3	1
IRC : INMATE RECEPTION CENTER	2	2	0

⁵² It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

⁵³ The chart reflects data from the Sheriff's Department Performance Recording and Monitoring System current as of April 7, 2025.

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
LCS : LANCASTER STN	11	11 ⁵⁴	2
LKD : LAKEWOOD STN	3	7	1
LMT : LOMITA STN	6	0	1
MAR : MARINA DEL REY STN	4	5	2
MCB : MAJOR CRIMES BUREAU	1	0	0
MLH : MALIBU/LOST HILLS STN	11	6	0
NAR : NARCOTICS BUREAU	2	0	0
NCF : NORTH CO. CORRECTL FAC	1	1	0
NWK : NORWALK REGIONAL STN	4	4	0
OCP : OFFICE OF CONSTITUTIONAL POLICING HQ	0	1	0
OSS : OPERATION SAFE STREETS BUREAU	2	2	0
PKB : PARKS BUREAU	2	0	0
PLM : PALMDALE STN	10	24	5
PRV : PICO RIVERA STN	2	3	2
RMB : RISK MANAGEMENT BUREAU	0	1	0
SCV : SANTA CLARITA VALLEY STN	11	12	3
SDM : SAN DIMAS STN	1	6	1
SIB : SHERIFF INFORMATION BUREAU	0	1	0
SLA : SOUTH LOS ANGELES STATION	0	5	0
SO : PITCHESS SOUTH FACILITY	0	1	0
SSB : SCIENTIFIC SERV BUREAU	1	0	0
TEM : TEMPLE CITY STN	8	4	4
TSB : TRANSIT SERVICES BUREAU	1	2	1
TT : TWIN TOWERS	1	2	0
WAL : WALNUT/SAN DIMAS STN	6	5	3
WHD : WEST HOLLYWOOD STN	2	14	2
WST : COURT SERVICES WEST	0	2	0
Total :	124	169	43

⁵⁴ PRMS shows 13 personnel complaints for Lancaster Station. Two of these complaints were generated by an internal Sheriff's Department audit, meaning that there were 11 personnel complaints as noted.



Office of Inspector General County of Los Angeles

Reform and Oversight Efforts: Los Angeles County Sheriff's Department

April through June 2025

Issued August 26, 2025

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between January 1 and March 31, 2025, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- Improving the Treatment of Family Members of Individuals Killed or Seriously Injured by Sheriff's Deputies
- Sheriff's Department's Policies Cooperation with Federal Immigration Authorities
- Compliance with the Settlement Agreement in *Johnson v. Los Angeles Sheriff's Department* for People in Custody with Mobility Impairments
- Jail Employment Opportunities at Century Regional Detention Facility

During the second quarter of 2025, the Office of Inspector General issued the following reports relating to the Sheriff's Department:

- [Request for Information: COC Deputy Gangs-Recommendation No. 19](#)
- [Inspector General's Ninth Implementation Status Report - *Johnson v. Los Angeles County Sheriff's Department*](#)

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. During this quarter, there were two incidents in which people were shot or shot at by Sheriff's Department personnel. Two people were fatally struck by deputies' gunfire. The Office of Inspector General staff responded to each of these deputy-involved shootings. As communicated in a [memorandum to the Board of Supervisors dated June 11, 2025](#), the Office of Inspector General suspended regular rollouts to deputy-involved shootings.

The information in the following shooting summaries is based on the limited information provided by the Sheriff's Department and is preliminary in nature. While the Office of

Inspector General receives information at the walk-through at the scene of the shooting, receives preliminary memoranda with summaries, and attends the Sheriff's Department Critical Incident Reviews, the statements of the deputies and witnesses are not provided until the Sheriff's Department completes its investigation. The Sheriff's Department permits the Office of Inspector General's staff limited access to monitor the ongoing investigations of deputy-involved shootings. The Sheriff's Department also [maintains a page on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.

Lancaster Station: Hit Shooting – Fatal

On June 7, 2025, at approximately 7:07 p.m., deputies from the Lancaster Station responded to an armed robbery, with a gun, in the 1200 block of Meadow View Circle in the city of Lancaster. One responding deputy saw a 31-year-old Hispanic man who matched the description of the robbery suspect in the 1000 block of West Avenue J-12. The deputy detained the suspect at gunpoint while waiting for back-up deputies to arrive. The suspect was not cooperative and failed to follow commands. Two deputies approached the suspect and attempted to physically detain him, at which point a struggle ensued. During the struggle, the deputies observed that the suspect was armed with a handgun. A third deputy on scene deployed a taser and the suspect then shot the deputy who initially detained him at gunpoint. When the suspect opened fire, the three deputies responded by returning fire. The suspect also pointed the gun at another deputy during the altercation.

Three deputies fired 9, 11, and 15 rounds respectively, striking the suspect.

The deputy who was hit by the suspect's gunfire was transported to the hospital and had emergency surgery. The deputy is expected to recover.

The deputies rendered aid to the suspect prior to the arrival of Los Angeles County Fire Department personnel. The suspect was pronounced dead at the scene.

A loaded handgun was recovered at the scene. It was later determined that the suspect was not involved in the robbery.

After the Sheriff's Department Homicide investigators completed their preliminary investigation, Office of Inspector General, the Sheriff's Department Internal Affairs Bureau (IAB), and District Attorney staff on scene were briefed by Homicide investigators and escorted from the command post to the crime scene where they were permitted to view the scene from a few car lengths away.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with audio from a 911 caller, video from deputies' body-worn cameras, and civilian cell phone video.

Areas for Further Inquiry

Was the approach to the suspect tactically sound and consistent with best practices?

Century Station: Hit Shooting – Fatal

On June 9, 2025, at approximately 12:32 a.m., Century Station deputies responded to a residential burglary in progress in the 3300 Block of Los Flores Boulevard in the city of Lynwood.

Two family members were able to flee from the house to a neighbor's house next door. The neighbor called 911 and stated that there was a man armed with a knife still inside breaking items. The family members told arriving deputies that there was an elderly woman still in the house.

The deputies approached the home from alongside the driveway where they could see inside through the kitchen window. As they looked in, deputies saw a 45-year-old, Hispanic man holding what looked to them like a pair of scissors. Deputies told the suspect to drop the scissors; he refused and went to another part of the house. The deputies then used a Public Announcement system in an unsuccessful attempt to have the man exit the house. The deputies formulated a tactical plan to rescue the victim inside by breaking and entering through a bedroom window. Soon after they shattered the bedroom window, deputies heard the victim inside screaming and one deputy saw the suspect stabbing the woman.

Deputies then forced entry through a side door and saw the suspect on his knees stabbing the victim in a hallway, at which time one of the deputies fired 11 rounds at the suspect, striking him numerous times.

Once the victim was moved to safety, deputies rendered medical aid, including CPR, to the suspect while waiting for Los Angeles County Fire Department personnel to respond. The suspect was transported to the hospital where he later died. The victim's injuries were not life threatening, and no deputies were injured. A knife with an approximate 7-inch blade and scissors were recovered from the scene.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with audio from a 911 caller and video from deputies' body-worn cameras.

After the Sheriff's Department Homicide investigators completed their preliminary investigation, Office of Inspector General, IAB, and District Attorney staff on scene were briefed by the investigators and escorted from the command post to the residence where the crime took place. During the briefing, members of the three offices remained outside of the home, along the sidewalk and driveway, and were not permitted to enter the residence where the shooting took place.

Areas for Further Inquiry

Was the time delay between the deputies' arrival and the time they entered the residence reasonable under the circumstances? Was there any consideration given to requesting a Special Enforcement Bureau (SEB) and or Mental Health Evaluation Team (MET) to respond to the location?

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.¹ For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and which occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between April 1 and June 30, 2025, the District Attorney's Office posted memoranda on its website for four findings on deputy-involved shooting cases involving the Sheriff's Department's employees.² The District Attorney's Office declined to file charges in each case, as they determined that use of force was not unlawful. The memoranda may be found on the [District Attorney's website page for Officer-Involved Shootings](#). The following are the deputy-involved shootings posted:

- The March 5, 2020, non-fatal shooting of Jesse Allan Janto and Non-hit shooting of Dain Edward Sanderson by Deputies Matthew Bistline, David Chavez-Cruz, Andrew De La Rosa, Jonathan Livingston, Collin Reddy, Ryan Thompson and Sergeant Jason Howell.
- The June 5, 2022, fatal shooting of Ricky Jimenez by Deputies Dany Soto, Joshua Bueso, Travis Long, and Josef Schirmeister.

¹ In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. See [A.B. 1506 \(McCarty 2020\)](#) (codified at [Govt. Code § 12525.3](#)). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*. Until the law took effect in 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet.

² The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#). The Office of Inspector General retrieves the information on District Attorney decisions from this webpage. Two of the listed cases were posted on the website within the second quarter of 2025, are dated during the first quarter of 2025.

- The June 22, 2023, non-fatal shooting of Jesus Cerda by Deputy Taylor May.
- The September 2, 2022, fatal shooting of Rushdee Anderson by Deputies Justin Sabatine and Meshawn Telemaque.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (CA-DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.³ CA-DOJ [is not currently investigating](#) any shootings involving deputies from the Sheriff's Department. During the second quarter of 2025, DOJ [issued no written reports](#) regarding shootings involving Sheriff's Department deputies.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has eight shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a July 20, 2024 shooting in the jurisdiction of West Hollywood Station. For further information as to that shooting, please refer to the Office of Inspector General's report [Reform and Oversight Efforts: Los Angeles Sheriff's Department - July through September 2024](#). The oldest case that the Homicide Bureau has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent three deputy-involved-shooting cases to the District Attorney's Office for filing consideration.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.⁴

³ Government Code § 12525.3(b).

⁴ Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

The Sheriff's Department reports that ICIB has 77 active cases. This quarter, ICIB reports sending 12 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 27 cases previously sent from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 130 new administrative investigations. Of these 130 cases, 50 were assigned to IAB, 41 were designated as unit-level investigations, and 39 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 108 cases were closed by IAB or at the unit level. There are 470 pending administrative investigations, of which 338 are assigned to IAB and the remaining 132 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between April 1 and June 30, 2025, the Civil Service Commission issued final decisions in nine cases involving Sheriff's Department employees. In these nine cases, the Civil Service Commission sustained the Department's discipline in eight cases and overruled the Department in one case. The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings](#) posted on the County's website for commission publications.

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) 27 times between April 1 and June 30, 2025.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracking and Documenting Taser Use

Status of Taser Policy Implementation and Training

On October 3, 2023, the Board of Supervisors (Board) passed a [motion](#) instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The motion directs the Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.

The Sheriff's Department reported the following information regarding training and policy implementation to date:

- Out of the 3,197 Taser 10s purchased by the Department as part of Phase I of the Taser 10 implementation plan, 2,686 Department members have been trained and issued a Taser 10. These members are primarily patrol personnel but also include personnel from Major Crimes Bureau, Operation Safe Streets, Special Enforcement Bureau, and Civil Management Bureau. There are 511 Taser 10s still available to assign to deputies once they are trained. Because the number of patrol deputies is in flux, there may be more Taser 10s than deputies in need of training.
- Deputies are generally trained on the Taser 10 only if they are issued one.
- According to the Weapons Training Unit (WTU), a list of approved CEWs is currently being created.⁵ This list will be maintained by the Tactics and Survival Unit (TAS) and posted on the TAS SharePoint site once the data is compiled.
- Per the Body-Worn Camera (BWC) Unit, approximately 3,000 CEWs (excluding the Taser 10) are currently out of warranty, with only about 50 still under warranty.

⁵ The Sheriff's Department refers to Tasers by the generic name, Conducted Energy Weapons, abbreviated as CEW. The term Taser and CEW are used interchangeably in this report.

- The following CEWs are currently still approved for use:
 - M26 (legacy model – currently being phased out)
 - X26 (currently being phased out)
 - X26P (currently being phased out)
 - Taser 7 (currently being phased out)
 - Taser 10
- All Department personnel may also purchase a Department-approved CEW for off-duty use, as specified in the Manual of Policy and Procedure (MPP) [section 5-06/045.10](#).
- For personnel assigned to the Custody Division, Custody Division Manual (CDM) section [7-08/030.00](#) allows personnel to purchase a CEW for on-duty use in custody, which “may be carried only after the approval of the unit commander, inspection by CTSB and successful completion of the Department’s TASER training program.” This policy also requires that the CEW be available for computer download at the request of a supervisor.⁶ The Department reports that [Custody Division, Custody Operations Directive 22-005, Updated Procedures for the Use of the Conducted Energy Weapon \(CEW\)](#), is the operative policy, superseding the relevant section of the CDM. Per this directive, Department personnel may only carry Department authorized CEWs whether on or off duty and may only carry personally owned CEWs with approval of their unit commander and after inspection by CTSB, which is consistent with the CDM. We recommend that the CDM be revised to ensure compliance with this directive and, if not immediately revised, that a reference to Custody Operations Directive 22-005 be referenced in CDM 7-08/030.00 as soon as possible.
- [MPP sections 5-06/045.00](#) through [05-06/045.14](#) are in effect and apply to all patrol personnel, including those issued a Taser 10.⁷
- Custody Division is not equipped with the Taser 10. [CDM section 7-08/030.00](#) is specific to personnel assigned to Custody Division.
- Court Services Division is also not equipped with the Taser 10. [Court Services Division Manual section 1-04/030.00](#) applies specifically to personnel assigned to Court Services Division.

⁶ CTSB is the initialism for Custody Training and Standards Bureau.

⁷ CEW policies are in the Department’s MPP in [Volume 5, Chapter 6](#).

Tracking Taser Use

In May 2024, the Sheriff's Department launched a [web dashboard reporting Taser usage](#) by date range with options to narrow the results by practice area (such as Patrol or Custody), patrol station or facility, incident type, or city. Beginning in July 2024, the Department began including in that data the "Result of the Use of Force" (i.e., whether the use resulted in serious injury or death).

Semi-Annual Report on Implementation of the Family Assistance Program

The Los Angeles County Board of Supervisors [established the Family Assistance Program](#) (Family Assistance), first in 2019 as a one-year pilot, that it later made permanent, with the aim of improving compassionate communication and providing trauma-informed support to families of those who died following a fatal use of force by a Sheriff's Department employee or while in the custody of the Sheriff's Department. The Office of Inspector General reports semi-annually on Family Assistance in its quarterly reports on the Sheriff's Department.

Family Assistance Status

The Family Assistance Program is administered by the Office of Violence Prevention (OVP) within the Department of Public Health (DPH). OVP has a webpage with an [overview of Family Assistance](#) with links to the Family Assistance [brochure in English](#) and [in Spanish](#) and to the [Family Assistance Application Form](#).

After review by the Contracts and Grants Division of DPH, OVP reports that OVP and the Los Angeles County Medical Examiner (DME) have finalized and executed the Memorandum of Understanding (MOU) that outlines the roles and responsibilities of the two Psychiatric Social Workers (PSW) IIs that are working onsite at DME, including the process for next-of-kin notifications and the process for families to claim the decedent's personal effects and property.

OVP also drafted and finalized the Family Assistance protocols that, as previously reported, were formed in collaboration with the multidisciplinary work group that meets monthly to discuss program design and implementation, protocols, eligibility criteria, and reviews cases. The work group includes representatives from the Sheriff's Department, DME, the Office of Inspector General, the Sheriff Civilian Oversight Commission (COC), Los Angeles County District Attorney Office, DMH, Los Angeles County Correctional Health Services, and Los Angeles Office of the County Counsel.

The Family Assistance Program annual report has also been drafted and shared with the work group. OVP anticipates the report will be ready to publish in August 2025.

Family Assistance Service Data

OVP reports that from January 1, 2025, to June 30, 2025, a total of 30 families experienced the death of a loved one through a fatal use of force by a Sheriff's deputy or while in the custody of the Sheriff's Department. Out of the 30 deaths, 25 individuals lost their lives while in custody at a Sheriff's Department facility and 5 died due to a fatal use of force by a Sheriff's deputy. The Sheriff's Department also reported to OVP 1 death due to a fatal use of force by South Gate Police Department because the Sheriff's Department Homicide Bureau assisted South Gate with the investigation.

For the 31 families referred to Family Assistance, 26 were engaged and received at least one type of support service (crisis intervention, grief counseling, financial assistance, case management, advocacy, and referrals to additional resources). Four families did not respond to outreach attempts to engage them in the available services, and 1 family could not be reached as no next of kin was located. OVP distributed burial expense assistance to 25 families, with costs ranging from \$1,415 to \$7,500. The total amount of burial assistance disbursed was \$144,249.00. We reiterate the recommendation by DPH that the County align the burial expense limit with the state's California Crime Victim Compensation Board limit, which would raise the limit from \$7,500 to \$12,818.

Improving the Treatment of Family Members of Individuals Killed or Seriously Injured by Sheriff's Deputies

On February 16, 2024, AB 3021 was introduced in the California Assembly.⁸ The bill aimed to provide family members of individuals who are killed or seriously injured by law enforcement certain rights during the investigation of such incidents. While the bill failed to pass, the requirements of the bill are good policy for law enforcement agencies.

The California Penal Code, as well as the Model Rules of Professional Conduct, require attorneys and investigators to disclose information to witnesses, including the interviewer's name and whether they represent a party in the legal matter, before conducting such interviews.⁹ AB 3021 would have added a section to the California Penal Code requiring a law enforcement officer or investigator conducting an interview to identify themselves by their full name, present identification, state the name of their employing agency (for example, Sheriff's Department, District Attorney's Office), and to disclose whether the interviewer represents or is retained by the prosecution.¹⁰

⁸ [AB-3021 Criminal procedure: interrogations](#) (2023-2024).

⁹ [California Code, PEN 1054.8](#); [Rule 4.3: Dealing with Unrepresented Person](#).

¹⁰ [AB-3021 Criminal procedure: interrogations \(2023-2024\) Bill Text](#).

Additionally, the proposed legislation required that the interviewer clearly inform a family member of the deceased or severely injured person that they are not being detained, may leave at any time, that anything they said or did could be used as evidence against them in civil or criminal court, that they have the right to remain silent, the right to refuse to be recorded, photographed, or searched, and the right to speak with a trusted person first and/or have them present during the interview.¹¹

The proposed legislation importantly also required the interviewer explain to the family member that they have the right to ask about the status of their relative who was killed or seriously injured prior to any questioning, and regardless of whether they choose to be interviewed.¹²

The introduction of AB 3021 was based upon concerns about the techniques law enforcement agencies employ to obtain information from families while protecting peace officers from potential civil and criminal actions resulting from deaths or serious injuries caused by law enforcement. Advocates of the legislation highlighted stories from families whose loved ones were killed by law enforcement and, when questioned, police provided them with false and/or misleading information in order to obtain statements from them concerning their loved ones that were later used to justify law enforcement's conduct leading to the death.¹³ In 2016, for example, a mentally ill teenage boy was killed by law enforcement and when questioning the father about his son's history and behavior, law enforcement never disclosed the son had been killed, even as the father asked about what would happen to his son in juvenile court.¹⁴

As reported by the Los Angeles Times, lawyers specializing in police misconduct cases describe these types of misleading and traumatizing tactics as routine across the country, where peace officers question family members to collect disparaging information about their loved one in an attempt to justify any force used and avoid civil and criminal liability.¹⁵ Meanwhile, those being interviewed are left in the dark about the purpose of the interview and the role of the interviewer, may have no idea their relative has been killed or seriously injured by law enforcement, and may inadvertently provide information to law enforcement that is used to justify police misconduct.

In the Office of Inspector General's report on permanent support for Family Assistance, we reported that "[s]ome families reported that in their interactions with the Sheriff's

¹¹ *Id.*

¹² *Id.*

¹³ [Assemblymember Kalra's Bill to Protect Grieving Families in Police Interrogations Moves Forward | Official Website - Assemblymember Ash Kalra Representing the 25th California Assembly District](#)

¹⁴ Brian Howey, [After police killings, families are kept in the dark and grilled for information](#), Los Angeles Times (March 28, 2023).

¹⁵ *Id.*

Department, they felt that the Sheriff's Department had predetermined that their deceased loved ones were guilty of crimes and treated families like 'co-conspirators.'"¹⁶ We also noted that the Department of Mental Health (DMH) reported that Sheriff's Department next-of-kin notifications were sometimes not made in a manner sensitive to grieving families. As a result, we recommended that the initial death notification be made by Family Assistance representatives or trained Department of Medical Examiner (DME) social workers.

In fact, the primary reason that Family Assistance Program was implemented by the County is to acknowledge that families of those killed by Sheriff's Deputies suffer trauma regardless of whether the Sheriff's Department is legally liable. The shift to initially notifying the next of kin to the DMH's Office of Violence Prevention or trained DME social workers, recognized that contact by members of the same department as the deputy who shot their loved one or were responsible for their care in custody causes additional trauma, especially if investigators use the notification as a means to gather information about the deceased.

Better policing practices include law enforcement agencies implementing policies without being forced to by state law. The requirements of AB 3021 are sound policies that improve Sheriff's Department communications with the public, including the families of those who are killed or seriously injured by Department members. These families routinely comment at Civilian Oversight Commission meetings about their treatment by Sheriff's Department personnel. Adopting as policy the requirements of the proposed legislation will likely result in more trauma-informed treatment of family members. The Office of Inspector General recommends that the Sheriff's Department implement a policy that provides the safeguards proposed by AB 3021.

Sheriff's Department's Cooperation with Federal Immigration Authorities

In 2017, during President Trump's first term, the Los Angeles County Board of Supervisors requested the Office of Inspector General to review, analyze, and make recommendations regarding the Sheriff's Department's policies as they relate to

¹⁶ [*Semi-Annual Report on Implementation of the Family Assistance Program and Report Back on Permanent Support for Families Affected by the Los Angeles County Sheriff's Department; Identifying Sustainable Funding For and Streamlining the Family Assistance Program*](#) (February 22, 2022).

immigration issues. From 2017 to 2020, the Office of Inspector General issued several reports on the matter.¹⁷

In our recent reporting on the Sheriff's Department's current immigration policies, the Office of Inspector General noted outdated policies in the Sheriff's Department Manual of Policy and Procedure. After bringing the outdated policies to the Department's attention, the Department reviewed them, determined that the policies should have been rescinded, and has since redacted the policies from departmental manuals.¹⁸ In addition to deleting these outdated policies, the Department re-briefed all personnel on the Department's current policies on immigration enforcement.

While the Sheriff's Department has policies that limit cooperation with federal authorities on immigration enforcement, data collected by the Sheriff's Department is sometimes unintentionally transferred to the federal government and such data may have the effect of assisting immigration authorities without the intent to do so. As discussed in a previous report, Live Scan data that includes a person's country of birth and other identifying information is collected by the Sheriff's Department at booking and then shared with the federal government by CA-DOJ, which requires the information.¹⁹

Like other policing agencies, the Sheriff's Department collects information from automatic license plate readers. While state law prohibits the sharing of this information with the federal government, there remain public concerns that the information from the license plate reader database may end up in the hands of federal agencies.²⁰ Below is a discussion of the use of license plate readers, California law on the prohibition of sharing the information, and the Department's policies on license plate readers that are relevant to their possible use by federal agencies.

¹⁷ See [Immigration: Public Safety and Public Trust](#) (October 2017); [First Report Back on the Sheriff's Department's Adherence to Policies Regarding Cooperation with Immigration Authorities](#) (June 2018); [Second Report Back – Sheriff's Adherence to Policies Regarding Cooperation with Immigration Authorities](#) (November 2018); [Inspector General's Monitoring of Los Angeles County Sheriff's Department's Cooperation with Immigration Authorities](#) (February 2019); and [Report Back on Truth Act Forum – LASD Inmate Locater System and Public Access to Inmate Release Information](#) (December 2019).

¹⁸ The following sections have been rescinded from the Sheriff's Department's policies: Manual of Policy and Procedures (MPP) section 4-01/090.35 "Immigration Law Violations," and FOSS Newsletter 19-03, "Immigration and Customs Enforcement Agents, Detainers, and Station Jails."

¹⁹ See the section on *The Sheriff's Department's Policies for Cooperating with Federal Immigration Authorities* in our report [Reform and Oversight Efforts: Los Angeles County Sheriff's Department – January to March 2025](#) (May 2025). The Sheriff's Department reports that it abides by its policies and state law on cooperating with federal immigration enforcement. We are not aware of any cooperation by the Sheriff's Department with the federal government that violates either state law or the Department's policies.

²⁰ A recent article in the Los Angeles Times discussed the use of technology by the Los Angeles Police Department. See Libor Jany, [How ICE is using the LAPD to track down immigrants for deportation](#), Los Angeles Times (July 30, 2025).

License Plate Readers

What Are License Plate Readers and How Do They Work

Automated license plate readers (ALPR) systems were first developed in 1976 by the United Kingdom as a tool to combat terrorism.²¹ As the name implies, these systems use cameras to capture and identify vehicle license plate information. ALPR cameras can be installed in fixed locations – such as traffic lights, buildings, or light poles – or mounted on police cars, making them mobile and capable of scanning plates while in motion. Once an image is captured, it is uploaded to a database where additional information can be extracted, including the vehicle’s make and model, as well as the exact location, date and time the image was taken.

The ALPR system works by comparing captured license plate images to “hotlists” created by law enforcement agencies. These hotlists contain information about vehicles of interest, such as those associated with criminal activity. For example, in a kidnapping case, investigators may issue a description of a suspect’s car, which would then be added to the hotlist. If that vehicle passes by a fixed ALPR camera or police car equipped with ALPR, the system automatically alerts law enforcement agents to its location, thereby, allowing law enforcement to quickly locate and detain the suspect.

The use of ALPR technology has expanded rapidly across the United States. A 2013 Department of Justice study found that nearly 77% of police agencies serving populations over 100,000 utilize the technology and that number has likely increased in the years since.²² This technology is not limited to use by law enforcement. In recent years private retailers such as Home Depot, and others, have purchased and installed ALPR systems on their premises.²³ When, and if, they choose to do so, these businesses can share the data collected by their private ALPR cameras with law enforcement agencies, further extending the reach of the technology.

Laws Governing ALPRs

Federal law is silent when it comes to the use of ALPRs. However, there are some U.S. Department of Justice (US-DOJ) policies that offer guidance on the broader framework for how such technologies may be employed. The US-DOJ’s publication entitled [Guidance for Federal Law Enforcement Agencies Regarding the Use of Race,](#)

²¹ Robert Spinks, “[What You Need to Know about Automatic License Plate Readers,](#)” *American Police Beat* (October 20, 2023).

²² [Ford School News, “Automated License Plate Readers Widely Used, Subject to Abuse,” University of Michigan \(February 22, 2023\).](#)

²³ [Jordan Elder, “San Antonio retailers turning to license plate readers to help curb theft,” Fox San Antonio \(September 11, 2023\); https://www.homedepot.com/privacy/privacy-and-security-statement#ALPR.](#)

[*Ethnicity, Gender, National Origin, Religion, Sexual Orientation, or Gender Identity*](#), provides some guidance.²⁴ As summarized on Congress.Gov, Justice Department policy includes the following prohibition:

‘federal law enforcement personnel may not consider race, ethnicity, gender, national origin, religion, sexual orientation, gender identity, or disability in law enforcement or intelligence activities.’²⁵

However, there are exceptions to this policy that include violations of federal immigration or customs law. The federal government can use race, ethnicity, or national origin when it utilizes the data in an ALPR system if the information is trustworthy, is context and content specific (e.g. the information contains specifics such as time frame, method, locality, or purpose), the characteristic-based information is specific to a violation of federal immigration or customs law, and the action is reasonably merited by the totality of the circumstances.²⁶ These standards also apply to technological tools like the ALPR systems that are used by law enforcement. Such exceptions are of concern when large datasets are accessed by the federal government.

In 2016, California passed Senate Bill 34 (SB 34), which defines what ALPR systems are, outlines how law enforcement may use the technology, and sets guidelines on who can and cannot access the data captured by the cameras. This bill is codified under [California Civil Code sections 1798.90.5 through 1798.90.55](#). As it pertains to sharing of the information gathered, SB 34 allows only the sharing of information with a “public agency,” which is defined in Civil Code section 1798.90.5(f) as “the state, any city, county, or city and county, or any agency or political subdivision of the state or a city, county, or city and county. The federal government is therefore not a public agency as defined by SB 34 and thus is not an entity with which ALPR information may be shared. An Information Bulletin issued by the California Department of Justice in October 2023 provides: “SB 34 does not permit California [law enforcement agencies (LEAs)] to share ALPR information with private entities or out-of-state or federal agencies, including out-of-state and federal law enforcement agencies. This prohibition applies to ALPR

²⁴ When accessing this publication, which was last published in May 2023, the first page of the document notes: “This is archived content from the U.S. Department of Justice website. The information here may be outdated and links no longer function.” It is therefore possible that the current administration does not prohibit the use of these characteristics in exercising enforcement of federal immigration laws.

²⁵ [Finklea, Kristin, “Law Enforcement and Technology: Use of Automated License Plate Readers,” Congressional Research Service \(August 19, 2024\).](#)

²⁶ [Guidance for Federal Law Enforcement Agencies Regarding the Use of Race, Ethnicity, Gender, National Origin, Religion, Sexual Orientation, or Gender Identity](#) (May 2023), at pages 7 to 11.

database(s) that LEAs access through private or public vendors who maintain ALPR information collected from multiple databases and/or public agencies.”²⁷

Sheriff's Department's Policies on ALPR

MPP sections 5-09/550.00 through 5-09/550.50, [Field Operations Directive 09-004](#), and the Department's [ALPR Privacy Policy](#) provide its employees with directives on how to handle, operate, and manage data collected through the Department's ALPR systems.²⁸ Access to the system is restricted; only designated and specially trained personnel are authorized to access and/or audit ALPR data.

All ALPR-trained personnel are required to know the Department's ALPR's privacy policy. The privacy policy states:

Information gathered or collected and records retained by LASD will not be:

- *Sold, published, exchanged, or disclosed for commercial purposes.*
- *Disclosed or published without authorization.*
- *Disseminated to persons not authorized to access or use the information.*

LASD shall not confirm the existence or nonexistence of information to any person or agency that would not be eligible to receive the information unless otherwise required by law.

LASD shares ALPR data with other law enforcement agencies upon the execution of an inter-agency agreement by which each agency agrees that all ALPR data will be gathered, accessed, utilized, and disclosed in accordance with applicable law, and further agrees:

- *ALPR data shall be available only to authorized users for legitimate law enforcement purposes.*

²⁷ [California Department of Justice, “California Automated License Plate Reader Data Guidance,” Information Bulletin No. 2023-DLE-06 \(October 27, 2023\).](#)

²⁸ See Los Angeles Sheriff's Department Manual of Policy and Procedure sections 5-09/550.00 through 5-09/550.50, and [Field Operations Directive 09-004, “Automated License Plate Recognition \(ALPR\) System.”](#)

- *Reasonable efforts will be made to ensure the accuracy of its data.*
- *Shared hotlist data will not be stored for more than 24 hours without refresh.*
- *Internal audits will be conducted periodically to ensure information is up to date and user queries are made for legitimate law enforcement purposes only.*
- *Audit trails shall be maintained by each agency as defined by their policy.*²⁹

Notably, the policy does not contain a definition of “public agency,” further it allows the data to be shared with other law enforcement agencies and does not have a specific prohibition on sharing the information with federal agencies.³⁰ The same is true of all the Department’s ALPR policies. The [privacy policy](#) does require the following:

Information gathered or collected and records retained by LASD may be accessed or disseminated for legitimate law enforcement, criminal justice, or public safety purposes *only to persons or entities authorized by law to have such access and only for those uses and purposes specified in the law.* (Emphasis added.)

The Department also reported that the provisions in its ALPR Inter-Agency Sharing Agreement comply with SB 34 and acknowledged that SB 34 prohibits the sharing of ALPR information with federal authorities, out-of-state agencies and private entities. The Communications and Fleet Management Bureau (CFMB), which oversees the ALPR system, confirmed through the Department’s Office of Constitutional Policing that:

²⁹ [The Los Angeles Sheriff’s Department, “The Los Angeles County Sheriff’s Department’s Automated License Plate Recognition \(ALPR\) Privacy Policy.”](#)

³⁰ In the past, the Sheriff’s Department shared ALPR data with [Palantir](#) but has not used Palantir for ALPR storage or access for the past five years. Palantir’s data analysis software was developed as a military intelligence tool but is now used by organizations in both the public and private sector to compile data. Palantir developed software to assist ICE in identifying and tracking undocumented migrants and asylum seekers raising concerns that Palantir’s data may be used as a government surveillance tool. (See Jeff Rumage, “[Inside Palantir: The Tech Giant Powering Government Intelligence](#),” BuiltIn.com (updated August 7, 2025).) The Sheriff’s Department reports that all ALPR data is maintained on its vendor’s secure cloud storage system.

there is no existing agreement between LASD and ICE or other federal agencies. Furthermore, LASD does not share ALPR data with out-of-state agencies that might provide access to ICE. Data sharing is strictly limited to California law enforcement agencies that adhere to similar restrictions and only after signing the ALPR Inter-Agency Sharing Agreement.³¹

As it pertains to the use of “hotlists,” the Department’s ALPR policy states:

The labeling of retained information (hotlist Information) will be evaluated by LASD or the originating agency when new information is gathered that may impact the reliability (content validity / software misread) of previously retained information. LASD will conduct periodic data quality reviews of information it originates and make every reasonable effort to ensure that the information from the ALPR System is correct.

The policy allows for ALPR data to be retained for up to five years. Data may be purged earlier due to privacy concerns or retained beyond five years if required for ongoing investigative purposes, including the prosecution or exoneration of criminal suspects.³²

The Department conducts periodic internal audits “to ensure information is up to date and user queries are made for legitimate law enforcement purposes only,” and those audits will be “conducted in such a manner as to protect the confidentiality, sensitivity, and privacy of the Department’s information system(s).”³³

Sheriff’s Department Use of ALPRs

The Sheriff’s Department Advanced Surveillance and Protection (ASAP) team, under the Department’s Communication and Fleet Management Bureau, is responsible for maintaining the Department’s ALPR systems. Four sworn deputies and one civilian are assigned to the unit

According to ASAP, the Department currently operates about 1,200 fixed ALPR cameras, with a majority of those located in contract cities. One city where such camera found is the city of Malibu, which in 2021 funded the installation of 12 ALPR cameras at a cost of approximately \$26,000.³⁴ Since the Department provides contracted law

³¹ This information was provided by the Department in an email dated March 18, 2025.

³² [The Los Angeles Sheriff’s Department, “The Los Angeles County Sheriff’s Department’s Automated License Plate Recognition \(ALPR\) Privacy Policy.”](#)

³³ *Ibid.*

³⁴ [Bravo, Samantha, “City begins implementation of the Automated License Plate Recognition Cameras,” *The Malibu Times*, January 14, 2023.](#)

enforcement services to Malibu, these cameras are operated by Department personnel assigned to patrol the area. The city consulted with the Department on optimal camera placement, as reflected by the Malibu City Council's request for advice to enhance the system's effectiveness in deterring and responding to crimes.³⁵

In addition to the 1,200 fixed cameras throughout the county, the Department also has roughly 44 out of 2,400 total patrol cars outfitted with mobile ALPR cameras. Most of these vehicles are funded by contract cities and are primarily assigned to patrol within the contract cities' jurisdictions. There are some exceptions where these contracted cars may be briefly reassigned as needed to assist with stopping crime in other areas.³⁶

Dependent on the needs of their job, several patrol deputies and detectives have been trained to use the ALPR systems. An example of persons who would not require access are personnel assigned to the custody department since their job duties would not involve seeking and tracking vehicle movements to capture outstanding suspects. Hypothetically, if a patrol deputy got transferred to custody or to another position where ALPR access is no longer necessary for their job duties, the Department states that their access is automatically deactivated after 90 days. Once deactivated, the individual can no longer retrieve ALPR data.

The Department regularly updates its hotlists used by the ALPR systems. When a deputy receives an alert that a car they are following – or a vehicle of interest – has passed a fixed ALPR camera, the deputy must perform a secondary verification through the Mobile Data Terminal system in their car or by calling dispatch to confirm the information is current and accurate.³⁷

The ASAP team is responsible for conducting audits of ALPR system usage, which are performed on a weekly basis. The purpose of these audits is to ensure deputies are using the system strictly in a “need-to-know,” or “right-to know” situations. During the audit, the team reviews the deputies' ALPR queries to see if the deputies had a legitimate law enforcement purpose to undertake those actions.

Over the years, the Department has collected millions of images through its use of ALPR. With a few exceptions (such as data related to ongoing investigations), these images are automatically deleted after five years. While state law does not specify the maximum retention period for ALPR data, the Department has established its own internal policy of five years to retain the data.

³⁵ *Ibid.*

³⁶ See [MPP section 5-09/550.30, “Field Protocols-Patrol.”](#)

³⁷ *Ibid.*

As stated previously, the Department emphasized that, in accordance with state law, it does not share any of its information with private agencies, out-of-state entities, and/or the federal government. For ALPR sharing agreements with other California law enforcement agencies the Department reports these agreements clearly state that partnering agencies must abide by the Sheriff's Department policies and state laws governing privacy, security, and confidentiality of the information shared. The onus for monitoring compliance lies with the partnering agencies. It is their duty to ensure their personnel use the shared ALPR data appropriately and not violate the terms of the agreement or applicable state laws.

Concerns

While state law clearly prevents the sharing of ALPR data with federal agencies, recent actions by the Trump administration raise concerns that the federal government may seek data from California law enforcement agencies. While the Los Angeles Times reported that Los Angeles County was not on the United States Department of Justice list of sanctuary jurisdictions published on August 5, 2025,³⁸ the federal government has already filed a lawsuit against the City of Los Angeles.³⁹ California is identified as one of 13 states that the Trump administration has flagged as having policies or laws that impede federal immigration agents.⁴⁰ An executive order titled [Protecting American Communities from Criminal Aliens](#) issued by the White House in April 2025, includes the suspension or termination of federal funding as a consequence for sanctuary jurisdictions that refuse to cooperate with federal immigration authorities. The Sheriff's Department's five-year retention policy potentially means that a huge amount of data could be shared with the federal government if a court were to decide that California law cannot forbid law enforcement agencies from sharing data with the federal government if the government demands access to the data for immigration enforcement.

Other concerns with the collection and storage of ALPR data involve what security protocols are in place to safeguard the data and how long the data is retained. A recent article in *The Guardian* illustrated how such data can potentially be used in a way that is antithetical with the original intent of the local law enforcement agency or municipalities that collect the data. ALPR systems capture images of vehicle activity, which can reveal travel patterns and even pinpoint a person's location at a specific time. In the case highlighted in the article, a sanctuary city in New York, had inadvertently shared its

³⁸ Jenny Jarvie, [Justice Department releases a new list of sanctuary jurisdictions. L.A. County is not on it](#), Los Angeles Times (August 5, 2025).

³⁹ [United States of America v. City of Los Angeles, et al. U.S. District Court Case number 2:25-cv-05917](#).

⁴⁰ Jenny Jarvie, [Justice Department releases a new list of sanctuary jurisdictions. L.A. County is not on it](#), Los Angeles Times (August 5, 2025).

ALPR data with the Department of Homeland Security, U.S. Immigration and Customs Enforcement (ICE), and Customs and Border Patrol by allowing them to continue to have access to its ALPR databases even after the city had passed laws prohibiting such sharing, raising concerns that these federal agencies could then track down persons using this information.⁴¹

Organizations such as the ACLU, Electronic Frontier Foundation, and even a state agency in California have expressed concerns about the use and storage of this data. In 2019, the California State Auditor conducted an audit of law enforcement agencies' use of ALPRs. The audit found that, despite the passage of relevant state legislation, many agencies did not have policies to dictate how personnel should handle the ALPR systems or how long the collected images should be stored. The report focused on four specific law enforcement agencies; the Sheriff's Department was not among them, although it did respond to the audit's survey on ALPR usage.⁴² Based on the audit's recommendation, in October 2023, the California Department of Justice issued updated guidelines of how law enforcement agencies should write policies and dictate the use of ALPRs.⁴³ The CA-DOJ Bulletin, "[California Automated License Plate Reader Data Guidance](#)," [Information Bulletin No. 2023-DLE-06](#) (October 27, 2023), has a [link to a template](#) for use by law enforcement agencies to create an ALPR policy that complies with state law. While the Sheriff's Department's policy contains many of the template policy provisions, it does not include a provision on sharing data only with public agencies as defined by Civil Code section 1798.90.5(f). There are also other areas where the Department could improve transparency and strengthen procedures to better protect citizens' privacy rights.

Storing of Sensitive Data. A key focus of the state audit report was the retention period for images captured by ALPR systems. These systems automatically photograph license plates, regardless of whether the vehicle is connected to any criminal activity. As a result, the vast majority of captured images involve individuals who are not suspected of wrongdoing. The audit found that as of 2019 the Los Angeles Police Department (LAPD) had accumulated over 320 million images in its ALPR database; yet, 99.9% "are for vehicles that were not on a hotlist when the image was made."⁴⁴ At a 2014 court hearing, the LAPD and the Sheriff's Department reported that they collect an average of

⁴¹ [Johana Bhuyian, "Ice accessed car trackers in sanctuary cities that could help in raids, files show," *The Guardian* \(March 11, 2025\).](#)

⁴² [California State Auditor, "Automated License Plate Readers to Better Protect Individuals' Privacy, Law Enforcement Must Increase Its Safeguards for the Data It Collects," Report Number 2019-118.](#)

⁴³ [Press Release, "Attorney General Bonta Advises California Law Enforcement on Legal Uses and Management of Automated License Plate Recognition Data," *California Department of Justice* \(October 30, 2023\).](#)

⁴⁴ *Ibid.*

3 million vehicle images per week using ALPR systems.⁴⁵ In an article authored by ACLU staff, the authors state “the ACLU has reported that only about .2% of plates scanned by ALPR systems are ever linked to any wrongdoing, and only 3% of those linked to wrongdoing (3 out of every 50,000 plates scanned) are linked to crimes other than licensing or emissions violations.”⁴⁶ Given that the overwhelming majority of these images are unrelated to criminal investigation, storing them for them for five years creates a privacy risk.

Other states have adopted far stricter limits on ALPR data retention. For example, Maine, Georgia, New Hampshire, Montana do not permit long-term storage of such data. New Hampshire requires the data to be purged within 3 minutes of capture if no arrest is effectuated.⁴⁷ California Highway Patrol (CHP) cannot retain the data for more than 60 days.⁴⁸ Some of the Sheriff’s Department’s contract cities have also imposed stricter local restrictions. At a November 2024 Santa Clarita City Council meeting, the city unanimously approved \$500,000 in funding for ALPRs but included a condition that all captured images be deleted within 30 days.⁴⁹

Those in favor of longer retention periods may argue that complex crimes – such as money laundering or organized criminal racketeering may only become apparent over longer time frames, making extended data retention periods more important to solve these crimes. While there may be validity to this argument, there must be a careful balance between public safety and privacy. Given the sheer number of images the system collects, most of which pertains to individuals not involved in any criminal activity, it is worth questioning whether the prolonged retention is justified.

With the goal of determining the evidentiary value of retaining ALPR data for five years, an evaluation of the retention policy should be undertaken. Such an evaluation should examine whether older data assists with solving crimes or the apprehension of suspects.⁵⁰

Sharing of the Data with other California Law Enforcement Partners. Criminal activity does not adhere to jurisdictional boundaries. For example, it is entirely plausible

⁴⁵ [Peter Bibring and Jennifer Lynch, *Secrecy trumps public debate in new ruling on L.A.’s license plate readers*, ACLU Southern California \(September 3, 2014\).](#)

⁴⁶ *Ibid.*

⁴⁷ [National Conference of State Legislatures, “Automated License Plate Readers: State Statutes,” NCLS, February 23, 2022.](#)

⁴⁸ See [California Vehicle Code § 2400-2429.7.](#)

⁴⁹ [Smith, Perry, “City OKs contract to help LASD with license-plate readers,” *The Santa Clarita Valley Signal*, November 13, 2024.](#)

⁵⁰ The Department reports that shortening the retention period would not result in any cost savings despite the fact that a significant reduction in the retention period would mean fewer data would be stored.

and even likely, that a fleeing suspect may travel through multiple jurisdictions, moving from LAPD territory to Sheriff's Department territory, to San Bernardino Sheriff's territory. In such cases, interagency cooperation and data sharing are essential for tracking suspects, preventing further harm and effectuating arrests.

In January 2024, the ACLU sent a letter to California Attorney General Rob Bonta to alert him that more than a dozen law enforcement agencies had failed to comply with SB 34 regarding the proper handling of ALPR data.⁵¹ The letter states that even nine years after SB 34's passage, a significant number of California law enforcement agencies continue to either refuse compliance or fall short of meeting the law's requirements. It should be noted that the Sheriff's Department was not among those agencies listed for non-compliance in the letter.

At this time, it remains unclear what actions, if any, the Attorney General has taken to address the concerns regarding non-compliance by certain law enforcement agencies, or whether the Attorney General's office has investigated and substantiated the claims made in the letter. Per the Sheriff's Department, agreements between the Sheriff's Department and other agencies are contingent upon those agencies adhering to state law and Sheriff's Department policies. If the state prosecutor determines that a partnering agency has failed to follow the law, the Sheriff's Department should take appropriate steps to terminate the sharing of ALPR data with that agency.

When the Sheriff's Department is the entity sharing the sensitive data, the onus is on the Department to routinely monitor and ensure that its partners comply with relevant laws and policies governing the handling of this sensitive information. Such monitoring should include implementing sunset clauses into the agreements with partnering agencies, which would force the parties to conduct periodic review of the terms of the agreement to ensure all parties are in compliance. Additionally, the Sheriff's Department should closely monitor actions taken by the Attorney General, so that if a law enforcement agency is found to be violating SB 34, other state laws, or Sheriff's Department policies, the Department can promptly terminate the data-sharing agreement.

Conclusion

ALPR technology is a valuable tool for solving crimes, which is why both the public and local governments have invested significant funds into purchasing and installing these systems. The same technology can also infringe on individuals' privacy rights if not used

⁵¹ ACLU to Attorney General Rob Bonta, ["Response to the Office of the Attorney General's Information Bulletin on the Sharing of ALPR Information by California Law Enforcement Agencies"](#) (January 31, 2024).

with proper oversight and safeguards. California's passage of SB 34 was meant to limit the sharing of ALPR data to only within the state of California as one way to protect the privacy rights of California residents.

The following recommendations are intended to ensure that Sheriff's Department explicitly include provisions required by state law, increase transparency, ensure the technology is being used for legitimate, lawful purposes, and help achieve the balance between privacy concerns and public safety priorities.

Recommendations

1. The Sheriff's Department should revise its ALPR policies to include either a specific prohibition from sharing ALPR data with federal and out-of-state agencies or include that the data may only be shared with a public agency as defined in Civil Code section 1798.90.5(f).
2. The Sheriff's Department should revisit its policy of retaining ALPR images for five years after conducting a study on the benefit of a lengthy retention period as and the privacy issues created by the longer retention rate.
3. The Sheriff's Department should continue to conduct periodic audits to ensure that personnel are using the ALPR systems for authorized purposes. Audits should include a review of a sample of individual queries, requiring the auditors to assess whether the query was necessary for the investigation or case cited by the employee.
4. The Sheriff's Department should implement sunset clauses in its agreements with partnering agencies that receive ALPR data. These clauses would ensure that data-sharing agreements are subject to periodic review and renewal, rather than remaining in place indefinitely or for extended periods of time. At the time of renewal, the Sheriff's Department should thoroughly review the terms to confirm they still are aligned with current laws, policies, and best practices. Part of this review would require verification that the partnering agency has not been flagged by the Attorney General's Office for non-compliance with SB 34.

Outstanding Requests to the Sheriff's Department

The Office of Inspector General made the following request for information to the Sheriff's Department for which responses are still outstanding:

- An April 18, 2025 request for additional materials responsive to a subpoena duces tecum that was served in October 2024 and included a request for all documents and information relating to any Sheriff's Department surveillance of any County oversight officials; this follow up request was made after it came to the Inspector General's attention that surveillance of a County oversight official

was conducted but information relating to that surveillance, including notes and an audio digital tape of an interview, were not provided. Although the subpoena duces tecum was served on October 1, 2024, no notes have been provided regarding the work of two peace officers alleged to have engaged in surveillance. Despite repeated assurances that additional information would be provided, either by providing additional documents or acknowledging the documents that purportedly exist cannot be located, no additional information has been provided. Additional communications were sent to the Sheriff's Department regarding this outstanding request on May 16, 2025, June 12, 2025, and August 1, 2025.

CUSTODY DIVISION

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide humane conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.⁵²

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.⁵³ According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of June 30, 2025, the total population of people in custody in the Los Angeles County jails was 12,364. While the total population may not exceed the rated capacity, some facilities are over capacity.

The table on the next page shows the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center – East (PDC-East), Pitchess Detention Center – North (PDC-North), Pitchess Detention Center – South (PDC-South), and North County Correctional Facility (NCCF) on the last day of the previous four quarters. On these dates, three

⁵² See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

⁵³ The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the pandemic, understaffing, or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

facilities (MCJ, PDC-North, and NCCF) that together account for more than half the Department's jail capacity operated significantly over the BSCC rated capacity.

Facility	BSCC	Facility Count			
	Capacity	9/30/2024	12/31/2024	3/31/2025	6/30/2025
MCJ	3512	3698	3850	3793	3441
TTCF	2432	2378	2350	2314	2433
CRDF	1708	1371	1341	1418	1416
PDC-East	926	20	10	11	7
PDC-North	830	1276	1221	1286	1373
PDC-South	782	633	462	423	546
NCCF	2214	2718	2612	3010	3148

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a [motion](#) requesting the Sheriff's Department and directing the Office of Inspector General, Sybil Brand Commission, and the Sheriff Civilian Oversight Commission to review and report back on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation, and directing the Office of Inspector General to include status on the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice.⁵⁴

The Sheriff's Department's report back to the Board on November 5, 2024, did not address security searches of menstruating people as requested by the Board's motion. In its initial [report back](#) to the Board, staff from the Office of Inspector General determined that issues persist with security search practices and recommended the Sheriff's Department establish specific policies for searching menstruating individuals in

⁵⁴ See [Penal Code, § 4023.5\(a\)](#). ("A person confined in a local detention facility shall be allowed to continue to use materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the incarcerated person."); [Cal. Code Regs., tit 15, § 1265](#). ("Each menstruating person shall be provided with sanitary napkins, panty liners, and tampons as requested with no maximum allowance."); Los Angeles County Sheriff's Department, Custody Division Manual, [§ 6-15/010.00 Inmate Clothing, Bedding, and Personal Hygiene](#). ("All menstruating inmates shall have ready access to sanitary napkins, panty liners, and tampons."); Los Angeles County Sheriff's Department, Custody Division Unit Orders, [§ 5-16-040 Distribution of Personal Care Items](#). ("Each menstruating inmate housed at CRDF shall be provided with sanitary napkins, panty liners, and tampons. All feminine hygiene products shall be readily available in a common space within each module or pod setting."); [Penal Code, § 3409\(a\)](#). ("A person incarcerated...who menstruates or experiences uterine or vaginal bleeding shall, without needing to request, have ready access to, and be allowed to use, materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the person.").

jail facilities, ensuring that these policies protect their dignity while maintaining facility security.

In June 2025, Office of Inspector General staff re-examined the availability and accessibility of menstrual products in the search area in reception at CRDF. This inquiry also included a review of Sheriff's Department policies, discussions with CRDF leadership, facility visits and observations, and interviews of custody personnel and people in custody.⁵⁵

Search policy reforms. In 2017, a court ruled in *Amador v. Baca* that strip searches conducted by the Sheriff's Department at CRDF violated incarcerated people's Fourth Amendment rights because they were conducted without reasonable suspicion and lacked privacy protections.⁵⁶ The searches were conducted in large groups, where individuals in custody were within view of one another, and involved degrading practices. The County agreed to pay a \$53 million settlement, which required the Sheriff's Department to implement policy reforms to improve privacy protections and uphold constitutional standards.⁵⁷

Since then, the Sheriff's Department has taken steps to enhance privacy and sanitation, including adding curtains and providing trash bins. Despite progress, some practices still present the need for further improvement.

As previously reported, Sheriff's Department policy lacks guidance on how personnel should conduct body searches when a person is menstruating.⁵⁸ CRDF leadership has incorporated instructions to the Protocol for Inmate Searches Unit Order § 6-01-00 and added menstrual cups as another option.⁵⁹ The revised unit order is pending approval from Custody Support Services Bureau.

Types of searches. Custody personnel most commonly conduct pat-down and body scanner searches on people in custody. When the body scanner is used, menstruating individuals are required to remove their pad or tampon. When body scanners are inoperable, pat-down searches, which currently do not require the removal of menstrual products, are most commonly conducted, though a facility unit order permits visual body

⁵⁵ Staff from the Office of Inspector General visited modules 1600 (disciplinary housing), 2700 and 3600 (general population housing), 1300 (FIP Stepdown program and high observation housing), 2100 (restrictive housing), 2400 (high observation housing), and 3100 and 3400 (moderate observation housing).

⁵⁶ *Amador v. Baca*, No. 2:10-cv-01649 (C.D. Cal. Mar. 5, 2010), <https://clearinghouse.net/case/14457/>.

⁵⁷ The settlement included monetary compensation for affected individuals incarcerated at CRDF between March 2008 and January 2015, http://shq.lasdnews.net/content/uoa/AS1/Class_Notice.pdf.

⁵⁸ See Los Angeles Sheriff's Department, Custody Division Manual, § 5-08/010.00, *Searches*.

⁵⁹ See Los Angeles County Sheriff's Department, Custody Division Unit Order, § 6-01-00 *Protocol for Inmate Searches Unit Order*. Unit order obtained via email message.

cavity searches as well.⁶⁰ More invasive searches, such as strip or physical body cavity searches, are carried out under limited conditions and must follow specific privacy, medical and documentation protocols.⁶¹

Search procedures upon facility re-entry. Upon returning to CRDF, individuals in custody are placed in a pre-search holding tank in reception. The length of time spent there varies depending on staffing levels and other operational demands. When personnel conduct searches, individuals are lined up outside the holding tank and are escorted to the search area where they are directed to stand behind a table. Custody personnel then instruct the group to untuck their shirts, empty their pockets, place any belongings on the table, remove their shoes and socks, and, if applicable, remove any menstrual products.

Menstruating individuals are directed to discard used pads or tampons in a trash bin located underneath the table.⁶² Curtains on the left and right sides of each station offer partial privacy from others in custody; however, the front of the partition remains open to allow deputies to maintain a direct line of sight throughout the process.⁶³ After all property is searched, incarcerated individuals are allowed to put on their socks and shoes to line up before walking through the scanner. Wait times vary, depending on the number of people being screened, which may be up to 12, and any issues that cause delays affecting the entire group.

Following the scan, individuals must stand by until custody personnel have reviewed and cleared the images. If a menstruating individual does not remove their pad or tampon, the body scanner typically detects it, prompting deputies to instruct the person to remove the product and rescan. If the body scanner continues to reveal an anomaly, the individual may be subjected to a pat-down search, and, if necessary, a more

⁶⁰ Custody Division Unit Order, § 6-01-00 Protocol for Inmate Searches Unit Order. Unit order obtained via email message.

⁶¹ Custody Division Manual, [§ 5-08/010.00, Searches](#); Custody Division Unit Order, § 6-01-00 *Protocol for Inmate Searches Unit Order*. Unit order obtained via email message.

⁶² At least two individuals reported inconsistencies in the enforcement of menstrual product removal: one stated the body scanner did not detect her product when she chose not to remove it, and another noted she was not instructed to remove hers on at least three separate occasions. Other individuals reported that menstruating people who refuse to remove their pad or tampon may face disciplinary action. One person stated she witnessed someone being sent to discipline for refusing to remove her menstrual product.

⁶³ At least one person reported that deputies stood and stared while they removed their menstrual product, raising concerns about privacy. Another person reported that some deputies do not allow menstruating individuals to use the privacy curtains when removing their menstrual product.

invasive search.⁶⁴ Once cleared, menstruating individuals should receive access to pads and tampons and may return to the curtained area to use the product.

Sometimes, everyone must wait in the search area until the entire group is scanned and cleared before moving to a holding tank. Other times, individuals can proceed to the holding tank as soon as they are cleared. Regardless, individuals face another wait before returning to their assigned housing unit. Multiple waiting periods pose a significant issue for those who are not immediately provided a new menstrual product after being scanned.

Provision of menstrual products and access to handwashing. Incarcerated individuals again reported inconsistent access to menstrual products after body scanner searches and to clean clothing if they experienced staining during the search.⁶⁵ Some stated they were given a pad or tampon immediately after the search, but only upon making a verbal request. A few mentioned they were able to take a product from a table next to the body scanner, while others reported they had to wait until they returned to a holding tank or their assigned housing location, which could take anywhere from a few minutes to several hours. A common concern among incarcerated individuals was the inconsistent replenishment of menstrual products in the search area and the lack of access to hand sanitizer or soap during the search process.⁶⁶

In July 2025, the Sheriff's Department installed hand sanitizer and paper towel dispensers in each search partition to support an updated process. Under the revised unit order on searches, pat-down searches will now be conducted on all individuals before they pass through the body scanner. Menstruating individuals will be required to remove their menstrual product prior to the pat-down search and, immediately afterward, be provided a new product and underwear and allowed to sanitize their hands before proceeding through the body scanner. These changes aim to reduce multiple waiting periods without menstrual protection, increase access to sanitation, and maintain safety and security in custody.

⁶⁴ One individual reported that in March 2025, she was subjected to a more invasive search requiring her to squat and cough, after custody personnel suspected she was concealing contraband. She stated that she was made to pass through the body scanner more than 10 times and was told she would be placed on contraband watch. She also reported being sent to disciplinary housing for 28 days. The Office of Inspector General was unable to verify the account.

⁶⁵ One person shared they were given a new pair of pants following a heavy menstrual flow. In contrast, several others reported it is common for menstruating individuals to stain their underwear and pants during the body scanner search process, with no assurance of receiving clean clothing. Some reported they must wait until the scheduled clothing exchange to obtain replacements.

⁶⁶ Several incarcerated individuals reported needing to wait until they returned to the holding tank in reception to wash their hands with water.

Recommendations. The Office of Inspector General recommends that the Sheriff's Department finalize updates to the Protocol for Inmate Searches Unit Order § 6-01-00 and ensure that hand sanitizer, paper towels, and menstrual products are replenished regularly and as needed in the search area.⁶⁷ Additionally, custody personnel should be reminded that menstruating individuals may partially close curtains to maintain privacy from other incarcerated individuals and unauthorized personnel. Resources permitting, the Sheriff's Department should also consider making individual determinations about whether all menstruating individuals, such as those who experience heavier flows and have no disciplinary history, need to remove their pad or tampon.

Commissary Prices

Background

On July 9, 2024, the Board of Supervisors passed a [motion](#) directing the Sheriff's Department to report back on measures taken to ensure commissary prices in the Los Angeles County Jails are not excessive and remain comparable with prices for groceries and other retail outlets. The motion directed the Office of Inspector General to review the Sheriff's Department's report back and provide an assessment, which was issued on February 6, 2025, entitled [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#). The motion also directed the Office of Inspector General to provide quarterly updates on the Sheriff's Department's progress on the removal of the profit mark-ups and reduction of prices on commissary items.

Since 2013, the Sheriff's Department has used a private, third-party contractor, [Keefe Commissary Network](#) (Keefe), to provide items to sell in the jail commissaries and vending machines. The contract between Keefe and the Sheriff's Department was set to expire this year. In the [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#), the Office of Inspector General recommended that rather than renewing the contract with Keefe, the Department should issue a request for proposals to provide commissary goods under the fair and equitable approach the Board has requested.

In January 2024, the County prepared a [Request for Proposals for Inmate and Commissary and Vending Services](#) (RFP No. 252-SH). The timetable in the RFP

⁶⁷ As previously recommended by the Office of Inspector General, policy may be communicated temporarily through a Unit Order; however, best practices dictate that such orders be implemented in as policy in the Custody Division Manual or the Manual of Policy and Procedure to ensure clearer communication to all Sheriff's staff.

provided that the proposals were due on May 10, 2024. The RFP was presented at the [Public Safety Cluster Agenda Review on May 14, 2025](#), and although there were three vendors that attended a mandatory proposers' meeting, Keefe was the only vendor that submitted a proposal. The [new contract with Keefe](#) was approved by the Board at the [June 3, 2025 Board of Supervisors meeting](#), allowing Keefe to continue providing commissary and vending services for the Department for an initial term of six years, with four one-year extension options.⁶⁸

Contract Provisions – Pricing and Contractor Obligations

The Office of Inspector General reviewed the new Keefe contract to analyze efforts to reduce commissary prices and examine whether the Department incorporated the recommendations made in the Office of Inspector General's [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#).

The contract includes a pricing provision regarding retail price benchmarking. Apart from some specialty items (which require manufacturer documentation), Keefe must price all products equal to or lower than the average retail prices from three local full-service retailers (excluding gas stations, mini-marts, or convenience stores). The new contract also requires Keefe to apply a 2% discount to all product prices, based on the approved retail average or manufacturer pricing.

The following compares prices for basic hygiene products between the previous period and new commissary contract with Keefe:

Item Name (Item No.)	Sales Price to Inmates FY 2024-2025	Sales Price to Inmates FY 2025-2026 (includes 2% rebate)	Price Change from FY 2024-2025
Shampoo 4 oz (0001)	\$2.75	\$3.19	Increase of \$0.44 (+16.22%)
Dandruff Shampoo 4 oz (0020)	\$3.95	\$3.92	Decrease of \$0.03 (-0.54%)
Toothbrush Flexible Security (0058)	\$1.25	\$1.25	No change
Freshscent Deodorant Push Up 1.6 oz. (0133)	\$3.85	\$3.50	Decrease of \$0.35 (-10%)
Skin Care Lotion 4 oz (0210)	\$3.85	\$3.53	Decrease of \$0.32 (-12.73%)

⁶⁸ See Item 74 of the June 3, 2025 Board of Supervisors meeting, which includes as an attachment, the Sheriff's Department's [Board Letter](#) containing the new contract provision.

Cocoa Butter Lotion 4 oz (0215)	\$3.85	\$3.25	Decrease of \$0.60 (-20.44%)
Irish Spring Soap 3.2 oz (0400)	\$1.45	\$1.26	Decrease of (\$0.19) (-18.29%)
Colgate Toothpaste Regular 1 oz (0518)	\$2.25	\$1.39	Decrease of (\$0.86) (-18.29%)
Freshmint Toothpaste 2.75 oz (0538)	\$4.75	\$4.35	Decrease of (\$0.40) (-18.29%)
Security Razor 1 each (0935)	\$0.61	\$0.78	Increase of \$0.17 (+12.73%)

Looking at the new contract prices, the following highlights the difference between the sales prices to inmates and the listed retail prices:⁶⁹

Item Name (Item No.)	Sale Price to Inmates FY 2025-2026 (includes 2% rebate)	Retail Price	Difference
Shampoo 4 oz (0001)	\$2.75	\$5.99	+\$0.44 (+16.22%)
Dandruff Shampoo 4 oz (0020)	\$3.95	\$4.49	-\$0.03 (-0.54%)
Toothbrush Flexible Security (0058)	\$1.25	Not available on the retail market	N/A
Freshscent Deodorant Push Up 1.6 oz. (0133)	\$3.85	\$2.49	-\$0.35 (-10%)
Skin Care Lotion 4 oz (0210)	\$3.85	\$3.79	-\$0.32 (-12.73%)
Cocoa Butter Lotion 4 oz (0215)	\$3.85	\$2.49	-\$0.60 (-20.44%)
Irish Spring Soap 3.2 oz (0400)	\$1.45	\$1.44	-\$0.19 (-18.29%)
Colgate Toothpaste Regular 1 oz (0518)	\$2.25	\$1.29	-\$0.86 (-18.29%)
Freshmint Toothpaste 2.75 oz (0538)	\$4.75	\$2.29	-\$0.40 (-18.29%)
Security Razor 1 each (0935)	\$0.61	Not available on the retail market	N/A

The contract also requires Keefe to attend monthly Title 15 meetings convened by the County to present reports on commissary and vending sales trends and spikes, billing issues, relevant complaints submitted by incarcerated people, machine maintenance and reliability, security concerns, and any other operational problems identified by the

⁶⁹[Board Letter](#), Commissary and Vending Product Master List, Attachment F at pg. 63.

parties. Keefe is also required to submit at the end of each contract year, and annually thereafter, a detailed cost comparison for all products, including documentation for any requests for price adjustments. The Office of Inspector General recommends our office attend those meetings and review the documentation to evaluate efforts between the parties to carry out the contract in alignment with the contract terms and the Board of Supervisors' directives. And while we do see a decrease in most prices, the Office of Inspector General continues to recommend that the Department audit the pricing structure and documentation provided by Keefe to identify any inequitable pricing markups.

Revenue Sharing and the Inmate Welfare Fund

Both the prior and new contract with Keefe allocate revenue sharing between Keefe and the Sheriff's Department's Inmate Welfare fund (IWF). Nationwide, prison and jail commissaries sell goods with several jurisdictions using profits from their commissaries to supply inmate welfare funds - pools of money used to support programming or services for incarcerated persons. California originally established inmate welfare funds by statute in 1949 for the "benefit, education, and welfare" of incarcerated persons, and later expanded the permissible use to include "required county expenses as determined by the sheriff to be in the best interest of inmates."⁷⁰

The Sheriff's Department indicated in its [October 30, 2024 report](#) that under the prior contract, the revenue sharing between Keefe and the IWF started as a split of commissionable revenue with 53% to the IWF and 47% to Keefe. In August of 2024, the revenue sharing was adjusted lowering the share allocated to the IWF to 51.5%. Under the new contract, 39% of gross commissary and vending sales will be deposited into the IWF, so while there is improvement in the new contract, the Office of Inspector General continues to recommend that the Department limit the markup of commissary items to the amount attributable to Keefe's profit and forgo the portion of the revenue generated by the contract for the IWF and pass along the savings directly to persons in custody. Funding for jail maintenance, programming, and for the welfare of persons in custody should be part of the Sheriff's Department budget allocated from County resources.

Resources for Indigent Persons in Custody

Per the contract with Keefe, certain commissary resources are made available for indigent inmates (an inmate is considered indigent if their trust account balance is below \$2.00 at the time of purchase/order.) Once a week, indigent persons in custody may

⁷⁰ [Penal Code § 4025\(e\)](#).

receive a hygiene maintenance kit and an indigent kit by submitting a commissary order form. The kits include items such as stamped envelopes and paper, shampoo, deodorant, with items subject to change based on housing location and/or medical restrictions. Additionally, one pair of reading glasses may be requested once every three months. Because these kits are necessary for basic hygiene, the Office of Inspector General recommends that all persons in custody be provided these kits free of charge.

As to pro-per inmates representing themselves in legal matters, indigent pro-per inmates may request one pro-per kit per week, submitted via the Department's legal unit, which forwards orders to Keefe for processing and delivery during regular commissary cycles. The pro-per kit includes materials such as pencils, legal pads, and envelopes.

Vending Services and Other Transaction Fees

As noted, Keefe provides commissary goods, as well as items for sale in vending machines. While Keefe completes installation of new vending machines, the contract requires the temporary sale of vending debit cards as an interim solution. The cards must be sold in \$10 and \$20 denominations, persons in custody are allowed a maximum of four cards per week (not to exceed \$60 total), and Keefe may charge a handling fee of up to \$0.75 per card. Vending debit cards are exempt from state and local sales tax, and purchase of vending debit cards count towards the \$300 weekly inmate spending limit; inmates are limited to \$300 per week for all purchases made through scantron or tablet app orders, including sales tax. The County will routinely collect used vending cards and refund any remaining balances to the associated person's trust account. Keefe must also advise inmates three weeks prior that new machines will be operational and the temporary vending debit cards will no longer be accepted.

Regarding web-based commissary orders, the contract sets a maximum transaction fee of \$2.00 for each order that may not be increased for the duration of the contract (including the optional extensions). The contract also limits the transaction fees Keefe may charge for inmate account deposits and kiosk-based inmate trust account deposits.

In the [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#), the Office of Inspector General recommended the Department evaluate whether certain purported costs borne by Keefe may be absorbed by the Department as a cost-saving measure. The \$0.75 fee for purchase of temporary vending debit cards, the \$2.00 web-based transaction fee, and the fees for inmate account and kiosk-based inmate trust account deposits may be examples of costs the

Department should consider covering via their own budget, rather than imposing such costs upon people in its custody.

Compliance with the Settlement Agreement in *Johnson v. Los Angeles Sheriff's Department* for People in Custody with Mobility Impairments

The Office of Inspector General serves as the court-appointed monitor for the *Johnson v. Los Angeles County Sheriff's Department* class-action lawsuit, in which a class of people (class members) with mobility impairments in Los Angeles County Jails alleged that the Sheriff's Department denied them accommodations or provided inadequate accommodations, inappropriately segregated them, excluded them from jail programs and services, and subjected them to multiple and pervasive physical access barriers throughout the facilities.⁷¹ The Sheriff's Department entered into a settlement agreement ("agreement") in 2015 to resolve the lawsuit and agreed to implement systemwide reform of the conditions of confinement for people with mobility impairments. The Office of Inspector General filed its [Ninth Implementation Status Report](#) on May 13, 2025, and reported that of the seven provisions that remain in effect, the Sheriff's Department has achieved substantial compliance with one, and partial compliance with six.⁷²

Although progress has been made in improving the conditions that gave rise to the agreement over the 10 years it has been in effect, the Office of Inspector General's report identified notable issues that erode the Sheriff's Department's reform efforts and make it unlikely that the Sheriff's Department will achieve compliance on the remaining provisions without additional extensions of its settlement term.⁷³

First, the Sheriff's Department continues to expand the areas where it houses class members in Men's Central Jail and Twin Towers Correctional Facility into non-ADA housing areas. Class members in these areas face architectural barriers that pose safety risks and yet have not been provided with adequate accommodations, and in some cases were denied accommodations, that would have enabled their mobility

⁷¹ *Johnson v. Los Angeles County Sheriff's Department*, Case No. CV 08-03515 DDP (C.D. Cal. Filed May 29, 2008).

⁷² The agreement contains a total of 49 provisions. Pursuant to stipulation of the Parties, the Court has severed 38 of the 49 provisions from the agreement that have either achieved sustained compliance or were documented as "completed" during settlement negotiations and are no longer subject to monitoring by the Office of Inspector General. Four additional provisions have achieved sustained compliance but have not been severed from the agreement.

⁷³ The agreement, which took effect on April 22, 2015, was originally set to expire on April 22, 2018. The parties have stipulated to, and the court approved, several extensions of settlement term, most recently extending the settlement term by one year to May 30, 2026.

despite the architectural barriers. For example, many of these housing areas lack access features such as grab bars and benches in the showers, making it difficult for mobility impaired class members to steady themselves while showering. Some class members reported difficulties with entering and exiting the shower areas due to the presence of a raised threshold at the bottom of the entrance designed to keep water in the shower basin. Office of Inspector General staff spoke with four class members who reported slipping and falling while showering. All four class members reported having to use non-accessible showers due to custody staff not always providing them with the opportunity to use the ADA showers. Office of Inspector General staff reviewed medical records and identified documentation reflecting that two of the four class members reported the slip-and-fall injury to medical staff and received medical treatment.⁷⁴

Class members housed on the 5000 floor of Men's Central Jail, a non-ADA housing area, reported having issues traveling to and from their housing locations. Class members housed on the 5000 floor must descend approximately 60 stairs on narrow escalators that are regularly out of service to get to the bus bays to attend court and must ascend the same escalator stairs to return to their housing location. Several class members reported declining yard time and, in some cases, medical appointments, due to their inability to descend and ascend the escalators. One class member reported tripping and falling on the escalators while going to court. Office of Inspector General staff reviewed medical records and identified documentation reflecting that the class member reported the fall to medical staff and received medical treatment.

Despite the Office of Inspector General's prior reporting in its [Eighth Implementation Status Report](#) on the issues stemming from the expansion of housing areas, the Sheriff's Department made little to no progress in addressing mobility concerns and ADA compliance in non-ADA housing areas. The Office of Inspector General stressed the need for the Sheriff's Department, in collaboration with Correction Health Services ("CHS"), to conduct a comprehensive assessment of its class member population to ensure that it houses all class members in appropriate areas of the jails and provides all necessary accommodation in accordance with the terms of the agreement.

Second, the Office of Inspector General staff encountered several class members who had a classification code for a mobility assistive device but had not received their prescribed device(s). Office of Inspector General staff spoke with 27 class members who reported not having received their prescribed device and confirmed that 11 had active medical orders for the device they reported not having at the time they spoke with

⁷⁴ It is important to note the Office of Inspector General does not discredit the information from class members on the basis that the injury was not reported to medical staff.

Office of Inspector General staff. Several class members we spoke with had a mobility assistive device but were not assigned the corresponding classification code. In speaking with medical and custody staff regarding this concern, the Office of Inspector General learned that prescriptions for mobility assistive devices are not actively monitored, resulting in delays in the removal of devices once prescriptions expire and secondary review options are exhausted. Medical and custody staff explained there is no established process for removing devices from Class Members, or clarity as to who is responsible for doing so, indicating a lack of collaboration or cooperation between the Sheriff's Department and CHS.

Third, although the Sheriff's Department has made progress towards compliance with two provisions on the processing of ADA-related grievances, it failed to meet the compliance standards required to achieve substantial compliance. This was, in large part, due to (1) CHS' failure to designate ADA-related grievances correctly, hampering any progress achieved by the Sheriff's Department, (2) methodological issues that impacted the accuracy of the Sheriff's Department's self-assessments that are used by the Office of Inspector General to make compliance determinations, and (3) not fully addressing all components of a grievance to ensure that it is adequately responded to.

Based on the findings in the [Ninth Implementation Status Report](#), the Office of Inspector General recommends that the Sheriff's Department and CHS ensure that adequate resources are dedicated towards implementing the terms of the agreement. In addition, the Sheriff's Department and CHS should take more active roles in overseeing compliance and focus on collaboration and agreement between the two agencies. Defendants should also continue to train and brief all personnel who work in the custody setting on the terms of the agreement.

Jail Employment Opportunities at Century Regional Detention Facility

The Office of Inspector General continues to monitor Century Regional Detention Facility's (CRDF) efforts to provide meaningful opportunities for people in custody to participate in therapeutic and rehabilitative programming.

In 2021, the Office of Inspector General issued a [report](#), finding inequitable racial/ethnic representation of people in custody at CRDF participating in credit-earning jail employment through the Prisoner Personnel Office (PPO). The Office of Inspector General has monitored racial/ethnic representation of inmate workers since, and Black women continue to be consistently underrepresented.

The Sheriff's Department provided data from June 24, 2025, detailing the number of people in custody at CRDF engaged in credit-earning jail employment by race/ethnicity. A percentage comparison analysis displayed representation percentages similar to those reported in previous Office of Inspector General reports. Specifically, the data showed:

- Approximately 13% of Inmate Workers were White, compared to approximately 18% of the CRDF population.⁷⁵
- Approximately 19% of Inmate Workers were Black, compared to approximately 33% of the CRDF population.
- Approximately 66% of Inmate Workers were Hispanic, compared to approximately 46% of the CRDF population.
- Approximately 4% of Inmate Workers were "Other" race/ethnicity, compared to approximately 4% of the CRDF population.

In 2022, the Office of Inspector General [recommended](#) that the Sheriff's Department "implement a system that documents reasons for denial of PPO participation, documents reasons for elective non-participation, explore ways to promote PPO participation for eligible persons, and explore alternative ways of evaluating persons for PPO to provide equitable opportunity for participation." That recommendation has not been implemented.

Despite the former Assistant Sheriff for the Custody Division stating in January 2023 that "more follow-up" was necessary to address the issue, the PPO has not made observable efforts to address racial/ethnic disparity for people in custody to be given the opportunity for employment as Inmate Workers. Recently, the Department informed us of plans to expand data tracking to document PPO denial and refusals, increase PPO recruitment efforts, and potentially revise criteria that may disqualify people from participating in PPO. A timeline for implementation was not provided.

In-Custody Deaths

Between April 1 and June 30, 2025, eight people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for seven deaths: two natural, one accidental, and four suicides. There were no homicides. For the one remaining death, the DME finding is

⁷⁵ Race/ethnicity categorizations reflect those utilized by the Sheriff's Department when reporting demographic data.

deferred.⁷⁶ One person died at MCJ, one person died at CRDF, one died at IRC, and five people died at hospitals after being transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a [dedicated page on Inmate In-Custody Deaths on its website](#).⁷⁷

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews for each of the eight in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of Death: April 3, 2025

Custodial Status: Sentenced

On March 26, 2025, CHS staff at MCJ responded to a health emergency in a single-person cell. The person was transported to Los Angeles General Medical Center (LAGMC) for medical care. Approximately seven hours later, the person was transported back to MCJ. Within an hour and a half of being back at MCJ, the person was found hanging and unresponsive in a single person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and CHS staff administered two doses of Narcan. The person was transported to LAGMC for a higher level of care where the person died. Areas of concern include adherence to procedures for hospital returnees, Behavioral Observation and Mental Health Referral process, temporary housing of people in custody referred to mental health, and handling of suicidal behavior. The preliminary cause of death according to the hospital is brain death due to anoxic brain injury due to asphyxiation due to hanging. The DME website currently reflects the manner of death as a suicide, and the cause of death as hanging.

Date of Death: April 19, 2025

Custodial Status: Pre-Trial

On April 19, 2025, a person in custody who was found disheveled and refusing to engage in their single person cell was transported from TTCF to LAGMC for a higher

⁷⁶ In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and Correctional Health Services use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

⁷⁷ [Penal Code § 10008](#) requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

level of care. Upon arrival to LAGMC, hospital staff were unable to locate the person's pulse, and the person died. Areas of concern include poor cell condition and medical provider referral upon intake. Preliminary manner of death: unknown. The DME website currently reflects the manner of death as natural, and the cause of death is Atherosclerotic and Hypertensive Cardiovascular Disease.

Date of Death: April 26, 2025

Custodial Status: Pre-Trial

On April 26, 2025, a person in custody was found hanging and unresponsive in a single-person cell at MCJ. Custody staff, CHS staff, and paramedics rendered emergency aid, and CHS staff administered three doses of Narcan. The person died at the scene. Areas of concern include quality of Title 15 Safety Checks, adherence to wristband count procedures, and inability to live monitor linear rows. Preliminary manner of death: apparent suicide by hanging. The DME website currently reflects the manner of death as a suicide, and the cause of death as hanging.

Date of Death: May 6, 2025

Custodial Status: Pre-Trial

On April 27, 2025, a person in custody was found hanging in a single-person cell at MCJ. Custody staff arrived, removed the noose, and rendered emergency aid. The person was transferred to LAGMC for a higher level of care. On May 2, 2025, the person was compassionately released from Sheriff's Department custody. Despite efforts by hospital staff, the person died on May 6, 2025. The DME website currently reflects the manner of death as a suicide, and the cause of death as sequelae of hanging.

Date of Death: May 7, 2025

Custodial Status: Sentenced

On May 7, 2025, a person in custody was found unresponsive in a multi-person holding cell at IRC Old Side. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody and CHS staff administered seven doses of Narcan. The person died at the scene. Areas of concern include quality and timeliness of Title 15 Safety Checks, Narcan availability, automated external defibrillator (AED) availability, proper radio frequency during emergency response, mental health staffing levels, and referrals to Addiction Medicine Services. The preliminary cause of death is urine positive for fentanyl. The DME website currently reflects the manner of death as an accident, and the cause of death as effects of fentanyl.

Date of Death: June 2, 2025

Custodial Status: Pre-trial

On May 24, 2025, a person in custody was transferred from IRC to LAGMC for a higher level of care due to a pre-existing medical condition. On June 2, 2025, the person died while receiving medical treatment. The preliminary cause of death according to the hospital is oropharyngeal (tonsil) cancer. The DME website currently reflects the manner of death as natural, and cause of death as sequelae of oropharyngeal cancer.

Date of Death: June 14, 2025

Custodial Status: Sentenced

On June 14, 2025, a person in custody was found unresponsive in a single-person cell at CRDF. Custody staff, CHS staff, and paramedics rendered emergency aid, and CHS staff administered three doses of Narcan. The person died at the scene. Areas of concern include quality of CHS provider evaluations, Title 15 Safety Checks, and timing of emergency response. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: June 18, 2025

Custodial Status: Pre-trial

On June 17, 2025, a person in custody was found hanging and unresponsive in a cell at Clara Shortridge Criminal Justice Center. Custody staff rendered emergency aid while paramedics were summoned. Paramedics continued resuscitative efforts and transported the patient to LAGMC. On June 18, 2025, the patient showed no signs of life and was pronounced dead by a LAGMC physician. Areas of concern involve a delay in rendering initial medical aid. The DME website currently reflects the manner of death as suicide, and the cause of death as hanging.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff's Department to "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the OIG," and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections." The Board also directed the Office of Inspector General to report quarterly on the Sheriff's Department's progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody overdose deaths.

Of the eight people who died in the care and custody of the Sheriff's Department between April 1 and June 30, 2025, the medical examiner's final reports, including toxicology assessments, confirm that one person died due to an accidental overdose. Toxicology results remain pending for one of the eight deaths and may indicate an additional overdose death once completed. As of this report, the DME has confirmed that seven individuals have died due to accidental overdose through the second quarter of 2025.

Tracking Narcotics Intervention Efforts

With regard to the directive to the Sheriff's Department to track narcotics recovery and evaluate drug detection interventions, as previously reported the Sheriff's Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Sheriff's Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Sheriff's Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

Improving Searches of Staff and Civilians

The Board's second directive requires that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails]." The Sheriff's Department previously reported that its current policy grants the Sheriff's Department broad authority to search staff and civilians entering the jails, so that no changes to existing policy are required to implement more comprehensive searches. The Sheriff's Department previously reported that it implemented more frequent unannounced and randomized staff searches beginning in May 2024.

Search practices. All seven facilities conduct searches of staff and civilians; however, as previously reported, the frequency of searches and search procedures vary by facility. Searches of Sheriff's Department and CHS staff are typically conducted by

supervisory personnel, namely sergeants,⁷⁸ at shift change near the main control entry. While K-9s may be present during searches, they do not search staff, civilians, or their property bags as they enter the facility. Targeted searches based on credible and actionable intelligence are overseen by the Internal Criminal Investigations Bureau.

Sheriff's Department policy allows staff and civilians to bring into the facility one clear backpack and one clear bag or lunch box, within specified dimensions, with an exception for Department-issued equipment and carrying bag.⁷⁹ Most facilities rely on informal enforcement of bag size limits. During routine searches, staff may be directed to shuffle through property or retrieve certain items from their bag. Only one facility reported that sergeants directly handle staff's property during searches, and even then, the practice occurs sporadically. One facility reported that civilians are infrequently searched because of varied arrival times and lack of resources, which is a violation of Sheriff's Department search policy.

The need for more robust search practices exists and most facilities reported no known search restrictions by the Association for Los Angeles Deputy Sheriffs (ALADS).

Data collection. Search data is entered in the Custody Watch Commander's Log (CWCL) at each facility. The Custody Support Services Bureau (CSSB) can extract data directly from the CWCL or request it from facility operations staff. Collection methods vary by staff conducting the search, thus affecting the data entered in the CWCL. The data typically includes the time, date, and shift of each search, though, the name of staff conducting the search is not consistently recorded, and the number of staff/civilians searched is not tracked at all. A combination of watch commanders, facility operations staff, and compliance staff review the data, primarily to verify search compliance. The frequency of search audits varies, and it is unclear whether the auditors verify that searches occur as documented.

Recommendations. The Office of Inspector General recommends that the Sheriff's Department standardize search procedures across all facilities with a focus on qualitative consistent data collection, clarifying property handling instructions, enforcing clear bag rules, and strengthening data review and audits. Adopting these measures will improve staff/civilian accountability and assist in determining whether searches are both conducted as required and effective at deterring or intercepting contraband.

As previously reported, the comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table below details the staff search practices at all jail facilities from April 1 to June 30, 2025. The data regarding the

⁷⁸ TTCF, IRC and NCCF also involve supervising line deputies and watch deputies in property searches.

⁷⁹ See Los Angeles County Sheriff's Department, Custody Division Manual, [§ 3-01/090.15 Personal Bags](#).

number of staff searches and searches with K-9 illustrated in the table was supplied by CSSB. CSSB extracted the data on searches from the CWCL on July 3, 2025. K-9 data was obtained from the Custody Investigative Services (CIS) Searches of Custody Personnel Report on July 3, 2025. The Office of Inspector General was unable to verify the data provided by CSSB without additional information.

	Number of Staff Searches	Number of Staff Searches with K-9	Monthly Minimum Search Requirement ⁸⁰	Search Inside Security	Search Evasion Concerns	Where Searches Logged
Facility	Q2	Q2				
MCJ	123	10	Unable to Determine ⁸¹	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
TTCF	80	3	Yes ⁸²	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
IRC	28	2	Unable to Determine ⁸³	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
CRDF	28	6	No ⁸⁴	No	Yes	Watch Commander Log; Searches of Custody Personnel Report

⁸⁰ Each jail facility's unit order regarding staff searches was used to determine whether it met its minimum search requirement by month. Where the unit order is silent regarding the minimum search requirement, the Office of Inspector General was unable to determine if the requirement was met. Also, the jail facility must meet the minimum search requirement during each of the three months in the quarter in order to be found in compliance.

⁸¹ Los Angeles County Sheriff's Department, Custody Division Unit Orders, [§ 3-08-021 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁸² Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-08-010 Security of Personal Property](#). ("Watch commander shall ensure a minimum of two random searches are conducted each week of persons entering the secured area during their assigned shift").

⁸³ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 5-23/006.00 Security and Searches of Person Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁸⁴ CRDF did not meet its minimum search requirement in April and May 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-01-090 Searches of Sworn Personnel, Custody Assistants, Professional Staff and their personal property-Approved by CSS 3/11/2024 ("The searches shall be conducted a minimum of once per week, per shift." [unit order obtained via email message]).

NCCF	158	3	No ⁸⁵	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-North	34	2	Unable to Determine ⁸⁶	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-South	42	3	Yes ⁸⁷	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the second quarter of 2025, Office of Inspector General personnel completed 88 site visits, totaling 362 monitoring hours, at IRC, TTCF, CRDF, MCJ, Pitchess Detention Center North, PDC South, and NCCF.

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 119 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 146 monitoring hours related to uses of force, in-custody deaths, Prison Rape Elimination Act (PREA) compliance, restrictive housing, and general conditions of confinement.

Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.⁸⁸ The Sheriff's Department most recent force report is for use-of force-incidents in custody through the first quarter of this year. [This report](#) and reports

⁸⁵ NCCF did not meet its minimum search requirement in June 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 07-145/10 Personal Property Searches](#). ("A minimum of four (4) random searches per shift per week of any personnel and/or official visitors shall be conducted at the discretion of the watch sergeant.").

⁸⁶ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-06-010 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁸⁷ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-02-080 Searches of Sworn Personnel, Custody Assistants, Professional Staff and Their Property on the Facility](#). ("The searches shall be conducted at a minimum of once per week, per shift.")

⁸⁸ Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

for prior quarters may be found on the Sheriff's Department website's transparency section under the [page for use of force](#).

Handling of Grievances and Comments

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received 329 new complaints in the second quarter of 2025 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

Of the complaints received, 298 were related to conditions of confinement within the Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	108
Personnel Issues	31
Living Condition	31
Food	16
Classification	14
Mail	13
Bedding	12
No Response to Grievance	12
Showers	11
Education	10
Commissary	7
Transportation	6
Dental	6
Mental Health	5
Telephones	4
Release Date issue	3
Visiting	2
Other	7

Thirty-one complaints were related to civilian contacts with Department personnel by persons who were not in custody, as shown in the chart on the following page:

Complaint/Incident Classification	Totals
Personnel	
Improper Tactics	9
Discourtesy	3
Alleged Criminal Conduct	2
Dishonesty	2
Harassment	2
Improper Detention, Search, Arrest	2
Force	1
Off Duty Conduct	1
Other	1
Service	
Policy Procedures	3

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 74 iPads installed in jail facilities: 38 at TTCF; 12 at MCJ; and 24 at CRDF. During the second quarter there were no new installations and two iPad replacements. The Department assures that the iPads that have been removed from circulation will eventually be redeployed. There were 198,127 automated responses provided to people in custody using the iPad application to request information.

The Sheriff's Department continues to experience technical issues with iPads primarily due to unreliable power sources. The Department reports that currently the iPads are powered through facility televisions, which are switched off every evening. As a result, the iPads lose power overnight, thereby requiring those iPads to recharge each morning. Each day, the iPads require manual connection to Wi-Fi once recharged. Facility Services Bureau (FSB) personnel have been working to install dedicated power and data lines for the iPads. The Department reports that walkthroughs have been completed at both TTCF and MCJ, with a quote received for TTCF, and a quote pending for MCJ.

The Department states that TTCF remains the most stable facility in terms of connectivity, and for this reason that facility has been prioritized. The Department noted that once the FSB project at TTCF is complete reconfiguration and programming of the iPads will resume.

As [previously reported](#), the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in custody.⁸⁹ The Sheriff's Department reports that between April 1 and June 30, 2025, no one in custody had been placed on restrictive filing and therefore did not reject any grievances under this policy.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.⁹⁰ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.⁹¹

The Sheriff's Department now has a [complaints dashboard](#) that can be sorted by date range with options to narrow the results by practice area (such as Patrol or Custody), rank, or station or unit.

Sheriff's Department's Response

The Sheriff's Department was provided with a draft of this report, and the following is the Department's response.

⁸⁹ See Los Angeles County Sheriff's Department, Custody Division Manual, § 8-04/050.00, [Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges](#).

⁹⁰ See [Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, Department Service Reviews](#).

⁹¹ It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

RESPONSE TO
Reform and Oversight Efforts: Los Angeles County Sheriff's Department
April through June 2025

From page 6

Internal Affairs Bureau

Correction on number of cases:

“During this quarter, the Sheriff’s Department reported opening **130** new administrative investigations. Of these **130** cases, 50 were assigned to IAB, 41 were designated as unit-level investigations, and 39 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff’s Department or another agency).”

From page 7

Status of Taser Policy Implementation and Training

Based on additional information from the Body Worn Camera Unit regarding CEW procurement and tracking, the earlier statement provided requires clarification.

Because the number of patrol deputies changes over time, there may be more Taser 10 units than deputies who still require training.

This can be clarified by stating, “There are 511 Taser 10 devices currently available for assignment to deputies upon completion of training; however, because the number of patrol deputies changes over time, the ratio of devices to untrained deputies cannot be precisely determined. In addition, further procurement of devices and training of personnel will be required to complete Phases II and III.”

The following information provides further context regarding the number of Taser 10 units still needed within the Department:

The Department procured 3,197 Taser 10 units as part of Phase I of a three-phase implementation plan. Phase I focused on equipping a large percentage of patrol personnel. The Department intends to expand deployment in:

- **Phase II:** Specialized Units and the Detective Division
- **Phase III:** Custody Division

To date, Phase I has been funded through internal Department resources. However, sustainable funding has not yet been allocated for the full implementation of the Taser

10 Project. The Department has formally requested that ongoing funding be incorporated into the Department's budget to support continued deployment and training.

The following additional information demonstrates the significant operational impact of the Taser 10 in field operations:

- 5 deputy-involved shooting mitigations
- 5 successful interventions in self-harm incidents
- An approximate 87% effectiveness rate
- In 15% of deployments, the involved party was armed with a weapon

These outcomes underscore the Taser 10's value as a critical public safety tool. Its enhanced capabilities over legacy models include:

- A warning alert feature that supports de-escalation
- A maximum range of 45 feet, nearly 20 feet farther than previous models
- The ability to accurately deploy up to 10 cartridges, increasing the likelihood of achieving neuromuscular incapacitation (NMI) and gaining safe control of the involved individual

Most of the Department's older taser models are no longer under warranty and do not provide the same capabilities as the Taser 10. The Taser 10's advanced features have already saved lives, and with sustainable funding, they will continue to enhance public safety. The Department strongly urges that funding for the Taser 10 Project be made a priority to ensure its continued success in protecting our communities.

From page 8

Regarding CEW information from the Custody Division, Custody Operations Directive 22-005, *Updated Procedures for the Use of the Conducted Energy Weapon (CEW)*, is the operative policy, superseding the relevant section of the CDM. The Directive specifically addresses the matter of personally owned CEWs as follows:

PERSONALLY OWNED CEW

Department personnel who purchase a CEW shall only carry Department-authorized CEWs whether on or off-duty. Department personnel shall only use personally owned CEWs in accordance with this COD.

Personnel may carry personally owned CEWs after approval of their unit commander and after inspection by CTSB.

Personally owned CEWs shall be numerically identifiable and available for computer download upon the request of a supervisor or during regular download intervals as defined in CDM section 7-08/030.05, "TASER Download Procedures."

Department personnel shall record all personally owned Department-authorized CEWs (carried on-duty and off-duty) with the Personnel Administration Bureau when the devices are purchased, obtained, sold, disposed of, lost, or stolen.

Attached is the Directive for reference.

Bottom Page 8:

Highlight the title "Semi-Annual Report on Implementation of the Family Assistance Program"

Page 12

Improving the Treatment of Family Members of Individuals Killed or Seriously Injured by Sheriff's Deputies

Adopting as policy the requirements of the proposed legislation will likely result in more trauma-informed treatment of family members. The Office of Inspector General recommends that the Sheriff's Department implement a policy that provides the safeguards proposed by AB 3021.

The Department will evaluate this recommendation, along with any reason why AB 3021 was not passed.

From page 13

Sheriff's Department's Cooperation with Federal Immigration Authorities

While the Sheriff's Department has policies that limit cooperation with federal authorities on immigration enforcement, data collected by the Sheriff's Department is sometimes unintentionally transferred to the federal government and such data may have the effect of assisting immigration authorities without the intent to do so. As discussed in a previous report, Live Scan data that includes a person's country of birth and other identifying information is collected by the Sheriff's Department at booking and then shared with the federal government by CA-DOJ, which requires the information.

It is important to note the Sheriff's Department complies with SB 34 and does not provide ALPR or other protected data to federal immigration authorities. Any transfer of booking data to federal agencies occurs only through the California Department of Justice as required by law and is entirely outside the Department's control. This added

context is important to include to ensure a better understanding of the issues, and we respectfully request it be included.

From page 22

Storing of Sensitive Data

*While there may be validity to this argument, there must be a careful balance between public safety and privacy. Given the sheer number of images the system collects, **most of which pertains to individuals not involved in any criminal activity**, it is worth questioning whether the prolonged retention is justified.*

ALPR does not store personal identifying information, making the reference to “individuals” inaccurate. The system records license plate data, and any link to a person requires a separate, legally authorized process. Suggesting that most records “pertain to individuals” may misrepresent the nature of the data and the system’s function. This added context is important to include to ensure a better understanding of the issues, and we respectfully request it be included.

From page 24

Recommendations

- 1. The Sheriff’s Department should revise its ALPR policies to include either a specific prohibition from sharing ALPR data with federal and out-of-state agencies or include that the data may only be shared with a public agency as defined in Civil Code section 1798.90.5(f).*
- 2. The Sheriff’s Department should revisit its policy of retaining ALPR images for five years after conducting a study on the benefit of a lengthy retention period as and the privacy issues created by the longer retention rate.*
- 3. The Sheriff’s Department should continue to conduct periodic audits to ensure that personnel are using the ALPR systems for authorized purposes. Audits should include a review of a sample of individual queries, requiring the auditors to assess whether the query was necessary for the investigation or case cited by the employee.*
- 4. The Sheriff’s Department should implement sunset clauses in its agreements with partnering agencies that receive ALPR data. **Theses** clauses would ensure that data-sharing agreements are subject to periodic review and renewal, rather*

than remaining in place indefinitely or for extended periods of time. At the time of renewal, the Sheriff's Department should thoroughly review the terms to confirm they still are aligned with current laws, policies, and best practices. Part of this review would require verification that the partnering agency has not been flagged by the Attorney General's Office for non-compliance with SB 34.

Response to OIG Recommendations on ALPR Policies

The Department will review these recommendations further to ensure continued compliance with all applicable laws, including SB 34 and SB 54, while balancing privacy concerns with legitimate law enforcement needs, including: (1) reviewing Civil Code section 1798.90.5(f) to consider incorporating it more fully into the ALPR privacy policy; (2) conducting a study to determine the feasibility of reducing the current five-year retention period (although the Department has concerns regarding shortening the retention period due to ongoing investigative needs and the evidentiary value that ALPR data provides); (3) continuing to conduct audits to confirm that ALPR usage complies with Department policies and applicable laws (it should be noted that in March 2025, an audit of 5,206 records, representing individual queries by staff, revealed zero violations), and reviewing whether expanding the scope of audits to include an assessment of the necessity of each query for the associated investigation or case is feasible; and (4) evaluating sunset clauses, although it should be noted that while the Department's ALPR Inter-Agency Agreement does not include a sunset clause, Section IX provides that either party may terminate the agreement with ten days' written notice (it is further important to note that these agreements are standard among agencies, and the Department cannot unilaterally change all of the agreements). Nevertheless, the Department will consider this proposed language once additional information is gathered to ensure it could be implemented effectively.

From page 24

Outstanding Requests to the Sheriff's Department

The Department responded to the October 2024 subpoena by providing over 55 gigabytes of data, contained on four thumb drives, consisting of documents, emails, phone logs, and other relevant material responsive to the subpoena. Due to the April 2025 request for additional materials, the Department requested that County Counsel retain outside counsel to conduct a thorough and independent review of the materials produced and assist the Department in locating any additional materials responsive to the document request. The request to hire counsel was made soon after the April 2025 OIG request, and counsel was ultimately retained in July 2025 and has begun working on this matter.

From page 33

Revenue Sharing and the Inmate Welfare Fund Section

“Funding for jail maintenance, programming, and for the welfare of persons in custody should be part of the Sheriff’s Department budget allocated from County resources.”

The Inmate Welfare Fund (IWF) stopped paying for any FSB projects on February 28, 2025. No new projects initiated by FSB in fiscal year 2024/2025 were charged to the IWF. The February 2025 date was to cover FSB projects approved prior to FY2024/2025.

From page 36

Compliance with the Settlement Agreement in Johnson v. Los Angeles Sheriff’s Department for People in Custody with Mobility Impairments

“The Office of Inspector General stressed the need for the Sheriff’s Department, in collaboration with Correction Health Services (“CHS”), to conduct a comprehensive assessment of its class member population to ensure that it houses all class members in appropriate areas of the jails and provides all necessary accommodation in accordance with the terms of the agreement.”

The Department agreed with the recommendation and completed a “questionnaire” with the class members to gain compliance with the recommendation. However, CHS has not agreed to the recommendation and as a result an assessment has not been conducted. The report should reflect our efforts.

Additionally, this quote is in reference to the comprehensive assessment OIG has repeatedly requested for several years. CHS indicated it does not have the funding, nor the personnel, to accomplish a comprehensive assessment of each class member in the custody environment. However, the ACB ADA team and the CCSB Johnson Team reached out to members of CHS to develop a system to comply with OIG’s request for a comprehensive assessment. In June 2025, the ACB ADA team and the CCSB Johnson Team contacted each class member that was housed outside of ADA housing and asked them a pre-designated series of questions pertaining to their mobility needs and services they were entitled to under ADA (i.e., cane/wheelchair, thermal clothing, proper wristband classification, foam “egg crate” mattresses, etc.). Where applicable, any service needs were fulfilled and addressed and/or routed to the unit for handling. Although CHS was not a part of this assessment, any Johnson class

members who requested a meeting with a medical professional were provided a Health Service Request form and the forms were submitted to CHS.

From page 36

“For example, many of these housing areas lack access features such as grab bars and benches in the showers, making it difficult for mobility impaired class members to steady themselves while showering. Some class members reported difficulties with entering and exiting the shower areas due to the presence of a raised threshold at the bottom of the entrance designed to keep water in the shower basin.”

A recent memorandum was forwarded to Division Director Conrad Meredith who oversees the Facilities Planning Bureau (FPB), requesting a spatial evaluation and analysis of potentially modifying the group showers at MCJ 2000 and 3000 Floors to be aligned with ADA requirements for shower accessibility. The request is part of a potential capital asset project, with FPB providing the initial evaluation and cost analysis prior to a budget request from the BOS.

Additionally, ACB worked closely with MCJ and Facilities Services Bureau (FSB) to identify the other impactful locations at MCJ to make modifications to the showers and bathrooms. The 5000 Floor dormitory showers were identified as the most ideal locations due to the high number of class member inmates and the ability for FSB to modify the showers in a cost-effective, less labor-intensive manner. Recent phasing plans to begin re-housing 5000 Floor inmates by dormitory were forestalled by an emergency work order from PDC North Facility. The subsequent delay will be approximately 15 weeks.

From page 36 (bottom) and 37 (top)

“Office of Inspector General staff spoke with 27 class members who reported not having received their prescribed device and confirmed that 11 had active medical orders for the device they reported not having at the time they spoke with Office of Inspector General staff. Several class members we spoke with had a mobility assistive device but were not assigned the corresponding classification code. In speaking with medical and custody staff regarding this concern, the Office of Inspector General learned that prescriptions for mobility assistive devices are not actively monitored, resulting in delays in the removal of devices once prescriptions expire and secondary review options are exhausted.”

The dispensation of medical devices is handled by CHS, as well as the prescription order monitoring process. As it relates to classification code assignment, during the comprehensive assessment conducted by the ACB ADA Team and CCSB Johnson Team in June 2025, any class member identified as missing the appropriate sub-classification on their wristband was immediately issued a new wristband once their medical device order was confirmed.

From page 37

“Third, although the Sheriff’s Department has made progress towards compliance with two provisions on the processing of ADA-related grievances, it failed to meet the compliance standards required to achieve substantial compliance. This was, in large part, due to (1) CHS’ failure to designate ADA-related grievances correctly, hampering any progress achieved by the Sheriff’s Department, (2) methodological issues that impacted the accuracy of the Sheriff’s Department’s self-assessments that are used by the Office of Inspector General to make compliance determinations, and (3) not fully addressing all components of a grievance to ensure that it is adequately responded to.”

Related to (1): This is a CHS data entry issue; however, the CHS, ACB and CCSB Johnson Teams met with CSS and CITU to include into CIGA the specific grievance designation OIG requested.

Related to (2): The OIG audited data received by CSS and discovered some of the grievances were not included in the auto-generated report, because they were submitted by sub-units, who were not included in the parameters of the auto-generated report. CCSB subsequently replicated the methodology used by the OIG to ensure the entire universe is captured and the CCSB team is examining every grievance individually to ensure all are reviewed properly.

Related to (3): CCSB worked with CSS to address data entry issues with third party grievances, because multiple issues were reported on one grievance form and it was difficult to track which issue was addressed and which issues potentially remained unresolved. CCSB requested that CSS require all third-party grievances submitted by the ACLU and OIG contain one complaint per grievance form. Although the method increased the overall number of grievances, the responses more accurately reflected each issue complained about and how each issue was resolved.

From page 42

Tracking Narcotics Intervention Efforts

With regard to the directive to the Sheriff's Department to track narcotics recovery and evaluate drug detection interventions, as previously reported the Sheriff's Department does not presently track narcotics detection in a format that allows data to be readily analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Sheriff's Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Sheriff's Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

The Department recognizes the importance of accurately tracking narcotics recoveries and evaluating the effectiveness of drug detection interventions. In response to the Board's directive and the Office of Inspector General's recommendations, the Department is in the initial stages of developing an in-house centralized database system where all narcotics recoveries, along with additional relevant recovery criteria, can be entered and maintained. This will serve as an interim solution, while Custody Division awaits the procurement and implementation of its modern Jail Management System.

This system will serve as a single, streamlined platform for querying data and compiling information, thereby enhancing the Department's ability to analyze trends, assess the efficacy of detection interventions, and produce reports in a more efficient and user-friendly manner. While development of this system will require time and resources, it represents a proactive step toward improving data collection and compliance with oversight expectations using a sustainable and scalable solution.

From pages 42 and 43

Search practices. All seven facilities conduct searches of staff and civilians; however, as previously reported, the frequency of searches and search procedures vary by facility. Searches of Sheriff's Department and CHS staff are typically conducted by supervisory personnel, namely sergeants, at shift change near the main control entry. ***While K-9s may be present during searches, they do not search staff, civilians, or their property bags as they enter the facility.*** Targeted searches based on credible and actionable intelligence are overseen by the Internal Criminal

When K-9 units are requested and deployed to assist with staff searches, their key role is to search property rather than individuals.

From pages 47 and 48

Handling of Grievances Filed by People in Custody

The OIG's reported concerns related to grievances generally, rather than ADA-related grievances specifically. As mentioned in the OIG Report, the Department intends to re-deploy the iPads. The use of such will be utilized for inmate requests for information, as well as grievances. The OIG Report did not cite specific investigations to demonstrate the OIG's issue with the quality of grievance investigations. The quality of grievances investigations is currently measured against objective criteria and reviewed by Department supervisors. The implementation of the CIGA system has improved timeliness concerns. CSS may also be able to provide an additional response.



Reform and Oversight Efforts: Los Angeles County Sheriff's Department

July through September 2025

Issued November 19, 2025

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between July 1 and September 30, 2025, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- Sheriff's Department Policies on Eyewitness Identification – Legal Compliance
- Rosas Compliance
- Shower Privacy for Transgender, Gender Non-Conforming, and Intersex People at Men's Central Jail
- Correctional Health Services Mortality Review
- Custody Administrative Death Review Pre-meet

During the third quarter of 2025, the Office of Inspector General issued the following reports relating to the Sheriff's Department:

- [Sixth Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421](#)
- [Thirteenth Report Back on Implementing Body-Worn Cameras in Los Angeles County](#)

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

Deputy-involved shootings are shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. As communicated in a [memorandum to the Board of Supervisors dated June 11, 2025](#), the Office of Inspector General suspended regular rollouts to deputy-involved shootings due to staffing reduction and lack of implementation of state laws on cooperation with external misconduct investigations (see, e.g. Government Code 25303.7(c)(2) and Penal Code 13510.8(a)(8)).

During this quarter, there were no incidents in which people were shot or shot at by Sheriff's Department personnel. The Sheriff's Department attributes this fact to

increased Taser usage. While the goal of deploying less-lethal Tasers is to reduce the use of firearms, that claim is currently without evidentiary basis. The Office of Inspector General encourages the Sheriff's Department's Audit and Accountability Bureau to conduct a multi-year study correlating Taser and shooting statistics to support the claim and to guide future policy.

The Sheriff's Department [maintains a page on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video. Records relating to the discharge of a firearm at a person by a peace officer or custodial officer are not confidential pursuant to Penal Code section 832.7(b)(1)(A)(i).¹ Disclosures of records of deputy-involved shootings may be delayed under some circumstances, but the agency must establish in writing the basis for its "determination that the interest in delaying disclosure clearly outweighs the public interest in disclosure" and the records must be released no later than 18 months after the date of the incident as set forth in Penal Code section 832.7(b)(8). Sheriff's Department practice in releasing such information had rarely complied with this legal mandate. In March 2022, the Board of Supervisors County enacted [Los Angeles County Code section 2.170.020](#), which sets minimum standards for the disclosure of records related to peace officers employed by the Sheriff's Department. The ordinance is only operative once the Peace Officer Records Division (PORD), the County Counsel division responsible for responding to SB 1421 requests is fully staffed. Because the unit is not yet fully staffed, the public still does not have access to information that the Board intended be publicly posted as anticipated by the ordinance timelines.²

¹ Penal Code section 832.7(b)(3) states that the records that must be released pursuant to this section include "all investigative reports; photographic, audio, and video evidence; transcripts or recordings of interviews; autopsy reports; all materials compiled and presented for review to the district attorney or to any person or body charged with determining whether to file criminal charges against an officer in connection with an incident, whether the officer's action was consistent with law and agency policy for purposes of discipline or administrative action, or what discipline to impose or corrective action to take; documents setting forth findings or recommended findings; and copies of disciplinary records relating to the incident, including any letters of intent to impose discipline, any documents reflecting modifications of discipline due to the *Skelly* or grievance process, and letters indicating final imposition of discipline or other documentation reflecting implementation of corrective action. Records that shall be released pursuant to this subdivision also include records relating to an incident specified in paragraph (1) in which the peace officer or custodial officer resigned before the law enforcement agency or oversight agency concluded its investigation into the alleged incident."

² SB 1421 is codified in Penal Code section 832.7 and requires the release of certain records that include records relating to deputy-involved shootings. A more detailed explanation for the delay in the implementation of the County ordinance is in the Office of Inspector General's most recent report on compliance with SB 1421, [Sixth Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421](#).

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.³ For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and that occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between July 1 and September 30, 2025, the District Attorney's Office posted memoranda on its website for eight findings on deputy-involved shooting cases involving Sheriff's Department's employees.⁴ The District Attorney's Office declined to file charges in seven cases, as it determined that use of force was not unlawful. For the remaining shooting, the District Attorney's Office determined the deputy did not fire his service weapon, but rather the suspect's gunshot wound was self-inflicted. The memoranda may be found on the [District Attorney's website page for Officer-Involved Shootings](#). The following are the deputy-involved shootings posted:

- The October 19, 2021, non-fatal shooting of Adrian Abelar by Deputy Yen Liu.
- The September 5, 2022, non-fatal shooting of Corey Crittenden by Deputies Michael Alburez, Terri Coats, and Brandon Vanarsdale.
- The November 3, 2022, fatal shooting of Ramiro Lozano by Deputy Adonay Molina.
- The December 22, 2022, fatal shooting of Willie Pendleton by Deputies Ervin Francois and Stephen Williams.
- The February 6, 2024, fatal shooting of Janathan Foster by Deputies Kyle Deluca, James Alvarado and Eric Torres.

³ In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. See [A.B. 1506 \(McCarty 2020\)](#) (codified at [Govt. Code § 12525.3](#)). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*. Until the law took effect in 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet.

⁴ The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#). The Office of Inspector General retrieves the information on District Attorney decisions from this webpage.

- The March 19, 2024, fatal shooting of Jose Acosta by Deputies Hector Macias and Zachary Van Der Zanden.
- The June 17, 2024, non-fatal shooting of Jason Baker by Deputy Madison Lee.
- The October 11, 2024, non-fatal shooting of Raul Martinez by Deputy Tarek Salah.
- The March 29, 2025, non-fatal shooting of himself, Jamon Allensworth, with Deputy Jairo Silva's service weapon.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (CA-DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.⁵ CA-DOJ [is not currently investigating](#) any shootings involving deputies from the Sheriff's Department. During the third quarter of 2025, CA-DOJ [issued no written reports](#) regarding shootings involving Sheriff's Department deputies.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has six shooting cases involving Sheriff's Department personnel open and under investigation. At the close of the quarter, the oldest case for which the Homicide Bureau maintained an active investigation relates to a January 21, 2025 shooting in the jurisdiction of Century Station. For further information as to that shooting, please refer to the Office of Inspector General's report [Reform and Oversight Efforts: Los Angeles Sheriff's Department - January to March 2025](#). The oldest case for which the Homicide Bureau completed its investigation but remains open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent four deputy-involved-shooting cases to the District Attorney's Office for filing consideration.

⁵ Government Code § 12525.3(b).

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in its jurisdiction, meaning for crimes occurring in unincorporated areas of Los Angeles County or in a city that is contracted with the Sheriff's Department for law enforcement services.⁶

The Sheriff's Department reports that ICIB has 80 active cases. This quarter, ICIB reports sending 9 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 33 cases previously sent from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 141 new administrative investigations. Of these 141 cases, 42 were assigned to IAB, 66 were designated as unit-level investigations, and 33 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 116 cases were closed by IAB or at the unit level. There are 474 pending administrative investigations, of which 333 are assigned to IAB and the remaining 141 are unit-level investigations.

⁶ Misconduct alleged to have occurred in other jurisdictions is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between July 1 and September 30, 2025, the Civil Service Commission issued final decisions in five cases involving Sheriff's Department employees. In these five cases, the Civil Service Commission sustained the Department's discipline in four cases and reduced the discharge to a thirty-day suspension in one case. The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings](#) posted on the County's website for commission publications.

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) 27 times between July 1 and September 30, 2025. Of the 27 deployments, 6 were categorized as "training exercise." The Office of Inspector General recommends that the Sheriff's Department provide more specific information regarding the use of UAS for a "high risk tactical operation." Circumstances justifying use of a UAS might include exigent circumstances, a reasonable suspicion that a crime is occurring, or execution of a search warrant. The law recognizes these exceptions to the Fourth Amendment of the United States Constitution, which does not have an exception for a "high risk tactical operation." Historically, members of the public have supported drone usage in law enforcement but have requested the activity be limited to areas of the most benefit to life and safety and that safeguards be in place to avoid usage encroaching into areas which are likely to result in excessive invasion of privacy. Imprecise categories and limited information can result in law enforcement action that undermines public trust.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracking and Documenting Taser Use

Status of Taser Policy Implementation and Training

On October 3, 2023, the Board of Supervisors (Board) passed a [motion](#) instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The motion directs the Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.

The Sheriff's Department reported the following information regarding training and policy implementation to date:

- The Department reported that from the Phase 1 purchase of 3,197 Taser 10s, over 2,800 are currently deployed.⁷
- As reported in our previous report, according to the Weapons Training Unit (WTU), a list of approved CEWs is currently being created.⁸ This list will be maintained by the Tactics and Survival Unit (TAS) and posted on the TAS SharePoint site once the data is compiled.

Tracking Taser Use

In May 2024, the Sheriff's Department launched [a web dashboard reporting Taser usage](#) by date range with options to narrow the results by practice area (such as Patrol or Custody), patrol station or facility, incident type, or city. Beginning in July 2024, the Department began including in that data the "Result of the Use of Force" (i.e., whether the use resulted in serious injury or death). The Sheriff's Department provided the following information for Taser usage for the third quarter of 2025:

- There were 242 Taser 10 field uses recorded with a reported 88% effectiveness rate.⁹
- Of the 242 field uses, the suspect was armed in 43 (18%) incidents. Of the 43 incidents, 10 involved firearms, 18 involved knives, and 15 involved other weapons.¹⁰
- Each Taser 10 is equipped with technology that signals the BWC to activate when a deputy turns off the Taser 10's *Safe Mode* as the deputy readies the

⁷ This section on Tasers includes the information reported by the Sheriff's Department for the quarter covered in this report and does not include information reported previously. For information reported previously, we refer to our reports: [Reform and Oversight Efforts: Los Angeles County Sheriff's Department – April to June 2025](#) and [Report on the Sheriff's Department's Taser Policy, Training, and Usage](#).

⁸ The Sheriff's Department refers to Tasers by the generic name, Conducted Energy Weapons, abbreviated as CEW. The term Taser and CEW are used interchangeably in this report.

⁹ According to the Sheriff's Department, effectiveness is determined by the assessment that a suspect was subdued as a result of the Taser usage.

¹⁰ It is this low percentage of Taser uses in which a suspect is armed that causes the Office of Inspector General to continue to warn against Sheriff's Department force policies that do not sufficiently protect against improper use of *less-lethal* technology.

Taser to fire. The Department reported 27 such activations, referred to as signal activations, during this quarter.¹¹

Sheriff's Department Policies on Eyewitness Identification – Legal Compliance

In 2018, California enacted Senate Bill 923, later codified as [Penal Code section 859.7](#), to establish uniform standards for eyewitness identifications. Effective January 1, 2020, the law requires law enforcement agencies to use evidence-based procedures designed to reduce wrongful convictions. This statute replaced the prior system of discretionary practices with mandatory safeguards to ensure consistency and reliability statewide.

California Penal Code section 859.7 requires all law enforcement agencies and prosecutorial entities to adopt standardized regulations for conducting photo and live lineups with eyewitnesses. The statute's purpose is to improve the reliability and accuracy of suspect identifications.

Key provisions include:

- **Eyewitness description first:** The eyewitness must describe the suspect before any lineup.
- **Blind/blinded administration:** The officer conducting the lineup should not know the suspect's identity ("blind"), or if he knows the suspect's identity ("blinded"), he must not know what position the suspect will be placed in. If blind administration is not used, the officer shall provide a written explanation for this decision.
- **Neutral instructions:** Eyewitnesses must be informed that the perpetrator may or may not be present, that they are not required to identify anyone, and that their decision will not conclude the investigation.
- **Lineup composition:** Fillers must generally match the eyewitness description. Only one suspect can be included, and writings or information concerning any previous arrests shall not be visible to the eyewitness.

¹¹ Per Sheriff's Department policy, a deputy should activate their BWC in advance of enforcement or investigative contact. In those incidents where the TASER 10 was deployed but no signal activation occurred, it was because the deputy's BWC was already recording. Per a response from the Department, the signal activation feature on the TASER 10 serves as a fail-safe to account for situations that unfold rapidly, where a deputy may need to react immediately for officer safety before manually activating the BWC. It also functions as a secondary safeguard in cases where the BWC was not activated as required. The Department should review the 27 signal activations to determine if those deputies should have already activated their BWCs.

- **Separation of eyewitnesses:** Multiple eyewitnesses cannot view the lineup together.
- **No influence:** Officers must refrain from making statements that could influence an eyewitness.
- **Confidence statement:** If an identification is made, the eyewitness confidence level must be recorded in writing, verbatim, of what the witness says. The officer shall not validate or invalidate the eyewitness identification.
- **Recording requirement:** "An Electronic recording shall be made that includes both audio and video of the entire identification procedure. Whether it is feasible to make a recording with both audio and visual representations shall be determined on a case-by-case basis. When it is not feasible to make a recording with both audio and visual representations, audio recording may be used. When audio recording without video recording is used, the investigator shall state in writing the reason that video recording was not feasible."

In February 2020, the Sheriff's Department revised [Section 5-09/530.20, Manual of Policy and Procedures, Photo Arrays](#), to reflect the changes in the law. The policy encompasses nearly all the key provisions required by Penal Code Section 859.7. In fact, the language of the policy often provides more detail than required by the law, thereby offering more precise guidance to its employees. However, there is one discrepancy between the law and the Department's policy regarding the recording requirement. The law is clear that an electronic recording "shall" be made (of the witness identification process) that includes both audio and video recording. When it is not feasible to have both, an audio recording may be sufficient, but a reason must be stated as to why a video recording was not feasible.

The Department's current policy does not meet this requirement. The policy states:

Documenting an eyewitness' response shall be in writing in case notes or records; but should include an audio or video recording as well.

The Department's use of the word "should" instead of "shall" is not in compliance with the law, as it leaves the ultimate decision to the investigating employee as to whether they will or will not record. It is essential to make this requirement mandatory, rather than optional, to ensure compliance with the language and spirit of the law. Furthermore, the policy states the response should include audio *or* video when in fact the law states both audio and video must be used unless not feasible.

Recommendation: The Department's policy should require and make mandatory the electronic recording that includes both audio and visual representations of the identification procedures. When it is not feasible to do both, audio recordings may be

used without video, accompanied by a written explanation as to why video recording was not feasible. The Department should provide training to ensure that personnel understand the requirements of Penal Code section 859.7, including that recording the identification is mandatory.

Outstanding Requests to the Sheriff's Department

The Office of Inspector General made the following request for information to the Sheriff's Department for which responses are still outstanding:

- An April 18, 2025 request for additional materials responsive to a subpoena duces tecum that was served in October 2024 and included a request for all documents and information relating to any Sheriff's Department surveillance of any County oversight officials; this follow-up request was made after it came to the Inspector General's attention that surveillance of a County oversight official was conducted but information relating to that surveillance, including notes and an audio digital tape of an interview, were not provided. Although the subpoena duces tecum was served on October 1, 2024, no notes have been provided regarding the work of two peace officers alleged to have engaged in surveillance. Despite repeated assurances that additional information would be provided, either by providing additional documents or acknowledging the documents that purportedly exist cannot be located, no additional information has been provided.

CUSTODY DIVISION

Rosas Compliance

An unreported use of force by a deputy (the Deputy) and a custody assistant (the CA) occurred at CRDF on January 23, 2020. Provision 13.1 of the Implementation Plan for the *Rosas Settlement Agreement and Release*¹² (*Rosas Implementation Plan*) requires

¹² The [Rosas Settlement Agreement](#) arose out of a federal class action lawsuit alleging a pattern of excessive uses of force in the Los Angeles County jails downtown facilities.

that the Sheriff's Department have a "firm policy of zero tolerance for acts of dishonesty and failure to report uses of force."¹³ Provision 13.1 further states:

If the Department does not terminate a member who is found to have been dishonest [or] used excessive force, ... the Department should document the reasons why the member was not terminated.

Pursuant to provision 13.2, if the Department does not terminate an employee for a finding of dishonesty or excessive force, the Department should report its reasons for not terminating the employee to the Office of Inspector General.

Following the use of force on January 23, 2020, and during the administrative investigation, the Deputy and the CA denied that they used reportable force, despite substantial evidence indicating that they employed resisted control holds, used a team takedown, and that their actions "result[ed] in an injury or a complaint of pain," each of which constitute reportable force under Custody Division Manual (CDM)

[Section 7-06/000.00, Use of Force Reporting Procedures.](#)

Although the Sheriff's Department sustained findings against the Deputy and the CA regarding their unreported uses of force, the Sheriff's Department's investigation concluded that it was "unresolved" as to whether the Deputy and the CA violated the Department Manual of Policy and Procedures MPP [Section 3-01/040.70, False Statements](#), and the Deputy and the CA were not discharged from the Department. A review and analysis of the investigation by the Office of Inspector General shows that the Deputy and the CA violated MPP [Section 3-01/040.70, Dishonesty/False](#)

¹³ While the use of force occurred in January of 2020, the results of the administrative investigation were reported to the Office of Inspector General during this past quarter. Per the Implementation Plan, the Department is required to report quarterly to the Office of Inspector General all findings of dishonesty, the punishment imposed, and the reasons why the department member was not terminated if the employed was not discharged. The Sheriff's Department did provide the Office of Inspector General with the results of the investigation and the discipline imposed even though the Department did not find that the Deputy and the CA were dishonest. Because the Department is only required to report findings of dishonesty and failure to report force, it is concerning that there are likely similar cases where dishonesty was alleged but not found or cases where the Department failed to alleged dishonesty at all. Such failures indicate a lack of compliance with the intent of the Settlement Agreement and the *Rosas* Implementation Plan.

[Statements](#), by a preponderance of the evidence standard,¹⁴ by making false statements, failing to disclose material facts related to engaging in reportable uses of force, and denying engaging in a reportable use of force, and that the Department should have found accordingly.¹⁵ Such a finding would have required the employees to be discharged or for the Department to provide the Office of Inspector General with an explanation as to why the Department did not discharge the employees pursuant to *Rosas* Implementation plan provision 13.1.

¹⁴ An early California case defined preponderance of the evidence: “The term simply means what it says, viz., that the evidence on one side outweighs, preponderates over, is more than, the evidence on the other side, not necessarily in number of witnesses or quantity, but in its effect on those to whom it is addressed.” *People v. Miller* (1916) 171 Cal. 649, 652-653. *Skelly v. State Personnel Board* (1975) 15 Cal. 3rd 194, 204, noted in footnote 19, “the appointing power has the burden of proving by a preponderance of the evidence the acts or omissions of the employee upon which the charges are based and of establishing that these acts constitute cause for discipline under the relevant statutes.”

¹⁵ [MPP 3-04/020.25 Administrative Investigation Terminology](#) includes the following definitions:

- Exonerated – a complaint shall be classified as exonerated when the investigation establishes by clear and convincing evidence either (1) that the employee was not personally involved or in any other way connected with the incident or incidents or allegation in question or (2) that the allegation giving rise to the investigation was demonstrably false and brought in demonstrable bad faith or by virtue of an obvious and demonstrable mental disease or defect or (3) that the allegation in question, broadly construed and even if true, would not, in any circumstance, constitute violation of law or Department policies, rules, or procedures and is not otherwise censurable. Any disposition of exonerated must be fully documented in writing and the complete reasoning and rationale set forth;
- Founded – when the investigation that the allegation is true, and when the action on the part of the Department members is prohibited by law or Department policy;
- Unfounded – when the investigation establishes by a preponderance of the evidence that the allegation is not true; and
- Unresolved – when the investigation fails to resolve the conflict between the complainant’s allegation and the Department member’s version of the incident; when there is no preponderance of the evidence to support either version of the incident.”

While there is no specific reference to the preponderance of the evidence standard as necessary for a finding of founded, the reference to the standard in unfounded indicates that a founded allegation is based on this legal standard consistent with case law. Proposed revisions to the Sheriff’s Department *Administrative Investigations Handbook* would change the possible outcomes for two categories, changing *founded* to *sustained* and *unresolved* to *not sustained*, and would clarify that a sustained finding is based on a preponderance of the evidence standard. The standard is also defined in the proposed revisions to the handbook as follows, “Preponderance of Evidence Standard – The weight of credible evidence, when viewed as a whole, more likely than not supports the disposition.” The Office of Inspector General recommends incorporating corresponding changes to the MPP.

Factual Summary

On January 23, 2020, a person in custody at CRDF refused to return to her cell after a pill call.¹⁶

The Deputy and CA determined that the inmate's behavior constituted insubordination and interference with module operations, and that she should be transported to discipline housing. The Deputy and the CA handcuffed the inmate to a bench pending transport to discipline. A supervising sergeant (the Supervising Sergeant), arrived in the module and was informed of the inmate's behavior. The Supervising Sergeant directed the deputy and the CA to notify him prior to beginning the inmate's transport, so that he could be present in case the inmate became recalcitrant as defined in CDM [7-02/020.00, Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmates](#).

The Deputy subsequently contacted the discipline module and learned that there was no cell availability. The Deputy and the CA moved the inmate to a cell in her current module pending housing availability in discipline housing. They did not notify the Supervising Sergeant of their intent to transfer the inmate to a cell.

As the Deputy and the CA handcuffed the inmate behind her back and escorted her to the cell. The inmate verbalized non-compliance and stated that she would not enter the cell but ultimately did enter the cell without incident. Once inside the cell, the inmate resisted efforts to remove the handcuffs and a "struggle ensued."¹⁷ After utilizing "failed control holds," the Deputy and the CA left the inmate handcuffed within the cell. Approximately 20 seconds later, they returned to the cell and spoke with the inmate through the door of the cell for just over a minute and then the Deputy and the CA entered the cell to remove the handcuffs where a secondary struggle ensued for approximately one minute and twenty-two seconds. At no point did the Deputy or CA utilize their radios, call for back-up, or request assistance from a supervisor during either the first or second use of force. It was only after the struggle in the cell that the Deputy notified the Supervising Sergeant via telephone, informing him that she had moved the inmate into a cell and that the inmate refused to relinquish the handcuffs. The Supervising Sergeant inquired as to why the inmate was moved without contacting him when he gave specific instructions to not transport the inmate unless he was present.

¹⁶ "Pill call is the process through which medical personnel administer prescribed medication to inmates in housing units." See [MPP 5-03/050.00 Access to Health Care](#).

¹⁷ Quotations in the Statement of Facts are taken directly from the Internal Affairs Investigation Summary.

When the Supervising Sergeant arrived back at the module, the inmate alleged that the Deputy and the CA had broken her arm. After observing redness on the inmate's arm, the Supervising Sergeant directed two deputies to escort the inmate to the medical clinic.¹⁸ The Supervising Sergeant asked the Deputy and the CA at least twice if they had used force against the inmate and both denied using force.

The Supervising Sergeant contacted a Risk Management Sergeant (RM Sergeant) regarding a possible unreported use of force incident. In response to the RM Sergeant's inquiry, the CA denied using force on the inmate. The Supervising Sergeant and the RM Sergeant reviewed and evaluated CCTV video of the incident and determined that the Deputy and the CA had both utilized reportable force on the inmate. The Supervising Sergeant notified the on-duty watch commander and the RM Sergeant returned to the module to identify potential witnesses to the use of force.

Department Disciplinary Determinations

At the time of the incident, the Deputy had been working at the Department for approximately one year, was off training, and had been working on the line in CRDF modules for approximately eight months. The Sheriff's Department sustained findings that the Deputy violated MPP Sections [3-01/050.10, Performance to Standards](#), [3-01/030.10, Obedience to Laws, Regulations and Orders](#) as it pertains to CDM [7-02/020.00, Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmates](#), [3-10/050.16, Performance to Standards – Performance Associated with the Use of Force](#) and CDM [7-06/000.00, Use of Force Reporting Procedures](#). The Department determined that the following charges against the Deputy were unresolved: MPP [Sections 3-01/040.70, False Statements](#), MPP [3-01/040.75, Dishonesty/Failure to Make Statements and/or Making False Statements During Departmental Internal Investigations](#), MPP [3-01/030.15, Conduct Towards Others](#), and MPP [3-01/030/85, Derogatory Language](#).¹⁹ The Deputy received a 10-day suspension without pay.

At the time of the incident, the CA had been working at the Department for approximately 20 years, had been working on the line in CRDF modules for approximately 14 years, and had been a training officer for approximately four years. She had been involved in 25 prior uses of force. The Sheriff's Department sustained findings that the CA violated MPP Sections [3-01/050.10, Performance to Standards](#), [3-01/030.10, Obedience to Laws, Regulations and Orders](#) as it pertains to CDM [7-02/020.00, Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmates](#),

¹⁸ The Deputy who used force was not one of the deputies who escorted the inmate.

¹⁹ The administrative investigation does not state the reason for the unresolved finding as to the Deputy.

[3-10/050.16, Performance to Standards – Performance Associated with the Use of Force](#) and CDM [7-06/000.00, Use of Force Reporting Procedures](#). The Department determined that the following charges against the CA were unresolved: MPP Sections [3-01/040.70, False Statements](#), MPP [3-01/040.75, Dishonesty/Failure to Make Statements and/or Making False Statements During Departmental Internal Investigations](#), MPP [3-01/030.15, Conduct Towards Others](#), and MPP [3-01/030/85, Derogatory Language](#).²⁰ The CA received a 15-day suspension without pay.

Analysis

MPP Section [3-01/040.70, Dishonesty/False Statements](#), states that “[Department] Members shall not make false statements or commit any other violations of the honesty policy, Section [3-01/040.69](#), when questioned, interviewed, or in reports or documents submitted. Department members who violate this section are subject to discipline up to and including discharge.” Provided in pertinent part, the Department’s Honesty Policy, MPP Section [3-01/040.69](#), reads, “[e]xamples of dishonesty and violations of trust include not only false statements, but also . . . concealment of or failure to disclose material facts, observations, or recollections, and failure to make full, complete and truthful statements when required.”

CDM Section [7-06/000.00, Use of Force Reporting Procedures](#), defines reportable force as “any force which is greater than that required for un-resisted Department-approved . . . control holds, . . . or any action which results in an injury or a complaint of pain.” CDM Section [7-06/000.00](#) further outlines reportable force categories, stating that “control holds or come-alongs resisted by a suspect [and] takedowns” constitute Category 1 Uses of Force.

Based on the Sheriff’s Department investigation, and the standard of proof by a preponderance of the evidence, the Deputy and the CA’s denials as to using force constitute dishonesty or false statements. Specifically, they each made false statements and/or failed to disclose (1) utilizing control holds on the inmate when she resisted, (2) conducting a takedown on the inmate, and (3) engaging in an action against the inmate resulting in her complaining of pain.

²⁰ The administrative investigation does not state the reason for the unresolved finding as to the CA.

Resisted Control Holds

Regarding the use of control holds that were resisted, is more likely than not that Deputy and the CA knew that utilizing control holds that were resisted by the inmate constituted reportable force pursuant to CDM Section [7-06/000.00](#).

Both the Deputy and the CA acknowledged that, immediately after escorting the inmate to a cell, they had utilized control holds, including re-directing the inmate toward the wall, to control her behavior. However, although the Deputy and the CA acknowledged that the inmate was non-compliant with their commands and refused to relinquish handcuffs, they denied that her behavior was recalcitrant or resistive, to constitute their use of control holds being considered reportable force.

All the evidence compiled in the course of the administrative investigation contradicts this claim. When interviewed by investigators, the inmate expressly realized that her resistance contributed to the use of force, stating explicitly that her “[continued] refus[al] to lock it down,” lead to the uses of force, which she stated were “[her] fault.” When describing this interaction, the inmate stated that the Deputy and CA “slammed” her against the wall, and utilized control holds to hold her against the wall. She stated that the Deputy and the CA “used pressure” to put her arms down and then exited the cell leaving her handcuffed behind her back. During a subsequent interview, the inmate provided consistent statements, admitting that she refused to comply with orders and resisted the Deputy and when they attempted to remove her handcuffs.

Other witness’s accounts mirror the inmate’s statements, with another person housed in the same module telling investigators that, during the first interaction, she observed the Deputy and the CA “roughing up” the inmate and that she observed the CA grabbing the inmate’s arms during the interaction.

A deputy who heard, but did not see the incident, told the investigators that he heard the inmate being “uncooperative” and refusing to be housed in the cell, disputing the Deputy and CA’s assertion that the inmate was cooperative and non-resistant during the interaction in which they utilized control holds.

A Mental Health Clinical Supervisor (Clinical Supervisor) who was present in the module, stated that she observed the Deputy and the CA on the upper tier “struggling with an inmate,” and that they “were hands on with her to try and get her to comply.” Describing the incident as the Deputy and the CA “tugging and wrestling” with the inmate, the Clinical Supervisor stated that she observed the Deputy and the CA utilize control holds and stated that the inmate was struggling against the Deputy and the CA’s efforts to control her throughout the entire incident. The Clinical Supervisor stated that she observed the Deputy and the CA hold the inmate in what she believed was an attempt to “get a handle on the inmate.”

A Psychiatric Technician III (Psychiatric Technician) also observed the first interaction, telling investigators that he heard and observed a “struggle” with the inmate and saw the Deputy and the CA attempting to control the inmate and describing the inmate as “being [physically] resistive and uncooperative,” when he observed the Deputy and the CA “holding [the inmate] and then moving her towards the wall to get her to calm down.”

In statements to the investigators, the Deputy admitted that the inmate was “verbally aggressive, agitated” and refused to enter the cell. The Deputy further admitted that when the Deputy and the CA attempted to remove the handcuffs, the inmate “took a step forward” in an attempt to pull away from the Deputy. The Deputy admitted that she “re-directed” the inmate toward the wall to keep the inmate from breaking free and explicitly stated that she had utilized a firm grip and control holds to place the inmate against the wall.

Despite describing these behaviors, the Deputy continued to claim that she did not perceive the inmate to be recalcitrant, because the inmate was following verbal commands despite being “verbally defiant.” Seemingly contradicting this denial of the inmate’s recalcitrance, the Deputy stated that prior to utilizing control holds, the CA told the Deputy they would end up going “hands-on” if they removed the inmate’s handcuffs, as the inmate was agitated.²¹ The fact that the Deputy and the CA initially left the inmate handcuffed in the cell also shows that the inmate was recalcitrant.

Following review of the CCTV, the Deputy admitted that the inmate was recalcitrant and that she resisted the Deputy and the CA’s control holds. Nevertheless, the Deputy continued to claim that she did not perceive the inmate to be resistant at the time of the incident, stating “at the time we didn’t feel the, like her being resistive. Like, it was more like we were just holding her against the wall.” The Deputy expressly admitted to utilizing resisted force, stating, “looking back, yes, I did violate the use of force [policy] when it came to control holds. But at the time I didn’t. But I did report my actions of the [incident] to the Supervising Sergeant.”

Similarly, the CA stated that, despite the inmate’s refusal to relinquish the handcuffs and follow their verbal commands, the CA believed that the inmate was not recalcitrant. The CA stated that her interpretation of a recalcitrant inmate (under CDM [7-01/020.00, Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmates](#)), as an “inmate

²¹ It should also be noted that, immediately preceding the use of force, the Deputy authored a Behavioral Observation and Mental Health Referral (BOHMER), in which the Deputy identified the inmate as a potential danger to staff/others and stated that she was displaying “combative/hostile” and “aggressive” behavior.

[who is] hostile and refusing to follow orders or commands given,” but stated that she perceived the inmate to be calm and cooperative.

The evidence contradicts the claims of both the Deputy and the CA even by their descriptions of the inmate’s behavior. Additionally, the fact that they left the handcuffs on the inmate after she was placed in the cell contradicts their **belief** that the inmate was not recalcitrant.

Following review of the CCTV, the CA stated that she still did not recall if the incident constituted force but stated that it seemed like “[the inmate was flailing around and [the Deputy and the CA] were holding her.” Despite acknowledging that CDM [7-06/000.00, Use of Force Reporting Procedures](#) requires Department members to report force where “there’s resistance involved,” the CA continued to claim that despite the inmate’s “flailing,” the CA did not believe that that the inmate was recalcitrant or resistant.

The Deputy and the CA are the only witnesses who ever describe the inmate as being cooperative; every other individual interviewed stated that they heard or observed the inmate behaving recalcitrantly prior to and during the encounter with the Deputy and the CA. Although the Deputy immediately admitted that the inmate was recalcitrant upon viewing CCTV of the incident, the CA continued to claim that, despite “flailing around,” the inmate was cooperative with the control holds. Based upon the evidence, it is more likely than not that, at the time of the incident, the Deputy and the CA were aware of the inmate’s resistance to their control holds, thus requiring them to report the use of control holds pursuant to CDM [7-06/000.00, Use of Force Reporting Procedures](#) and indicating that their statements to investigators were false.

Takedown

A takedown is also a reportable use of force pursuant to CDM [7-06/000.00, Use of Force Reporting Procedures](#).

In recounting their second interaction with the inmate in which the Deputy and CA attempted to remove the inmate’s handcuffs, both the Deputy and the CA admitted that they had utilized control holds to place the inmate on her lower bunk prior to exiting the cell. Most of the other witnesses to the force described this action as a team takedown, which is reportable force under CDM 7-06/000.00, Use of Force Reporting Procedures.

In the summary of the incident, the Internal Affairs investigators detailed the Deputy and the CA’s second interaction with the inmate as “another obvious struggle.” The Investigators noted that, based on a review of CCTV footage, it appeared as though the Deputy and the CA conducted a team takedown on the inmate by forcefully placing her in a lower bunk inside the cell.

In describing this part of the incident to investigators, the inmate described that the Deputy and the CA “forced [her] down” to her bed. Recognizing that she “kept refusing, so therefore [the force] was [her] fault as well,” the inmate stated that she was handcuffed behind her back when the Deputy and the CA “threw” her face-first on her bunk.

Two persons in custody who were housed in the module observed the inmate being forced to the lower bunk. One described that she observed the CA “throw” the inmate on the bed and bend the inmate’s arms behind her back. The other person stated that, she heard a “fight” and observed the inmate face-down on the bed with the Deputy and the CA on top of the inmate. Similarly, the Clinical Supervisor described the second incident as the Deputy and the CA “on the lower bunk” with the inmate “to try and get her to comply.”

During her interview, the Deputy was not initially forthcoming about the takedown and stated that she and the CA told the inmate to lie down on the bed. When pressed by the investigators, the Deputy eventually admitted that she and the CA “placed the inmate face down on the bunk using control holds.” Contrary to the evidence and her own statements, the Deputy continued to claim that she “didn’t feel as if [the inmate] was resisting.”

The CA described the second incident similarly to the Deputy claiming she did not recall the inmate resisting during the interaction, and that she had directed the inmate to bend over and lean on the lower bunk. The CA told investigators that she believed that the inmate was compliant and cooperative with these instructions to lean over onto the lower bunk and that she did not believe that she forced the inmate onto the bunk.

Upon review of the CCTV footage of the second incident, the CA continued to assert that it “seem[ed] like [the inmate complied],” but also noted that the inmate was “either flailing or jerking her body around bit.” Despite these observations, the CA stated that the inmate was only verbally resistive, not physically resistive and that she “didn’t feel like [the inmate] was forced onto the bunk.”

Given the statements of those who witnessed the use of force, including the statements of the Deputy and the CA that proved they used force to move the inmate onto the bunk despite continuing to deny it, the evidence shows likely than not that, at the time of the incident the Deputy and the CA were aware of the inmate’s resistance to their attempts to take her down to the bunk, which required them to report the use of a team takedown pursuant to CDM Section [7-06/000.00, Use of Force Reporting Procedures](#) and is evidence that shows more likely than not that the statements by the Deputy and the CA were false.

Complaints of Pain

The evidence is uncontroverted that the inmate complained that the Deputy and the CA had broken her arm. That allegation alone required the Deputy and the CA to report a use of force as required by CDM Section [7-06/000.00, Use of Force Reporting Procedures](#), which defines reportable force as “any action which results in an injury or a *complaint of pain*.” In this case, all the witnesses interviewed in the Internal Investigation reported hearing the inmate claim that her arm was broken following the use of force. In fact, the medical evaluation found that the inmate sustained injuries as a result of the use of force. The CA correctly identified that reportable force includes instances “when there is resistance or any complaint of pain or injury,” and admitted that she heard the inmate claim they broke her arm, and that she failed to report the use of force. The Deputy also admitted hearing the inmate yell that her arm was broken following the second use of force. Therefore, it is more likely than not that the Deputy and the and CA were dishonest in denying that their actions constituted reportable force based on the inmate’s complaint of a broken arm. ²²

Conclusion

The evidence detailing that the Deputy and the CA engaged in force that was reportable because they used control holds to place the inmate up against the wall of the cell, that they utilized a team takedown to force the inmate onto the lower bunk, and that the inmate complained of pain after the uses of force, which required them to report the force pursuant to CDM Section [7-06/000.00, Use of Force Reporting Procedures](#), indicates by a preponderance of the evidence that the Deputy and the CA’s claims that they did not use reportable force are dishonest. It is more likely than not that the Deputy and the CA withheld information or falsified their statements by denying engaging in a use of force, in violation of the Department’s zero tolerance policy against dishonesty and failures to report a use of force pursuant to *Rosas Implementation Plan* provision 13.1. By failing to find that the Deputy and the CA were dishonest, the Department avoided discharging these employees or explaining why a decision was made not to terminate their employment as required by the *Rosas Implementation Plan*.

²² Notably, the CA had previously received a five -day suspension for a violation of MPP section 3-01/040.75, Failure to Make Statements, and/or Making False Statements. During Departmental Internal Investigations. During the administrative interview for this incident, the CA was asked if she had ever lied in a previous administrative investigation, to which she responded, “no.”

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide habitable, humane, and safe conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.²³

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.²⁴ According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of September 30, 2025, the total population of people in custody in the Los Angeles County jails was 12,797. As of June 30, 2025, the total population of people in custody in the Los Angeles County jails was 12,364.

The table below shows the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center – East (PDC-East), Pitchess Detention Center – North (PDC-North), Pitchess Detention Center – South (PDC-South), and North County Correctional Facility (NCCF) on the last day of the previous four quarters. On these dates, three facilities (MCJ, PDC-North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity.

Facility	BSCC Capacity	Facility Count			
		12/31/2024	3/31/2025	6/30/2025	9/30/2025
MCJ	3512	3850	3793	3441	3751
TTCF	2432	2350	2314	2433	2403
CRDF	1708	1341	1418	1416	1496
PDC-East	926	10	11	7	17
PDC-North	830	1221	1286	1373	1348

²³ See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

²⁴ The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the understaffing or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

PDC-South	782	462	423	546	640
NCCF	2214	2612	3010	3148	3142

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a [motion](#) requesting the Sheriff's Department and directing the Office of Inspector General, Sybil Brand Commission, and the Sheriff Civilian Oversight Commission to review and report back on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation, and directing the Office of Inspector General to include the status of the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice.²⁵

Between July and September 2025, Office of Inspector General staff periodically verified the availability and accessibility of menstrual products at Century Regional Detention Facility (CRDF).²⁶ Any issues, such as the need to restock certain products, were addressed with line personnel and resolved promptly.

In its initial [report](#) to the Board, staff from the Office of Inspector General detailed the availability of pads, tampons and panty liners for menstruating individuals—the only products available in custody at the time. In September 2025, the Sheriff's Department began piloting menstrual cups for incarcerated workers and incarcerated persons

²⁵ See [Penal Code, § 4023.5\(a\)](#). (“A person confined in a local detention facility shall be allowed to continue to use materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the incarcerated person.”); [Cal. Code Regs., tit 15, § 1265](#). (“Each menstruating person shall be provided with sanitary napkins, panty liners, and tampons as requested with no maximum allowance.”); Los Angeles County Sheriff's Department, Custody Division Manual, [§ 6-15/010.00 Inmate Clothing, Bedding, and Personal Hygiene](#). (“All menstruating inmates shall have ready access to sanitary napkins, panty liners, and tampons.”); Los Angeles County Sheriff's Department, Custody Division Unit Orders, [§ 5-16-040 Distribution of Personal Care Items](#). (“Each menstruating inmate housed at CRDF shall be provided with sanitary napkins, panty liners, and tampons. All feminine hygiene products shall be readily available in a common space within each module or pod setting.”); [Penal Code, § 3409\(a\)](#). (“A person incarcerated...who menstruates or experiences uterine or vaginal bleeding shall, without needing to request, have ready access to, and be allowed to use, materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the person.”).

²⁶ Staff from the Office of Inspector General visited the CRDF-Reception Center and modules 1400 (medical and mental health intake); module 1700 (Conservation Work Program housing); module 2100 (restrictive housing); module 2200 (high observation housing); and modules 2500, 2600, 2700, 2800 and 3800 (general population housing).

enrolled in rehabilitation/education programs in dedicated housing modules.²⁷ Office of Inspector General investigators reviewed Sheriff's Department policies, engaged in discussions with CRDF personnel, visited facilities, and attended learning sessions to gather information on the menstrual cup pilot program.

Revised protocol for searches. In August 2025, the Custody Support Services Policy Review team approved the revised Protocol for Inmate Searches Unit Order § 6-01-00. CRDF leadership disseminated the unit order and briefed line custody personnel on August 6, 2025. The unit order adds menstrual cups as an option alongside the previously available pads, tampons and panty liners, and provides guidance for personnel on how to conduct body searches when a person is menstruating.²⁸ Under the revised unit order, menstruating individuals are required to remove their menstrual product prior to a pat-down search and, immediately afterward, be provided a new product and underwear and allowed to sanitize their hands before proceeding through the body scanner. Building on recent enhancements to privacy and sanitation through the addition of curtains, paper towel dispensers, hand sanitizer, and trash bins in the search area, the pilot of a new menstrual product demonstrates further progress.

Menstrual cups pilot program. In early 2025, the Sheriff's Department partnered with the Los Angeles-based nonprofit, The Flow, to expand access to menstrual cups for people in custody at CRDF.²⁹ To date, the organization has participated in stakeholder meetings with custody personnel and Correctional Health Services (CHS) staff; conducted learning sessions with incarcerated individuals to introduce the new product and address questions; and distributed menstrual cups and informational materials.³⁰

In April 2025, the Sheriff's Department and The Flow held a stakeholder meeting with custody personnel and CHS staff. Custody personnel raised concerns about security and misuse, noting that menstrual cups could potentially be used for "gassing" or to

²⁷ Modules 1700 and 3600 were selected for the menstrual cup pilot program. Participants included incarcerated persons from the Conservation Work Program in module 1700 and those enrolled in rehabilitation/education programs in module 3600.

²⁸ Custody Division Unit Order, § 6-01-00, *Protocol for Inmate Searches*.

²⁹ [The Flow](#) "distributes free menstrual cups and provides bilingual education to help people manage their periods with dignity, autonomy, and sustainability." Menstrual cups are small, medical-grade silicone devices inserted into the vagina to collect menstrual fluid. Each cup can be worn safely for up to 12 hours at a time.

³⁰ [The Flow](#) has received menstrual cup donations from [saalt](#), [Pixie](#), and [Diva](#), and funding from a number of entities including the Los Angeles Giving Circle, Sidney E. Frank Foundation, and Bloomberg Philanthropies. The organization has partnered with community organizations like A New Way of Life, CASA of Los Angeles, Los Angeles Regional Food Bank, and Women's Foundation California.

smuggle narcotics during off-site transportation such as to court or medical appointments.³¹ CHS staff expressed hygiene and medical concerns, including the cleaning and sterilization of menstrual cups, overall facility cleanliness, access to handwashing, and the potential for infections or other complications, particularly given limited its reported medical staffing capacity. The Sheriff's Department and The Flow acknowledged the concerns raised and reaffirmed their commitment to piloting the product, monitoring incidents, and adjusting as needed.

In May 2025, leadership from the Sheriff's Department and The Flow met with representatives from the Office of Inspector General and American Civil Liberties Union of Southern California to review the pilot program. In September 2025, staff from The Flow and the Sheriff Department's Gender Responsive Services (GRS) conducted learning sessions for incarcerated persons in the pilot modules who chose to participate.³² A total of four sessions were held, with 41 individuals participating, of whom 40 chose to take a menstrual cup. Participants in the pilot program completed pre- and post-questionnaires and received a menstrual cup along with instructions.³³ Sign-up sheets, which recorded full names, booking numbers and housing locations, were shared with CHS to monitor any infections or other complications.

From October to December 2025, the Sheriff's Department and The Flow will follow up with participants still in custody through additional learning sessions, Q&A, and a post-pilot survey to gather feedback and address concerns.

Response to the pilot program. Participants in the incarcerated workers' housing module have expressed appreciation for the menstrual cups, citing their usefulness for long work schedules and the difficulty of accessing a toilet to change out pads or tampons. Other pilot program participants shared similar feedback regarding off-site transportation to court and medical appointments, noting that menstrual cups allow

³¹ [Penal Code, § 243.9\(b\)](#) defines "gassing" as "intentionally placing or throwing, or causing to be placed or thrown, upon the person of another, any human excrement or other bodily fluids or bodily substances or mixtures containing human excrement or other bodily fluids or bodily substances that result in actual contact with the person's skin or membranes."

³² See Los Angeles County Sheriff's Department, Custody Division Unit Order, § 5-21-20, Education Based Incarceration: "The Gender Responsive Services Unit is responsible for providing inmate educational programs in accordance with the Minimum Standards for Adult Local Detention Facilities, Title 15, section 1061, 'Inmate Education Plan' [at Century Regional Detention Facility.]" At CRDF, Gender Responsive Services offers services in numerous housing modules, including 1700 and 3600.

³³ Pre- and post-questionnaires collected demographic information and asked about menstrual product shortages, familiarity with menstrual cups, and willingness to try them. Menstrual cups were disinfected in a boiling water dispenser prior to distribution.

them to go several additional hours without needing to empty or clean the product, unlike pads or tampons, which must be changed more frequently. Some custody personnel and CHS staff remain concerned about potential misuse or complications.

As of the end of September 2025, no incidents of infection or gassing attempts were documented. However, an incarcerated worker reported that custody personnel instructed her to remove her menstrual cup during a search conducted after she completed her work shift.³⁴ The menstruating individual further stated that she was denied access to a toilet and was directed to remove her menstrual cup in the designated search area in accordance with the revised unit order.³⁵ During the removal process, the menstrual cup slipped from the individual's grasp, resulting in spillage on her legs, clothing, and the floor.³⁶ The Sheriff's Department is reviewing relevant policies, operational procedures, and staff training to prevent recurrence of such incidents.

Recommendations. The incident where a person was required to remove the cup without access to a toilet, concerns raised by custody personnel about security and misuse, particularly using the cups for gassing and contraband smuggling, and concerns raised by CHS personnel about the potential for infections or other complications, highlight the need for additional policy, operational protocols, and training. The Office of Inspector General recommends that the Sheriff's Department continue collecting and incorporating feedback on menstrual cup implementation; revise directives and training as needed; re-brief custody personnel on relevant policies and unit orders; and ensure that hand sanitizer, paper towels, and menstrual products in the search area are regularly replenished.

Commissary Prices

Background

On July 9, 2024, the Board of Supervisors passed a [motion](#) directing the Sheriff's Department to report back on measures taken to ensure commissary prices in the

³⁴ See Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 5-23-010, Inmate Workers](#) states: "All inmate workers shall be escorted to the CRDF Reception Center to be searched utilizing the B-SCAN at the end of the inmate worker's shift prior to returning to their housing location."

³⁵ Custody Division Unit Order, § 6-01-00, Protocol for Inmate Searches states: "Inmates utilizing the menstrual cup shall be instructed to hold the lower portion of the cup and empty the content into the biohazard container."

³⁶ The menstruating individual stated that custody personnel provided her with new pants but no underwear. She described the experience as humiliating and embarrassing.

Los Angeles County Jails are not excessive and remain comparable with prices for groceries and other retail outlets. The motion directed the Office of Inspector General to review the Sheriff's Department's report back and provide an assessment, which was issued on February 6, 2025, entitled [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#). The motion also directed the Office of Inspector General to provide quarterly updates on the Sheriff's Department's progress on the removal of the profit mark-ups and reduction of prices on commissary items.

Kosher Meal Menu and Religious Diet Agreement

People in custody who require a kosher diet may enter into a Religious Diet Agreement (RDA) with the Department that outlines the required responsibilities and conditions to remain in the religious diet program. By signing the agreement, the individual commits to consuming only the food provided through the program and agrees not to eat food from the general population meals or purchase non-compliant items from commissary. The RDA allows the Department to routinely monitor commissary purchases to ensure compliance and specifies that individuals are prohibited from giving away, trading, or selling any portion of their religious meals.

The RDA also indicates that if a person in custody violates the terms of the agreement, they will receive a written warning. A second violation results in removal from the program, and reapplication is permitted after six months. The decision to remove someone for non-compliance is made by the Office of Religious and Volunteer Services (RVS). Additionally, individuals prescribed a medical diet will be automatically removed from the religious diet program.

The current commissary price list does not designate kosher items with a "K," which is the designation for kosher products. The Department advises that they are aware of the issue and ordered updated menus that will have the proper kosher designations. In the interim, as the majority of the commissary items are the same between this and last year, the Department has provided the prior commissary price list with the kosher designations for people in custody to compare the lists to see which items are kosher before placing an order.

The Office of Inspector General received multiple complaints from people in custody at different custodial facilities participating in the kosher religious diet program because of failure of the current price list to properly designate items as kosher. Complainants stated that before they had a copy of the previous year's commissary price list, they ordered items from the new list, not knowing whether they were kosher items, and were subsequently written up for violating the terms of the RDA. Specifically, these individuals received Inmate Record Tracking System (IRTS) write ups concerning ordering non-kosher items while on the kosher diet. In response to the complaints, the

Department indicated that the IRTS entries were “Information Only” entries that were provided to the affected individuals as a reminder of the RDA, and that no one was removed from the religious diet program. However, since these individuals had no way of knowing what items on the list were kosher without access to the previous price list, the Department lacked a sufficient basis to issue the warnings. The Office of Inspector General recommends that any IRTS warning entry for a violation prior to the issuance of the updated price list with the proper kosher designations be rescinded from their records.

As part of the Office of Inspector General’s inquiry into this topic, the Department noted that kosher diets are nearly four times more expensive than general population meals. This year, Food Services has conducted two evaluations of commissary orders for people participating in the religious diet program and reports that from February to April of this year, there were 147 individuals on kosher diets and 109 of those on kosher diets (74%) ordered commissary during that time period. Of the 109, only 2 restricted their order to kosher items. The other 107 inmates ordered a variety of items that were not kosher, in violation of the RDA. During this time period, the Department reported no IRTS entries were made and none of the individuals were notified of the RDA violation, nor were any kosher diets cancelled. Food Services merely shared their findings with RVS. The Department expressed concerns regarding the excessively high number of individuals (107 out of 147) on kosher diets who ordered non-kosher commissary items.

The Office of Inspector General recommends that the Department review the RDA and evaluate the terms, including the possibility of inmates ordering non-kosher items for other inmates.³⁷ It is understandable that the Department limits kosher, or other specialized diets for religious purposes, only to those individuals who require it, but the RDA should be clear regarding what constitutes a violation. Additionally, the Department needs to ensure that information on commissary purchasing contains sufficient information to ensure that the inmate has notice that they are violating the agreement when the order is placed.

Vending Machine Installation Update

As previously reported, Keefe provides commissary goods and items for sale in vending machines and while Keefe completes installation of new vending machines, the contract requires the temporary sale of vending debit cards so that people in custody can

³⁷ The RDA should make clear that an inmate on a kosher diet may not place an order for a non-kosher item on behalf of another inmate and should also make clear that an inmate on a kosher diet may not have another inmate order a non-kosher item on their behalf. Clear rules are needed to ensure that inmates are aware of what constitutes a violation.

continue to purchase items from the vending machines before the phase out. Keefe must also advise people in custody that new machines will be operational and the temporary vending debit cards will no longer be accepted three weeks before that point.

The Department indicates that installation of the new vending machines program is moving forward in two phases for each custody facility. The first phase is to ensure the facility has the proper infrastructure to support the vending machines, including completing the required wiring and conduit. The second phase is the delivery and physical installation of the vending machines. Every machine requires a dedicated data line (ethernet, Wi-Fi) to capture transactions in real time.

The vending machine installation process will begin with CRDF, followed by TTCF. The Department reports that phase one has been completed at CRDF, with the expected to arrive beginning in mid-October and operational as soon as the end of October. The wiring installation at TTCF is in progress and the tentative arrival for the first vending machines at TTCF is mid-November 2025. Old vending machines are being moved out of the facilities in the same sequence as the new installations to maintain continuity of service as much as possible.

The Sheriff's Department states that the process will continue over the next several months by facility, until all the new vending machines are installed and operational.

Inmate Welfare Fund Update

As previously reported, the profits from the sale of goods in the County's jails go to the Inmate Welfare Fund (IWF) to support programming and services for inmates as well as funding operational expenses of the Sheriff's Department that the Department designates as related to inmate welfare. The Department provided a recap to the Inmate Welfare Fund Commission of the financial statements for Fiscal Year 2024-25 closing and the first two months of Fiscal Year 2025-26.

The IWF began Fiscal Year 2025-26 with a carryover balance of nearly \$15.4 million, which is \$3 million higher than anticipated in the Fiscal Year 2024-25 budget due to lower than anticipated costs to reimburse the salaries and employee benefits for Inmate Services Bureau personnel assigned to units that provide inmate programs, and higher than anticipated revenues from commissary and vending sales. All remaining encumbrances for jail facility maintenance have been cancelled and the money returned to the IWF for inmate programs.

The financial report for August 31, 2025, presents the most recently updated budget forecast for Fiscal Year 2025-26. The Department indicates that the revenue from commissary and vending profit sharing will be closely monitored for any impact resulting from the negotiated reduction in profit sharing and new menu items and pricing, and the

budget forecast will be adjusted accordingly. Future monthly financial reports will be also updated as money for inmate programs is encumbered and spent.

As previously reported, under the new contract, the revenue sharing was adjusted and now 39% (down from 51.5%) of gross commissary and vending sales will be deposited into the IWF. While the lower percentage taken by the Sheriff's Department is a theoretical improvement in the contract terms, it is not clear that this adjustment resulted in reducing the costs of commissary items. The Office of Inspector General continues to recommend that the Department limit the markup of commissary items to the amount attributable to Keefe's profit and forgo the portion of the revenue generated by the contract for the IWF in order to reduce the costs of commissary items for persons in custody and their families. Funding for jail maintenance, programming, and for the welfare of persons in custody should be part of the Sheriff's Department budget allocated from County resources.

The last quarterly report of the Office of Inspector General also noted that Keefe is required to attend monthly Title 15 meetings convened by the County to present reports on various commissary issues and present annual detailed cost comparisons for all products. The Office of Inspector General requested notification of the dates and times of such meetings in order to monitor discussions on commissary pricing.

Shower Privacy for Transgender, Gender Non-Conforming, and Intersex People at Men's Central Jail

The Prison Rape Elimination Act (PREA) standards include specific protections aimed at protecting transgender and intersex people in custody "based on the unique risks these populations face while incarcerated."³⁸ Subsection (f) of the PREA Standard 115.42 requires that transgender and intersex people in custody be given an opportunity to shower separately from other people in custody. The National PREA Resource Center states that facility layout will inform the best practices in implementing this standard, and that this standard "may be accomplished either through physical separation (e.g., separate shower stalls) or by time-phasing or scheduling (e.g., allowing an inmate to shower before or after others)."³⁹

The Department's Office of PREA Compliance (OPC) is responsible for screening transgender, gender non-conforming, and intersex (TGI) people in custody in

³⁸ [National PREA Resource Center, PREA Standards: § 115.42 Use of screening information and Placement of residents.](#)

³⁹ [National PREA Resource Center, PREA Standards in Focus: 115.42 Use of Screening Information.](#)

Los Angeles County Jails. TGI people in custody assigned female at birth are generally housed at Century Regional Detention Center and TGI people in custody assigned male at birth are generally booked into custody through the Inmate Reception Center (IRC) and housed in the K6G dorms, which house gay, bisexual, transgender, queer, and intersex people at Men's Central Jail (MCJ).⁴⁰ While the OPC offers TGI people the opportunity to request to be re-housed at the facility that conforms with their gender identity through the Gender Identity Review Board (GIRB), the GIRB has often denied TGI people's request to be rehoused in their gender-conforming facility. Even where the GIRB has affirmed a TGI person's request to be rehoused, GIRB meetings are conducted monthly, meaning that TGI people in custody are often housed in a gender non-conforming facility for over one month prior to being re-housed.

Transmasculine, gender non-conforming, and intersex people housed at CRDF have access to individual shower stalls, consistent with PREA Standard 115.42.

Transfeminine, gender non-conforming, and intersex people housed in K6G dorms at MCJ have access to a dormitory shower that does not afford TGI people in custody the opportunity to shower alone as required to PREA Standard 115.42. Although the Office of Inspector General recommended that the Sheriff's Department "utilize housing that will give TGI people in custody an opportunity to shower separately from others," the OPC has not developed a solution to achieve compliance with PREA Standard 115.42 for TGI people housed in K6G dorms.⁴¹

The Department's Custody LGBTQ+ Committee, which is chaired by Custody Services Division: Specialized Programs command staff and is attended by representatives from the Office of Inspector General and the American Civil Liberties Union (ACLU), began developing a plan to allow TGI people housed in K6G dorms to shower alone during the second quarter of 2025. The Committee chair recommended that MCJ install shower partitions within K6G dorm showers and implement a "shower time," during which TGI people housed in K6G dorms may individually utilize dorm showers. The Committee chair additionally proposed a draft unit order outlining expectations for TGI shower times at MCJ, specifically requiring that staff assigned to K6G dorms at MCJ announce the shower time to the dorm, ensure that the shower is only occupied by a single occupant and clear of on-lookers, and log that the shower time allotment was completed in the electronic Uniform Daily Activity Log (e-UDAL).

MCJ has not implemented the unit order, nor has the facility began implementing TGI shower times at MCJ, stating that it would be difficult for staff assigned to K6G to execute and monitor. Citing infrastructure concerns, MCJ staff has not made progress

⁴⁰ K6G houses cisgender, transgender, and gender-non-conforming people in custody.

⁴¹ See [Report Back on the Sheriff's Department's Compliance with the Prison Rape Elimination Act](#).

with installing partitions and has instead opted to install shower curtains, pictured in the photograph on the next page, in K6G dorms.



The Office of Inspector General recognizes that the installed shower curtains have the potential to afford TGI people housed in K6G dorms more privacy than previously afforded. However, the cloth paneling in the shower curtains that were installed by the Department, depicted in this photograph, does not obstruct a person's genitals, buttocks, and breasts, rendering them useless at affording TGI people in custody shower privacy. Even if installed shower curtains cover an individual's body, the installation of a shower curtain alone does not fulfill PREA standard 115.42, as other people housed in K6G dorms may still access the shower while a TGI person is utilizing it. Additionally, Office of Inspector General staff conducted a site visit at the K6G dorms, and opposite gender staff who entered K6G dorms did not announce their presence to allow people in custody to cover their genitals, buttocks, and breasts, which is required by PREA Standard 115.15(d).

MCJ command staff noted that they requested that the NCCF print shop make signs for the K6G dorms designating shower times but to date these designated shower times have not been implemented.

In-Custody Deaths

Between July 1 and September 30, 2025, fifteen people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for eleven deaths: eight natural, one accidental,

two suicides, and one homicide that was attributed to an officer-involved shooting by the Los Angeles Police Department. For the remaining three deaths, the DME findings have been deferred.⁴² Two people died at MCJ, one person died at CRDF, one person died at Lancaster Station jail, five people died at TTCF, and six people died at hospitals after being transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a dedicated page on the [Inmate In-Custody Deaths](#) on its website.⁴³

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews for each of the fifteen in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of Death: July 4, 2025

Custodial Status: Pre-Trial

On June 28, 2025, CHS and custody staff at CRDF discovered an unresponsive person in a single-person intake cell during nursing rounds. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered three doses of Narcan. The person was transported to Long Beach Medical Center for a higher level of care, where the person was pronounced dead on July 4, 2025. Areas of concern include CCTV being non-operational at the time of the incident and custody staff failing to utilize a handheld camera during a medical emergency. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, the cause of death as diabetic ketoacidosis, and an "other significant condition" as effects from methamphetamine and cocaine.

⁴² In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and Correctional Health Services use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

⁴³ Penal Code § 10008 requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

Date of Death: July 11, 2025*Custodial Status: Pre-trial*

On July 11, 2025, custody staff conducting Title 15 safety checks at TTCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody and CHS staff administered three doses of Narcan. The person died at the scene. Areas of concern include timeliness of the emergency response. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as acute asthma exacerbation and chronic bronchial asthma.

Date of Death: July 12, 2025*Custodial Status: Pre-Trial*

On July 12, 2025, custody staff conducting Title 15 safety checks at TTCF discovered a person bleeding from both arms on the floor of their cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include the emergency response (moving the patient from the cell before initiating CPR),⁴⁴ the quality and timeliness of Title 15 checks, boarding of the cell,⁴⁵ and an inquiry into how the person was able to obtain razor blades. Preliminary manner of death: Suicide. The DME website reflects the manner of death as suicide, and the cause of death as incised wounds to bilateral upper extremities.

Date of Death: July 20, 2025*Custodial Status: Pre-Trial*

On June 28, 2025, a person was admitted to Los Angeles General Medical Center (LAGMC) after suffering from multiple gunshot wounds following an officer involved shooting by Los Angeles Police Department. The Sheriff's Department took custody of the person while he was hospitalized on July 5, 2025, and the person was pronounced dead on July 20, 2025. The DME website reflects the manner of death as homicide, and the cause of death as gunshot wounds.

⁴⁴ The Department reported that emergency response concerns related to removing a person from a cell prior to initiating CPR were addressed through "man-down" drills conducted jointly by the Sheriff's Department and CHS.

⁴⁵ Boarding is the term used when people in custody obstruct cell windows to inhibit custody staff from observing inside their cell.

Date of Death: July 21, 2025*Custodial Status: Pre-trial*

On July 21, 2025, custody staff conducting Title 15 safety checks at TTCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered five doses of Narcan. The person died at the scene. Areas of concern include the timeliness of the emergency response and CHS's evaluation of the decedent's mental health. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as acute bronchopulmonary pneumonia.

Date of Death: July 31, 2025*Custodial Status: Sentenced*

On July 13, 2025, a person in custody with a pre-existing medical condition was transported from Correctional Treatment Center (CTC) to LAGMC for a higher level of care. On July 31, 2025, medical staff detected no pulse, and the person was pronounced dead. Areas of concern include missed/cancelled and rescheduled specialty clinic appointments at LAGMC. Preliminary manner of death: Natural. The DME website reflects the manner of death as natural, and the cause of death as pulmonary thromboembolism.

Date of Death: August 5, 2025*Custodial Status: Partially Sentenced*

On August 5, 2025, custody staff conducting Title 15 safety checks at MCJ found an unresponsive person in a multi-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include CCTV being non-operational at the time of the incident and custody staff failing to utilize a handheld camera. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death is sequelae of respiratory viral infection (Covid-19 and human rhinovirus/enterovirus).

Date of Death: August 14, 2025*Custodial Status: Partially Sentenced*

On August 14, 2025, CHS staff at TTCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody and CHS staff administered three doses of Narcan. The person died at the scene. Areas of concern include the medical evaluation of the person at IRC and the failure to conduct a body scan of the person at IRC. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: August 15, 2025*Custodial Status: Sentenced*

On August 15, 2025, custody staff at MCJ responded after a person in custody yelled “help me” from a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered three doses of Narcan. Areas of concern include referrals to Addiction Medicine Services and timely application of the Automated External Defibrillator (AED). Preliminary manner of death: Unknown. The DME website reflects the manner of death as accidental, and the cause of death as methamphetamine intoxication.

Date of Death: August 15, 2025*Custodial Status: Pre-Trial*

On August 15, 2025, custody staff conducting Title 15 safety checks at Lancaster Station jail found an unresponsive person in a single-person cell. Custody personnel and paramedics rendered emergency aid, but did not administer Narcan. The person died at the scene. Areas of concern include the quality and timeliness of Title 15 safety checks, the timeliness of the emergency response, housing medically fragile people at station jails, and custody staff’s failure to administer Narcan. Preliminary cause of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as coronary artery atherosclerosis.

Date of Death: August 23, 2025*Custodial Status: Pre-Trial*

On August 20, 2025, a person in custody with a pre-existing medical condition was transported from CTC to LAGMC for a higher level of care. On August 23, 2025, the person was pronounced dead. Preliminary manner of death: Natural. The DME website reflects the manner of death as natural, and the cause of death as acute cardiac dysfunction and atherosclerotic cardiovascular disease.

Date of Death: August 25, 2025*Custodial Status: Sentenced*

On August 25, 2025, custody staff and nursing staff conducting vitals checks at CTC found an unresponsive person in a single-person cell with a ligature around his neck. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff administered three doses of Narcan. The person died at the scene. Preliminary manner of death: Suicide. The DME website reflects the manner of death as suicide, and the cause of death as asphyxia.

Date of Death: August 29, 2025*Custodial Status: Pre-Trial*

On August 29, 2025, a person in custody at CRDF alerted custody staff that her cellmate was “man down.” Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include delays in medical treatment despite the person making multiple requests for medical care. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: September 10, 2025*Custodial Status: Pre-Trial*

On August 19, 2025, a person in custody in a single-person cell at the San Fernando Superior Court alerted custody staff that he was in medical distress. Custody staff requested paramedics who transported the person to Olive View Medical Center. On September 10, 2025, the person was pronounced dead. Areas of concern include the quality and timeliness of Title 15 safety checks, the timeliness of the emergency response, the lack of appropriate care by custody staff in moving the person, the person being involved in three uses of force approximately three months prior to his death, potential medical and mental health misclassification, and the person retaining contraband. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: September 17, 2025*Custodial Status: Pre-Trial*

On September 3, 2025, a person in custody with a pre-existing medical condition was transported from TTCF to LAGMC for a higher level of care. On September 17, 2025, the person was pronounced dead. Preliminary manner of death: Natural. The DME website reflects the manner of death as natural, and the cause of death is as sequelae of abdominal aortic aneurysm with rupture.

Correctional Health Services Mortality Review

Office of Inspector General staff attend the Custody Services Division (CSD) Administrative Death Reviews for every in-custody death. Prior to this quarter, Correctional Health Services (CHS) and the Sheriff’s Department jointly engaged in the Death Review process. In August of 2025, CHS began conducting a separate “Mortality Review,” lead by the Chief Medical Officer with participation limited to medical personnel, the quality assurance team, Office of Inspector General staff, and the two Sheriff’s Department CSD Chiefs.

According to the Chief Medical Officer, CHS conducting a Mortality Review separate from but in addition to the Sheriff's Department's Administrative Death Review aligns with national best practices. The National Commission on Correctional Health Care (NCCHC), a non-profit organization that seeks to "improve the quality of health care in jails, prisons, and juvenile facilities," established a standard procedure in the event of an in-custody death.⁴⁶ In addition to working with custody staff to assess the "correctional and emergency response actions surrounding an [in-custody] death" in an administrative review, NCCHC compliance indicators establish that correctional health authorities should conduct a clinical mortality review, defined as an "assessment of the clinical care provided and the circumstances leading up to an [in-custody] death," within 30-days of an in-custody death.⁴⁷

Similarly, in a lawsuit filed by the California Attorney General against the County of Los Angeles, the Sheriff's Department, and CHS regarding conditions of confinement in the Los Angeles County Jails, the Attorney General noted that "CHS fail[ed] to conduct its own death review or morbidity-and-mortality review process."⁴⁸ To address the allegation in the lawsuit, to align with the NCCHC standards, and to mitigate CHS concerns about health related information being adequately protected by custody staff, CHS began conducting Mortality Reviews to analyze the medical and mental health care provided to each person who has died in Sheriff's Department custody, with particular focus on the care provided to the individual during the intake process and the peri-death period.⁴⁹

To achieve this, CHS nursing, mental health, and medical providers conduct an independent review of each in-custody death. Corrective Action Plans (CAPs) that CHS develops at Mortality Reviews will be reviewed every two weeks until completed, and CHS plans to track CAPs longitudinally as a long-term improvement project. CAPs developed at Mortality Review are provided to the Custody Compliance and Sustainability Bureau (CCSB) death team at each 30-day Administrative Death Review and documented in the CCSB death book. The Chief Medical Officer continues to attend each custody Administrative Death Review to address issues that involve both CHS and custody.

⁴⁶ National Commission on Correctional Health Care, Strategic Planning Summary Document (2024). Available at: [2024 NCCHC Mission Vision Goals](#).

⁴⁷ National Commission on Correctional Health Care, Standards for Health Services in Jails, Procedure In The Event Of An Inmate Death (J-A-09) (2018).

⁴⁸ *The People of the State of California v. County of Los Angeles*, Case No. 25STCV26152.

⁴⁹ CHS defines the peri-death period as six-months prior to an individual's death.

Custody Administrative Death Review Pre-Meet

This quarter, CSD executives also modified the Administrative Death Review process so that issues that do not have a direct nexus to an in-custody death would be raised outside of Administrative Death Reviews. Thus, CSD executives developed a “pre-meet,” where staff from the Office of Inspector General and County Counsel meet with the custody team to review each incident and may raise these systemic issues more effectively.

Where issues identified in the pre-meet are directly related to an in-custody death, they are addressed during the Administrative Death Review and tracked by the CCSB death review team. If issues identified in the pre-meet are not directly related to an in-custody death but present systematic concerns, a CAP will be developed by the General Population or Specialized Programs chief’s aide and tracked by Custody Support Services (CSS).

CSD executives reported that the changes to the Administrative Death Review process are preliminary, and that the department is building an electronic database to track pre-meet CAPs. CSD executives articulated that implementing these changes will keep Administrative Death Reviews focused on issues directly related to each in-custody death, and that the Department aspires to develop meaningful corrective actions within both the Administrative Death Review and the Administrative Death Review Pre-Meet.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff’s Department to “[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the OIG,” and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections.” The Board also directed the Office of Inspector General to report quarterly on the Sheriff’s Department’s progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody overdose deaths.

Of the fifteen people who died in the care and custody of the Sheriff’s Department between July 1 and September 30, 2025, the medical examiner’s final reports, including toxicology assessments, confirm that one person died due to an accidental overdose. Toxicology results remain pending for four of the fifteen deaths and may indicate an additional overdose deaths once completed. As of this report, the DME has confirmed

that eight individuals have died this year due to accidental overdose through the third quarter of 2025.

Tracking Narcotics Intervention Efforts

With regard to the directive to the Sheriff's Department to track narcotics recovery and evaluate drug detection interventions, as previously reported the Sheriff's Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Sheriff's Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Sheriff's Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

Improving Searches of Staff and Civilians

The Board's second directive requires that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails]." The Sheriff's Department previously reported that its current policy grants the Sheriff's Department broad authority to search staff and civilians entering the jails, so that no changes to existing policy are required to implement more comprehensive searches. The Sheriff's Department previously reported that it implemented more frequent unannounced and randomized staff searches beginning in May 2024.

Since last quarter, the Office of Inspector General has engaged with the Department to discuss potential ways to improve search procedures for employees of the Department and CHS and professional employee visitors, such as independent contractors and vendors, entering secured custodial facilities. The Department asserts that greater resources, including funding for more staff and equipment, are needed in order to implement more thorough search procedures. The Department emphasized that the current practice is to focus narcotics detection resources on incarcerated persons as the Department believes these individuals to be the primary source of narcotics and contraband entering the facilities. For example, the Department has seventeen new body scanners coming into their facilities that will be operational once staff complete the required training on how to use them, however, the machines will only be used to

screen people in custody. There are also thirteen K-9s employed by the Department that perform property scanning only. Although the K-9s are used at facilities upon request when available, they are mostly reserved for custodial areas.

Unless employees and professional employee visitors are searched and screened at the same frequency and thoroughness as those in custody and the civilians entering for visitation, it is difficult to determine how much contraband enters the facility via employees and professional visitors.

The Department described several proposals that could support enhanced narcotics interdiction, including (1) establishing a single point of entry and exit, (2) restricting allowable personal property, (3) monitoring traffic in the security/transportation compound, and (4) enhancing security and monitoring.

Establishing a single point of entry and exit. Employees and professional employee visitors at Twin Towers Correctional Facility and Men's Central Jail can use multiple entrances and exits with minimal screening, and although random searches are permitted, they are rarely conducted. The Department indicated that ideally there would be a single point of entry and exit with thorough, airport-like screenings. This plan would require 24/7 staffing, with the Department estimating that employee shifts would be extended by two hours in order to compensate employees for the time spent in the screening process and to change into their uniforms before starting their duties. The Department maintains that due to current staffing and budget conditions these screenings are operationally unfeasible but agrees that the potential for random screenings at this level would act as a deterrent.

Restricting allowable personal property. Another proposal includes further restricting the items that employees may bring into secure areas, such as disallowing food items. As discussed above, the Department maintains that its current staffing and budget are insufficient to thoroughly examine employee property entering the secure facilities. Additionally, this proposal raises concerns with how the Department would accommodate employee special dietary and medication needs and would likely require the Department to negotiate with its employee labor unions.

Monitor traffic in the security/transportation compound. One area of interest at Twin Towers is the transportation security compound area situated behind the building, essentially a gated parking lot that is particularly vulnerable due to high vehicle and foot traffic with minimal monitoring remotely via cameras. There is significant traffic in and out of this area for inmate medical appointments, court transports, vendor deliveries, and maintenance and custodial service work. The Department indicated there are challenges to preventing contraband flowing in this area, particularly with inmate workers (trustees) and unsupervised external contractors. Indeed, at the [September 27, 2025 Public Safety Cluster Agenda Review Meeting](#), when discussing

an agendaized Board Letter to execute a contract for custodial services at six of the Department's jail facilities, members of the Department and the public expressed concern about an outside vendor contract for cleaning jail facilities because of the potential for smuggling in narcotics. Based on current search practices, this is a legitimate concern.

Enhancing security and monitoring. Another possibility is using independent contractors to manage security operations, or armed, non-sworn Sheriff Security Officers (SSO), which could improve accountability and allow for stricter and more consistent enforcement without taxing Department resources. Such contractors would be responsible for staffing and would not be impacted by internal departmental staffing challenges. Of course, an independent contractor may have the similar hiring challenges as the Department. Using K-9s to sweep employee parking lots, and installing license plate readers to monitor vehicle access, are other ways to potentially combat the flow of narcotics.

Despite the Department indicating they do not believe employees and professional employee visitors to be the main source of narcotics entering secured facilities, the Department recognizes it does occur. Employees are encouraged to report anomalies, and the Department does investigate credible tips. The process typically involves initial inquiry by the facility, followed by referral to internal bodies such as ICIB or IAB if sufficient evidence exists. However, Custody Investigative Services (CIS) generally does not investigate staff, and the Department reports that ICIB lacks the resources to pursue full investigations unless CIS has already confirmed potential criminal activity.

Recommendations. The Office of Inspector General recommends that the Sheriff's Department continue to assess the feasibility of the discussed proposals and explore allotting funds from its current budget to implement some of these strategies. Adopting these measures will improve staff/civilian accountability and assist in determining whether searches are both conducted as required and effective at deterring or intercepting contraband.

Department Search Statistics

As previously reported, the comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table on the following pages details the staff search practices at all jail facilities from July 1 to September 30, 2025. The data regarding the number of staff searches and searches with K-9 illustrated in the table was supplied by CSSB. CSSB extracted the data on searches from the Custody Watch Commander's Log (CWCL) on October 7, 2025. K-9 data was obtained from the Custody Investigative Services (CIS) Searches of Custody Personnel Report on October 7, 2025. The Office of Inspector General was unable to verify the data provided by CSSB without additional information.

Facility	Number of Staff Searches	Number of Staff Searches with K-9	Monthly Minimum Search Requirement ⁵⁰	Search Inside Security	Search Evasion Concerns	Where Searches Logged
	Q3	Q3				
MCJ	125	17	Unable to Determine ⁵¹	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
TTCF	84	1	Yes ⁵²	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
IRC	77	10	Unable to Determine ⁵³	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
CRDF	49	1	No ⁵⁴	No	Yes	Watch Commander Log; Searches of Custody Personnel Report

⁵⁰ Each jail facility's unit order regarding staff searches was used to determine whether it met its minimum search requirement by month. Where the unit order is silent regarding the minimum search requirement, the Office of Inspector General was unable to determine if the requirement was met. Also, the jail facility must meet the minimum search requirement during each of the three months in the quarter in order to be found in compliance.

⁵¹ Los Angeles County Sheriff's Department, Custody Division Unit Orders, [§ 3-08-021 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁵² Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-08-010 Security of Personal Property](#) states: "Watch commander shall ensure a minimum of two random searches are conducted each week of persons entering the secured area during their assigned shift".

⁵³ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 5-23/006.00 Security and Searches of Person Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁵⁴ CRDF did not meet its minimum search requirement in September 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-01-090 Searches of Sworn Personnel, Custody Assistants, Professional Staff and their personal property-Approved by CSS 3/11/2024 states: "The searches shall be conducted a minimum of once per week, per shift."

NCCF	134	4	No ⁵⁵	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-North	52	3	Unable to Determine ⁵⁶	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-South	38	5	Yes ⁵⁷	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the third quarter of 2025, Office of Inspector General personnel completed 189 site visits, totaling 434 monitoring hours, at IRC, TTCF, CRDF, MCJ, Pitchess Detention Center North, PDC South, and NCCF.

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 151 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 178 monitoring hours related to uses of force, in-custody deaths, Prison Rape Elimination Act (PREA) compliance, restrictive housing, and general conditions of confinement.

Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel

⁵⁵ NCCF did not meet its minimum search requirement in August and September 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 07-145/10 Personal Property Searches](#) states: "A minimum of four (4) random searches per shift per week of any personnel and/or official visitors shall be conducted at the discretion of the watch sergeant."

⁵⁶ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-06-010 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁵⁷ NCCF did not meet its minimum search requirement in September 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-02-080 Searches of Sworn Personnel, Custody Assistants, Professional Staff and Their Property on the Facility](#) states: "The searches shall be conducted at a minimum of once per week, per shift."

by people in custody.⁵⁸ The Sheriff's Department most recent force report is for use-of force-incidents in custody through the first quarter of this year. [This report](#) and reports for prior quarters may be found on the Sheriff's Department website's transparency section under the page for use of force.

Handling of Grievances and Comments

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received 405 new complaints in the third quarter of 2025 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

Of the complaints received, 372 were related to conditions of confinement within the Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	178
Personnel Issues	20
Living Condition	32
Food	26
Classification	6
Mail	9
Bedding	11
Property	5
Showers	6
Education	5
Commissary	3
Dental	17
Mental Health	7
Telephones	4
Visiting	3
Other	40
Total	372

⁵⁸ Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

Thirty-three complaints were related to civilian contacts with Department personnel by persons who were not in custody, as shown in the chart on below:

Complaint/Incident Classification	Totals
Personnel	
Improper Tactics	5
Discourtesy	3
Discrimination	1
Neglect of Duty	4
Harassment	2
Improper Detention, Search, Arrest	2
Force	1
Off Duty Conduct	1
Other	2
Service	
Response Time	3
Other	9
Total	33

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 73 iPads installed in jail facilities: 37 at TTCF; 12 at MCJ; and 24 at CRDF. During the third quarter, there were no new installations, four iPads were salvaged and there were two iPad replacements. The Department assures that the iPads that have been removed from circulation will eventually be redeployed. There were 156,720 automated responses provided to people in custody using the iPad application to request information.

The Sheriff's Department continues to experience technical issues with iPads primarily due to unreliable power sources. The Department reports that currently the iPads are powered through facility televisions, which are switched off every evening. As a result, the iPads lose power overnight, thereby requiring those iPads to recharge each morning. Each day, the iPads require manual connection to Wi-Fi once recharged. Facility Services Bureau (FSB) personnel have been working to install dedicated power and data lines for the iPads. The Department reports that walkthroughs have been completed at both TTCF and MCJ, with a quote received for both facilities.

The Department states that TTCF remains the most stable facility in terms of connectivity, and for this reason that facility has been prioritized. The Department noted

that once the FSB project at TTCF is complete reconfiguration and programming of the iPads will resume. Additionally, the Department states that given the unstable iPad connectivity at MCJ, a decision was made to proceed with the installation of data line drops at that facility. Afterwards, efforts will be made to identify funding to facilitate payment to FSB.

As [previously reported](#), the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in custody.⁵⁹ The Sheriff's Department reports that between July 1 and September 30, 2025, no one in custody had been placed on restrictive filing and therefore did not reject any grievances under this policy. There were however, 16 excessive filing grievances from multiple inmates who reached their maximum limit, and 860 duplicate grievances were identified in this quarter.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.⁶⁰ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.⁶¹

⁵⁹ See Los Angeles County Sheriff's Department, Custody Division Manual, § 8-04/050.00, [Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges](#).

⁶⁰ See [Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, Department Service Reviews](#).

⁶¹ It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

The Sheriff's Department now has a [complaints dashboard](#) that can be sorted by date range with options to narrow the results by practice area (such as Patrol or Custody), rank, or station or unit.

Sheriff's Department's Response

The Sheriff's Department was provided with a draft of this report, and the following is the Department's response.

RESPONSE TO
Reform and Oversight Efforts: Los Angeles County Sheriff's Department
July to September 2025

From pages 1 and 2

Deputy-Involved Shootings

In March 2022, the Board of Supervisors County enacted [Los Angeles County Code section 2.170.020](#), which sets minimum standards for the disclosure of records related to peace officers employed by the Sheriff's Department. The ordinance is only operative once the Peace Officer Records Division (PORD), the County Counsel division responsible for responding to SB 1421 requests is fully staffed. Because the unit is not yet fully staffed, the public still does not have access to information that the Board intended be publicly posted as anticipated by the ordinance timelines.

Response: Due to limited staffing within the PORD Unit, the unit has not yet assumed full responsibility for responding to SB 1421 requests. However, PORD staff have begun performing redactions on responsive documents the Department has provided. The Department also continues to process requests and post disclosable records to its transparency page.

From page 5

Internal Affairs Bureau

If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

Response: For clarity, it would be more accurate to state that IAB reviews all deputy-involved shootings to determine whether any Department policies were violated, regardless of the District Attorney's decision to file criminal charges.

From page 10

Sheriff's Department Policies on Eyewitness Identification – Legal Compliance

Recommendation: The Department's policy should require and make mandatory the electronic recording that includes both audio and visual representations of the identification procedures. When it is not feasible to do both, audio recordings may be used without video, accompanied by a written explanation as to why video recording was not feasible. The Department should provide training to ensure that personnel understand the requirements of Penal Code section 859.7, including that recording the identification is mandatory.

Response: California penal code section 859.7 (a)(11) states: *“An electronic recording shall be made that includes both audio and visual representations of the identification procedures. Whether it is feasible to make a recording with both audio and visual representations shall be determined on a case-by-case basis. When it is not feasible to make a recording with both audio and visual representations, audio recording may be used. When audio recording without video recording is used, the investigator shall state in writing the reason that video recording was not feasible.”*

The Department will review MPP Section 5-09/530.20, *Photo Arrays*, to make the necessary changes to align with the statute.

From page 10

Outstanding Requests to the Sheriff’s Department

Response: The Department responded to the October 2024 subpoena by providing over 55 gigabytes of data, contained on four thumb drives, consisting of documents, emails, phone logs, and other relevant material responsive to the subpoena. Due to the April 2025 request for additional materials, the Department requested that County Counsel retain outside counsel to conduct a thorough and independent review of the materials produced and assist the Department in locating any additional materials responsive to the document request. The request to hire counsel was made soon after the April 2025 OIG request, and counsel was ultimately retained in July 2025 and continues to work on this matter.

From page 25

Availability of Menstrual Products in the Los Angeles County Jails

“ The Office of Inspector General recommends that the Sheriff’s Department continue collecting and incorporating feedback on menstrual cup implementation; revise directives and training as needed; re-brief custody personnel on relevant policies and unit orders...”

Response: CRDF Training staff, along with shift sergeants and Bonus I deputies, received an initial demonstration and training on the Menstrual Cup product. An email was also sent to all CRDF personnel providing information about the product and specific instructions on how searches are to be conducted. A formal training session on the Menstrual Cup product has been scheduled. Unit Order 6-01-00, *Protocol for Inmate Searches*, which includes procedures related to menstrual cups, was distributed on August 6, 2025.

From page 29

Shower Privacy for Transgender, Gender Non-Conforming, and Intersex People at Men's Central Jail

Response: In response to concerns regarding PREA Standard 115.42 and shower privacy for transgender, non-binary, and intersex (TGI) individuals housed in Dorms 9400 and 9500, Men's Central Jail has implemented the following operational measures:

1. Designated TGI Shower Times Implemented:

MCJ established a daily designated shower period for TGI individuals from 7:00 PM – 9:00 PM in Dorms 9400 and 9500.

- a. MCJ has posted visible signage in Dorms 9400 and 9500, for the designated shower times.
- b. The booth officer makes an audible announcement at the beginning and end of this period.
- c. Only one individual is permitted in the shower during this timeframe to ensure privacy and PREA compliance.

2. Shower Curtains Installed:

MCJ installed individual shower curtains from an approved County vendor in both dorms.

- a. The curtains are manufactured with solid-color privacy panels, with translucent sections at the top and bottom as part of the vendor's standard design.

3. Identified Height Issue and Corrective Action:

During assessment, staff identified that the curtains were mounted too high, which resulted in the solid section not fully covering the individual's private areas.

- a. A purchase order has been submitted and approved to reposition the curtain mounts to the appropriate height.
- b. Adjusted mounting hardware is currently awaiting delivery, after which facilities staff will complete the installation.



**Reform and Oversight Efforts:
Los Angeles County Sheriff's Department**

October through December 2025

Issued February 26, 2026

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between October 1 and December 31, 2025, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- *Rosas Compliance*
- Sheriff's Department's Policies on Cooperation with Federal Immigration Authorities
 - Joint Regional Intelligence Center
 - Automatic License Plate Readers
- Public Records Act Requests to the Sheriff's Department
- Law Enforcement Gang Update
- Jail Employment Opportunities at Century Regional Detention Facility

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. During this quarter, there were three incidents in which people were shot or shot at by Sheriff's Department personnel. Two people were fatally struck by deputies' gunfire. The Office of Inspector General staff was notified of the deputy-involved shootings but did not respond per the suspension of rollouts as stated in a [memorandum to the Board of Supervisors dated June 11, 2025](#).

The Sheriff's Department [maintains a page on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.

The information in the following shooting summaries is based on the information provided by the Sheriff's Department at the Critical Incident Reviews (CIR).¹ The information presented at CIR is preliminary in nature. Statements of deputies and witnesses are not provided until the Sheriff's Department completes its investigation.

Special Enforcement Bureau: Hit Shooting – Fatal

On October 22, 2025, at approximately 5:05 p.m., deputies from the Temple Station responded to a call regarding a mentally unstable person at a home on Sullivan Avenue in the city of Rosemead. The caller stated that the person was armed with a high-powered assault rifle, was suicidal, and wanted to harm persons inside the home.

When deputies arrived at the location, they made telephonic contact with the suspect, a 41-year-old Asian man. The suspect threatened to harm himself and any deputies who came on his property. He told the deputies that he was holding his juvenile son and his elderly father as hostages and would not release them. Mental Evaluation Team (MET) deputies and Special Enforcement Bureau deputies (SEB) were called to the scene to communicate with the suspect. The SEB Crisis Negotiation Team (CNT) also communicated with the suspect for several hours in an effort to convince him to release the hostages and surrender. The suspect told them he was armed and intended to kill his family members at a specific time.

Approximately four hours after the initial call for service, the suspect abruptly cut off communication and walked out of the home armed with the assault rifle. He proceeded to walk toward SEB personnel armed with the rifle, at which time three deputies shot at the suspect a total of 13 times.

The deputies rendered medical aid until Los Angeles County Fire Department personnel arrived on scene. The suspect was pronounced dead at the scene.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website, which includes audio from a 911 caller and video from body-worn cameras.

Lakewood Station: Hit Shooting – Fatal

On December 4, 2025, at approximately 9:30 p.m., deputies from the Lakewood Station responded to a call reporting a man armed with a gun inside a vehicle on Alhambra Avenue in the city of Paramount. Upon arrival, deputies encountered the suspect on the porch of a residence. The suspect, a 35-year-old Hispanic man, held a gun in one hand while holding his 2-year-old son in his opposite arm. Deputies attempted to negotiate

¹ [Manual of Policy and Procedure \(MPP\) section 3-09/330.00 Critical Incident Review Panel](#) identifies what is a critical incident and describes the process for reviewing such incidents.

the release of the toddler and relinquishment of the handgun for approximately a half-hour. The suspect refused to comply and pointed the handgun toward the deputies, at which point a deputy-involved shooting occurred.

One deputy fired one round from a rifle, striking the suspect.

Deputies rescued the toddler who was unharmed. Deputies rendered medical aid to the suspect until the arrival of Los Angeles County Fire Department personnel. The suspect was transported to a local hospital, where he was later pronounced dead. No deputies or other persons were injured during this incident.

A 9mm semiautomatic handgun and a loaded magazine were recovered at the scene.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website with audio from a 911 caller and video from deputies' body-worn cameras.

Areas for Further Inquiry

Was there any tactical communication between the shooting deputy and other on-scene deputies prior to the shooting?

Industry Station: Hit Shooting – Non-Fatal

On December 21, 2025, at approximately 5:33 p.m., deputies from the Industry Station responded to a priority call for service for a disturbance by a possibly mentally ill person at a fast-food restaurant located on Workman Mill Road, in Bassett. The call stated that a Hispanic male transient entered the employee service area of the business and refused to leave.

Deputies arrived and observed the man standing in the doorway of the south entrance. As deputies approached the suspect, a 34-year-old Hispanic man, he retreated into the business near the service counter area. The deputies ordered the man to stop moving and remove his hands from his pockets, but he refused to comply. The man then retrieved what appeared to be a firearm from his jacket pocket and pointed it at the deputies, at which time a deputy-involved shooting occurred. Two deputies fired a total of 10 rounds at the suspect.

The man was struck by gunfire and the deputies rendered medical aid until the arrival of LA County Fire Department personnel.

The man was transported to the hospital where he received medical treatment for his injuries.

One replica Glock 17 pellet handgun and one magazine with unfired 9mm cartridges were recovered at the scene. The replica handgun had been modified to accept a magazine with live rounds but was incapable of firing them.

The Sheriff's Department posted a [Critical Incident Briefing](#) on its website, which includes body-worn camera video of the shooting.

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.² For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting in Los Angeles County that results in a person being struck by a bullet to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between October 1 and December 31, 2025, the District Attorney's Office posted memoranda on its website for four findings on deputy-involved shooting cases involving the Sheriff's Department's employees.³ The District Attorney's Office declined to file charges in each case, as they determined that the use of force was not unlawful. The memoranda may be found on the [District Attorney's website page for Officer-Involved Shootings](#). The following are the deputy-involved shootings posted:

- [The July 19, 2023, fatal shooting of Benjamin Chin by Detective Hector Vasquez and Deputy Marisol Barajas.](#)
- [The January 13, 2024, fatal shooting of Noor Sherif Ramsis by Deputy Jonathan Sandoval.](#)

² In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. See [A.B. 1506 \(McCarty 2020\)](#) (codified at [Govt. Code § 12525.3](#)). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*. Until the law took effect in 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet.

³ The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#). The Office of Inspector General retrieves the information on District Attorney decisions from this webpage. Two of the listed cases were posted on the website within the second quarter of 2025, are dated during the first quarter of 2025.

- [The June 13, 2024, fatal shooting of Jerman Magana by Deputies Omaar Covarrubias and Emmanuel Mercado.](#)
- [The July 20, 2024, fatal shooting of Cody Dodd-Thompson by Deputies Daniel Ike and Brandon Campos.](#)

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (CA-DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.⁴ CA-DOJ [is not currently investigating](#) any shootings involving deputies from the Sheriff's Department. During the fourth quarter of 2025, DOJ [issued no written reports](#) regarding shootings involving Sheriff's Department deputies.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has seven shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a June 7, 2025, shooting in the jurisdiction of Lancaster Station. For further information as to that shooting, please refer to the Office of Inspector General's report [Reform and Oversight Efforts: Los Angeles Sheriff's Department - April through June 2025](#). The oldest case that the Homicide Bureau has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent two deputy-involved-shooting cases to the District Attorney's Office for filing consideration.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB

⁴ Government Code § 12525.3(b).

investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.⁵

The Sheriff's Department reports that ICIB has 84 active cases. This quarter, ICIB reports sending 8 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 32 cases previously sent from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident and recommends discipline regardless of the District Attorney's decision not to prosecute. If the District Attorney files charges, IAB proceeds with a review following the prosecution and determines if discipline should be imposed up to and including termination depending on the outcome of the prosecution.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 130 new administrative investigations. Of these 130 cases, 49 were assigned to IAB, 50 were designated as unit-level investigations, and 31 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 130 cases were closed by IAB or at the unit level. There are 465 pending administrative investigations, of which 334 are assigned to IAB and the remaining 131 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between October 1 and December 31, 2025, the Civil Service Commission issued final decisions

⁵ Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

in two cases involving Sheriff's Department employees. In these two cases, the Civil Service Commission sustained the Department's discipline in one case and overruled the Department in one case. The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings](#) posted on the County's website for commission publications.

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) 34 times between October 1 and December 31, 2025. The Office of Inspector General continues to recommend that the Sheriff's Department provide more specific information regarding the use of UAS for a "high risk tactical operation." Circumstances justifying use of a UAS might include exigent circumstances, a reasonable suspicion that a crime is occurring, probable cause to conduct a search, or the execution of a search warrant. The law recognizes these reasons for conducting a search as legal under the Fourth Amendment of the United States Constitution, which does not have an exception for a warrantless search based on a "high risk tactical operation." Historically, members of the public have supported drone usage in law enforcement but have requested the activity be limited to areas of the most benefit to life and safety and that safeguards be in place to avoid usage encroaching into areas which are likely to result in excessive invasion of privacy. Imprecise categories and limited information can result in law enforcement action that undermines public trust.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracking and Documenting Taser Use

Status of Taser Policy Implementation and Training

On October 3, 2023, the Board of Supervisors (Board) passed a [motion](#) instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The motion directs the Office of Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.

The Sheriff's Department reported the following information regarding training and policy implementation to date:

- The Department reported that from the Phase 1 purchase of 3,197 Taser 10s, approximately 2,965 are currently deployed.⁶
- The Tasers approved for use by the Department are the Taser 10, the Taser X26, and the Taser 7. The intention is to phase out the Taser X26 and the Taser 7.

Tracking Taser Use

In May 2024, the Sheriff's Department launched [a web dashboard reporting Taser usage](#) by date range with options to narrow the results by practice area (such as Patrol or Custody), patrol station or facility, incident type, or city. Beginning in July 2024, the Department began including in that data the "Result of the Use of Force" (i.e., whether the use resulted in serious injury or death). The Sheriff's Department provided the following information for Taser usage:⁷

- Since the deployment in 2024 there were approximately 326 field uses, including four jail uses with a reported 88% effectiveness rate.⁸
- During the 4th quarter there were 75 Taser uses: four in Custody and 71 in Patrol Operations.

⁶ This section on Tasers includes the information reported by the Sheriff's Department for the quarter covered in this report and does not include information reported previously. For information reported previously, see: [Reform and Oversight Efforts: Los Angeles County Sheriff's Department - July through September 2025](#), [Reform and Oversight Efforts - Los Angeles County Sheriff's Department - April through June 2025](#) and [Report on the Sheriff's Department's Taser Policy, Training, and Usage](#).

⁷ In a letter in response to a validation draft of this report, the Sheriff's Department noted that the statistics presented "reflect only Taser 10 activity rather than all conducted-energy weapon (CEW) usage across the Department. More specifically, the figures provided, such as total field uses, effectiveness rate, patrol vs. custody deployment, and signal activations, are all specific to the Taser 10 rollout and do not represent the full scope of Taser use in the Department." The report includes the information provided to the Office of Inspector General by the Department albeit in response to questions posed by us. Previous corrections were made to this section based on informal feedback from the Department, but the letter is the first time OIG was informed of this discrepancy. In the future, OIG requests that information on all Taser uses be provided for inclusion. The first sentence in this section contains a hyperlink to the Department's dashboard with the most accurate information. Finally, the bullet points in the report note that the BWC Unit tracks only Taser 10 usage while the dashboard tracks all usage.

⁸ According to the Sheriff's Department, effectiveness is determined by the assessment that a suspect was subdued as a result of the Taser usage.

- The Department reports that in the 21 incidents (28%) an individual was armed with a weapon. Two of these 21 incidents involved a firearm, 10 involved a knife and 9 involved another weapon.
- 50 Phase 1 Taser 10s have been deployed in Custody Division in Men's Central Jail and Inmate Reception Center.
- Each Taser 10 is equipped with technology that signals the BWC to activate when a deputy turns off the Taser 10's *Safe Mode* as the deputy readies the Taser to fire. The Department reported four such activations, referred to as signal activations, during this quarter.⁹ All four signal activations were for Tasers used in a custody setting. Due to the recent implementation of body-worn cameras in custody facilities, staff may still be getting used to activating the cameras.¹⁰
- The Sheriff's Department Body-Worn Camera Unit tracks only Taser 10 usage, while the Department's dashboard tracks all Taser usage.

Semi-Annual Report on Implementation of the Family Assistance Program

The Los Angeles County Board of Supervisors [established the Family Assistance Program](#) (Family Assistance), first in 2019 as a one-year pilot that it later made permanent, with the aim of improving compassionate communication and providing trauma-informed support to families of those who died following a fatal use of force by a Sheriff's Department employee or while in the custody of the Sheriff's Department. The Office of Inspector General reports semi-annually on Family Assistance in its quarterly reports on the Sheriff's Department.

Family Assistance Status

On February 8, 2024, the administration of Family Assistance officially transitioned from the Department of Mental Health (DMH) to the Office of Violence Prevention (OVP)

⁹ Per Sheriff's Department policy, a deputy should activate their BWC in advance of enforcement or investigative contact. In those incidents where the TASER 10 was deployed but no signal activation occurred, it was because the deputy's BWC was already recording. Per a response from the Department, the signal activation feature on the TASER 10 serves as a fail-safe to account for situations that unfold rapidly, where a deputy may need to react immediately for officer safety before manually activating the BWC. It also functions as a secondary safeguard in cases where the BWC was not activated as required.

¹⁰ In patrol operations deputies are trained to activate the camera when interacting with civilians. Because custody staff interact with incarcerated persons throughout the day, the training for activating the cameras is not quite as straightforward.

within the Department of Public Health (DPH), pursuant to the plan to make Family Assistance permanent as recommended to the Board in 2022.¹¹ OVP has a webpage with an [overview of Family Assistance](#) with links to the Family Assistance [brochure in English](#) and [in Spanish](#) and to the [Family Assistance Application Form](#). DPH reported to the Board on the OVP Family Assistance Program in its report dated August 26, 2025, [Permanent Funding and Implementation of the Family Assistance Program](#). Additionally, Family Assistance received a [National Association of Counties \(NACO\) Achievement Award](#), a national recognition for innovative county government programs.

In March 2024, OVP formed a multidisciplinary work group that meets monthly to discuss program design and implementation, protocols, eligibility criteria, and reviews cases. The work group includes representatives from the Sheriff's Department, the Department of Medical Examiner's (DME), the Office of Inspector General, the Sheriff Civilian Oversight Commission (COC), Los Angeles County District Attorney's Office, Department Mental Health (DMH), Los Angeles County Correctional Health Services, and Los Angeles Office of the County Counsel. In collaboration with the workgroup partners, OVP drafted Family Assistance protocols. An updated draft of the protocols was circulated in December 2025 with a request for feedback to be submitted by January 9, 2026. The protocols are expected to be approved in February 2026.

Family Assistance Service Data

OVP reports that from July 1, 2025, to December 31, 2025, OVP was notified of 30 deaths to individuals under the jurisdiction of the Sheriff's Department. Out of these 30 deaths, 25 individuals lost their lives while in a custody facility and the remaining five individuals died due to a fatal use of force incident in the community. Three of the deaths were due to shootings by Sheriff's Department deputies and two involved uses of force by other agencies for which the Sheriff's Department Homicide Bureau assisted in the investigation.¹² OVP engaged with all 30 families referred to Family Assistance and each family received at least one of the following services: program information and access, crisis intervention, grief counseling, financial assistance, case management, advocacy, and referrals to additional resources. OVP distributed burial expenses to

¹¹ See [Office of Inspector General's Semi-Annual Report on Implementation of the Family Assistance Program and Report Back on Permanent Support for Families Affected by Los Angeles County Sheriff's Department: Identifying Sustainable Funding for and Streamlining the Family Assistance Program \(Item No.14, Agenda of July 9, 2019 and Item No. 9, Agenda of October 19, 2021\)](#) (Feb. 22, 2022).

¹² The Sheriff's Department Homicide Bureau sometimes assists other local agencies with homicide investigations including officer-involved shootings. The two agencies that the Department assisted for the last two quarters of 2025 are South Gate Police Department and Claremont Police Department.

sixteen families, with expenses ranging from \$1,000 to \$7,500 per family, totaling approximately \$86,810 for the period.

The Office of Inspector General previously reiterated the recommendation by DPH that the County align the burial expense limit with the state's California Crime Victim Compensation Board limit of \$12,818. At its [November 18, 2025 meeting](#), the Board approved a [motion](#) to increase the Family Assistance's funeral expense reimbursement cap from \$7,500 to \$12,818 to align with current state Victim Compensation Board cap.

Rosas Compliance

The Court appointed monitors for the [Rosas Settlement Agreement](#) evaluated compliance with the Action Plan for the period of January 1, 2024 to June 30, 2024 in a report to the court dated October 15, 2025. The [Panel's Fifteenth Report](#), noted significant progress towards compliance with the settlement agreement including noting the Sheriff's Department's issuance of clear and specific use-of-force policies applicable in the Department's custody facilities and using its force-review systems to focus on decreasing overall uses of force in the Department's Downtown Jail Complex. The report notes that the parties have been working to develop plans to achieve compliance in four key areas:

(1) eliminating impermissible head strikes; (2) proper use of the WRAP Restraint;¹³ (3) appropriate utilization of force avoidance and de-escalation techniques; and (4) accountability.¹⁴

In particular, the monitors note that this fifteenth report highlights two key areas necessary for achieving Rosas compliance:

¹³ Custody Division Manual section **7-03/050.00 WRAP RESTRAINT** describes the WRAP restraint: *The WRAP restraint device (manufactured by Safe Restraints, Inc.) is a Department approved security restraint device authorized for use within the Custody Services Division. The WRAP restraint device immobilizes the body and restricts the inmate's ability to kick. The WRAP restraint device restrains the inmate in an upright position and puts the inmate in a position for transport or movement.* Use of The Wrap restraint, especially on an agitated person, has been questioned by some use-of-force experts. A recent report by Bloomberg law identified 41 incidents in which law enforcement officers used The Wrap restraint on someone who died and that in 32 of those deaths the manufacturer's instructions were followed. The Office of Inspector General recommends that the Sheriff's Department review the report by Bloomberg Law and consider opinions of use-of-force experts to assess whether it would be a better practice to ban use of The Wrap. (See Alexia Fernández Campbell and Umar Farooq, ['I Can't Breathe.' Police Use Restraint With Fatal Results](#), Bloomberg Law (January 23, 2026).

¹⁴ [Panel's Fifteenth Report](#) at page 2.

(1) eliminating impermissible head strikes and (2) developing an effective system of accountability for impermissible uses of force.¹⁵

In noting the Department's resistance to opening administrative investigations for possible use-of-force violations the report notes:

The Panel continued to encounter resistance from Department leaders to opening administrative investigations in the face of apparent use of force violations, including impermissible head strikes. This resistance has been communicated in certain meetings with Department leaders and is highlighted by several cases reviewed by the Panel in the Fifteenth Reporting Period. Of the 50 cases the Panel reviewed for the Fifteenth Reporting Period, the Department used head strikes in 15 cases. The Panel found the Department's actions in 8 of the 15 cases met the criteria for 2.6 and were therefore compliant. In the 7 remaining cases, the Department concluded the actions of staff were objectively reasonable and within Departmental policy in all seven.¹⁶

Contrary to the Department's findings, the monitors found that in these seven cases, the head strikes violated Departmental policy. [In a December 16, 2025 letter from the ACLU to the Board of Supervisors](#), the ACLU calculated that the monitors find head-strike violations 15 times more than the Sheriff's Department.

The monitoring report points out that unlike other law enforcement agencies, the only Department members who are permitted to request an administrative investigation are Department Chiefs. In response to a draft of this report, the Sheriff's Department clarified that while only Department Chiefs may request an administrative investigation by IAB, unit commanders or higher-ranking executives have the authority to order administrative investigation conducted at the unit level. Nevertheless, the monitors identified the limitation on opening IAB investigations as a cultural problem, noting that some supervisors believe that identifying and referring a policy violation that could lead to an administrative investigation is not being "supportive" of staff.¹⁷ The Office of Inspector General agrees with this assessment as well as with the assessment in the

¹⁵ [Panel's Fifteenth Report](#) at page 2.

¹⁶ [Panel's Fifteenth Report](#) at page 6.

¹⁷ [Panel's Fifteenth Report](#) at page 7.

panel's report that the practice of having the facility where the force was used conduct the investigation "does not offer the independence that the Panel had hoped for and recommended."¹⁸

To achieve compliance with the *Rosas Settlement Agreement*, investigations must be unbiased and rigorous, and discipline must be imposed. Additional information on compliance and achieving compliance in the remaining provisions of the Action Plan are fully discussed in the [Panel's Fifteenth Report](#). The Office of Inspector General recommends that the Sheriff's Department consider the report and implement the changes necessary to achieve compliance.

Sheriff's Department's Cooperation with Federal Immigration Authorities

In 2017, during President Trump's first term, the Los Angeles County Board of Supervisors requested the Office of Inspector General to review, analyze, and make recommendations regarding the Sheriff's Department's policies as they relate to immigration issues. From 2017 to 2020, the Office of Inspector General issued several reports on the matter.¹⁹

While the Sheriff's Department has policies that limit cooperation with federal authorities on immigration enforcement, data collected by the Sheriff's Department is sometimes accessed by or provided to the federal government upon request and such data may have the effect of assisting immigration authorities without the intent to do so.²⁰

To date, the Office of Inspector General has not identified any data that has been used to assist the federal government with immigration enforcement.

¹⁸ [Panel's Fifteenth Report](#) at page 7.

¹⁹ See [Immigration: Public Safety and Public Trust](#) (October 2017); [First Report Back on the Sheriff's Department's Adherence to Policies Regarding Cooperation with Immigration Authorities](#) (June 2018); [Second Report Back – Sheriff's Adherence to Policies Regarding Cooperation with Immigration Authorities](#) (November 2018); [Inspector General's Monitoring of Los Angeles County Sheriff's Department's Cooperation with Immigration Authorities](#) (February 2019); and [Report Back on Truth Act Forum – LASD Inmate Locater System and Public Access to Inmate Release Information](#) (December 2019).

²⁰ The Sheriff's Department's formal response to the validation draft of this report notes that it "does not proactively transfer data to federal immigration authorities and operates in compliance with the California Values Act, Senate Bill 54, which limits cooperation with federal immigration enforcement activities." The entire letter sent in response to the draft of this report is included at the end of this report.

Joint Regional Intelligence Center

The Sheriff's Department is part of the Joint Regional Intelligence Center (JRIC). Office of Inspector General staff met with Sheriff's Department and JRIC staff to discuss what, if any, information is provided through JRIC to federal authorities regarding immigration enforcement. According to the information provided, no information related to the immigration status individuals or relating to immigration enforcement is provided by any Sheriff's Department personnel to the federal government through JRIC.

In response to the attacks of September 11, 2001, the Department of Homeland Security established fusion centers across the United States. A fusion center is intended to be "[a] collaborative effort of two or more agencies that provide resources, expertise, and information to the center with the goal of maximizing the ability to detect, prevent, investigate, and respond to criminal and terrorist activity."²¹ In late 2005, the Sheriff's Department, Los Angeles Police Department (LAPD), the United States Attorney's Office for the Central District of California, the California Department of Justice, and the FBI signed a Memorandum of Understanding to create the first fusion center in Southern California – the Joint Regional Intelligence Center (JRIC).²² Today, there are approximately 80 fusion centers nationwide, with JRIC being one of the largest, second only to New York in terms of both the volume of information processed and the area that it is responsible for handling. JRIC covers six counties – Los Angeles, Riverside, San Bernardino, Santa Barbara, San Luis Obispo, and Ventura – covering nearly 40,000 square miles, approximately 16 million residents, and more than 200 public safety agencies, including law enforcement, fire services, and public health partners.²³

From its inception, the intent of JRIC has been to "improve coordination and intelligence sharing by putting all the important players together-not on a conference call or in a warren of cloistered cubicles, but in an open, collaborative bullpen that encourages back-and-forth exchanges."²⁴ This bullpen is located in an FBI provided office space in Norwalk. Housed within this facility are representatives from the Sheriff's Department, the LAPD, the FBI, and U.S. Customs and Border Protection, among others.

²¹ [Global Justice Information Sharing Initiative, "Baseline Capabilities for State and Major Urban Areas Fusion Center, A Supplement to the Fusion Center Guidelines," United States Department of Justice \(September 2008\).](#)

²² [Joint Regional Intelligence Center \(JRIC\) Memorandum of Understanding \(MOU\), October 3, 2005.](#)

²³ [Joint Regional Intelligence Center, "About the JRIC."](#)

²⁴ [Federal Bureau of Investigation, "Hand-to-Hand Cooperation Intel Sharing Without Walls," August 14, 2006.](#)

The Sheriff's Department, LAPD, and the FBI comprise the largest of the participating entities at JRIC.

JRIC is governed by a board and managed by an Executive Director. The Governance Board is "responsible for determining JRIC's direction, setting policy, and maintaining accountability for the actions of JRIC."²⁵ The Board meets quarterly and includes among others, representatives from the FBI, Los Angeles Area Fire Chiefs Association, Sheriff's Department, LAPD, Long Beach Police Department, and the Los Angeles County Department of Public Health. The Board is tasked with identifying, agreeing upon, and articulating JRIC's goals and objectives.

JRIC does not conduct criminal investigations. When JRIC receives a tip, it adheres to applicable state, local, and federal guidelines for analyzing and documenting the information, as set forth in 28 Code of Federal Regulations Part 23.²⁶ All new tips entered into the system must be evaluated, scored, and rated in accordance with these guidelines. Information may only be retained if it is supported by a tip or lead based on reasonable suspicion or a criminal predicate.

If a tip includes information related to a person's immigration status or status as an undocumented immigrant, that information is neither entered into the database nor disseminated unless it is directly relevant to a *criminal investigation*. When a tip is submitted online, the user will receive a prompt asking whether the information provided by the user relates to immigration enforcement and advises the user that state and local laws prohibit law enforcement agencies from using their resources to support federal immigration enforcement.

All tips are automatically purged from the system within a year, and after staff review.²⁷ If information is deemed relevant and incorporated into an intelligence file, it is assigned a five-year review date to determine if the data is still relevant or if it can be deleted after that time.²⁸ All of this activity is input into a database, which is maintained by the Sheriff's Department. Any activity within the database is fully captured through an audit trail to ensure accountability and compliance.

²⁵ Letter from Robert Luna, Los Angeles County Sheriff, to Los Angeles County Board of Supervisors (Nov. 7, 2023), <https://file.lacounty.gov/SDSInter/bos/supdocs/185455.pdf>.

²⁶ Bureau of Justice Assistance, "28 CFR Part 23 A Guide to Criminal Intelligence Policies," United States Department of Justice, October 25, 2022.

²⁷ Robert Fox, [Los Angeles Joint Regional Intelligence Center, \[PowerPoint slides\]](#).

²⁸ *Ibid.*

The Sheriff's Department maintains JRIC's databases and serves as the fiduciary for the funds used to operate and sustain the center. JRIC is funded primarily through grants provided by Urban Area Security Initiative, administered by the Department of Homeland Security and the Federal Emergency Management Agency. The Sheriff's Department has assigned one lieutenant, two sergeants, one deputy, and one civilian administrative employee to manage these grants and to provide training to law enforcement as outlined by JRIC's mission. Through its management of both the funding and the database, each of which is critical to the operation of JRIC, the Sheriff's Department plays an integral part in JRIC's day-to-day operation.

Pursuant to the original Memorandum of Understanding executed in 2005, and reaffirmed through subsequent signed iterations/updates, personnel assigned to JRIC remain subject to the rules, regulations, laws, and policies of their respective home agencies. All California agency designees working at JRIC are required to comply with Senate Bill 54, which prohibits the use of state and local resources to assist in federal immigration enforcement. In addition, the Sheriff's Department's internal policies prohibit the sharing of such information with federal law enforcement.

JRIC is not an investigative entity. Its role is limited to collecting tips and leads and disseminating credible information to appropriate participating agency for investigation. As the manager of the database, the Sheriff's Department stated that immigration-related information is not entered or maintained in the database unless it is directly pertinent to a criminal predicate, as defined by federal regulations and state laws. Tips that relate solely to immigration enforcement are not entered into the database. Sheriff's Department representatives stated that members assigned to JRIC have not participated in the recent federal enforcement activity by ICE and U.S. Customs and Border Protection, nor have they disseminated or shared information to assist these federal immigration enforcements.

Sheriff's Department designees reaffirmed that JRIC's mission is limited to the dissemination of credible criminal and terrorist threat information – its mission does not include immigration enforcement activities, particularly those that would violate state or local laws, or internal Sheriff's Department policies. As such, the Sheriff's Department personnel do not share any such information with federal agents.

Automatic License Plate Readers

On September 16, 2025, the Board of Supervisors adopted the motion [Safeguarding Automated License Plate Readers \(ALPR\) Data to Restore Community Trust and Prevent Improper Civil Enforcement](#). The Board's aim was to ensure Los Angeles County residents "feel safe traveling from place to place without fear that their movements are being tracked, stored, and shared in ways that violate their privacy." In

support of this effort, the Board sent a letter to Governor Gavin Newsom advocating for Senate Bill 274.²⁹ If passed, the bill would have limited the retention of non-hit plates to 60 days, mandated annual audits, and instituted yearly privacy training for ALPR users. On October 1, 2025, Governor Gavin Newsom vetoed the bill, stating that it “does not strike the delicate balance between protecting individual privacy and ensuring public safety.”³⁰

Anticipating that the Senate Bill may not be adopted, the Board’s motion outlined steps the Sheriff’s Department should take independently, to address concerns within immigrant communities and prevent erosion of public trust. Among the key action items, the Sheriff’s Department was directed to update its ALPR policy. On November 10, 2025, the Sheriff’s Department provided the Office of Inspector General with a draft of its amended policy. Upon review, the Office of Inspector General found that the updated policy incorporated all of the action items required by the Board motion. The only concern raised is the timeline for data retention – how long the images captured by the ALPR cameras are stored. Even though the Board did not mandate a particular retention period, the Board motion expressed a desire for Los Angeles County to “lead” the State by adopting the provisions of SB 274.

Accepting the Board’s directive to reduce the retention period of these stored images, the Sheriff’s Department settled on a two-year period; the same retention period as LAPD.³¹ While aligning with the other major law enforcement agency in the Los Angeles area is one consideration, the major consideration should be the value in retaining the information. In order to find the optimal retention period, what is sometimes referred to as the *Goldilocks zone*, the Office of Inspector General continues to recommend that Department conduct a study to determine when the majority of retained images provide the most value in preventing crime and apprehending offenders, while ensuring all images outside this effective use period are deleted. (See [Reform and Oversight Efforts: Los Angeles County Sheriff’s Department – April through June 2025.](#))

²⁹ Letter from Los Angeles County Board of Supervisor Hilda L. Solis, Holly J. Mitchell, Lindsey P. Horvath, and Janice Hahn to Governor Gavin Newsom (September 17, 2025). <https://file.lacounty.gov/SDSinter/bos/supdocs/207693.pdf>.

³⁰ Letter from Governor Gavin Newsom to Members of the California State Senate (October 1, 2025). <https://www.gov.ca.gov/wp-content/uploads/2025/10/SB-274-Veto.pdf>.

³¹ [Los Angeles Police Department Automated License Plate Recognition Usage and Privacy Policy- Established, Section 568.53, Revised by Special Order No. 31.](#)

For example, if a significant portion of the images remain useful for two years in solving crimes, this may justify the Sheriff's Department's amended retention period.³² If most cases are resolved within a shorter or longer period, it may be the better practice to choose a timeframe that serves the purpose of crime solving while respecting privacy concerns by deleting images outside of the optimal timeframe.

Public Records Act Requests to the Sheriff's Department

California Public Records Act

The California Public Records Act (CPRA) is the statute that governs public access to government records in California. The legislation was enacted in 1968 and is codified in [Government Code sections 7920.000-7931.00](#). The CPRA recognizes that while being mindful of privacy concerns, to promote transparency in government, "access to information concerning the conduct of the people's business is a fundamental and necessary right of every person."³³

Upon request, government entities must disclose records to the public, unless the CPRA provides a specific reason for not providing the information, referred to as an exemption. For example, personnel or medical files are exempt from disclosure for privacy concerns.³⁴ Records related to pending litigation where the agency is a party are also exempt from disclosure.³⁵ Outside of a specific exemption, the government agency

³² Cities that installed fixed cameras in some of the jurisdictions patrolled by the Sheriff's Department have retention periods that are not aligned with the proposed Sheriff's Department policy. For example, Santa Clarita requires all ALPR data from fixed cameras, which the city funded, to be deleted within 30 days. (See Perry Smith, [City OKs contract to help LASD with license-plate readers](#), The Santa Clarita Valley Signal (November 13, 2024.) This misalignment in retention periods means that residents may have greater privacy protections in some areas as opposed to others and makes transparency difficult. The Sheriff's Department faces a unique challenge compared to other local agencies in the greater Los Angeles area, as it provides contract services to multiple cities and must honor each of their contract cities' retention, a complexity that agencies like the LAPD do not encounter. This misalignment should be another policy consideration when determining the optimal retention period.

³³ [Government Code § 7921.000](#).

³⁴ [Government Code § 7927.700](#).

³⁵ [Government Code § 7927.200](#).

may attempt to justify withholding a record under the catch-all exemption balancing test when “the public interest served by not disclosing the record clearly outweighs the public interest served by disclosure of the record.”³⁶

Peace Officer Records

Specific provisions of California law apply to the disclosure of peace officer records. Historically, peace officer personnel records were considered confidential and exempt from disclosure under the CPRA pursuant to [Penal Code section 832.7](#).

However, peace officer names, employing departments, and the dates of employment are required to be disclosed because this information is not “personal data” within the meaning of Penal Code section 832.8(a), which defines “personnel records” as used in section 832.7. In *Commission on Peace Officer Standards & Training v. Superior Court* (2007) 42 Cal.4th 278, 299, the court noted:

We find no indication that the Legislature, in adopting sections 832.7 and 832.8, was concerned with making confidential the identities of peace officers or the basic fact of their employment. Rather the legislative concern appears to have been with linking a named officer to the private or sensitive information listed in section 832.8.

Additionally, changes in the law by [Senate Bill \(SB\) 1421](#), effective January 1, 2019, and [SB 16](#), effective January 1, 2022, made certain categories of peace officer records nonconfidential and subject to disclosure. Specifically, records may be released related to an incident involving the discharge of a firearm at a person by a peace officer or custodial officer, where any use of force causes great bodily injury or death, and where there is a sustained finding of unreasonable or excessive force, including failing to intervene when another peace officer is using unreasonable or excessive force.³⁷ Records are also disclosable where there is a sustained finding against a peace officer for dishonesty in their reporting, investigating, or prosecution of a crime, for dishonestly directly relating to reporting or investigating misconduct of another peace officer, for committing a sexual assault on a member of the public, for discriminatory conduct, and for unlawful arrests or searches.³⁸

³⁶ [Government Code § 7922.000](#).

³⁷ [Penal Code § 832.7\(b\)\(1\)\(A\)](#).

³⁸ [Penal Code § 832.7\(b\)\(1\)\(A-E\)](#).

Sheriff's Department Deputy Exemption List

Government agencies may still use the catch-all exemption's balancing test and provisions in Penal Code section 832.7 to withhold peace officer records if "there is a specific, articulable, and particularized reason to believe that disclosure of the record would pose a significant danger to the physical safety" of the involved peace officer.³⁹ General assertions about the risks officers face, even after a shooting in which they are involved, are insufficient and there must be evidence presented of a specific safety concern particularized to the officer seeking exemption from disclosure in order to outweigh the public's interest in disclosure. (See *Long Beach Police Officers Assn. v. City of Long Beach* (2014) 59 Cal.4th 59, 74-75.) The justification for withholding any record is made in a "case-by-case balancing process, with the burden of proof on the proponent of nondisclosure to demonstrate a clear overbalance on the side of confidentiality." (*Long Beach Peace Officers Assn. v. City of Long Beach*, *supra*, at page 67, citing *Michaelis, Montanari & Johnson v. Superior Court* (2006) 38 Cal.4th 1065, 1071.).

In the past, the Office of Inspector General requested records concerning deputy unit assignments and was informed that certain employee names were exempt from public disclosure due to a deputy being on the departmental exemption list. Because the names of the deputies were given to Office of Inspector General staff, a search on Google was conducted for the exempt employees, each of whom was found in the search and some of whom were pictured in uniform in news reports or social media.⁴⁰ In response, the Sheriff's Department determined some employees were improperly noted as exempt on the Department's list.

This issue is not unique to the Sheriff's Department. In 2023, LAPD officers filed a [lawsuit](#) claiming that release of their information and photographs in response to a CPRA request put them in danger due to their undercover status.⁴¹ Upon review, however, many officers were similarly identifiable as LAPD employees via simple online

³⁹ [Penal Code § 832.7\(b\)\(6-7\)](#).

⁴⁰ The Office of Inspector General requested the information on behalf of the Civilian Oversight Commission but intended to withhold information for any deputy who qualified as exempt under the law.

⁴¹ Myung J. Chun, [Nearly 700 LAPD undercover officers sue city for releasing their photos](#), Los Angeles Times (September 13, 2023).

searches, negating the claim that disclosure of their status with LAPD put them in significant danger. The City Attorney subsequently requested dismissal of the lawsuit.⁴²

The Office of Inspector General reviewed the Department's protocols for placing a deputy on the exemption list given the concerns that deputies on the list provided in response to the Office of Inspector General's request were not exempt from disclosure.

The Department uses a system called the Exemption MANagement System (EXMAN) to store the information of exempted employees and is in the process of developing an updated version called Confidential Operators Verified Enrollment and Roster Tracking (COVERT).⁴³ The Department indicates the system aims to ensure a secure, transparent, and case-specific electronic process for managing exemption requests and disclosures. The exemption list and CPRA requests involving possible exemption of an employee's name are handled by the Office of Constitutional Policing – Risk Management Bureau's (RMB) PRA unit.

Any Sheriff's Department employee may request an exemption from having their name disclosed in response to a CPRA request. Department members are advised via email notifications and bulletins about the legal requirements and process to submit the request. In the advisements, the Department indicates that submission of a request does not guarantee approval and if the public already knows the person is a Department member for example, because they normally work in uniform or are identified as a Department member on social media, there is no legal justification for

⁴² Libor Jany, [Many 'undercover' officers in lawsuit over LAPD photos are just regular cops, city says](#), Los Angeles Times (November 13, 2024).

⁴³ In the attached letter response from the Sheriff's Department, the Department states that "the EXMAN system is no longer in use by the Department. The Department has created a new system called COVERT." The letter goes on to state that the COVERT system "has not yet launched, pending testing of the technological system." This report notes the development of COVERT but not its implementation nor the phase out of EXMAN. This information was based upon a January 28, 2026 communication from the Department that stated: "The transition from ExMan to COVERT is temporarily on hold. Our personnel who create these applications have been focused on launching a new PRA tracking system named ReqTrak. We finally launched ReqTrak and are expanding it to Custody division. Once that project has been fully finalized, we'll be reinitiating COVERT. ExMan is still in place and is still being used." While the response letter clarifies that EXMAN is no longer in use, the letter also states the new COVERT system has not yet launched. Therefore, it remains unclear from the response what system is in use currently given that EXMAN is no longer in use, but COVERT remains in the testing phase. It should also be noted that when transmitting drafts of reports to the Department, OIG asks routinely that any corrections to the report be provided prior to the Department sending a formal response. OIG depends on the accuracy of information received from the Department when we have no way to independently verify the information. No corrections were received regarding the information pertaining to PRAs until the Department's formal response.

placing the employee on the exemption list. The advisements also direct employees to submit an exemption request if they are transferred to an undercover assignment.

A Department member may complete their request to be on the exemption list via an online form, which creates an entry in the EXMAN system. In the application, the Department member must indicate they are involved in an undercover assignment and there are specific threats against them or their family because of that work.

Alternatively, if the employee does not work undercover but wishes to be on the exemption list, the employee must demonstrate that if their association with the Department were made public, they would be placed in danger. The Department notes that the latter is typically supported by documentation such as protective orders or related reports. Departmental guidelines also specify that the fact that an employee considers their work location or the population they serve to be dangerous is not in itself legal justification for approval. However, the email to Department employees states: “[g]enerally, those working in an undercover capacity are exempt.”⁴⁴ This statement could give employees the false impression that working in an undercover capacity **automatically** means they are exempt, rather than still requiring the case-by-case analysis as articulated in the case law. (See, *Long Beach Peace Officers Assn. v. City of Long Beach*, *supra*, at page 67.).⁴⁵

The exemption request first goes to the requestor’s unit commander to make a preliminary determination. The unit commander can add comments into the EXMAN system to support the approval or rejection. If approved by the unit commander, the request then goes to the RMB PRA Unit Lieutenant or designee who makes the final determination after consulting with County Counsel as needed.

The EXMAN automated system updates the list regularly based on rejections, approvals, and weekly updates on employee transfers and assignments, noting the

⁴⁴ The Department’s response to this report notes that it does not include a discussion of [Assembly Bill 1178](#). The amendments to Penal Code section 832.7 addressed in this legislation “require a court in **an action to compel disclosure** pursuant to specified provisions, in determining whether there is a specific, articulable, and particularized reason to believe that disclosure of the record would pose a significant danger to the physical safety of a person, **to consider** whether the particular peace officer is operating undercover and their duties demand anonymity.” (Emphasis added.) As noted, being undercover is part of but not the only consideration. OIG staff reviewed the current version of Penal Code section 832.7 and thus found it unnecessary to research when certain amendments to the code section were made.

⁴⁵ It’s unimaginable that deputies working undercover are using their real name, so it is unclear why providing a deputy’s name without information that a deputy is working in an undercover capacity would automatically result in a threat to that deputy’s safety. Certainly, a request for a photograph of the deputy would put the deputy in danger in those circumstances.

employee's current position and whether they are approved for an exemption. If there is a discrepancy, the EXMAN system will initiate a recertification process that must be completed within thirty days. Failure to recertify results in non-exempt status. Any exempt personnel who subsequently promote to Captain or above will also automatically be set to non-exempt status as such ranks are considered public officials.

The Office of Inspector General recommends that the Department in consultation with County Counsel regularly audit the information stored in EXMAN to ensure accuracy and sufficient particularity of the potential threats pursuant to statutory and case law. Review of the documentation and justifications provided by Department members should also be conducted on a regular basis and not just when a CPRA request is submitted for specific information.

Law Enforcement Gang Update

In response to an Office of Inspector General inquiry about the Sheriff's Department identification of any group that meets the definition of a law enforcement gang pursuant to California Penal Code section 13670, the Department [responded](#) that, to date, no such group has been identified.⁴⁶ The Department reports that there are 10 pending administrative investigations with allegations relating to law enforcement gang or deputy subgroups. Information provided by the Department with regard to its open investigations shows that two of the pending investigations were opened over three years ago and three were opened over a year ago. The Department also reported that it has referred 213 allegations of participation in a law enforcement gang to the Commission on Peace Office Standards and Training (POST).

After an inquiry by the Office of Inspector General seeking to confirm that the Department has not identified any group that qualifies as a law enforcement gang, the Department [responded](#) that Penal Code section 13670 does not require the Department to identify groups *by name* and notes that "any suggestion that the Department should be identifying groups by name is a misreading of the Penal Code section which itself states that such groups 'may identify themselves by a name' but is not necessary that

⁴⁶ The [Department's response](#), which was received on December 26, 2025, explains the status of their investigations and cites to Penal Code section 13670. While the response does not explicitly state that no groups have been identified, when read as a whole, it is reasonable to conclude that no groups have been identified by the Department. The first question and the follow-up question posed to the Department are contained in the Department's [follow-up response](#). The first question also listed 20 names of possible subgroups that might qualify as law enforcement gangs and a reference to a possible unnamed subgroup at the Lakewood Station.

they do.”⁴⁷ The problem with this explanation is that there are allegations of the existence of law enforcement gangs that **use names**. In fact, the request to the Department listed the names of 20 such possible groups. While the Department may not be **required** by law to identify groups by name, if such groups use an identifying name, the Department **should** identify the group **by name**.

In its initial response the Department also noted that “there is no statutory requirement or mechanism for reporting alleged groups under POST’s certification and decertification process.” But in order to find that a department member belongs to such a group and that the group has engaged in “serious misconduct” as defined by the statute, it is necessary for the Department to **identify** the existence of such groups. Neither of the Department responses explain why no such group has been identified. While it is true that the request asked for the name of any such group, the Department could have responded that a group or groups have been identified but that no name is associated with the group or groups. But given the number of allegations of the existence of such groups with names, one would expect that at least one group with a name or even a common symbol has been identified.⁴⁸

In fact, the Undersheriff identified the Banditos as such a group in her testimony before the Civilian Oversight Commission. See [Los County Sheriff’s Department Legal Compliance: Deputy Gangs](#) (February 26, 2024) at pages 16-17. The Sheriff’s Department reported both to the Office of Inspector General and publicly that two deputies were fired for membership in a tattooed subgroup known as the Industry Indians and for engaging in conduct associated with the subgroup.⁴⁹ Given that these

⁴⁷ The [Department’s follow-up response](#) was received on January 6, 2026. The second response also inexplicably provides a discourse that a law enforcement gang should not be compared to a criminal street gang as defined in the Penal Code section 186.22(f). No such comparison was made nor did the questions asked of the Department conflate the two distinct laws. There was no reference by OIG to Penal Code section 186.22(f).

⁴⁸ The Sheriff’s response letter included at the conclusion of this report states that the question “was framed in a challenging manner.” If OIG poses a question that the Department does not understand, OIG staff welcome a discussion to clarify the information being sought. This report in no way claims that the Department is not investigating conduct associated with deputy subgroups that might qualify as law enforcement gangs. However, to the knowledge of anyone at OIG, the Department has not **identified** any group that would qualify as a law enforcement gang under Penal Code section 13670 by name or otherwise.

⁴⁹ The deputies were terminated as discipline for, among other things, a violation of [MPP section 3-01/050.83 Employee Groups which Violate the Rights of Other Employees or Members of the Public](#). This policy was

two groups have been publicly referred to by the Sheriff and the Undersheriff in 2024 that investigations have not led to identifying any group qualifies as a law enforcement gang under Penal Code section 13670.

Outstanding Requests to the Sheriff's Department

The Sheriff's Department provided responses to each of the requests made by the Office of Inspector General during the fourth quarter. However, one request remains outstanding. The outstanding request is an April 18, 2025 request for additional materials responsive to a subpoena duces tecum (SDT) that was served in October 2024 and included a request for all documents and information relating to any Sheriff's Department surveillance of any County oversight officials; this follow-up request was made after it came to the Inspector General's attention that surveillance of a County oversight official was conducted but information relating to that surveillance, ***including notes and an audio digital tape of an interview***, were not provided. Although the SDT was served on October 1, 2024, no notes have been provided regarding the work of two peace officers alleged to have engaged in surveillance.

The Sheriff's Department responded regarding this outstanding request when it was referenced in the Office of Inspector General's report for the third quarter of 2025 with the following statement:

Due to the April 2025 request for additional materials, the Department requested that County Counsel retain outside counsel to conduct a thorough and independent review of the materials produced and assist the Department in locating any additional materials responsive to the document request. The request to hire counsel was made soon after the April 2025 OIG request, and counsel was ultimately retained in July 2025 and continues to work on this matter.

Outside counsel provided information to the Office of Inspector General on September 6, 2025, stating that in comparing the documents received by the Office of Inspector General in response to the SDT to the documents produced to them, there

implemented by the previous administration. A policy on Penal Code section 13670 had not been implemented at the time the deputies engaged in the misconduct. The firing of the deputies per this policy is discussed in the Office of Inspector General's Report, [Los Angeles County Sheriff's Department Legal Compliance: Deputy Gangs](#) (February 26, 2024) at pages 18 to 21. The Los Angeles Times reported on the firing of the two deputies: Keri Blakinger and Alene Tchekmedyan, [A bowling alley, a boozy fight and allegations of a new deputy gang in Los Angeles](#) (January 11, 2024) and Keri Blakinger, [Sheriff's Department announces long-awaited policy banning deputy gangs](#) (September 18, 2024).

were 2,934 documents that appear not to have been provided to the Office of Inspector General.⁵⁰ Counsel indicated that the 2,934 documents would be provided to the Office of Inspector General.

After multiple inquiries by Office of Inspector General staff as to the status of providing the documents, on January 21, 2026, counsel sent an email communication that they were reviewing the documents. The email stated:

We were asked by LASD to compare its records of prior productions to OIG with the materials OIG provided us as having been produced by LASD and we have verified that all of the documents LASD initially determined to be responsive have been produced. Currently, we are reviewing additional materials recently collected by LASD for responsiveness and privilege.

No particular privilege was identified in the response. The Office of Inspector General is unaware of any privilege that would allow for these documents to be withheld. The Chief Deputy, Inspector General sent a response to counsel stating:

I am not sure what the basis would be to withhold any documents from the Office of Inspector General on the basis of a privilege, other than possibly attorney-client privilege for communications with counsel retained at the expense of Sheriff Luna or Sheriff Villanueva. As special counsel to the Board of Supervisors, any opinion from County Counsel can, and should, be shared with us. I do know that the Department employed Constitutional Policing Advisers who are attorneys, but those attorneys are not counsel for the Department and thus any communications including those advisers are not privileged. If you could provide an explanation, we would greatly appreciate it. Is there any explanation as to why you received a greater number of documents you received than OIG was given? It's hard to imagine that there are 2,934 documents protected by a privilege.

As far as non-responsive documents, we are requesting those documents, as we want to review them to see why the Department would give you non-responsive documents when the ask was for the documents responsive to the OIG subpoena.

⁵⁰ The Office of Inspector General provided the documents it received in response to the SDT to outside counsel.

In a subsequent communication, outside counsel clarified that they were reviewing the 2,934 documents to determine whether they were responsive to the subpoena and not duplicative of the approximately 6,000 documents produced previously by the Sheriff's Department and reiterated that the documents would also be reviewed for the applicability of any privilege.⁵¹

Because no additional materials have yet been provided, it is unknown whether the records provided to outside counsel include the notes or audiotape that were referred to by Department members. The SDT for these records was made pursuant to the Office of Inspector General's authority under state and County laws. The establishing ordinance for the Office of Inspector General, Los Angeles County Code section 6.44.190, as amended, states the following:

As part of the Board of Supervisors' duty to supervise the official conduct of County officers under Government Code section 25303, the Office of Inspector General ("OIG") is created in the Department of the Board of Supervisors to promote constitutional policing and the fair and impartial administration of justice, and to facilitate the Board of Supervisors' responsibility without obstructing the Sheriff's criminal investigative function. The OIG's scope includes matters relevant to the policies, procedures, practices, and operations of the Sheriff's and Probation departments (collectively, the "Departments"). In accordance with Government Code section 25303, ***the OIG shall have access to all Departments' information; documents; materials; facilities; and meetings, reviews, and other proceedings necessary to carry out the OIG's duties under this section.*** (Emphasis added.)

An inquiry by the Office of Inspector General into surveillance of County officials is clearly within the purview of the Office of Inspector General's oversight function as delegated by the Board of Supervisors and expressed in the County ordinance.⁵² The

⁵¹ In its letter responding to this report, the Department notes that it has "undertaken all reasonable efforts to identify responsive material." It should be noted that OIG executive staff were informed by a then-member of the Sheriff's Department's command staff that a current employee had notes. Those notes are not in the materials provided to us, nor has anyone at OIG received an explanation as to why the notes of that employee were not provided or even if someone asked the employee for the notes.

⁵² Subsection G of the ordinance states that the OIG shall have the authority to undertake an inquiry and audit or perform monitoring at the request of the Board of Supervisors, the COC, or the POC, or the Sheriff or the CPO, ***or on its own initiative.*** (Emphasis added.)

only limitation is that the Office of Inspector General may not obstruct any Sheriff's Department criminal investigative function. It is difficult to imagine that receiving and reviewing documents could obstruct a criminal investigation, but even if it were possible, that reason for noncompliance has not been asserted. The Office of Inspector General continues to request that these documents be provided pursuant to the lawful SDT.

CUSTODY DIVISION

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide habitable, humane, and safe conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.⁵³

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.⁵⁴ According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of December 31, 2025, the total population of people in custody in the Los Angeles County jails was 12,236. As of September 30, 2025, the total population of people in custody in the Los Angeles County jails was 12,797.

The table below shows the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center – East (PDC-East), Pitchess Detention Center – North (PDC-North), Pitchess Detention Center – South (PDC-South), and North County Correctional Facility (NCCF) on the last day of the previous four quarters. On these dates, three facilities (MCJ, PDC-North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity.

⁵³ See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

⁵⁴ The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the pandemic, understaffing, or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

Facility	BSCC Capacity	Facility Count			
		3/31/2025	6/30/2025	9/30/2025	12/31/2025
MCJ	3512	3793	3441	3751	3609
TTCF	2432	2314	2433	2403	2309
CRDF	1708	1418	1416	1496	1414
PDC-East	926	11	7	17	11
PDC-North	830	1286	1373	1348	1321
PDC-South	782	423	546	640	611
NCCF	2214	3010	3148	3142	2961

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a [motion](#) requesting the Sheriff's Department and directing the Office of Inspector General, Sybil Brand Commission, and the Sheriff Civilian Oversight Commission to review and report back on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation, and directing the Office of Inspector General to include status on the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice.⁵⁵

In its initial [report](#) to the Board, staff from the Office of Inspector General detailed the availability of pads, tampons, and panty liners for menstruating individuals. In September 2025, the Sheriff's Department began piloting menstrual cups for incarcerated workers and students in dedicated housing modules.⁵⁶ In response an

⁵⁵ See [Penal Code, § 4023.5\(a\)](#). ("A person confined in a local detention facility shall be allowed to continue to use materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the incarcerated person."); [Cal. Code Regs., tit 15, § 1265](#). ("Each menstruating person shall be provided with sanitary napkins, panty liners, and tampons as requested with no maximum allowance."); Los Angeles County Sheriff's Department, Custody Division Manual, [§ 6-15/010.00 Inmate Clothing, Bedding, and Personal Hygiene](#). ("All menstruating inmates shall have ready access to sanitary napkins, panty liners, and tampons."); Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 5-16-040 Distribution of Personal Care Items](#). ("Each menstruating inmate housed at CRDF shall be provided with sanitary napkins, panty liners, and tampons. All feminine hygiene products shall be readily available in a common space within each module or pod setting."); [Penal Code, § 3409\(a\)](#). ("A person incarcerated...who menstruates or experiences uterine or vaginal bleeding shall, without needing to request, have ready access to, and be allowed to use, materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the person.").

⁵⁶ Incarcerated persons participating in the Conservation Work Program are housed in module 1700, while those enrolled in education services offered by Gender Responsive Services are housed in module 3600.

incident⁵⁷ noted in the Office of Inspector General's last report on the availability of menstrual products, the Sheriff's Department revised CRDF Unit Order # 6-01-00 on searches and trained reception personnel in December 2025.⁵⁸ Reception personnel are responsible for conducting searches of incarcerated workers after the completion of their work shift and all people in custody returning to CRDF following off-site transportation. Under the revised unit order, custody personnel must allow menstrual cup users access to a toilet prior to being searched in the reception area. Menstruating individuals must be given the opportunity to discard menstrual cup contents in the toilet, rinse the cup in the sink, and wrap it in a paper towel. In accordance with the former unit order, menstruating individuals are then required to enter the B-Scanner in the search area. Once the search is complete, menstruating individuals should be provided a new menstrual product or allowed to retain possession of their menstrual cup, and, if needed, one pair of underwear, and must be allowed to sanitize their hands.

The Sheriff's Department reported that it has not received any complaints regarding the revised process. However, incarcerated workers reported to Office of Inspector General staff that some reception deputies continue to request that they remove their menstrual cup in the search area after completing their work shift. One incarcerated worker reported being required to do so as recently as late December 2025. Another incarcerated worker claimed she was instructed to do the same, but she successfully advocated for access to a toilet. Other incarcerated workers stated that some deputies do not ask whether they are wearing a menstrual cup and acknowledged not self-disclosing to avoid possibly being asked to remove it in the search area.

Between October 1 and December 31, 2025, Office of Inspector General staff periodically verified the availability and accessibility of menstrual products at CRDF.⁵⁹

⁵⁷ In the incident described, custody personnel instructed an incarcerated worker to remove her menstrual cup during a search conducted after she completed her work shift. The menstruating individual reported being denied access to a toilet and losing hold of the menstrual cup which resulted in the spillage of menstrual fluid on her legs, clothing, and the floor. The incident revealed deficiencies in the search process, which states: "[a]ll inmate workers shall be escorted to the CRDF Reception Center to be searched utilizing the B-SCAN at the end of the inmate worker's shift prior to returning to their housing location." (See Los Angeles County Sheriff's Department, Custody Division Unit Order, § 5-23-010, Inmate Workers.).

⁵⁸ See CRDF Unit Order, # 6-01-00 *Protocol for Inmate Searches* (version obtained via email). CRDF reception personnel were trained on 12/10/2025 (PM shift) and 12/11/2025 (EM and AM shifts).

⁵⁹ Staff from the Office of Inspector General visited modules 3100, 3200, and 3400 (moderate observation housing), and 2200, 2300, and 2400 (high observation housing).

The need to resupply certain products was addressed with line personnel and resolved promptly.

Moderate and high observation housing. Office of Inspector General staff verified the inventory of menstrual pads, tampons and panty liners in all moderate observation and high observation housing modules visited during the reporting period.⁶⁰ Although the availability of menstrual products was consistent across housing units, accessibility and distribution practices varied.

In most high observation housing units, menstrual products were available in clear plastic bags tied to stair railings in common areas. As previously reported, incarcerated people in these housing classifications typically do not have access to common areas for most of the day, which may limit their ability to access menstrual products.

Additionally, when incarcerated persons access common areas in high observation housing units, their ability to access products may be further restricted depending on whether they remain handcuffed.

Moderate observation housing units previously employed the same method for making menstrual products available. During this reporting period, menstrual products in most moderate observation housing units were generally available in cardboard boxes set out in common areas. According to custody personnel, trustees, and some people in custody, the switch to boxes in these units, and in some instances the placement of boxes at the trustee table area, was implemented in response to reports that people in custody were hoarding products and removing the clear plastic bags previously used for distribution. Incarcerated persons reported mixed experiences with accessibility after this change. While many indicated no issues obtaining products, others expressed concern about having to request products from incarcerated workers, commonly referred to as trustees. This concern was particularly noted in moderate observation housing units where supply boxes were placed on, underneath, or behind the trustee table. The change reportedly took effect several months ago at the discretion of module personnel and trustees.

Some custody personnel, trustees and other people in custody described persistent misuse as primarily involving the use of menstrual pads to clean cells, cushion toilet seats, and cover vents. Custody personnel also expressed more serious concerns, including the potential for people in custody to conceal contraband inside menstrual

⁶⁰ See Los Angeles County Sheriff's Department, Custody Division Manual, [§ 5-01/050.10 Housing for Mentally Ill Inmates](#). ("Moderate impairment. Generally requires moderate observation housing (MOH) in jail with mental health supervision; Significant impairment. Generally requires high observation housing (HOH) in jail with mental health supervision.").

products or pose safety risks for those on suicide precautions; however, they were unable to provide recent examples to substantiate these concerns. Hoarding was attributed by some to a belief that menstrual products are limited and may run out, while other people in custody reported needing additional products to manage longer cycles and heavier flows. As previously reported, the Sheriff's Department should avoid limiting access to menstrual products based on perceived reasonableness of need.

To address persistent allegations of hoarding and misuse, custody personnel should identify any underlying factors contributing to these reported behaviors. If hoarding stems from concerns about future product availability communicating that the products will always be available and having the products routinely available can alleviate these concerns. For concerns about misuse, having cleaning supplies, ensuring toilet seats are in working condition, and regulating the temperature will reduce using the products for non-menstrual uses. Providing clear information on inventory, ensuring access to necessary materials, and addressing other concerns is the responsibility of staff. Regardless of the underlying cause or whether the concerns are substantiated, a lack of ready access risks noncompliance with state law, the Board directive, and Sheriff's Department policy.

Recommendations. As previously recommended, along with the access to products in common areas, the Sheriff's Department should consider resuming cell-to-cell distribution of menstrual products to ensure ready access. Relying solely on either placing the products in common areas, whether in clear plastic bags or cardboard boxes, leaves access largely to the discretion of custody personnel and trustees. Combining cell-to-cell distribution with accessible products in common areas would improve access and support compliance with state law, the Board directive, and Sheriff's Department policy. Additionally, the Sheriff's Department should continue to re-brief custody personnel on the revised unit order on searches, monitor performance, and implement accountability for noncompliance.

Commissary Prices

Background

On July 9, 2024, the Board of Supervisors passed a [motion](#) directing the Sheriff's Department to report back on measures taken to ensure commissary prices in the Los Angeles County Jails are not excessive and remain comparable with prices for groceries and other retail outlets. The motion directed the Office of Inspector General to review the Sheriff's Department's report back and provide an assessment, which was issued on February 6, 2025, entitled [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#).

The motion also directed the Office of Inspector General to provide quarterly updates on the Sheriff's Department's progress on the removal of the profit mark-ups and reduction of prices on commissary items.

Title 15 Meetings with Keefe Commissary Network

As noted in previous reports, the vendor for commissary items and vending machines is [Keefe Commissary Network](#) (Keefe).

The contract requires Keefe to attend monthly Title 15 meetings the County convenes to present reports on commissary and vending sales trends and spikes, billing issues, complaints submitted by incarcerated people, machine maintenance and reliability, security concerns, and any other operational problems identified by the parties. The Office of Inspector General attended the Title 15 monthly meeting for November 2025, which included representatives from each custodial facility, representatives from phone services, and Keefe staff.

At the meeting representatives from the facilities presented concerns. For example, one facility needed hot pots, which were previously on back order. Keefe confirmed a large order was approved and that the order had been placed when the supply was noted to be low in the weeks prior to the meeting. Staff from another facility requested an update for maintenance requests for a broken vending machine and out-of-service phones. Preparations for the end of the year holiday sales were also discussed. The Department is set to receive invoices from Keefe that include sales figures during the holiday season in January 2026 and will share that information with the Office of Inspector General.

During the meeting, the representative from CRDF inquired about having hygiene kits, also called "fish kits," available for sale in vending machines to supplement stock supplies. The Department indicated they have historically found that hygiene and medicinal items are poor sellers in vending machines as indigent persons in custody are able to get the kits at no cost.

Ways of increasing stock supplies of hygiene kits should be explored. As previously reported, the Department does not always have hygiene kits readily available.⁶¹ The Department reported there was a tariff and shipping issue on the hygiene kits but is working with Keefe to reduce or eliminate delays. In addition to increasing stock and eliminating delays in shipment, the Office of Inspector General recommends

⁶¹ See Office of Inspector General's report [Reform and Oversight Effort: Los Angeles Sheriff's Department January to March 2023](#) (June 7, 2023) at page 26.

the Department work with Keefe to identify options for purchasing hygiene kits from locations that do not have tariffs imposed as a way to reduce pricing.

The Inmate Welfare Commission (IWC) met in October and December 2025 where Keefe reported \$5,098.56 in sales for Indigent Hygiene Kits for September 1, 2025 - September 30, 2025, and \$6,278.21 for October 1, 2025 - October 31, 2025. It is not known what the estimated cost is for all kits to be provided free of charge, but the kits are necessary for basic hygiene. The Office of Inspector General continues to recommend the Department provide all incarcerated persons hygiene kits free of charge.⁶²

Vending Machine Installation

The Department is also still in the process of installing new vending machines with Keefe. The new vending machines are installed and operational at CRDF and the transition remains in progress at TTCF and PDC.

Kosher/Halal Menu Availability

Regarding the availability of updated Kosher/Halal menus discussed in the Office of Inspector General's report [Reform and Oversight Efforts: Los Angeles County Sheriff's Department – July through September 2025](#), the new menu has not yet been released. However, Keefe distributed Kosher/Halal item informational handouts during commissary operations in November and again in December 2025. The Department reports that the first change order to the new contract that will incorporate the Kosher/Halal identifiers into new menus remains in the approval process and will be completed before the end of January 2026. The Department directed Keefe to distribute additional handouts during January 2026 to ensure Kosher/Halal items continue to be readily identifiable to people in custody.

Jail Employment Opportunities at Century Regional Detention Facility

The Office of Inspector General continues to monitor Century Regional Detention Facility's (CRDF) efforts to provide meaningful opportunities for people in custody to participate in therapeutic and rehabilitative programming.

⁶² [Reform and Oversight Efforts: Los Angeles County Sheriff's Department – April through June 2025](#) (August 26, 2025) at page 34.

In 2021, the Office of Inspector General issued a finding of inequitable racial/ethnic representation of people in custody at CRDF participating in credit-earning jail employment through the Prisoner Personnel Office (PPO). The Office of Inspector General has monitored racial/ethnic representation of inmate workers since, and Black women continue to be consistently underrepresented.

The Sheriff's Department provided data from December 30, 2025, detailing the number of people in custody at CRDF engaged in credit-earning jail employment by race/ethnicity. A percentage comparison analysis displayed representation percentages similar to those reported in previous Office of Inspector General reports. Specifically, the data showed:

- Approximately 20% of Inmate Workers were White, compared to approximately 18% of the CRDF population.⁶³
- Approximately 15% of Inmate Workers were Black, compared to approximately 32% of the CRDF population.
- Approximately 61% of Inmate Workers were Hispanic, compared to approximately 46% of the CRDF population.
- Approximately 4% of Inmate Workers were "Other" race/ethnicity, compared to approximately 4% of the CRDF population.

In 2022, the Office of Inspector General [recommended](#) that the Sheriff's Department "implement a system that documents reasons for denial of PPO participation, documents reasons for elective non-participation, explore ways to promote PPO participation for eligible persons, and explore alternative ways of evaluating persons for PPO to provide equitable opportunity for participation." The Department reported that it has made efforts to implement these recommendations.

The Department reports that it changed the way that it is capturing data regarding PPO participation at CRDF. Consistent with Office of Inspector General recommendations, Population Management Bureau (PMB) tracks data documenting denial of PPO participation and reasons for elective non-participation.

The Department disqualification data details whether people in custody at CRDF were disqualified from participating in the PPO due to their criminal history, current charges, mental health level, institutional behavior, keep-away status, medical limitations,

⁶³ Race/ethnicity categorizations reflect those utilized by the Sheriff's Department when reporting demographic data.

participation in a program, or security level. The Department's data shows that, as of January 13, 2026, approximately 80 percent of people who were disqualified from participating in PPO were restricted from participation due to their criminal charges.

The Department refusal data tracks people in custody who refuse to participate in PPO by race/ethnicity. PMB reports that, if a person in custody refuses a work assignment, PPO tracks data to contact the person again within 30 days to re-offer a work assignment. PMB reports that while most people who initially refuse work assignments continue to refuse, a small number of people who initially decline work assignments decide to participate in PPO within 30 days of their initial refusal. The data tracking does not reflect a unique reason why people in custody refuse PPO participation and simply denotes that the person in custody was "not interested." However, PMB operations staff indicated that they will require PPO staff to document explicit reasons why people in custody refuse to participate in PPO in future data tracking. The Office of Inspector General is of the opinion that documenting specific reasons why people in custody decline PPO participation will assist in better identifying barriers to participation.

The Department reports that it has promoted participation in the PPO for eligible people in custody housed at CRDF. PMB reports that the PPO worked to increase participation by reviewing inmate request forms and conducting comprehensive screenings of the CRDF population to identify individuals who may be eligible for work assignments.

The PPO engaged directly with people during town hall meetings at CRDF to explain the PPO selection process, describe available positions, and offer adjusted positions where appropriate. Prior to PPO engaging in town halls, module deputies were responsible for notifying people in custody of PPO selection but were unable to follow up with people who refused work assignments. The Department reported that, by PPO interfacing with people in custody directly, the PPO has been able to better understand PPO participation refusals and potentially adjust PPO position offerings to increase participation in the program.

The Department has also developed posters, displayed below, which are posted across high-traffic areas at CRDF to educate people in custody about available assignments within PPO and how to apply to participate.



Finally, the Department reports that it explored alternative ways of evaluating people for PPO to provide equitable opportunities for participation. The Department reports that two charges, Penal Code section 243(e) and Penal Code section 273.5, both of which are crimes related to domestic violence, which previously resulted in automatic exclusion from participation in PPO, are now evaluated on a case-by-case basis. Although the Department acknowledges that this change did not result in a dramatic increase in PPO participation, the Department reports that changes in eligibility criteria will lead to individualized suitability determinations and may increase diversity amongst PPO participants.

The Office of Inspector General recommends that the Department continue to undertake these efforts. By tracking and analyzing refusal data, promoting PPO to eligible people, and continuing to refine eligibility criteria and make individualized determinations for participation in PPO, the Department will likely continue to see an increase in eligible workers and heightened diversity in PPO participation at CRDF.

In-Custody Deaths

Between October 1 and December 31, 2025, eight people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for seven: five natural, one accidental, and one suicide.⁶⁴ For the remaining death, the finding is not available on the DME website.⁶⁵ One person died at MCJ, one person died at CRDF, one person died at TTCF-CTC, and five people died at hospitals after being transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a [dedicated page on Inmate In-Custody Deaths on its website](#).⁶⁶

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews and the Correctional Health Services Mortality Reviews for each of the eight in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of Death: October 21, 2025

Custodial Status: Sentenced

On October 21, 2025, people housed in a multi-person cell at MCJ alerted custody staff that their cellmate was "man down." Custody staff, CHS staff, and paramedics rendered

⁶⁴ During the time for what OIG refers to as the validation process, the time between when the draft report is sent to CHS and the Sheriff's Department and when the response is due to OIG, OIG staff continue to check for updates to the DME website. CHS also provides suggested corrections to the report. The information from the DME website and CHS was incorporated in the report prior to receipt of the formal letter response from the Sheriff's Department. Thus, some of the information noted in the formal response at the conclusion of this report was corrected prior to receipt of the letter from the undersheriff.

⁶⁵ In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and Correctional Health Services use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

⁶⁶ Penal Code § 10008 requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

emergency aid, and CHS staff administered Narcan. The person died at the scene. Areas of concern include the emergency response and timely administration of Narcan. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as atherosclerotic cardiovascular disease.

Date of Death: October 22, 2025

Custodial Status: Sentenced

On October 21, 2025, a person in custody at CRDF was transported to Martin Luther King, Jr. Outpatient Center (MLK OPC) for a higher level of care. On October 21, 2025, the person was transferred from MLK OPC to Long Beach Medical Center where they were pronounced dead. Areas of concern include CHS's emergency response. Preliminary manner of death: Unknown. The DME website reflects the manner of death as accidental, and the cause of death as ruptured aortic dissection and hypertensive cardiovascular disease, and an "other significant condition" as methamphetamine abuse.

Date of Death: November 7, 2025

Custodial Status: Sentenced

On November 7, 2025, custody staff conducting Title 15 safety checks at CRDF found an unresponsive person in a single-person cell with a ligature around their neck. Custody staff, CHS staff, and paramedics rendered emergency aid and administered Narcan. The person died at the scene. Areas of concern include the level of care provided by CHS clinicians in determining the decedent's suicidality. Preliminary manner of death: Suicide. The DME website reflects the manner of death as suicide, and the cause of death as ligature hanging.

Date of Death: December 5, 2025

Custodial Status: Pre-Trial

On December 5, 2025, custody staff distributing lunch at TTCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered multiple doses of Narcan. The person was transported to Los Angeles General Medical Center (LAGMC) and was pronounced dead. Areas of concern include custody staff not activating body-worn cameras during Title 15 safety checks, CCTV video depicting the decedent falling in his cell not being shown during the preliminary death review, and why the decedent, who was booked into Sheriff's Department custody less than 24 hours prior, was not body

scanned or strip searched at the Inmate Reception Center (IRC).⁶⁷ Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as atherosclerotic and hypertensive cardiovascular disease.

Date of Death: December 9, 2025

Custodial Status: Sentenced

On November 25, 2025, people housed in a dorm at MCJ alerted custody staff at a deputy booth of a “man down” within the dorm. Custody staff, CHS staff, and paramedics rendered emergency aid and custody staff and CHS staff administered four doses of Narcan. The person was transported to LAGMC and was pronounced dead on December 9, 2025. Areas of concern include the quality of Title 15 safety checks and the booth deputy’s potential nine-minute delay in requesting emergency aid after being notified of the “man down.” Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the causes of death as pulmonary thromboemboli and deep vein thrombosis of leg.⁶⁸

Date of Death: December 9, 2025

Custodial Status: Pre-Trial

On December 9, 2025, CHS staff were assessing a person housed at TTCF-CTC when he stopped breathing and had no pulse. CHS staff and paramedics rendered emergency aid and CHS staff administered two doses of Narcan.

Areas of concern include the emergency response. Preliminary manner of death: Unknown. The DME website does not currently have a public record for this death.⁶⁹

Date of Death: December 10, 2025

Custodial Status: Pre-Trial

On December 10, 2025, custody staff and CHS staff returned to a person’s cell at TTCF after witnessing the person laying on the floor of the cell approximately 20 minutes prior. Custody personnel requested a nurse and gurney to transport the person to the Urgent Care Clinic (UCC). After the individual was transported to the UCC, custody staff requested fire/paramedics. CHS staff and paramedics rendered emergency aid, and the individual was transported to LAGMC where he was pronounced dead. Areas of concern include the emergency response, an inquiry as to why the individual was not

⁶⁷ In its formal response to this report, the Sheriff’s Department notes that the CCTV video was displayed during the second death review meeting.

⁶⁸ While the DME website notes both the manner and causes of death, the case status is noted as *open*.

⁶⁹ The public record for this death is not posted as the decedent’s next of kin has not been notified.

housed at TTCF-CTC for a higher level of care, adherence to policies regarding medication refusal, an unfulfilled referral to Addiction Medicine Services, and why the decedent, who was booked into Sheriff's Department custody less than 72 hours prior, was not body scanned or strip searched at IRC. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as diabetic ketoacidosis due to diabetes mellitus; other conditions: effects of fentanyl.

Date of Death: December 29, 2025

Custodial Status: Pre-Sentenced

On December 12, 2025, a person in custody with a pre-existing medical condition was transported from a medical appointment to LAGMC for a higher level of care. On December 29, 2025, the person was pronounced dead. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as complications of relapsed b-cell acute lymphoblastic leukemia/lymphoma.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff's Department to "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the OIG," and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections." The Board also directed the Office of Inspector General to report quarterly on the Sheriff's Department's progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody overdose deaths.

Of the eight people who died in the care and custody of the Sheriff's Department between October 1 and December 31, 2025, the medical examiner's final reports, including toxicology assessments, do not confirm that any person died due to an accidental overdose, but the effects of fentanyl were noted as other effects for the December 10, 2025 death summarized in the previous section. Toxicology results remain pending for one of the eight deaths and may indicate additional overdose deaths once completed. As of this report, the DME has confirmed that nine individuals have died due to accidental overdose through the third quarter of 2025.

Tracking and Improving Narcotics Intervention Efforts

With regard to the directive to the Sheriff's Department to track narcotics recovery and evaluate drug detection interventions, as previously reported the Sheriff's Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Sheriff's Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Sheriff's Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

The Board's second directive requires that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails]." The Sheriff's Department previously reported that its current policy grants the Sheriff's Department broad authority to search staff and civilians entering the jails, so that no changes to existing policy are required to implement more comprehensive searches. The Sheriff's Department previously reported that it implemented more frequent unannounced and randomized staff searches beginning in May 2024.

The Office of Inspector General continues to engage with the Department to discuss potential ways to improve narcotics detection efforts, particularly as it relates to preventing and finding narcotics being brought in by employees of the Department, CHS, and professional employee visitors, such as independent contractors and vendors entering secured facilities. Some of these efforts further examined below include (1) training employees on narcotics detection, (2) conducting custody narcotics investigations, and (3) recruitment efforts as it relates to screening and background investigations for potential new hires.

Narcotics detection training. The Department trains its employees regarding narcotics prevention and detection. Search tactics are covered within the ninety-six-hour *Use of Force* training at the Academy. Jail Operations reinforces search of persons policy, including [Custody Division Manual \(CDM\) 6-07/010.00 Inmate Searches](#), which outlines how to search a person before placing them in a booking cell and provides guidance on identifying suspicious behavior. Deputies are trained in executing searches of people in

custody. Jail Operations continues to train deputies working in custody assignments on narcotics detection tactics, including looking for suspicious activity or considering any information they receive.

Deputies also respond to intelligence that a person in custody is returning from the medical unit or court with contraband. People in custody carry their property to and from court to ensure access to food, to prevent property from being stolen, or because they may be transferred to another facility or released directly from court. Deputies are aware that searches of people in custody returning to the facility are important safeguards for preventing the introduction of contraband. Court-assigned deputies can provide valuable assistance in foiling attempts to smuggle in contraband by detecting contraband before inmates are transferred back to jail facilities.

Fraternization by deputies, civilian employees, and other civilians in the facility with persons in custody may lead to relationships that cause deputies to turn a blind eye to misconduct or the presence of drugs or contraband or even result in a deputy or civilian with facility access agreeing to bring narcotics or contraband into custodial facilities.⁷⁰ The Department reports providing an annual four-hour ethics training that covers issues of inappropriate fraternization. The CDM prohibits deputies from associating with people in custody or the friends and relatives of incarcerated persons. The CDM also directs deputies not to perform any favors or accept any services from incarcerated persons or their loved ones and friends.⁷¹ Deputies are trained to report suspicious activity by a colleague to their supervisor.⁷² Regarding potential fraternization between deputies and the trustees they supervise, it was indicated that positions are rotated annually, sometimes every six months, to prevent close relationships. Typically, a deputy supervises three to four trustees working outside the facility at a time. Upon re-entry, these trustees are searched.

There are signs at the checkpoints used by these individuals to enter custody facilities regarding the use of clear bags and what items are prohibited inside the facilities, such as cellphones. As reported in the Office of Inspector General's report [*Reform and Oversight Efforts: Los Angeles Sheriff's Department – July to September 2025*](#), not every deputy or professional employee visitor is searched upon entry, searches are not

⁷⁰ The fraternization by an Office of Inspector General staff member was brought to OIG's attention by the Sheriff's Department. That person is no longer employed by the Office of Inspector General.

⁷¹ See [MPP 3-01/050.84 Fraternization and Prohibited Associations](#).

⁷² The Office of Inspector General encourages investigation of any suspicious activity by members of OIG staff, just as OIG would for investigations of Sheriff's Department employees or anyone with access to the jail facilities.

always thorough, and deputies and professional employee visitors may exit the custody facility and re-enter in the middle of a shift when there is no search operating at any point of entry.

When asked about tracking, the Department reported that it does not currently collect data on staff who are found attempting to bring items, even inadvertently, that are not permitted inside custodial facilities, such as cellphones. The Department further reported concerns that some deputies would complain to the employee unions about data collection and its potential use for disciplinary purposes. Data collection detailing the number of searches conducted that prevented prohibited items from being brought into facilities might assist with improving search techniques throughout the jail facilities.

Custody narcotics investigations.⁷³ As part of its narcotics prevention efforts, the Department also conducts narcotics investigations in custody. Sergeants and detectives are assigned to various custody investigative units to conduct these investigations.

The Office of Inspector General notes that although employees are trained in the academy and in annual ethics training to report to their supervisor any suspected criminal activity conducted by their colleagues, more tips may be generated if they were collected and investigated by an independent party rather than the tipster's chain of command. Deputies may have concerns about confidentiality, impartiality, or fear retaliation within their unit if they have concerns that any information they provide about potential misconduct will first be investigated by their supervisor. However, the Department notes that there are avenues that staff may utilize to report suspected misconduct, including a tip line that allows for anonymous reporting.

Recruitment efforts. Part of preventing narcotics from entering custodial facility is examining why employees engage in such conduct in the first place. Deputies, civilian employees, and other civilians with authorized access to jail facilities may have preexisting relationships with someone in custody such that they may be convinced to bring in contraband. Deputies and civilians may also be incentivized monetarily to bring narcotics into custody. Maintaining strict hiring standards and screenings to ascertain factors that indicate a possible propensity to engage in nefarious behavior, including financial issues, prior thefts, dishonesty, and domestic violence, which may increase the likelihood or risk that staff or others with access to the facilities will be susceptible to requests to smuggle in contraband.

⁷³ Based upon security concerns expressed by the Sheriff's Department, some information referred to in the Sheriff's response letter was deleted from this section.

The Department follows Peace Officer Standards and Training (POST) guidelines regarding hiring requirements and background checks for potential new hires including standards under [Senate Bill \(SB\) 2](#) that went into effect January 1, 2022. A person cannot be employed as a peace officer if they have a felony conviction in any state or were convicted of an offense in another state that would be considered a felony in California.⁷⁴ [Government Code section 1031.1](#) and [Penal Code section 832.12](#) also require the Department to review personnel and misconduct files from previous employers to examine any disqualifying actions or pending issues.

The Department uses POST's [Background Investigation Manual](#) that includes background investigation "dimensions" to be considered in every peace officer background investigation that have been incorporated into [California Code of Regulations, Title 11 section 1953](#). The dimensions include screening for Integrity, Impulse Control/Attention to Safety, Substance Abuse and Other Risk-Taking Behavior, Stress Tolerance, Confronting and Overcoming Problems, Obstacles and Adversity, Conscientiousness, Interpersonal Skills, Decision-Making and Judgment, Learning Ability, and Communication Skills. These dimensions are meant to determine whether the candidate possesses the moral character and suitability for law enforcement duties. POST audits the background and pre-employment files twice a year.

The Department requests self-disclosure of illicit drug use and considers the time and distance from such usage. In terms of connections with friends or family who are gang affiliated or incarcerated, the Department asks about the extent of the applicant's contact with these individuals and advises them of the fraternization policy that applies if hired. Regarding financial issues, the Department reviews the applicant's credit report and tax returns, as well as tax returns for any business the applicant owns. Essentially, the Department looks for patterns of mismanaging money, taking into consideration that the pandemic impacted many businesses and increased bankruptcy filings. After the interview, a candidate will go through a standard polygraph test. If there are any discrepancies noted from the polygraph, the investigator will follow up with a discrepancy interview, followed by a specific polygraph test related to the discrepancy. It is at this stage that some candidates may be disqualified.

If the investigator passes the applicant, the packet will move on to the team Sergeant, followed by the Operations Sergeant, and lastly a three Lieutenant hiring panel. At any stage, additional interviews with the applicant may be requested. The entire panel must agree to pass the applicant for them to move on to a psychological assessment. The

⁷⁴ [Government Code § 1029](#).

Department contracts out psychological assessments and, if a person passes, they are then eligible to join the academy. If a person fails the psychological exam, leaves the academy, or is disqualified for any other reason during the process, they may re-apply to the Department after one year. There is an appeals process specific to failing the psychological exam, and one administered by the County's Department of Human Resources.

Department Search Statistics

As previously reported, the comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table below details the staff search practices at all jail facilities from October 1 to December 31, 2025. The data regarding the number of staff searches and searches with K-9 illustrated in the table was supplied by CSSB. CSSB extracted data on searches from the CWCL on January 6, 2026. K-9 data was obtained from the Custody Investigative Services (CIS) Searches of Custody Personnel Report on January 5, 2026. The Office of Inspector General was unable to verify the data provided by CSSB without additional information.

	Number of Staff Searches	Number of Staff Searches with K-9	Monthly Minimum Search Requirement ⁷⁵	Search Inside Security	Search Evasion Concerns	Where Searches Logged
Facility	Q4	Q4				
MCJ	77	13	Unable to Determine ⁷⁶	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
TTCF	71	4	Yes ⁷⁷	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

⁷⁵ Each jail facility's unit order regarding staff searches was used to determine whether it met its minimum search requirement by month. Where the unit order is silent regarding the minimum search requirement, the Office of Inspector General was unable to determine if the requirement was met. Also, the jail facility must meet the minimum search requirement during each of the three months in the quarter in order to be found in compliance.

⁷⁶ Los Angeles County Sheriff's Department, Custody Division Unit Orders, [§ 3-08-021 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁷⁷ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-08-010 Security of Personal Property](#). ("Watch commander shall ensure a minimum of two random searches are conducted each week of persons entering the secured area during their assigned shift").

IRC	60	6	Unable to Determine ⁷⁸	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
CRDF	116	2	Yes ⁷⁹	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
NCCF	119	0	No ⁸⁰	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-North	50	1	Unable to Determine ⁸¹	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-South	40	1	No ⁸²	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the fourth quarter of 2025, Office of Inspector General personnel completed 128 site visits, totaling 288 monitoring hours, at IRC, TTCF, CRDF, MCJ, Pitchess Detention Center North, and NCCF.

⁷⁸ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 5-23/006.00 Security and Searches of Person Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁷⁹ Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-01-090 Searches of Sworn Personnel, Custody Assistants, Professional Staff and their personal property-Approved by CSS 3/11/2024 ("The searches shall be conducted a minimum of once per week, per shift." [unit order obtained via email message]).

⁸⁰ NCCF did not meet its minimum search requirement in any month this quarter. Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 07-145/10 Personal Property Searches](#). ("A minimum of four (4) random searches per shift per week of any personnel and/or official visitors shall be conducted at the discretion of the watch sergeant.").

⁸¹ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-06-010 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁸² PDC-South did not meet its minimum search requirement in December 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-02-080 *Searches of Sworn Personnel, Custody Assistants, Professional Staff and Their Property on the Facility*. ("The searches shall be conducted at a minimum of once per week, per shift.").

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 124 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 159 monitoring hours related to uses of force, in-custody deaths, Prison Rape Elimination Act (PREA) compliance, restrictive housing, and general conditions of confinement.

Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.⁸³ The Sheriff's Department most recent force report is for use-of force-incidents in custody through the second quarter of 2025. [This report](#) and reports for prior quarters may be found on the Sheriff's Department website's transparency section under the page for use of force.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.⁸⁴ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.⁸⁵

The Sheriff's Department has a [complaints dashboard](#) that can be sorted by date range, with options to narrow the results by practice area (such as Patrol or Custody), rank, or station or unit.

⁸³ Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

⁸⁴ See [Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, Department Service Reviews](#).

⁸⁵ It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.

Sheriff's Department's Response

The Sheriff's Department was provided with a draft of this report and sent a letter in response, which is incorporated on the following pages. Some of the comments from the Sheriff's Department resulted in edits to the report. Most of these edits are referenced in the sections to which the edits.



OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

ROBERT G. LUNA, SHERIFF



February 24, 2026

Eric D. Bates, Interim Inspector General
Office of Inspector General
County of Los Angeles
312 South Hill Street, Third Floor
Los Angeles, California 90013

Via Electronic Submittal

Dear Interim Inspector General Bates:

**RESPONSE TO THE OFFICE OF INSPECTOR GENERAL'S REPORT,
REFORM AND OVERSIGHT EFFORTS: LOS ANGELES COUNTY SHERIFF'S
DEPARTMENT, OCTOBER THROUGH DECEMBER 2025**

On February 13, 2026, the Office of Inspector General (OIG) provided the Los Angeles County Sheriff's Department with a validation draft of its report titled *Reform and Oversight Efforts: Los Angeles County Sheriff's Department, October through December 2025*, and requested a response by February 24, 2026 ("Draft Report"). We thank the OIG for the opportunity to comment on the Draft Report.

The Draft Report was distributed to the Department units responsible for the subject areas addressed in the report. Following a thorough review, the Department determined that, due to the amount of comments received, it is appropriate to respond in letter form to address certain statements that may benefit from clarification or additional context, provide corrections where necessary, and identify areas where the Department's position or understanding differs from that described in the Draft Report.

The following sections address the specific areas identified during our review.

211 WEST TEMPLE STREET, LOS ANGELES, CALIFORNIA 90012

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Taser Tracking Use Section:

The OIG report states that “The Sheriff’s Department Body-Worn Camera Unit tracks only Taser 10 usage, while the Department’s dashboard tracks all Taser usage” (Draft Report at 8-9). However, the statistics presented in this section of the report reflect only Taser 10 activity rather than all conducted-energy weapon (CEW) usage across the Department. More specifically, the figures provided, such as total field uses, effectiveness rate, patrol vs. custody deployment, and signal activations, are all specific to the Taser 10 rollout and do not represent the full scope of Taser use in the Department, in that those numbers do not include other approved CEWs (e.g., X26/X26P). To avoid misinterpretation of the data, the Draft Report should clarify this issue and either list all Department-wide usage, distinguish between Taser 10 specific data and non-Taser 10 usage, or explicitly state that the statistics provided are limited to the Taser 10 project.

Rosas Compliance

The Draft Report recommends that “the Sheriff’s Department review the report by Bloomberg Law and consider opinions of use-of-force experts to assess whether it would be a better practice to ban use of the Wrap” (Draft Report at 11, footnote 13).

The Department is always willing to review the reports and opinions of others and has done so in the past. The Department and federal monitors have worked on this issue, and will continue to engage to ensure “proper use of the WRAP Restraint” (Draft Report at 11).

While open to evaluating alternative views, the Department is currently focused on ensuring proper use of the device rather than imposing a ban. This approach is because the WRAP restraint remains a critical tool for de-escalation and the prevention of escalating physical force. In high-tension custodial environments, an agitated or combative individual poses a continuous threat of injury to themselves and staff. Without the WRAP restraint, deputies would be forced to maintain manual pressure or body weight on the person resisting, to prevent kicking or thrashing. By safely immobilizing the lower extremities and securing the individual in a seated, upright position, the device WRAP can effectively end the “struggle” more quickly than traditional prone-restraint methods with less force and injury than the alternative.

It is also important to note that the Department’s use of the WRAP is governed by rigorous safety protocols that exceed basic manufacturer guidelines and

specifically target the prevention of medical distress. A core requirement of Department training is that the individual is kept in an upright, seated position to mitigate the risk of positional asphyxia. Per CDM Section 7-03/050.00, any inmate placed in a WRAP restraint is never left unobserved. Staff are required to maintain constant line-of-sight monitoring to identify any signs of respiratory distress or changes in consciousness. Furthermore, a mandatory medical assessment by qualified health professionals must be conducted when the device is applied to ensure that any physiological stress is addressed by clinicians.

Transparency and accountability are embedded in the application process through the mandatory use of a WRAP log, which serves as a formal record of the intervention. This log tracks the exact time of application, the specific staff members involved, the justification for continued retention, and the results of periodic checks performed while the inmate remains restrained. While the Department acknowledges the concerns raised by outside reports and will continue to review all perspectives, the practical reality of custody operations requires tools that manage violent behavior while minimizing force. When applied in accordance with the Department's strict administrative and medical guidelines, the WRAP remains a safe and effective alternative for protecting the lives of both staff and those in our care.

Next, the Draft Report discusses the issues related to head strikes. It states that in 7 out of 15 cases determined to involve head strikes, "the Department concluded the actions of staff were objectively reasonable and within Department policy in all seven cases" (Draft Report at 12, citing the Monitoring Panel's Fifteenth Report). The Department recognizes that the OIG is citing the monitoring report for this section of the Draft Report. However, the Department conducted a review of the seven head strike cases determined by the Monitors to be non-compliant during the Fifteenth Reporting Period and the Department, in fact, found two of the seven head strike cases out of policy. One case led to an administrative investigation, and the other to additional training for the involved personnel. In the remaining five head strike cases, the Department ensured that involved personnel, including supervisors, received additional training and/or received documented counseling via Performance Log Entries.

The Department will continue to review these cases and work with the monitors to ensure our practices improve in accordance with the terms of the settlement agreement.

The Draft Report cites the monitoring report and states that unlike other law enforcement agencies, only Department Chiefs are permitted to request an administrative investigation (Draft Report at page 12, citing the Monitoring Panel's Fifteenth Report).

This characterization does not accurately reflect Department policy. Manual of Policy and Procedures Section 3-04/020.05, Initiation of Administrative Investigations, provides that upon receipt of a personnel complaint, or notification of a personnel incident involving possible misconduct, a unit commander or higher-ranking executive may order an administrative investigation. Such investigations may be conducted by the concerned unit at the direction of the unit commander or by the Internal Affairs Bureau. Only a division chief or division director may request an administrative investigation by the Internal Affairs Bureau. Accordingly, while administrative investigations conducted by the Internal Affairs Bureau require a request from a division chief or division director, unit commanders also have the authority to order administrative investigations conducted at the unit level.

Sheriff's Department's Cooperation with Federal Immigration Authorities

The Draft Report states, "While the Sheriff's Department has policies that limit cooperation with federal authorities on immigration enforcement, data collected by the Sheriff's Department is sometimes transferred to the federal government and such data may have the effect of assisting immigration authorities without the intent to do so" (Draft Report at 13).

The Department does not proactively transfer data to federal immigration authorities and operates in compliance with the California Values Act, Senate Bill 54, which limits cooperation with federal immigration enforcement activities. To the extent federal entities obtain access to data, such access occurs pursuant to lawful process, statutory authority, or other legally authorized mechanisms.

As a result, the Department requests that the statement that data "*is sometimes transferred to the federal government*" be clarified to avoid misinterpretation, since it suggests affirmative sharing by the Department in violation of California law.

Clarifying this distinction would ensure the report accurately reflects current practice and the Department's adherence to governing law and policy.

Automatic License Plate Readers

In reference to the Automated License Plate Recognition (ALPR) data retention period, the OIG recommends that the Department conduct a study to determine the optimal retention period, focusing on maximizing investigative value while ensuring that images outside the effective use period are deleted (Draft Report at 17).

The Department will continue reviewing case data related to ALPR use in investigations to assess the effectiveness of the revised two-year retention period. The updated policy reflects a deliberate reduction from 5 years, while preserving the investigative and evidentiary value of ALPR data.

The Department recognizes the need to balance investigative capability with privacy considerations. Based on existing safeguards, audit protocols, and compliance measures, the two-year retention period reflects that balance. Retention practices will continue to be evaluated to ensure the Department does not unnecessarily retain data while maintaining the ability to use information that may be critical to investigations.

Public Records Act Requests and Deputy Exemption List Section

Approximately four pages of the Draft Report focus on the California Public Records Act and the Department's process of identifying employees for whom "there is a specific, articulable, and particularized reason to believe that disclosure of the record would pose a significant danger to the physical safety" of the involved peace officer under California Penal Code section 832.7 (Draft Report at 18-22). The Draft Report proceeds to describe the Exemption Management System (EXMAN) and how it was used to identify exempt employees and makes recommendations for improvement (Draft Report at 21-22).

The EXMAN system is no longer in use by the Department. The Department has created a new system called "COVERT" (Confidential Operators Verified Enrollment and Roster Tracking system). It has done so with the advice of counsel, in creating a system that requires a more detailed explanation of the "specific, articulable, and particularized" reason warranting an exemption from non-disclosure. The system has not yet launched, pending testing of the technological system. The newly-developed process, which includes internal verification and counsel's review of the specific justifications for non-disclosure, appears to address the OIG's recommendation that the Department:

“ensure accuracy and sufficient particularity of the potential threats pursuant to statutory and case law. Review of the documentation and justifications provided by Department members should also be conducted on a regular basis and not just when a CPRA request is submitted for specific information.”

(Draft Report at 21-22). A demonstration of the system can be provided to the OIG upon request.

While the Draft Report refers to some exemptions, the report fails to reference Assembly Bill 1178, which was approved by the Governor on October 11, 2025, and requires courts to consider redacting or withholding confidential records from all duly sworn officers working an undercover assignment in the past 24 months from public disclosure.

It is also important to note that records related to ongoing and active investigations are exempt from disclosure (Draft Report at 18), and that safety concern exemptions are not limited to sworn personnel but can include professional staff members of the Department (Draft Report at 19, Section Title).

Law Enforcement Gang Update Section

The Draft Report provides a summary of the Department's response to the question:

“Has the Sheriff's Department identified any group that meets the definition of a law enforcement gang under California Penal Code section 13670? If so, please provide the name of any such group and any documentation reporting the existence of such group or its members to POST.”

(Draft Report at 22-23).

Contrary to the statement made in the Draft Report, the Department never stated that “no such group has been identified” (Draft Report at 22). Instead, the Department attempted to respond to the specific question posed, namely whether, under California Penal Code section 13670, such a group has been identified. The Department then responded that the Code section does not require the identification of a specific group. However, in that same response, the Department also provided the OIG a list of pending administrative investigations and a table of individuals against whom allegations of

involvement with a law enforcement gang, subgroup, and/ or clique have been made. Those tables list the subgroup associated with the allegation when such a group was identified. This establishes that, contrary to the implication made in the Draft Report, the Department does in fact investigate the existence of such groups. However, it is not necessary for a group name to be part of an allegation and, in fact, many allegations are made without a group name associated with the conduct. The Department investigates all allegations, regardless of whether a group is named or not, as is required by section 13670. The importance in doing so is based on the fact that some groups may be unnamed or could easily change any name previously used to avoid detection. As Penal Code section 13670 states groups "may" identify themselves by name but also may not. Therefore, the Department takes a broad approach to investigation of such allegations.

As stated in the Department's two efforts to respond to a question that was framed in a challenging manner, and as acknowledged in the OIG report, the Department is not required by law to name groups. Instead, the Department is required to, and remains committed to, investigating allegations of patterns of behavior that violate the law or the principles of professional policing by any group of employees, regardless of a label. If employees are found to have violated MPP 3-01/050.82 and/or MPP 3-01/050.83, and they belonged to a named group, that group would therefore be identified.

The Draft Report emphasizes the Department's naming of groups, stating:

"While the Department may not be **required** by law to identify groups by name, if such groups use an identifying name, the Department **should** identify the group **by name**."

(Emphasis in Original, Draft Report at 22). The OIG report correctly states that the Department discharged two deputies found to have violated MPP 3-01/050.83, and that both had tattoos associated with the Industry Indians. The discharge demonstrates that when conduct is found to be associated with a named group, it is identified and punishment is imposed on the individuals involved. As also noted in the Draft Report, the Sheriff and Undersheriff have also spoken publicly about various groups.

All of these facts demonstrate that the Department can and does identify the names of specific groups when the evidence establishes such a group by name. However, nothing in the statute requires naming a group or limits investigations to named groups. The Department takes a much broader reading of the statute than the OIG, and will continue to investigate all allegations of

gangs, cliques, or groups that engage in prohibited behavior. Any suggestion to narrow the scope of the statute or Department policy to named groups is contrary to the mission of eliminating such groups from the Department.

Outstanding Requests to the Sheriff's Department Section

The Draft Report, as with several past reports, has a section entitled "Outstanding Requests to the Sheriff's Department (Draft Report at 23-26). This section describes efforts by the Department to locate materials that may exist that are responsive to a subpoena issued by the OIG. As noted in the Draft Report, the Department hired outside counsel to review the materials, assist in locating any additional materials, and produce any additional materials identified.

The Department hired, at great expense, outside counsel to assist in the review and production of subpoenaed material in an effort to establish that the Department had undertaken all reasonable efforts to identify responsive material. The Department did this due to concerns about the actions undertaken in the last administration and suspicions that additional materials exist. The OIG now calls into question the work of that outside counsel.

Outside counsel has stated that "we have verified that all of the documents LASD initially determined to be responsive have been produced. Currently, we are reviewing additional materials recently collected by LASD for responsiveness and privilege" (Draft Report at 24).

Counsel will continue and complete their work and will produce any additional materials determined to be responsive. At that point, the Department will consider the matter concluded as it will have gone to great lengths to identify responsive materials to the subpoena.

In-Custody Deaths

The Draft Report also discusses in-custody deaths (Draft Report at 36-39). A number of the descriptions of the death investigations are outdated. For ease of review, the Department provides the following summary and requests that the appropriate updates be included in the final published report.

Draft Report Page	Draft Report Page	Department Comment
36	“Between October 1 and December 31, 2025, eight people died in the care and custody of the Sheriff’s Department. The Department of Medical Examiner’s (DME) website currently reflects the manner of death for six: four natural, one accidental, and one suicide. For the remaining two deaths, one finding has been deferred by the DME and one is not available on the DME website.”	The DME website for the remaining two deaths shows the manner of death as natural.
37	“Areas of concern include custody staff not activating body-worn cameras during Title 15 safety checks, CCTV video depicting the decedent falling in his cell not being shown during the preliminary death review...”	The CCTV video footage was subsequently displayed during the second death review meeting.
36-37	“Areas of concern include the quality of Title 15 safety checks and the booth deputy’s nine-minute delay in requesting emergency aid after being notified of the ‘man down.’ Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the causes of death as pulmonary thromboembolic and deep vein thrombosis of leg.”	The use of the phrase “deputy’s nine-minute delay” suggests that there was an actual nine-minute delay. However, it has not been determined exactly when Department members were made aware of a “man down.” We respectfully request re-phrasing to “potential” nine-minute delay. Further, the DME website indicates the case status as open. As a result, the manner of death, as listed, is a preliminary result only.

38	"The DME website does not currently have a public record for this death."	The final autopsy report has been received, and the manner of death was natural, due to arteriosclerotic cardiovascular disease.
38	Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.	Per the DME website, the manner of death is natural due to diabetic ketoacidosis and diabetes mellitus. The case status is open.

Tracking and Improving Narcotics Intervention Efforts

The Draft Report provides an overview of the Department's tracking and narcotics intervention efforts (Draft Report at 39-42). The Department wishes to address several issues in this section of the Draft Report.

First, the Draft Report states that the Department:

"does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Sheriff's Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions."

(Draft Report at 39).

For clarification, it is important to note that tracking does occur. The tracking is decentralized and unit/facility-specific, rather than centralized/aggregated in a single, queryable system for Department-wide analysis or efficacy. LASD requires entry of all narcotics seizures into LARCIS for prosecution tracking and PRELIMS for evidence tracking. Additional details are captured in unit-specific or intervention-specific systems (cell searches in CARTS, contraband watches in e-LOTS, staff searches in watch commander logs, and Custody Investigative Services Unit [K-9, mailroom, OSJ, and OCTF] recoveries on internal spreadsheets. This provides information at the individual unit/facility

level where day-to-day operations and oversight occur and permits data to be analyzed.

The Department agrees that an easily queryable system that provides immediate information is necessary to enable Department-wide analysis, trend identification, and the evaluation of the efficacy of specific drug-detection interventions across all facilities and units. Therefore, the Department maintains its position that constructing a comprehensive, integrated jail management data system remains the most effective long-term solution. Such a system would 1) consolidate data from disparate sources into one platform, 2) incorporate standardized, extractable fields for detection mechanisms and outcomes, 3) enable real-time querying, dashboards, and analytics to evaluate intervention performance holistically, and 4) support data-driven decisions on resource allocation, policy refinements, and compliance with Board directives.

Second, with respect to Narcotics Detection training, the Draft Report provides:

“Deputies will also respond to intelligence that a person in custody is returning from the medical unit or court with contraband. People in custody carry their property to and from court to have access to food and to prevent property from being stolen or going missing from their housing unit while they are away in court.”

(Draft Report at 40). We respectfully request that the OIG add the following to the final sentence above “and because they may be released directly following court proceedings or transferred to another facility.” The inclusion of this phrase provides a more comprehensive explanation as to why people take property to court.

Third, in that same section, the Draft Report states:

“Fraternalization by deputies with persons in custody may lead to relationships that cause deputies to turn a blind eye to misconduct or the presence of drugs or contraband or even result in a deputy agreeing to bring narcotics or contraband into custodial facilities. The Department reports providing an annual four-hour ethics training that covers issues of inappropriate fraternization. The CDM prohibits deputies from associating with people in custody or the friends and relatives of incarcerated persons.”

(Draft Report at 40-41).

The Draft Report improperly limits the fraternization concern to “deputies.” In a correctional environment, the risk of fraternization is not limited to sworn personnel, but is a concern as to every person who is in contact with the inmate population. We are all aware of an unfortunate situation involving a staff member of your agency who was, apparently, engaged in a romantic relationship with an inmate in 2025. The Department raises this not to highlight this one issue, but to underscore that everyone is susceptible to improper fraternization, whether they are sworn or civilian, and whether they are employed by the Department or another agency. We suggest referring to all personnel rather than limiting this concern to “deputies.”

Next, the Draft Report states:

“the Department reported that it does not currently collect data on staff who are found attempting to bring items, even inadvertently, that are not permitted inside custodial facilities, such as cellphones. The Department further reported concerns that some deputies would complain to the employee unions about data collection and its potential use for disciplinary purposes. Data collection detailing the number of searches conducted that prevented prohibited items from being brought into facilities might assist with improving search techniques throughout the jail facilities.”

(Draft Report at 41).

The Department tracks personnel searches and captures data such as the time and duration of the search, the number of personnel searched, the number and type of items confiscated, the names of the supervising personnel involved, and whether K-9 was involved. The Department handles inadvertent possession (e.g., personal use or lawfully possessed, but inadvertently brought to the facility) and purposeful smuggling differently.

When contraband is smuggled, a criminal investigation is initiated. Complaints to labor unions do not dictate investigative outcomes, nor do they interfere with criminal investigations. The Department’s primary mandate is the safety and security of the jail environment, and employee grievances do not stop the Department from pursuing policy violations.

Significantly, the Draft Report contains a lengthy section that provides a blueprint of specialized investigative tactics that could be exploited (Draft Report at 42). The Department respectfully requests that the four paragraphs that describe internal investigations be removed.

Finally, the Draft Report states:

“that although employees are trained in the academy and in annual ethics training to report to their supervisor any suspected criminal activity conducted by their colleagues, more tips may be generated if they were collected and investigated by an independent party rather than the tipster’s chain of command. Deputies may have concerns about confidentiality, impartiality, or fear retaliation within their unit if they know any information they provide about potential misconduct will first be investigated by their Supervisor.”

(Draft Report at 42).

The assertion that internal reporting is limited to a “chain of command” structure is incorrect. It is important to clarify that the Custody Investigative Service (CIS), the entity referenced in drawing this conclusion, is not a personnel investigation unit. The CIS’s primary mandate is the security of the facility and the investigation of crimes committed by the incarcerated population. Investigations into potential staff misconduct are the purview of the Internal Criminal Investigations Bureau (ICIB) or the Internal Affairs Bureau (IAB). These bureaus operate independently of a deputy’s immediate unit-level chain of command, to ensure impartiality and to prevent the very retaliation or “blind eye” scenarios described in the Draft Report.

It is important to note that the Department provides employees with several secure and confidential avenues to report misconduct, allowing them to bypass their direct supervisors entirely. Staff members are encouraged to utilize the 1-800-698-TALK (8255) tip line, which allows for completely anonymous reporting 24 hours a day. This system ensures that information regarding criminal activity or policy violations reaches the appropriate investigative bureau (IAB or ICIB) without the tipster’s unit or supervisors knowing. By offering these high-level, centralized reporting options, the Department maintains a robust system of accountability that prioritizes confidentiality and professional integrity over local unit dynamics.

Similar to feedback provided as to other sections of the Draft Report, the Recruitment Efforts section continually focuses on the deputy hiring process, suggesting that only deputies could be bringing narcotics into the custodial environment (Draft Report at 43). Employees of other county agencies have been identified as having brought narcotics inside the jails, and any recommendation made about the recruitment and hiring process should include all personnel who have access to the custodial environment.

Conclusion

While this is a lengthy response to the Draft Report, the Department takes the OIG reports seriously as they are a public presentation of the status of the Department's efforts in several areas. We recognize that these are complex reports for your office to compile and that many communications occur in the months prior to their publication. At the same time, the Department presents the above comments in an effort to ensure a complete presentation of the issues and to avoid misunderstandings with your office and the public.

If you have any questions or concerns, please contact Commander Ernie Bille at (323) 307-8358.

Sincerely,

ROBERT G. LUNA, SHERIFF


APRIL L. TARDY
UNDERSHERIFF



Office of Inspector General County of Los Angeles

Reform and Oversight Efforts: Los Angeles County Sheriff's Department

January through March 2026

Issued May 21, 2026

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period.¹ This quarterly report covers Department activities and incidents that occurred between January 1 and March 31, 2026, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- High Risk Traffic Stops
- *Johnson v. Los Angeles County Sheriff's Department* Monitoring Report

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. During this quarter, there were four incidents in which people were shot or shot at by Sheriff's Department personnel. Three people were fatally struck by deputies' gunfire. In one off-duty shooting a deputy shot at three people but it is unknown if anyone was hit.

The Office of Inspector General staff was notified of the deputy-involved shootings but did not respond per the suspension of rollouts as stated in a [memorandum to the Board of Supervisors dated June 11, 2025](#). A modified roll out protocol began on May 4, 2026. Office of Inspector General staff members assigned to our rollout team now respond to the scene of deputy-involved shootings during the workday.²

¹ This report refers to the Sheriff's Department, the Department, or LASD when referencing the Los Angeles County Sheriff's Department. The Office of Inspector General is also referred to as OIG in some places throughout the report.

² Beginning on May 4, 2026, Office of Inspector General staff will also respond to the scene of in-custody deaths during the workday. Deputy inspectors general and inspectors are assigned to the deputy-involved-shooting and in-custody-death rollout teams.

The Sheriff's Department [maintains a page on its website](#) listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.³

The information in the following shooting summaries is based on the information provided by the Sheriff's Department at the Critical Incident Reviews (CIR) and the information on the Department's website, including the written summaries and Critical Incident Briefings.⁴ The information presented at CIR, in the written summaries, and in the Critical Incident Briefing is preliminary in nature. Statements of deputies and witnesses are not provided until the Sheriff's Department completes its investigation.

Narcotics Bureau: Hit Shooting – Fatal⁵

On January 13, 2026, at approximately 12:20 p.m.,⁶ Narcotics Bureau personnel were in the city of Palmdale to serve a search warrant. Prior to serving the warrant, they were advised by other deputies on scene that a person was sitting in a vehicle adjacent to the location in question. This person, who was later determined to be a twenty-five-year-old Hispanic man, was seated in the driver's seat of the subject car. He was the sole occupant.

For “a potential risk to officer safety,”⁷ and to determine if the vehicle or the driver were connected to the warrant location, the deputies drove up near to the vehicle, exited their cars, and surrounded it. From video of the incident, it appears that the deputies were

³ Penal Code section 832.7(b)(1)(A)(i) requires that in response to a Public Records Act request, records relating to the report, investigation, or finding of an “incident involving the discharge of a firearm at a person by a peace officer or custodial officer” be made available. Delaying the availability of some information is permissible if certain criteria are met. On April 10, 2026, OIG inquired as to whether non-hit shootings meeting the criteria in this subsection are posted on the website or whether LASD has any plans to include non-hit shootings on its deputy-involved shootings transparency page. The Department replied that it is in the process of determining the answer.

⁴ [Manual of Policy and Procedure \(MPP\) section 3-09/330.00 Critical Incident Review Panel](#) identifies what is a critical incident and describes the process for reviewing such incidents.

⁵ The [summary of the incident](#) linked on the Sheriff's Department's transparency page notes that OIG staff responded to the scene of this shooting. While OIG was notified, staff did not respond to the scene. OIG staff attended a Department Critical Incident Review.

⁶ The written summary of the incident on the LASD transparency page for deputy-involved shootings indicates this incident occurred at 12:20 pm. However, the [Critical Incident Briefing](#) accessible from that same page indicates that the incident occurred at 11:55 a.m.

⁷ This phrase is in quotes as this is the reason provided by the Department in the Critical Incident Briefing. By including this as the reason for contacting the driver, OIG is not opining as to whether or not the deputies were in any danger at the time they approached the decedent's vehicle.

wearing tactical vests and that at least some of the vests had the word *Sheriff* on it.⁸ From the video it is not clear if the wording on the vests would have been noticeable to the driver of the car. One deputy was positioned at the driver's side rear door and others were near the front and rear of the vehicle.⁹ The driver drove forward and, in doing so, the rear tire of the car went over the foot of a deputy positioned at the driver's side rear door. As the vehicle continued forward in what appeared to be an attempt to maneuver around the deputies and leave, a deputy fired one round at the suspect.

The deputies rendered aid to the driver prior to the arrival of the Los Angeles County Fire Department personnel, but the driver died at the scene.

To date, there is no information tying the deceased driver to the crimes that were the subject of the search warrant.

The Sheriff's Department posted a [written summary](#) and a [Critical Incident Briefing](#) of this incident on the [Transparency page for Deputy-Involved Shootings](#).

Areas of Further Inquiry

Did the decision to approach the vehicle by Narcotics personnel compromise public safety and the safety of the deputies?

Did the deputies have a reasonable suspicion that the driver of the car was involved in criminal activity that justified commanding the driver to stop the car?¹⁰

Were any of the deputies directly in the path of the vehicle as it began moving forward?

Did the shooting violate the [Department's policy](#) against discharging a firearm at a stationary or moving vehicle?

Was the approach to the suspect's vehicle and the deputies subsequent positioning tactically sound and consistent with best practices and Department policies?

Did the tactics used escalate the situation, possibly contributing to the use of force?

⁸ The Critical Incident Briefing indicates that the faces of the deputies are blocked out because they are undercover. The fact that deputies were in tactical gear suggests that the deputies were not undercover, although they may not have been readily identifiable to the decedent as deputies.

⁹ The [Critical Incident Briefing](#) describes a detective as being "near the front driver's side of the vehicle."

¹⁰ The language by the deputies and threats to shoot the driver of the car in commanding him to stop may also violate [MPP section 3-01/030.85: Derogatory Language](#).

Why were no body-worn camera videos activated until after the shooting?¹¹

Was there a crossfire issue, meaning were other deputies potentially in the line of fire?

Off-Duty Shooting – Twin Towers Correctional Facility Deputy: Unknown Hit/Non-Hit Shooting

The Sheriff's Department reported that on January 13, 2026, at approximately 9:10 p.m., a Twin Towers Correctional Facility deputy returned home from work and, as he parked in his driveway and exited his car, a white 4-door sedan pulled up behind him. Two men exited the vehicle and approached the trunk of the deputy's vehicle and rummaged through its contents. The deputy retrieved his back-up weapon, fully exited his vehicle, and took cover behind a second vehicle parked in the driveway. The deputy pointed his firearm at the men and ordered them to get away from his vehicle. One man produced a firearm and fired two to three rounds at the deputy. Those rounds struck the deputy's house, directly behind him.

¹¹ The Critical Incident Briefing notes "Body-worn cameras preserve a period of pre-event video, without audio once the record function is activated. The discharge occurred during this buffered footage, which therefore contains no audio." It is not clear from the briefing whether there is any other body-worn camera video of the incident. If more than one deputy was outfitted with a body-worn camera, no explanation was provided in the Critical Incident Review or Briefing as to why all deputies with the cameras did activate their cameras as required by [Department policy when making a vehicle stop](#). OIG has raised activation concerns in the past and continues to recommend that body-worn cameras be activated for all interactions with civilians.

OIG has recommended that **all** special units deploy body-worn cameras. This recommendation was made in the context of two deputy-involved shootings by a surveillance teams. (See [Sixth Report Back on Implementing Body-Worn Cameras in Los Angeles County](#) (April 11, 2022) and [Seventh Report Back on Implementing Body-Worn Cameras in Los Angeles County](#) (September 22, 2022).) [OIG's eighth report](#) sent on March 21, 2023, notes that the Department informed OIG that then-newly elected Sheriff Luna's goal was to equip specialized units such as the Narcotics Bureau and the Major Crimes Bureau with body-worn cameras.

As noted in the OIG's September 2025 [Thirteenth Report Back on Implementing Body-Worn Cameras in Los Angeles County](#), the Department reported that it is negotiating with its employee unions regarding changes to its policies to cover specialized units in order to deploy body-worn cameras to these units. It is not clear to OIG why such negotiations are necessary given the Department's current policies on cameras.

Also of note is a recent summary corrective action plan for a million-dollar settlement of a deputy-involved shooting that found one of the root causes was the unavailability of body-worn camera video. (See [County Claims Board Recommendation for Estate of Nicholas Burgos, et al. v. County of Los Angeles](#).)

The deputy fired approximately three to four rounds at the man. The two men ran off in different directions and a third man who was in the suspects' vehicle drove away. It is unknown if the deputy's rounds struck any of the men or their vehicle.

This incident occurred in the jurisdiction of Whittier Police Department, which is handling the criminal investigation. Whittier Police Department declined to share any investigative reports with the Sheriff's Department until the conclusion of its criminal investigation. Because the Sheriff's Department is not the handling agency, there was no Critical Incident Review or Briefing for this shooting.

Major Crimes Bureau: Hit Shooting – Fatal

On January 22, 2026, at approximately 8:32 p.m., Major Crimes Bureau sworn personnel were conducting surveillance of robbery suspects.¹² The deputies followed the suspects to several shopping centers. While at a shopping center in West Hills, the deputies observed the two suspects sitting in a car while appearing to observe people in the parking lot at the shopping center. The suspect driver of the car was a Black woman, and the passenger was a Hispanic man. When a woman exited a nearby store, the suspects drove towards the woman, the male suspect exited the passenger's side of the car, pointed a handgun at the woman, ran towards her, and pushed her to the ground. While holding the gun to her head and dragging her, the suspect forcefully took her purse. The deputies reported that the suspect was heard threatening to shoot the woman as he dragged her.

Having just witnessed this crime the deputies went to detain the suspect, who attempted to flee. Deputies in multiple vehicles drove towards that suspect and his victim. The two deputies in the vehicle closest to the suspect exited their car. As the suspect attempted to flee, he pointed his firearm in the direction of the deputies and deputies fired at the suspect. One deputy reported seeing a flash from the suspect's gun pointed in his direction. Video from a business security camera shows the weapon being pointed in the direction of deputies who had exited their car and what appears to be a muzzle flash from the suspect's weapon.¹³ At least one deputy continued firing at the suspect. A total

¹² The deputies were wearing U.S. Marshals vests during the time they were conducting surveillance and at the time of the incident. While the deputies are dual certified as U.S. Marshals, they were not working as U.S. Marshals while following the suspects. LASD reported that the deputies were working in the capacity as U.S. Marshals earlier in the day and did not have time to change their vests.

¹³ The business security video may be viewed as part of the [Critical Incident Briefing](#).

of 11 rounds were fired by one deputy, and one round was fired by the other deputy. Three bullets hit the window of a nearby business.

The second suspect fled in the car and was later apprehended.

The male suspect was pronounced deceased at the scene by a paramedic. A loaded 9 mm ghost gun with an extended magazine was recovered at the scene.

No deputies were injured and the victim was treated at the scene for minor injuries.

The deputies conducting the surveillance did not have body-worn cameras and therefore there is no body-worn camera video of this shooting. The Department reported that members of its Major Crimes Bureau are not assigned cameras and are not obligated to wear them.¹⁴

The Sheriff's Department posted a written [summary](#) of the incident and [Critical Incident Briefing](#) on its website, which includes security camera video of the shooting.

Areas of further Inquiry

Are there concerns about why one deputy fired 11 rounds, and the other fired 1 round?

Did the deputies have a tactical plan in place that considered they might witness a robbery and that the suspects might be armed?

Did the deputies consider the backdrop of the shooting and that there were people in the area of the shooting, including the victim?

Lancaster Station: Hit Shooting – Fatal

On March 15, 2026, Lancaster Station received a call for service at 1:30 p.m., stating that a Hispanic man was shooting an assault rifle at neighbors. When deputies responded to the location, three victims flagged them down and reported being shot at, with two of them suffering non-life-threatening injuries that appeared consistent with shotgun pellet wounds. The victims stated the suspect left the location on foot.

¹⁴ As noted in a footnote regarding the January 13, 2026 deputy-involved shooting by Narcotics Bureau deputies, OIG has recommended that **all** special units deploy body-worn cameras. This recommendation was made in the context of two deputy-involved shootings by a surveillance teams. (See [Sixth Report Back on Implementing Body-Worn Cameras in Los Angeles County](#) (April 11, 2022) and [Seventh Report Back on Implementing Body-Worn Cameras in Los Angeles County](#) (September 22, 2022).).

Using binoculars, deputies located a person who appeared to be the suspect and relayed the information to an assisting airship. Deputies responded to the location, where they observed in a fenced-in area standing behind a travel trailer. The suspect failed to obey commands to put up his hands and surrender. The commands were made in both English and Spanish as the call for service included that the suspect was Spanish speaking. The suspect produced a handgun and shot multiple rounds at deputies, at which point four deputies shot at the suspect; the three deputies fired their service weapons, and a sergeant fired a duty rifle.

While still armed with the handgun, the suspect ran to a makeshift building. Shortly after, the suspect emerged and the sergeant fired at him. The suspect appeared to have been struck by gunfire. Once it was deemed safe, deputies approached the suspect and saw that he sustained one gunshot wound to the head. The suspect was subsequently pronounced dead at the scene.

Some of the deputies' bullets struck nearby trailers, at least one of which was occupied.

One .40 caliber semi-automatic handgun, one 12-gauge pump action shot gun, and shell casings were recovered at the scene. The handgun was in arm's reach of the suspect.

The body-worn camera video included in the Critical Incident Briefing shows that the deputies and the sergeant all activated their cameras prior to the shooting. At least one deputy activated the camera prior to exiting his car, which is aligned with the Department's policy, training, and best practices.¹⁵ Due to the distance and obstructions, none of the body-worn cameras captured an image of the suspect as he was firing.

The [shooting summary](#) and [Critical Incident Briefing](#) are posted on [the Sheriff's Department webpage for deputy-involved shootings](#).

Areas of Further Inquiry:

When the second shooting occurred, did the suspect point a firearm at the deputies before they fired?

Was there time to evacuate the nearby trailers knowing that the suspect was armed and that the deputies might have to engage by firing their weapons?

¹⁵ Based on the timing of the incident relative to when the deputies and sergeant exited their vehicles, it is likely that all four activated the camera prior to exiting. This aligns not only with Department training but with best practices and OIG's recommendations regarding camera activation.

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.¹⁶ For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting in Los Angeles County that results in a person being struck by a bullet to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between January and March 31, 2026, the District Attorney's Office posted memoranda on its website for two findings on deputy-involved shooting cases involving the Sheriff's Department's employees.¹⁷ The District Attorney's Office declined to file charges in each case, as they determined that the use of force was not unlawful. The memoranda may be found on the [District Attorney's website page for Officer-Involved Shootings](#). The following are the deputy-involved shootings posted:

- [The January 30, 2025, fatal shooting of Juan Manuel Alvarez.](#)
- [The March 24, 2024 fatal shooting of a juvenile by Deputy Antonio Del Rio.](#)
- [The July 4, 2023 fatal shooting of Greg Covey, Jr. by Deputy Randy Austin.](#)
- [The January 30, 2025 fatal shooting of Juan Manuel Alvarez by Deputy Zachary Van Der Zanden.](#)

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (CA-DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue

¹⁶ In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. See [A.B. 1506 \(McCarty 2020\)](#) (codified at [Govt. Code § 12525.3](#)). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*.

¹⁷ The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under [Officer-Involved Shootings](#). The Office of Inspector General retrieves the information on District Attorney decisions from this webpage.

written reports or file criminal charges against a peace officer, if appropriate.¹⁸ [No CA-DOJ investigations were opened during the first quarter of this year](#) regarding shootings by deputies from the Sheriff's Department and all previous investigations regarding Sheriff's Department shootings are closed.¹⁹ During the first quarter of 2026, DOJ [issued no written reports](#) regarding shootings involving Sheriff's Department deputies.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has six shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a June 9, 2025, shooting in the jurisdiction of Century Station. For further information as to that shooting, please refer to the Office of Inspector General's report [Reform and Oversight Efforts: Los Angeles Sheriff's Department - April through June 2025](#). The oldest case that the Homicide Bureau has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent four deputy-involved-shooting cases to the District Attorney's Office for filing consideration.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.²⁰

The Sheriff's Department reports that ICIB has 76 active cases. This quarter, ICIB reports sending 17 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 36 cases previously sent from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits

¹⁸ Government Code § 12525.3(b).

¹⁹ On April 1, 2026, Sheriff's Deputies allegedly shot an unarmed man resulting in his death and CA-DOJ opened an investigation.

²⁰ Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges, IAB conducts an independent investigation to determine whether Sheriff's Department personnel violated any policies during the incident regardless of the District Attorney's decision not to prosecute. If the District Attorney files charges, IAB proceeds with a review for policy violations following the prosecution. If IAB finds policy violations, the Department may impose discipline up to and including termination.²¹

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 129 new administrative investigations. Of these 129 cases, 48 were assigned to IAB, 61 were designated as unit-level investigations, and 20 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 136 cases were closed by IAB or at the unit level. There are 474 administrative investigations pending, of which 333 are assigned to IAB and the remaining 141 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between January 1 and March 31, 2026, the Civil Service Commission issued final decisions in five cases involving Sheriff's Department employees. In these five cases, the Civil Service Commission sustained the Department's discipline in four cases and adopted the findings and recommendation of the Hearing Officer in one case. The Civil Service Commission reports its actions, including final decisions, in [minutes of its meetings](#) posted on the County's website for commission publications.

²¹ If a deputy were convicted of criminal charges and decertified by the Commission on Peace Officer Standards and Training, the deputy would be unable to be employed as a peace officer.

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to [data posted by the Sheriff's Department](#), it deployed its Unmanned Aircraft Systems (UAS) 34 times between January 1 and March 31, 2026.

The Office of Inspector General continues to recommend that the Sheriff's Department provide more specific information regarding the use of UAS for a "high risk tactical operation." Circumstances justifying use of a UAS for a search might include exigent circumstances, a reasonable suspicion that a crime is occurring, probable cause to conduct a search, or the execution of a search warrant. The law recognizes these reasons for conducting a search as legal under the Fourth Amendment of the United States Constitution, which does not have an exception for a warrantless search based on a "high risk tactical operation."

Historically, members of the public have supported drone usage in law enforcement but have requested usage be limited to activity that provides the greatest benefit to life and safety, and that safeguards be in place to avoid usage encroaching into areas which are likely to result in excessive invasion of privacy. Imprecise categories and limited information can result in law enforcement action that undermines public trust.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracking and Documenting Taser Use

Status of Taser Policy Implementation and Training

On October 3, 2023, the Board of Supervisors (Board) passed a [motion](#) instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The motion directs the Office of Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.

The Sheriff's Department reported that from the Phase 1 purchase of 3,197 Taser 10s, approximately 3,000 are currently deployed.²² The Sheriff's Department reports that full Taser 10 deployment is expected within the next few months. Additional Taser 10s have not been purchased due to reported funding constraints. After full deployment of the 3,197 units, the Sheriff's Department intends to provide annual

²² This section on Tasers includes the information reported by the Sheriff's Department for the quarter covered in this report and does not include information reported previously.

recertification training and training for newly assigned personnel as part of routine Department operations.

Tasers approved for use by the Department are Taser 10, Taser X26, and Taser 7. The intention is to phase out Taser X26 and Taser 7.

The Sheriff's Department Body-Worn Camera Unit tracks only Taser 10 usage, the Department's dashboard tracks all Taser usage.

Tracking Taser Use

In May 2024, the Sheriff's Department launched [a web dashboard reporting Taser usage](#) by date range with options to narrow the result parameters by patrol or custody, patrol station or facility, incident type, or city. The available data includes the result of the use of force (i.e., whether the use resulted in serious injury or death). The Sheriff's Department provided the following information for Taser usage:

- Since the deployment in 2024, web dashboard shows there were approximately 548 total Taser deployments. Out of the 548 deployments, 466 were in patrol operations, 54 were in custody and 28 deployments were in various other units.
- During the first quarter of 2026, the Department reports there were 69 Taser uses: four in Custody and 65 in Patrol Operations.
- The Department reports that in incidents involving a weapon, there were eight (12%). One of these eight incidents involved a firearm, three involved a knife and four involved another weapon.
- At end of the first quarter of this year, 50 Phase 1 Taser 10s have been deployed in Custody Division in Men's Central Jail and Inmate Reception Center.
- Each Taser 10 is equipped with technology that signals the BWC to activate when a deputy turns off the Taser 10's *Safe Mode* as the deputy readies the Taser to fire. The Department reported four such activations, referred to as signal activations, during this quarter.²³ The four signal activations were for Tasers used

²³ Per Sheriff's Department policy, a deputy should activate their BWC in advance of enforcement or investigative contact. In those incidents where the TASER 10 was deployed but no signal activation occurred, it was because the deputy's BWC was already recording. Per a response from the Department, the signal activation feature on the TASER 10 serves as a fail-safe to account for situations that unfold rapidly, where a deputy may need to react immediately for officer safety before manually activating the BWC. It also functions as a secondary safeguard in cases where the BWC was not activated as required.

in a custody setting. Due to the recent implementation of body-worn cameras in custody facilities, staff may still be getting used to activating the cameras.²⁴

High-Risk Traffic Stops

On September 25, 2022, Los Angeles County Sheriff Deputies conducted a high-risk, felony traffic stop²⁵ of Gabriela Koutantos, who was driving a U-Haul cargo van, the license plate for which was entered as stolen in the California Law Enforcement Telecommunications system (CLETS).²⁶ According to the lawsuit filed on October 12, 2023, by Ms. Koutantos and her mother, who witnessed the stop, Ms. Koutantos rented a U-Haul cargo van to transport donations to the East Los Angeles Women's Center when she was stopped at gunpoint by deputies, forced to kneel, put into the back of a patrol car, and detained for nearly an hour. Prior to being placed in the patrol car, a female deputy searched Ms. Koutantos and handcuffed her. The lawsuit alleged excessive force and unreasonable search and seizure.²⁷ While Ms. Koutantos was detained, an investigation by one of the deputies determined that the information in the CLETS system regarding the vehicle was incorrect and that Ms. Koutantos was not driving a stolen vehicle.²⁸ On March 3, 2026, the Board of Supervisors authorized a settlement of the case in the amount of \$900,000.²⁹

²⁴ In patrol operations deputies are trained to activate the camera when interacting with civilians. Because custody staff interact with incarcerated persons throughout the day, the training for activating the cameras is not quite as straightforward.

²⁵ Law enforcement agencies use the term felony-traffic stops or high-risk stops or some combination of these terms to refer to traffic stops where guns are drawn and either placed in a low-ready position or pointed at the subject of the stop. See Field Operations Support Services [Newsletter 25-07 - High-Risk Stop Tactics Chinarian v. City of Los Angeles](#).

²⁶ See *Gabriela Koutantos, et. al. v. County of Los Angeles, et al.*, United States District Court Case No. 2:23-cv-08592; [County of Los Angeles Claims Board Agenda for January 5, 2026](#) at page 13; Cameron Kiszla, [Women sue LASD alleging 'traumatizing' traffic stop was unnecessary, illegal](#), KTLA5, (October 13, 2023); [Mark Nero, LA County Sheriff's Dept. Sued Over 'Violent' Traffic Stop](#), Patch, (October 12, 2023).

²⁷ *Gabriela Koutantos, et. al. v. County of Los Angeles, et al.*, United States District Court Case No. 2:23-cv-08592; [County of Los Angeles Claims Board Agenda for January 5, 2026](#) at page 13.

²⁸ *Ibid.*

²⁹ [Statement of Proceedings for the Regular Meeting of the Board of Supervisors, March 3, 2026](#).

The proposed settlement was presented to the County of Los Angeles Claims Board (Claims Board) on January 5, 2026. The case summary presented to the Claims Board includes a summary corrective action plan. The summary corrective action plan noted that a case against the Los Angeles Police Department had similar facts, but that counsel for the Sheriff's Department argued that the deputies pulling over Ms. Koutantos had more than reasonable suspicion when they stopped Ms. Koutantos at gunpoint. The claims board summary corrective action plan noted that "on July 19, 2024, the policy regarding pointing firearms at suspects during high-risk traffic stops has changed."

The Sheriff's Department revised its use of force policy, which became effective March 14, 2025.³⁰ While the revised policy discusses displaying firearms, the language speaks to when an officer *may* display a weapon, rather than limiting displaying a weapon to when it is legally justified. (See [MPP section 3-10/045.00 Use of Deadly Force and Firearms](#).) With respect to conducting traffic stops at gunpoint there is no specific policy that aligns with case law on excessive force, and the use-of force-policy does not sufficiently align with the cases on stolen vehicle stops.

Reasonable Use of Force for a Traffic Stop

Peace officers may stop a vehicle if there is a "particularized and objective basis" for suspecting the particular person stopped of criminal activity. (See *United States v. Cortez* (1981) 449 U.S. 411, 417-418.) In conducting a traffic stop, peace officers may only use the force necessary to make an arrest, prevent escape, or overcome resistance. The case of *Washington v. Lambert* (9th Cir. 1996) 98 F.3d 1181 and *Green v. City & County of San Francisco* (9th Cir. 2014) 751 F.3d 1039 established that peace officers may be held liable for using excessive force based on conducting a traffic stop at gunpoint where the basis of the traffic stop is nothing more than a reasonable suspicion that a vehicle was stolen. As noted in *Washington v. Lambert*:

³⁰ Perhaps the policy draft was finalized by July 19, 2024.

In this nation all people have the right to be free from the terrifying and humiliating experience of being pulled from their cars at gunpoint, handcuffed or made to lie face down on the pavement when insufficient reason for such intrusive police conduct exists. The police may not employ such tactics *every time* they have an “articulable basis” for thinking that someone may be a suspect in a crime. The infringement on personal liberty resulting from so intrusive a type of investigatory stop is simply too great. Under ordinary circumstances, when the police have only a reasonable suspicion to make an investigatory stop, drawing weapons and using handcuffs and other restraints will violate the Fourth Amendment. (*Washington v. Lambert, supra*, at page 1181.)

In *Green v. City and County of San Francisco* (9th Cir. 2014) 751 F.3d 1039, 1047, the court addressed the significance of officers pointing firearms at an individual as part of its analysis of whether a detention rises to the level of a de facto arrest.³¹ The court explained that drawing and aiming a firearm constitutes a substantial show of force that weighs heavily in favor of finding an arrest, particularly when combined with other coercive measures such as physical restraint or prolonged detention. The court, however, did not adopt a categorical rule that pointing a gun automatically converts a stop into an arrest. Instead, it applies a totality of the circumstances approach, emphasizing that such force may be permissible during an investigatory detention if it is reasonably necessary for officer safety in light of the perceived threat. Where the use of firearms is disproportionate to the circumstances or unsupported by specific safety concerns, it can transform what would otherwise be a temporary detention into a de facto arrest requiring probable cause.³²

In *Chinaryan v. City of Los Angeles* (9th Cir 2024) 113 F.4th 888, Los Angeles Police Department officers stopped Ms. Chinaryan after a reported stolen vehicle alert, conducted a high-risk stop, and detained her at gunpoint before they were able to confirm the vehicle was stolen. Ms. Chinaryan sued, arguing the stop, detention, and use of force were unconstitutional because the underlying alert or suspicion was mistaken and the force used was excessive under the circumstances. Addressing precedent cases, the Ninth Circuit held that law enforcement can be liable for

³¹ *Green v. City & County of San Francisco* (9th Cir. 2014) 751 F.3d 1039, 1047.

³² California Penal Code section 836(a)(3) codifies constitutional law on arrests and permits an arrest when there is probable cause to believe the individual committed a felony, regardless of whether a felony was ultimately committed in fact. Given the case law, stopping the driver of a vehicle at gunpoint would seem to be excessive force if the only evidence known to the officer is a database entry that a vehicle is stolen. From the summary corrective action plan there appears to be no evidence supporting the de facto arrest of Ms. Koutantos.

conducting a high-risk traffic stop based on nothing more than reasonable suspicion that the vehicle was stolen.³³ In the *Chinaryan* case, the court noted that while “vehicle theft is an ‘arguably severe’ crime, the officers had no articulable basis to suspect that [Ms. Chinaryan or her passengers] posed a threat to anyone beyond the generic threat that a suspected vehicle thief poses.” Ms. Chinaryan was not “uncooperative or taking action” that suggested the possibility of flight or that she was a danger to anyone. (*Chinaryan*, *supra*, at page 898.)

While these cases would seem to establish that excessive force was used in the traffic stop of Ms. Koutantos and that her detention at gunpoint, forcing her to kneel, her handcuffing, and being seated in a patrol car for a substantial period of time constituted a de facto arrest, the summary corrective action plan asserts that the deputies who stopped Ms. Koutantos had *more than reasonable suspicion* without articulating any facts supporting that claim or supporting probable cause for the de facto arrest. Based on the facts presented in the claims board case summary and summary corrective action plan, it is hard to imagine what facts constituted *more than reasonable suspicion* justifying the deputies’ use of force and de facto arrest of Ms. Koutantos.

Sheriff’s Department Policies on Traffic Stops

The current concern raised by this settlement, is that the summary corrective action plan asserts that at the time of the incident deputies were in compliance with high-risk traffic stop tactics and procedures but fails to acknowledge that case law from as early as 1996 essentially held that the deputies’ conduct in the stop of Ms. Koutantos and her de facto arrest constituted excessive force and an unreasonable search and seizure in violation of the Fourth Amendment. Additionally, current Sheriff’s Department policy does not sufficiently prohibit displaying firearms when stopping the driver of a suspected stolen vehicle absent specific information that the driver or passengers pose a danger. The policy on displaying firearms states the following:

- *Unnecessarily or prematurely displaying a firearm (pistol, rifle, or shotgun) could limit a Department member’s alternatives in controlling a situation, may create unnecessary anxiety on the part of members of the public, and could result in an unwarranted or unintentional discharge of the firearm. Department members are expected to*

³³ *Chinaryan*, *supra*, citing to *Washington v. Lambert* (9th Cir. 1996), 98 F.3d 1181 and *Green v. City and County of San Francisco* (9th Cir. 2014) 751 F. 3d 1039.

exercise sound judgment and critical decision-making when choosing to display a firearm or point it at a person.

- *Department members may display a firearm to a threatening person to help establish or maintain control in a potentially dangerous situation if the totality of the circumstances creates an objectively reasonable belief that it may be necessary to use the firearm.*
- *When a Department member displays their firearm to a threatening person, in the absence of an imminent threat but where they reasonably believe that a potential threat exists, based on the totality of the circumstances, Department members should generally point their firearm in a safe direction without pointing it at a person.*
- *In situations where a Department member reasonably believes an imminent threat exists based on the totality of the circumstances, that Department member may point their firearm at the threatening person or animal until they no longer reasonably perceive the threat.*

While this policy states that displaying the firearm should be necessary, most of the language is permissive as to when a deputy *may* display a firearm; there is nothing requiring “more than reasonable suspicion” to display or point a firearm at the driver or passenger of a suspected stolen vehicle. The policy does not sufficiently state the stopping the driver of a stolen vehicle at gunpoint without additional facts is excessive force and that subsequent restraints on liberty are a de facto arrest that requires probable cause.

The Department did send out a newsletter intended for training on stolen vehicle stops. But that newsletter by the Department’s Field Operations Support Services (FOSS) was not sent out until *November 6, 2025*, three years after the traffic stop of Ms. Koutantos, and two years after the filing of the lawsuit, despite an acknowledgement in the newsletter citing to the *Washington* and *Green* cases and noting that the “Ninth Circuit found that the law governing high-risk tactics was ‘clearly established’ long before the LAPD’s 2019 stop that is the subject of the *Chinaryan* case.”³⁴ Given the acknowledgement that the law regarding excessive force for stopping stolen vehicles was established long before the LAPD’s 2019 stop, the laws were clearly established long before the stop of Ms. Koutantos.

³⁴ See [FOSS 25-07 High Risk Stop Tactics Chinaryan v. City of Los Angeles](#).

While the Office of Inspector General acknowledges that not all situations can be implemented into policy, limitations on conducting traffic stops at gunpoint should be implemented into policy because these stops are not infrequent. Additionally, there is a policy covering tactical incidents that includes traffic stops. By failing to address *Chinaryan* and the earlier cases, the policy does not sufficiently notify deputies that traffic stops at gunpoint require articulable reasons that the driver or passengers pose a threat to the safety of the deputies or others. [MPP section 3-10/150.00 Tactical Incidents](#) outlines departmental expectations for managing and responding to tactical incidents that involve elevated risk and may require specialized coordination and resources. The policy defines tactical incidents broadly as situations involving potential armed confrontation and high-risk suspects, including traffic stops. The policy emphasizes officer safety, scene control, and coordinated response rather than establishing specific rules governing the drawing of firearms. Within this framework, the policy requires deputies to continuously assess evolving threats during tactical incidents and to respond in a manner consistent with the level of perceived risk. When circumstances indicate an elevated or potentially dangerous situation, deputies may adopt heightened tactical postures, which can include positioning themselves defensively and, when appropriate based on reasonable perception of threat, drawing or readying their firearms. By failing to include limitations on drawing guns when conducting traffic stops of stolen vehicles in MPP section 3-10/150.00 there is a gap that could easily be filled by aligning the policy with case law on drawing guns when the only information is that the vehicle is stolen.

[FOSS Newsletter 15-24 Detaining Felony Suspects](#), provides additional tactical guidance for deputies detaining felony or high-risk suspects, again emphasizing officer safety, coordination, and control of the scene. It instructs deputies to maintain visual awareness of threats, use clear verbal commands, request backup, and position themselves advantageously during encounters. The policy stresses that suspects should not be allowed to remain standing and should be handcuffed and secured as soon and as safely as possible, because no detention is considered fully controlled until the suspect is restrained. The automatic handcuffing of a detained suspect is inconsistent with the law and the later FOSS newsletter ([High Risk Stop Tactics](#) *Chinaryan v. City of Los Angeles*).

While the Department correctly noted that the preamble to the use-of-force policy states that Department members “may only use that amount of force that is objectively reasonable, proportional, and which reasonably appears necessary at the time to defend others or themselves, effect an arrest or detention, prevent escape, or overcome resistance,” the broad language of the policy preamble does not sufficiently convey the law expressed in the line of cases leading up to and including *Chinaryan*.

A statement in the summary corrective action plan that the case of *Chinaryan v. City of Los Angeles* is under review by the Sheriff's Department suggests the Sheriff's Department is open to revising its policies to reflect the line of cases on traffic stops at gunpoint. The Office of Inspector General is encouraged that there is the possibility of a policy change.

Additionally, the Department reports that it conducts a number of training classes related to High-Risk traffic stops, including the *Chinaryan* case, these include: Tactics and Survival Courses (TAS1, TAS2), High Risk Stops, Patrol School, and High-Risk classes address cases relevant to high-risk traffic stops. In addition, the Department utilizes the Briefing Room, an online training tool that provides video training on California law and federal cases. The Department is also updating its in-house video on Felony Traffic Stops. The Department extended an open invitation for OIG staff to attend these classes to conduct ongoing oversight of this issue. That invitation is appreciated and represents the type of engagement that fosters collaboration.

Recommendations

1. The Department should implement a policy consistent with the case law prohibiting traffic stops at gunpoint based solely on information that a vehicle is stolen.
2. The Department should conduct training for all deputies assigned to patrol consistent with the information in [FOSS Newsletter 25-07](#).
3. The Department should rescind or modify [FOSS Newsletter 15-24](#) for consistency with FOSS Newsletter 25-07 and the cases cited on traffic stops and de facto arrests that violate constitutional rights.

Outstanding Requests to the Sheriff's Department

The Sheriff's Department provided responses to each of the requests made by the Office of Inspector General during the first quarter. The only outstanding request may be found in the [Office of Inspector General's report covering the fourth quarter of 2025](#).

CUSTODY DIVISION

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department

to provide habitable, humane, and safe conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.³⁵

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.³⁶ According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of March 31, 2026, the total population of people in custody in the Los Angeles County jails was 12,462. As of December 31, 2025, the total population of people in custody in the Los Angeles County jails was 12,236.

The table below shows the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center – East (PDC-East), Pitchess Detention Center – North (PDC-North), Pitchess Detention Center – South (PDC-South), and North County Correctional Facility (NCCF) on the last day of the previous four quarters. On these dates, three facilities (MCJ, PDC-North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity.

Facility	BSCC	Facility Count			
	Capacity	6/30/2025	9/30/2025	12/31/2025	3/31/2026
MCJ	3512	3441	3751	3609	3812
TTCF	2432	2433	2403	2309	2270
CRDF	1708	1416	1496	1414	1430
PDC-East	926	7	17	11	15
PDC-North	830	1373	1348	1321	1253
PDC-South	782	546	640	611	640
NCCF	2214	3148	3142	2961	3042

³⁵ See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

³⁶ The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the understaffing or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a [motion](#) requesting the Sheriff's Department and directing the Office of Inspector General, Sybil Brand Commission, and the Sheriff Civilian Oversight Commission to review and report back on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation, and directing the Office of Inspector General to include status on the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice.³⁷

In its initial [report](#) to the Board, staff from the Office of Inspector General detailed the availability of pads, tampons, and panty liners for menstruating individuals. In September 2025, the Sheriff's Department, in partnership with the Los Angeles-based nonprofit, The Flow, began piloting menstrual cups for incarcerated workers and incarcerated persons enrolled in rehabilitation/education programs at CRDF.³⁸ In March 2026, staff from The Flow and the Sheriff Department's Gender Responsive Services (GRS) conducted additional learning sessions for incarcerated people in the pilot modules.³⁹ A total of two sessions were held, with 54 individuals participating, of

³⁷ See [Penal Code, § 4023.5\(a\)](#). ("A person confined in a local detention facility shall be allowed to continue to use materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the incarcerated person."); [Cal. Code Regs., tit 15, § 1265](#). (Each menstruating person shall be provided with sanitary napkins, panty liners, and tampons as requested with no maximum allowance."); Los Angeles County Sheriff's Department, Custody Division Manual, [§ 6-15/010.00 Inmate Clothing, Bedding, and Personal Hygiene](#). ("All menstruating inmates shall have ready access to sanitary napkins, panty liners, and tampons."); Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 5-16-040 Distribution of Personal Care Items](#). ("Each menstruating inmate housed at CRDF shall be provided with sanitary napkins, panty liners, and tampons. All feminine hygiene products shall be readily available in a common space within each module or pod setting."); [Penal Code, § 3409\(a\)](#). ("A person incarcerated...who menstruates or experiences uterine or vaginal bleeding shall, without needing to request, have ready access to, and be allowed to use, materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the person.").

³⁸ The Flow "distributes free menstrual cups and provides bilingual education to help people manage their periods with dignity, autonomy, and sustainability." The organization has received menstrual cup donations from saalt, Pixie, and Diva, and funding from a number of entities including the Los Angeles Giving Circle, Sidney E. Frank Foundation, and Bloomberg Philanthropies. The Flow has also partnered with community organizations like A New Way of Life, CASA of Los Angeles, Los Angeles Regional Food Bank, and Women's Foundation California. Incarcerated persons participating in the Conservation Work Program are housed in module 1700, while those enrolled in education services offered by Gender Responsive Services are housed in modules 3500 and 3600.

³⁹ See Los Angeles County Sheriff's Department, Custody Division Unit Order, § 5-21-20, Education Based Incarceration: "The Gender Responsive Services Unit is responsible for providing inmate educational programs in accordance with the Minimum Standards for Adult Local Detention Facilities, Title 15, section 1061, 'Inmate Education Plan' [at Century Regional Detention Facility.]" At CRDF, Gender Responsive Services offers services in numerous housing modules, including 1700, 3500 and 3600.

whom 53 were new to the pilot program. All 53 chose to take a menstrual cup and received instructions.⁴⁰ The next round of learning sessions was scheduled for April 2026. Plans to expand access to menstrual cups in other housing modules is contingent on feedback and grant funding.

Between January and March 2026, Office of Inspector General staff periodically verified the availability and accessibility of menstrual products at Century Regional Detention Facility (CRDF) during site visits.⁴¹

Communication with CRDF leadership. In January 2026, OIG staff raised concerns about reported search practices and menstrual product accessibility to CRDF leadership via email. In February 2026, the Office of Inspector General met with CRDF leadership to discuss the concerns and recommendations outlined in OIG's last [quarterly report](#). Two incarcerated workers reported that some reception deputies continued to request that they remove their menstrual cup in the search area after completing their work shift and denied them access to a toilet as required by the revised unit order on searches.⁴² Other incarcerated workers reported to the Office of Inspector General that some deputies do not ask whether they are wearing a menstrual cup and acknowledged not self-disclosing to avoid possibly being asked to remove it in the search area. In the meeting, CRDF leadership confirmed the in-person briefings were conducted in December 2025 about the revised unit order on searches. To address concerns, CRDF leadership committed to directing supervisors to re-brief reception personnel.

Concerns about accessibility and distribution practices outlined in previous OIG [reporting](#) were also discussed during the meeting. OIG reiterated that the Sheriff's Department should consider resuming cell-to-cell distribution of menstrual products in addition to placing products in common areas. CRDF leadership agreed to consider the recommendation, and acknowledged the risks associated with leaving access largely to the discretion of custody staff and incarcerated workers.

Grievances. For this reporting period, the Office of Inspector General independently retrieved grievance data from the Custody Inmate Grievance Application ("CIGA") for March 1 through March 31, 2026, and queried predetermined search terms to review

⁴⁰ Menstrual cups were disinfected in a boiling water dispenser prior to distribution.

⁴¹ Staff from the Office of Inspector General visited general population, moderate observation housing, high observation housing, Gender Responsive Services, and incarcerated worker housing modules.

⁴² See CRDF Unit Order, # 6-01-00 Protocol for Inmate Searches (version obtained via email).

grievances about the availability and accessibility of menstrual products, searches while menstruating, and related matters.⁴³

A total of 1,218 records were retrieved from CIGA for the one-month period, of which 1,175 were requests, 36 were standard grievances, and 7 were grievances against staff. Office of Inspector General staff identified a total of two grievances containing one or more of the search terms.⁴⁴ One grievance contained the terms “period” and “blood,” and one contained the term “blood.” Both grievances were submitted by individuals temporarily housed in the detox/intake module at CRDF. Of the two grievances, one was deemed to be related to the availability and accessibility of menstrual products. That grievance covered multiple issues, among them an allegation that the grievant was not provided “panties while on [her] period.”⁴⁵ The complainant submitted the complaint to the Executive Office of the Board of Supervisors after her release from custody, and the Executive Office forwarded the complaint to the Office of Inspector General. The Office of Inspector General forwarded this third-party complaint to the Sheriff’s Department for processing on March 26, 2026. The Sheriff’s Department issued a finding of “sustained in part” but did not address the complainant’s allegation of not being provided “panties” while she menstruated.⁴⁶

Because of the low number of grievances related to the availability and accessibility of menstrual products, the Office of Inspector General is optimistic that the steps taken regarding past concerns will result in sufficient availability of menstrual products and commends the Sheriff’s Department in their sustained efforts to comply with state law, the Board directive, and Sheriff’s Department policy. Notwithstanding this, the Office of Inspector General also recognizes that some people in custody may hesitate and opt not to submit grievances about menstrual products for a variety of reasons, for example, shame, humiliation, normalization of inadequate access, fear of retaliation or little faith in the grievance system. It is imperative that the Sheriff’s Department maintain product availability and accessibility while addressing and resolving

⁴³ The Office of Inspector General selected ten terms, including menstrual product(s), menstrual cup(s), pad(s), tampon(s), panty liner(s), sanitary napkin(s), menstruation, period, bleeding, and blood, to identify potentially relevant grievances.

⁴⁴ The ID number for the two identified grievances are 26-13-00902 and 26-13-01343.

⁴⁵ Other issues included cleanliness, clothing, general living conditions, hygiene, medical care, and water quality.

⁴⁶ See Los Angeles County Sheriff’s Department, Custody Division Manual, [§ 8-03/005.00 Inmate Grievances](#).

complaints in a manner that upholds the dignity and health of menstruating individuals in custody.

Johnson v. Los Angeles County Sheriff's Department Monitoring Report

The Office of Inspector General serves as the court-appointed monitor for the *Johnson v. Los Angeles County Sheriff's Department* class-action lawsuit. The lawsuit alleged that the Sheriff's Department denied proper accommodations for a class of people (Class Members) with mobility impairments housed in Los Angeles County Jails or provided them with inadequate accommodations. The lawsuit also alleged that the Department inappropriately segregated them, excluded them from jail programs and services, and subjected them to multiple and pervasive physical access barriers throughout the facilities.⁴⁷ In 2015, the Sheriff's Department entered into a settlement agreement ("Agreement") to implement systemwide reform of the conditions of confinement for people with mobility impairments. The Office of Inspector General filed its [Tenth Implementation Status Report](#) on March 31, 2026, and reported that of the seven provisions of the Agreement that remain in effect, the Sheriff's Department has achieved sustained compliance with one, and partial compliance with six.⁴⁸

While progress has been slow at times, the Department took significant steps to address several issues. For example, it exceeded the requirements set forth for providing thermal clothing by implementing a process for distributing such clothing to all Class Members, without a prescription, and upon their arrival at the IRC and CRDF Reception Center. Another example of the Department's efforts towards achieving compliance is the Department's use of harnessing technology to address the Agreement terms which requires all "ADA" grievances be identified and marked as "ADA."⁴⁹ In October 2025, the Department used its digital databases to assist in identifying and marking grievances as required under the provision. While the technological update came after this past year's self-assessment period, the

⁴⁷ *Johnson v. Los Angeles County Sheriff's Department*, Case No. CV 08-03515 DDP (C.D. Cal. Filed May 29, 2008).

⁴⁸ The Agreement contains a total of 49 provisions. Pursuant to stipulation of the Parties, the Court has severed 38 of the 49 provisions from the Agreement, these are provisions that have either achieved sustained compliance or were documented as "completed" during settlement negotiations and are no longer subject to monitoring by the Office of Inspector General. As noted in the Office of Inspector General's *Tenth Implementation Status Report*, the Sheriff's Department achieved sustained compliance with one additional provision. There are now five sustained provisions which have not been severed from the Agreement.

⁴⁹ ADA stands for the Americans with Disabilities Act. This act requires that reasonable accommodations be made for people with disabilities.

Department's efforts to find innovative ways to address issues are commendable and the Office of Inspector General is optimistic this will bring the Department closer to compliance in the coming years.

Although notable progress has been made in improving the conditions that gave rise to the Agreement, the Office of Inspector General's report again identified systemic issues which stymie the Sheriff's Department's reform efforts and make it unlikely that the Sheriff's Department will achieve compliance on the remaining provisions without additional extensions of its settlement term.⁵⁰

First, the Sheriff's Department continues to expand the areas within the jails where it houses Class Members by placing them in non-ADA housing areas within the MCJ and TTCF. Class members in these areas continue to face architectural barriers, which pose safety risks and have not been provided with adequate accommodations to assist them. The Department acknowledged that there is a need for accessible showers on the 2000, 3000, 5000, 9000 floors of MCJ; however, since the *Ninth Implementation Status Report*, there have been no architectural improvements made to any jail facility where Class Members are housed. As a result, Class Members continue to struggle with steadying themselves while showering and those who cannot stand for long periods of time reported having to use alternatives to shower benches, like utilizing plastic chairs that are not intended for use in a shower. Although the Department has distributed some shower chairs with non-slip feet to certain housing areas, Office of Inspector General staff continue to see the use of plastic chairs in showers throughout the facilities.

Second, as reported in the *Eighth Implementation Status Report* and the *Ninth Implementation Status Report*, Office of Inspector General staff again observed that prescriptions for mobility assistive devices are not actively monitored, resulting in delays in the removal of devices once prescriptions expire and secondary review options are exhausted. Medical and custody staff explained there is no established process for removing devices from Class Members and neither provided any clarity as to who is responsible for doing so, indicating a lack of collaboration or cooperation between the Sheriff's Department and Correctional Health Services. The Office of Inspector General staff spoke with several Class Members at MCJ, TTCF, and CRDF who were in a wheelchair that did not belong to them based on the classification on their wristband. When questioned regarding the wheelchair, they confirmed that the wheelchair did not

⁵⁰ The Agreement, which took effect on April 22, 2015, was originally set to expire on April 22, 2018. The parties have stipulated to, and the court approved, several extensions of settlement term, most recently extending the settlement term by one year to May 30, 2027.

belong to them, but they used it to sit. In fact, Office of Inspector General staff observed several wheelchairs in one Class Member's housing location at TTCF that were not assigned to anyone. The unaccounted-for mobility assistive devices throughout facilities could contribute to the delay in Class Members receiving their prescribed mobility assistive devices. In addition, mobility assistive devices that are not properly inventoried or monitored once they are no longer medically necessary present jail safety and security concerns.

Lastly, as the Office of Inspector General has previously reported, a lack of standardized documentation practices and procedures continues to hinder the Department's ability to demonstrate compliance with the terms of the Agreement. Specifically, documentation indicating Class Members are offered and provided programming information at townhall meetings, are properly designated as requiring mobility assisted devices, and whether Class Member grievances are addressed by the proper entities should be standardized. The Office of Inspector General urges the Department to establish standardized documentation practices and procedures among its jail facilities to identify where gaps exist in providing accommodations as required by the Agreement. Without proper accommodations, Class Members face the same conditions and barriers as they did when the Agreement was signed 10 years ago.

Commissary Prices

Background

On July 9, 2024, the Board of Supervisors passed a [motion](#) directing the Sheriff's Department to report back on measures taken to ensure commissary prices in the Los Angeles County Jails are not excessive and remain comparable with prices for groceries and other retail outlets. The motion directed the Office of Inspector General to review the Sheriff's Department's report back and provide an assessment, which was issued on February 6, 2025, entitled [Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails](#). The motion also directed the Office of Inspector General to provide quarterly updates on the Sheriff's Department's progress on the removal of the profit mark-ups and reduction of prices on commissary items.

Title 15 Meetings with Keefe Commissary Network

As noted in previous reports, the vendor for commissary items and vending machines is [Keefe Commissary Network](#) (Keefe).

The contract requires Keefe to attend monthly Title 15 meetings the County convenes to present reports on commissary and vending sales trends and spikes, billing issues,

complaints submitted by incarcerated people, machine maintenance and reliability, security concerns, and any other operational problems identified by the parties. Office of Inspector General staff attended the Title 15 meetings held this quarter, which included representatives from each custodial facility, representatives from telephone services, and Keefe staff.

The Sheriff's Department received grievances requesting vending card refunds. The Department provided assurances that cards with a positive balance will result in a refund to the holder; this includes the initial deposit unless the card is damaged. Personnel are processing the requests in batches as they are received. If a person is released from custody before they receive their refund, they can retrieve the refund from the cashier of the correlated custody facility. The Department was unable to provide a timeline for completion of the process.

Multiple telephones at MCJ were removed by people in custody. At the meeting, Department staff provided assurances that they conduct regular monitoring of the telephones to observe the need for repairs, including replacing parts and remounting the telephones.

Because of a consistent demand for hotpots, the department placed a bulk order in early March to meet demand.

Vending Machine Installation

The process of installing new vending machines remains ongoing. New vending machines are now installed and operational at CRDF, Twin Towers, and NCCF. The transition remains in progress at PDC and MCJ. The old machines were scheduled to be removed from PDC North and South by mid-April 2026. Keefe is setting up the new machines off site to ensure functionality upon installation. MCJ is next on the schedule. The goal is to have all the new vending machines installed and operational by the end of June 2026.

A vending machine at MCJ was vandalized. Because of the planned installation of the new machines, the damaged machine will be removed but not replaced. If an old-style machine malfunctions and is fixable, repairs will be made.

Kosher/Halal Menu Availability

Regarding the availability of updated Kosher/Halal menus originally discussed in the Office of Inspector General's report [Reform and Oversight Efforts: Los Angeles County Sheriff's Department – July through September 2025](#), the new menu has not yet been

released. Keefe, ISB, and the Contracts Unit continue to meet to work on the menus and food options.

Department staff directed Keefe to distribute information regarding Kosher and Halal products until the menus with the proper designations are finalized. Keefe's handouts include proper designation for the Kosher and Halal products. The Department also disseminates information directly to all the facilities and Food Services to ensure there is full clarity on the identification of the items.

Inmate Welfare Commission

The Inmate Welfare Commission (IWC) met in January and March of 2026. There is an anticipated end-of-fiscal year closing fund balance of \$14.3 million, which exceeds the anticipated closing balance by approximately \$5 million. This is attributable in part to cost savings from vacancies among Inmate Services Bureau (ISB) positions that are financed by the Inmate Welfare Fund (IWF) and lower expenditures on Approved Inmate Programs than budgeted.

MCJ Captains are working on a proposal for the IWC for new workout equipment for the two MCJ roof recreational areas. NCCF is working on an estimate for their garden nursery program, including rebuilding the classroom/shed used for that program that was damaged in a recent storm. NCCF seeks to have its vocational welding school resume operations by June of this year.

Classes for the LGBTQ+ population at Men's Central Jail taught by Community Based Organizations and Public Health are planned in order to provide learning opportunities and for earning milestone and work credits.

The IWC seeks to sell the Department's tattoo removal machine in order to purchase a newer model and reinstitute a tattoo removal program. The IWC is seeking to consult with experts to improve tattoo removal services.⁵¹

In-Custody Deaths

Between January 1 and March 31, 2026, eleven people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for ten of these deaths, which were determined to

⁵¹ On May 13, 2026, Inmate Services Bureau requested funding for the Mobile Tattoo Removal Program. The program would better facilitate the removal of tattoos compared to the outdated machine currently in the Department's possession.

be natural.⁵² For the remaining death, the DME finding has been deferred.⁵³ One person died at MCJ, one person died at TTCF, one person died at NCCF, and eight people died at hospitals after being transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a [dedicated page on Inmate In-Custody Deaths on its website](#).⁵⁴

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews and the Correctional Health Services Mortality Reviews for each of the eleven in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of Death: January 1, 2026

Custodial Status: Pre-Trial

On December 28, 2025, a person in custody with a pre-existing medical condition was transported from NCCF to LAGMC for a higher level of care. On January 1, 2026, the person was pronounced dead. Areas for further inquiry include whether the person received the proper medical referral from IRC providers and a Peer Review into the person's medical care. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as peritonitis, mesh-associated necrotizing soft tissue infection of the groin and abdominal wall, methicillin-resistant staphylococcus aureus cellulitis secondary to excoriation, and scabies infection.

⁵³ In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five classifications for manner of death: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and Correctional Health Services use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

⁵⁴ Penal Code § 10008 requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

Date of Death: January 12, 2026

Custodial Status: Pre-Trial

On January 12, 2026, custody staff conducting Title-15 safety checks at MCJ found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and administered five doses of Narcan. According to the paramedic on scene, the person presented with early onset rigor mortis and was pronounced dead at the scene. Areas for further inquiry include the quality of the earlier Title-15 safety checks. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as acute bacterial bronchopneumonia.

Date of Death: January 13, 2026

Custodial Status: Pre-Trial

On January 12, 2026, a person in custody with a pre-existing medical condition was transported from NCCF to Henry Mayo Newhall Hospital for a higher level of care. On January 13, 2026, the person was pronounced dead. Areas for further inquiry include the quality and timeliness of Title-15 safety checks and the use of a simple face mask for severe hypoxia. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death acute respiratory failure, acute respiratory distress syndrome, severe pneumonia (viral and bacterial), and chronic alcohol use and early liver cirrhosis.

Date of Death: January 22, 2026

Custodial Status: Pre-Trial

On January 22, 2026, a person in custody with a pre-existing medical condition was transported from TTCF's Correctional Treatment Center (CTC) to LAGMC for a higher level of care. The person was pronounced dead the same day. Areas for further inquiry include the emergency response and a Peer Review into the utilization of resources when there is a lack of CTC beds available. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as atherosclerotic cardiovascular disease and pulmonary thromboembolism.

Date of Death: January 27, 2026

Custodial Status: Pre-Trial

On January 12, 2026, a person in custody with a pre-existing medical condition was transported from TTCF to LAGMC for a higher level of care. On January 27, 2026, the person was pronounced dead. Areas for further inquiry include Health Service Request processing. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as acute respiratory distress syndrome and influenza A pneumonia.

Date of Death: January 29, 2026

Custodial Status: Pre-Trial

On January 19, 2026, a person in custody with a pre-existing medical condition was transported from TTCF to LAGMC for a higher level of care. On January 29, 2026, the person was pronounced dead. Areas for further inquiry include whether the Sheriff's Department had the authority to release the person from custody based on the charges and their medical condition. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as chronic ethanol use disorder.

Date of Death: January 29, 2026

Custodial Status: Pre-Trial

On January 29, 2026, custody staff conducting Title-15 safety checks at TTCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and administered three doses of Narcan. The person died at the scene. Areas for further inquiry include the timeliness and quality of the emergency response, the quality and timeliness of Title-15 safety checks, and the person refusing medical care. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as hypertensive and atherosclerotic cardiovascular disease.

Date of Death: February 2, 2026

Custodial Status: Sentenced

On February 2, 2026, custody staff and CHS distributing medication at NCCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and administered five doses of Narcan. The person died at the scene. Areas for further inquiry include whether CHS staff were in command of the emergency response and re-briefing IRC medical providers on the expectations for addressing Opioid Use Disorder (OUD) in the IRC Clinic. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as hypertensive cardiovascular disease and severe obesity.

Date of Death: February 4, 2026

Custodial Status: Pre-Trial

On February 3, 2026, a person in custody with a pre-existing medical condition was transported from MCJ to LAGMC for a higher level of care. On February 4, 2026, the person was pronounced dead. Areas for further inquiry include whether there were observable signs indicating the person required immediate medical attention during the earlier Title-15 safety checks, whether the person's medical information was properly reported to CHS staff, and the quality of medical care that the person received at

LAGMC.⁵⁵ Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as hypertensive and atherosclerotic cardiovascular disease and metastatic hepatocellular carcinoma and diabetes mellitus.

Date of Death: February 13, 2026

Custodial Status: Sentenced

On February 11, 2026, a person in custody with a pre-existing medical condition was transported from TTCF's CTC to LAGMC for a higher level of care. On February 13, 2026, the person was pronounced dead. Areas for further inquiry include TTCF custody staff failing to activate their Body-Worn Cameras. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as metastatic rectal cancer.

Date of Death: March 24, 2026

Custodial Status: Pre-Trial

On March 24, 2026, people housed in a dorm at MCJ alerted custody staff at a deputy booth of a man down within the dorm. The person, who was conscious and breathing, was transported to the MCJ clinic and paramedics transferred the person to LAGMC for a higher level of care. The person was pronounced dead the same day. Areas for further inquiry include MCJ custody staff failing to activate their body-worn cameras and the quality of Title-15 safety checks.⁵⁶ Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Efforts to Reduce In-Custody Deaths

On March 3, 2026, the Board of supervisors passed a motion, [Strengthening Accountability to Significantly Decrease Jail Deaths in the Los Angeles County Jails](#). The motion directs the Office of Inspector General to include in quarterly reporting information on the Medication Assisted Treatment program, summaries and status of corrective action plans instituted after an in-custody death, improvements to the Corrective Action Plan tracker, compassionate release efforts, and an analysis of the Mortality Review process. The Office of Inspector General began monitoring and

⁵⁵ This concern is not to suggest that the patient received inadequate care while at MCJ or LAGMC. Rather, a review of the person's medical care while at LAGMC might assist CHS in the mortality review of this death.

⁵⁶ While the activation of the body-worn cameras is noted here, the deputies were within the 120-grace period, during which the deputies transition to wearing the cameras. There is an expected period of adjustment for deputies for whom the cameras are newly deployed.

tracking the requested items and will include this information in future reporting as directed.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors [passed a motion](#) directing the Sheriff's Department to "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the OIG," and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections." The Board also directed the Office of Inspector General to report quarterly on the Sheriff's Department's progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody overdose deaths.

Of the eleven people who died in the care and custody of the Sheriff's Department between January 1 and March 31, 2026, the medical examiner's final reports, including toxicology assessments, do not confirm that any person died due to an accidental overdose. Toxicology results remain pending for one of the eleven deaths and may indicate an overdose death once completed. As of this report, the DME has confirmed that nine individuals died due to accidental overdose during the 2025 calendar year and no individuals died due to accidental overdose during the first quarter of 2026.

Tracking and Improving Narcotics Intervention Efforts

The Sheriff's Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizures by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Sheriff's Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Sheriff's Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

The Board's second directive requires that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the

belongings of staff and civilians who enter the [jails].” The Sheriff’s Department previously reported that its current policy grants the Sheriff’s Department broad authority to search staff and civilians entering the jails, so that no changes to existing policy are required to implement more comprehensive searches. The Sheriff’s Department previously reported that it implemented more frequent unannounced and randomized staff searches that began in May 2024.

Narcotics detection training

Office of Inspector General staff attended Department trainings related to narcotics and contraband detection within custodial settings.

Person searches. Jail Operations conducts in-person training on searching inmates for recent Academy graduates and also conducts refresher courses every one to two years. Custody Assistants (CA) received this training as well.

The training includes the best practice of activating body-worn cameras prior to the search and articulating the search after camera activation and in reports. The training also emphasized using tactics to avoid using force in completing the search.

Screening and Distribution of Supplies and Mail. The Jail Operations training on the screening and distribution of supplies and mail provided an overview of the processes. While Deputies open and inspect all mail for contraband, they are instructed not to read legal mail, including confidential legal mail from lawyers and entities such as the State Bar or the ACLU. There is training on recognizing counterfeit seals or mail falsely designated as legal correspondence.

Because contraband smuggled through the mail does enter custodial facilities, the Department is considering digitizing the mail system to reduce the risk of contraband smuggling through the mail. If such a system is introduced, the Department will need to ensure that privacy concerns are addressed in policies for monitoring digitized mail.

Fraternization. The training included prohibitions on fraternization and the dangers associated with developing close personal relationships with people in custody, noting that these relationships might result in manipulation to assist the incarcerated person in ways that are against policy or illegal. At least one real-life example was included in the training.

Department Search Statistics

As previously reported, the comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table below details the staff search practices at all jail facilities from January 1 to March 31, 2026. The data regarding the number of staff searches and searches with K-9 illustrated in the table was supplied by CSSB. CSSB extracted data on searches from the CWCL on April 7, 2026. K-9 data was obtained from the Custody Investigative Services (CIS) Searches of Custody Personnel Report on April 8, 2026. The Office of Inspector General was unable to verify the data provided by CSSB without additional information.

	Number of Staff Searches	Number of Staff Searches with K-9	Monthly Minimum Search Requirement ⁵⁷	Search Inside Security	Search Evasion Concerns	Where Searches Logged
Facility	Q1	Q1				
MCJ	127	29	Unable to Determine ⁵⁸	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
TTCF	190	10	Yes ⁵⁹	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
IRC	44	8	Unable to Determine ⁶⁰	No	Yes	Watch Commander Log; Searches of Custody Personnel Report

⁵⁷ Each jail facility's unit order regarding staff searches was used to determine whether it met its minimum search requirement by month. Where the unit order is silent regarding the minimum search requirement, the Office of Inspector General was unable to determine if the requirement was met. Also, the jail facility must meet the minimum search requirement during each of the three months in the quarter in order to be found in compliance.

⁵⁸ Los Angeles County Sheriff's Department, Custody Division Unit Orders, [§ 3-08-021 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁵⁹ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-08-010 Security of Personal Property](#). ("Watch commander shall ensure a minimum of two random searches are conducted each week of persons entering the secured area during their assigned shift").

⁶⁰ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 5-23/006.00 Security and Searches of Person Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

CRDF	101	6	Yes ⁶¹	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
NCCF	153	6	No ⁶²	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-North	63	2	Unable to Determine ⁶³	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-South	46	6	No ⁶⁴	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the first quarter of 2026, Office of Inspector General personnel completed 97 site visits, totaling 240 monitoring hours, at IRC, TTCF, CRDF, MCJ, Pitchess Detention Center North, South and East, and NCCF.

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 105 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 130 monitoring hours related to uses of force, in-custody deaths, Prison Rape Elimination Act (PREA) compliance, restrictive housing, and general conditions of confinement.

⁶¹ Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-01-090 Searches of Sworn Personnel, Custody Assistants, Professional Staff and their personal property-Approved by CSS 3/11/2024 ("The searches shall be conducted a minimum of once per week, per shift." [unit order obtained via email message]).

⁶² NCCF did not meet its minimum search requirement in January 2026. Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 07-145/10 Personal Property Searches](#). ("A minimum of four (4) random searches per shift per week of any personnel and/or official visitors shall be conducted at the discretion of the watch sergeant.").

⁶³ Los Angeles County Sheriff's Department, Custody Division Unit Order, [§ 3-06-010 Security of Personal Property](#) does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

⁶⁴ PDC-South did not meet its minimum search requirement in February 2026. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-02-080 *Searches of Sworn Personnel, Custody Assistants, Professional Staff and Their Property on the Facility*. ("The searches shall be conducted at a minimum of once per week, per shift.").

Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.⁶⁵ The Sheriff's Department most recent force report is for use-of force-incidents in custody through the third quarter of 2025. [This report](#) and reports for prior quarters may be found on the Sheriff's Department website's transparency section under the page for use of force.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.⁶⁶ The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.⁶⁷

The Sheriff's Department has a [complaints dashboard](#) that can be sorted by date range, with options to narrow the results by practice area (such as Patrol or Custody), rank, or station or unit.

Sheriff's Department's Response

The Sheriff's Department was provided with a draft of this report and sent a letter in response, which is incorporated on the following pages.

⁶⁵ Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

⁶⁶ See [Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, Department Service Reviews](#).

⁶⁷ It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.



OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

ROBERT G. LUNA, SHERIFF



May 26, 2026

Eric D. Bates, Interim Inspector General
Office of Inspector General
County of Los Angeles
312 South Hill Street, Third Floor
Los Angeles, California 90013

Dear Mr. Bates:

**RESPONSE TO THE OFFICE OF INSPECTOR GENERAL'S REPORT
REFORM AND OVERSIGHT EFFORTS:
LOS ANGELES COUNTY SHERIFF'S DEPARTMENT
JANUARY THROUGH MARCH 2026**

On May 11, 2026, the Office of Inspector General (OIG) provided the Los Angeles County Sheriff's Department with an initial validation draft of its report titled *Reform and Oversight Efforts: Los Angeles County Sheriff's Department, January through March 2026*, and requested a response by May 20, 2026 (Draft Report).

The Draft Report was distributed to the Department units responsible for the subject areas addressed in the report. During the review period, the Department engaged with the OIG in an effort to address areas requiring additional information, correction, or clarification, as well as those where the Department's perspective differed from the OIG's position.

On May 21, 2026, the OIG provided the Department with a revised Draft Report that reflected some, but not all, of the Department's earlier feedback. In these instances, the Department has prepared this letter to offer comment and additional context to ensure clarity in the final presentation.

The following sections address those specific areas in the Draft Report:

211 WEST TEMPLE STREET, LOS ANGELES, CALIFORNIA 90012

A Tradition of Service
— Since 1850 —

Deputy-Involved Shootings

The Department agrees that all field personnel, including specialized units, should be equipped with body worn cameras. As previously reported by the Department, this matter remains under meet-and-confer with the respective labor unions. The Department is statutorily obligated to engage in the meet-and-confer process when proposed changes affect the working conditions of represented employees.

High-Risk Traffic Stops

The Department appreciates the OIG's continued engagement on the important issue of high-risk traffic stop policies and welcomes the opportunity to respond fully. While the Department agrees with the OIG on several points, and has already acted on two of the three recommendations, the Department has significant concerns about the analytical framework the OIG employs, particularly its use of the Koutantos case as the centerpiece of a critique that, on closer examination, does not fairly account for the legal landscape at the time or the substantial policy work the Department had already undertaken.

The Use of the Koutantos Case

The OIG's analysis focuses on the Koutantos settlement, treating it as evidence of a systemic policy failure (Report at 13-16). The Department respectfully submits that this framing is both analytically flawed and fundamentally unfair.

The traffic stop of Ms. Koutantos occurred on September 25, 2022. At that time, the Department was already engaged in a multi-year, comprehensive revision of its Use of Force Policy – a process undertaken in direct collaboration with the United States (US) Department of Justice (DOJ), federal monitors, and nationally recognized use-of-force experts. That process involved years of substantive work, extensive legal review, and a lengthy meet-and-confer process with labor. The revised policy was published in July 2024 and, following training to the policy, became effective in early 2025.

Developing a responsible, durable policy of this complexity takes time – particularly when there are federal monitors involved and particularly when a new administration came into office that made revision of the Use of Force Policy a priority. The OIG criticizes the Department for not having a more specific policy in place at the time of the Koutantos stop, while declining to acknowledge that the Department was, at that very moment, engaged in

exactly the kind of careful, expert-guided, federally-overseen policy development that responsible governance requires. That omission is significant and undermines the fairness of the critique.

More importantly, it would have been neither practical nor appropriate for the Department to pause that multi-year collaborative process, one involving the DOJ and labor negotiations, in order to insert an interim policy response to a single incident whose litigation had not yet concluded. The OIG's implicit suggestion that the Department should have done so conflates reactive policymaking with sound institutional practice. Good policy is not written case-by-case in response to pending litigation; it is developed deliberately, with broad legal and operational expertise, and with the input of all affected stakeholders. That is precisely what the Department did.

Furthermore, the Koutantos stop predates the Ninth Circuit's decision in *Chinaryan v. City of Los Angeles* (9th Cir. 2024) 113 F.4th 888 by nearly two years. The OIG uses Koutantos to establish a baseline of policy failure, yet the legal standard the OIG applies in its critique is one that was not authoritatively articulated by the Ninth Circuit until August 2024. It is simply not appropriate to evaluate the Department's 2022 conduct and 2022 policies through a legal lens that did not fully crystallize until 2024. Courts themselves do not apply newly clarified legal standards retroactively to find that prior conduct was obviously unlawful; the OIG should exercise similar restraint.

The Department also notes that the Koutantos Summary Corrective Action Plan (SCAP) was not a unilateral Department document. It was prepared collaboratively, with the involvement of County Counsel, outside counsel, and the CEO's OIG. The OIG takes issue with the SCAP's assertion that the deputies had "more than reasonable suspicion" without articulating specific supporting facts. The Department notes that characterizations of the evidentiary record in a SCAP (suitable for public posting) reflect litigation counsel's assessment of the facts and applicable law in the context of ongoing legal proceedings, not a formal policy position. Reading the SCAP's litigation framing as a definitive statement of the Department's constitutional understanding elevates a litigation document beyond its proper purpose and scope.

The Law Prior to *Chinaryan*

The OIG argues that *Washington v. Lambert* (9th Cir. 1996) and *Green v. City & County of San Francisco* (9th Cir. 2014) already established the relevant legal standards clearly enough that no additional development was needed, and that the Department's failure to specifically incorporate those standards into policy long before 2022 reflects institutional neglect (Report at 14-15). The Department respectfully but firmly disagrees.

While *Washington* and *Green* addressed excessive force in the context of traffic stops, the practical application of those holdings to the specific and varied circumstances of a high-risk stolen vehicle stop remained genuinely contested in the courts and among law enforcement agencies throughout California and the broader Ninth Circuit for years. The fact that the Ninth Circuit itself did not publish a decision squarely addressing this precise question until *Chinaryan* in 2024, nearly thirty years after *Washington*, is itself telling. If the law were as settled and clearly applicable as the OIG suggests, there would have been no need for the Ninth Circuit to take up the question again. The *Chinaryan* decision added critical precision: it held explicitly that the absence of suspect-specific, articulable safety concerns cannot justify high-risk stop tactics based solely on a stolen vehicle report, and it did so with a clarity and directness that earlier decisions did not provide in the context of vehicle theft stops specifically.

The OIG cites the Field Operations Support Services (FOSS) Newsletter's own acknowledgment that the law was established before the 2022 Koutantos stop as evidence against the Department (Report at 17). The Department notes that statements in training materials about the state of the law are designed to instill caution and compliance. They are not judicial admissions about what a reasonable law enforcement agency should have understood years earlier. Law enforcement agencies throughout California, including the Los Angeles Police Department, the San Francisco Police Department, and the Pasadena Police Department, responded to *Chinaryan* by issuing training bulletins and updated guidance and not by amending their formal policy manuals, reflecting the widespread understanding that *Chinaryan* represented a meaningful legal development, not a mere repetition of settled doctrine. The Department acted consistently with that understanding, and the OIG's criticism of that approach does not fairly account for how the law enforcement community as a whole interpreted the pre-*Chinaryan* legal landscape.

The Sufficiency of Current Policy

The OIG contends that existing Department policy does not adequately restrict firearm use during traffic stops of suspected stolen vehicles, and that Manual of Policy and Procedures (MPP), Section 3-10/150.00 (Tactical Incidents) contains a gap that the Department has failed to address (Report at 18). The Department disagrees and believes the OIG significantly understates the scope and quality of the policy framework now in place.

As noted above, that framework was not developed hastily or in response to a single case. It was the product of years of collaboration with the US DOJ, federal monitors, and nationally recognized Use of Force experts who conducted a comprehensive review of applicable federal law and national best practices. The result was a policy architecture that is deliberately principles-based rather than scenario-specific, and intentionally so. Broad, principles-based policies are preferable to policies that attempt to enumerate every specific situation the deputies may encounter, because the latter approach risks creating internal inconsistencies, leaving gaps for unanticipated circumstances, and producing a policy manual that is too cumbersome to be operationally useful.

The MPP Section 3-10/045.00 (Use of Deadly Force and Firearms), published July 2024, established for the first time a Department-wide standard requiring that a deputy may only point a firearm at a person when they reasonably believe an imminent threat exists based on the totality of the circumstances. This standard applies comprehensively to all firearm pointing, including during tactical incidents and high-risk traffic stops, and is not inconsistent with the *Chinarian* framework. The OIG argues that, because this provision does not specifically reference high-risk stolen vehicle stops, it is insufficient. But by that logic, every permissible application of a Use of Force standard would need to be individually enumerated in policy, rendering comprehensive, expert-developed policy frameworks meaningless in favor of an ever-expanding list of scenario-specific rules. That is not how sound policy development works.

The Department also notes that MPP Section 3-10/100.00 (Use of Force Reporting - Department Member Responsibilities) requires deputies to verbally notify a supervisor following any incident in which a firearm is pointed at a person, and MPP 3-10/110.00 (Use of Force Review – Sergeant Responsibilities) requires supervisory review of all available video footage as

part of the review of the electronic Pointed Firearm at Person Report. These accountability and oversight mechanisms are precisely the tools that allow the Department to identify and address problematic patterns in deputy conduct, including in the context of high-risk traffic stops, before they become systemic issues.

The OIG's criticism of MPP Section 3-10/150.00 (Tactical Incidents) for focusing on officer safety coordination rather than force limitations misreads the purpose of that policy and the broader policy architecture (Report at 18). The Tactical Incidents policy works in conjunction with, not in isolation from, the Use of Force provisions throughout the manual. The MPP Section 3-10/000.00 (Preamble to the Use of Force Policy) mandates that deputies may only use force that is objectively reasonable, proportional, and necessary under the circumstances. That mandate does not disappear because a separate policy addresses tactical coordination. The OIG's assertion that the absence of duplicative force-limitation language in MPP 3-10/150.00 (Tactical Incidents) constitutes a policy gap ignores the integrated structure of the Department's policy manual.

The Recommendations

Recommendation 1 — The Department does not agree that a stand-alone policy specifically addressing firearm use during stolen vehicle traffic stops is required. The comprehensive coverage provided by MPP 3-10/045.00 (Use of Deadly Force and Firearms) and the broader Use of Force policy framework addresses the relevant constitutional standards applicable to all firearm pointing, including during high-risk traffic stops. The Department's view is that this integrated approach, developed with federal oversight and national expertise, is more durable and operationally sound than a proliferation of scenario-specific policy provisions. That said, the Department commits to continued monitoring of developments in this area of law and will reassess whether additional specificity is warranted if the legal landscape evolves further or operational experience indicates a need.

Recommendation 2 — The Department agrees and has acted. A training directive has been assigned for completion by all patrol units addressing high-risk traffic stops in light of *Chinaryan*. This training is delivered through the Briefing Room platform, which is updated weekly and provides deputies with current guidance on applicable case law. The assigned training directly addresses the question of whether high-risk stop tactics may be used based

solely on a stolen vehicle report. The Department's implementation of this training is fully consistent with the OIG's recommendation.

Recommendation 3 — The Department has rescinded Newsletter 15-24. The Department acknowledges that its rescission, together with the guidance provided in FOSS Newsletter 25-07, better reflects the Department's expectations for deputies conducting high-risk stops and aligns Department training with current Ninth Circuit law.

Summary to High-Risk Traffic Stops

The Department takes seriously its obligation to ensure that deputies conduct traffic stops in full compliance with constitutional requirements and the evolving body of applicable case law. The Department's policy framework, developed through years of collaboration with the DOJ, federal monitors, labor, and national experts, provides a principled, comprehensive, and legally grounded foundation for that conduct. The Department has already acted on two of the three OIG recommendations and will continue to monitor the law in this area. The Department also reiterates its open invitation to OIG staff to attend relevant training sessions and looks forward to continued collaboration on these important issues.

Johnson v. Los Angeles County Sheriff's Department Monitoring Report:

Shower Accessibility and Use of Non-ADA Compliant Chairs

The OIG report references shower accessibility issues (Report at 25).

The Department conducted an analysis of the Johnson class member population, which was completed on April 20, 2026, and is enabling the Department to strategically evaluate areas to improve shower accessibility with the installation of The Americans with Disabilities Act (ADA)-compliant grab bars and shower benches. Potential installation sites have since been identified for both row and dormitory showers at Men's Central Jail (MCJ) and Century Regional Correctional Facility (CRDF).

Furthermore, recognizing the need to improve ADA-compliant shower access, the Department procured and distributed 28 portable shower chairs during June and July 2025 among multiple class member housing areas at CRDF, MCJ, and Twin Towers Correctional Facility (TTCF). Since that time, the

Department obtained and distributed 29 additional chairs to MCJ housing areas which housed the most class members. In April 2026, the Department ordered 20 additional shower chairs, which are currently being distributed to MCJ class member housing locations.

The Custody Compliance and Sustainability Bureau's (CCSB) Johnson Team and the ADA coordinators assigned to CRDF, MCJ, and TTCF continue to brief line personnel regarding the availability of portable shower chairs and the requirement that such chairs be provided to all Johnson class members. Personnel are also being reminded to discontinue the use of standard plastic chairs that are not designed or approved for shower use and remove them from shower areas.

Monitoring and Accountability for Mobility Assistive Devices

The OIG report references issues with mobility assistive devices being given to individuals without need, possibly making it more challenging for those needing the devices to have access to them (Report at 25-26).

Correctional Health Services (CHS) is responsible for the prescription and issuance of mobility assistive devices and for monitoring their continued medical necessity upon expiration of the prescription orders. A class member list, containing information about prescribed devices, including their expiration dates, is made available to custody personnel daily. To streamline efforts and improve efficiency, the Department provided CHS personnel with a culled list of class members with expired prescription orders to allow CHS to identify any potential informational discrepancies and initiate the secondary review process required by the Johnson Settlement Agreement.

The MCJ ADA coordinator submitted eight secondary review requests on behalf of class members. To date, one has been completed, resulting in the discontinuation and removal of the mobility assistive device. The Department is currently evaluating new operational protocol by which ADA coordinators will be required to review expired orders on a periodic basis and assist class members with requesting secondary reviews of expired device orders via the health service request system.

With respect to unassigned wheelchairs being observed at CRDF, MCJ, and TTCF, the ADA Compliance Team assigned to Access to Care Bureau conducts alternating weekly collection efforts at each facility. As a result of these

efforts, nine unassigned wheelchairs were removed from housing areas in January 2026, 23 in February 2026, and 16 in March 2026. Because the wheelchairs cannot be safely reconditioned, they are discarded. Consequently, wheelchairs are not reassigned to other class members and unassigned wheelchairs do not potentially delay the issuance of a new wheelchair for another class member.

Currently, the facilities have a limited supply of transport chairs, which are used for class members upon request for intra-facility transport. To address this issue, the Access to Care Bureau ordered ten additional transport chairs on April 29, 2026. Upon receipt, the chairs will be strategically distributed among CRDF, MCJ, and TTCF.

In certain housing areas with a high number of class members, Custody personnel reported using wheelchairs, as an interim measure and in lieu of transport chairs, to ensure intra-facility transportation to court and medical appointments within the facility.

Standardized Documentation for Town Hall Meetings and Program Information

The OIG report references a lack of standardized documentation practices for townhall meetings (Report at 26).

The CCSB Johnson Team conducts weekly monitoring of Town Hall Meeting (THM) submissions from CRDF, MCJ, and TTCF to assess compliance with the Settlement Agreement. Since implementation of this oversight process, measurable improvements have been observed in both the accuracy and timeliness of submissions. Additionally, a revised THM form was distributed in February 2026, to improve standardization and full documentation.

As a result, there have been noted improvements in documentation and reporting consistency at TTCF and significant improvements in both areas at MCJ. To remedy identified deficiencies, the Corrective Action Plan (CAP) process has been implemented for impacted facilities.

To standardize practices, improve documentation quality, and increase compliance, the CCSB Johnson Team distributes a daily email, Monday through Friday, to personnel responsible for conducting THMs. The communication includes an updated "Custody Programs" half-sheet flyer

(updated August 2024), and the revised THM form. The daily email also provides instructions for conducting and documenting THMs in accordance with the Johnson Settlement Agreement.

Standardized Documentation for Mobility Assistive Device Classifications

The OIG references a lack of standardized documentation for those designated as requiring mobility assisted devices (Report at 26).

To ensure class members are properly designated with the proper classification code on their wristbands, the ADA coordinators at CRDF, MCJ, and TTCF are required to conduct wristband verification checks for all class members during quarterly egg-crate mattress audits. The most recent audit was completed on March 23, 2026.

At the conclusion of the audit, and when necessary, class members were issued wristbands which accurately reflected their current classification. The next quarterly audit is scheduled for the last week of June 2026.

Standardized Documentation Demonstrating Proper Handling of Class Member Grievances

The OIG references a lack of standardized documentation practices indicating whether Class Member grievances are addressed by the proper entities (Report at 26).

Grievance investigations are evaluated using objective criteria and are subject to supervisory review. Additionally, the use of the Custody Inmate Grievance Application system has improved both ADA designation accuracy and timeliness tracking.

During the first quarter of 2026, the Department implemented a structured monitoring and quality control process to achieve compliance with the grievance provisions of the Johnson Settlement Agreement. Assessments are conducted on a systematic and frequent basis to ensure timeliness and the quality of the response, with an associated increase in communication between the ADA Compliance Team and certain facilities to relay concerns and provide recommendations to ensure provision alignment.

Conclusion

The Department values the opportunity to engage with the OIG on matters that are critically important to our mission. We take these reports seriously, as they serve as a public representation of the Department's ongoing efforts across several key areas. For that reason, we welcome the chance to provide the Department's comments, with the aim of offering additional clarity and ensuring full transparency for your office and the public.

Should you have any questions or concerns, please contact Commander Ernest Bille, Office of Constitutional Policing, at (323) 307-8358.

Sincerely,

ROBERT G. LUNA, SHERIFF


APRIL L. TARDY
UNDERSHERIFF