



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

January through March 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.

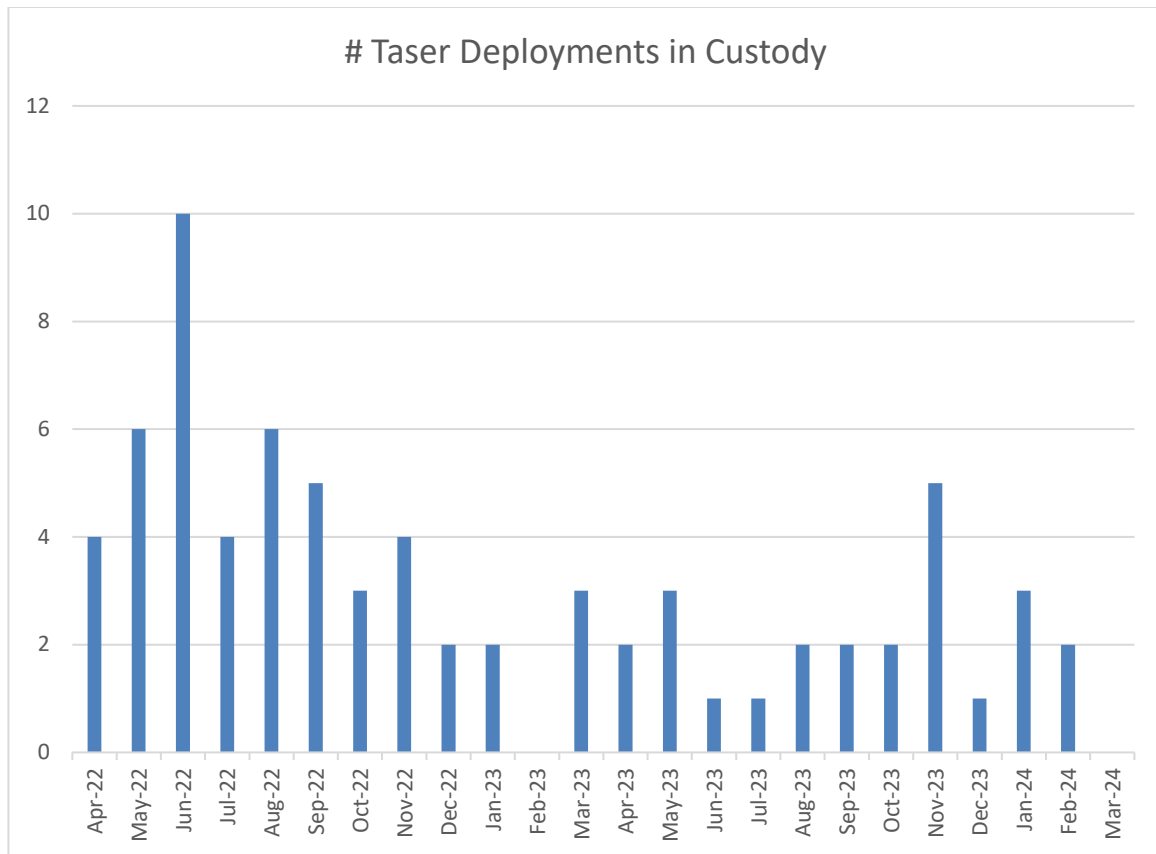
Documenting and Tracking Taser Use

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

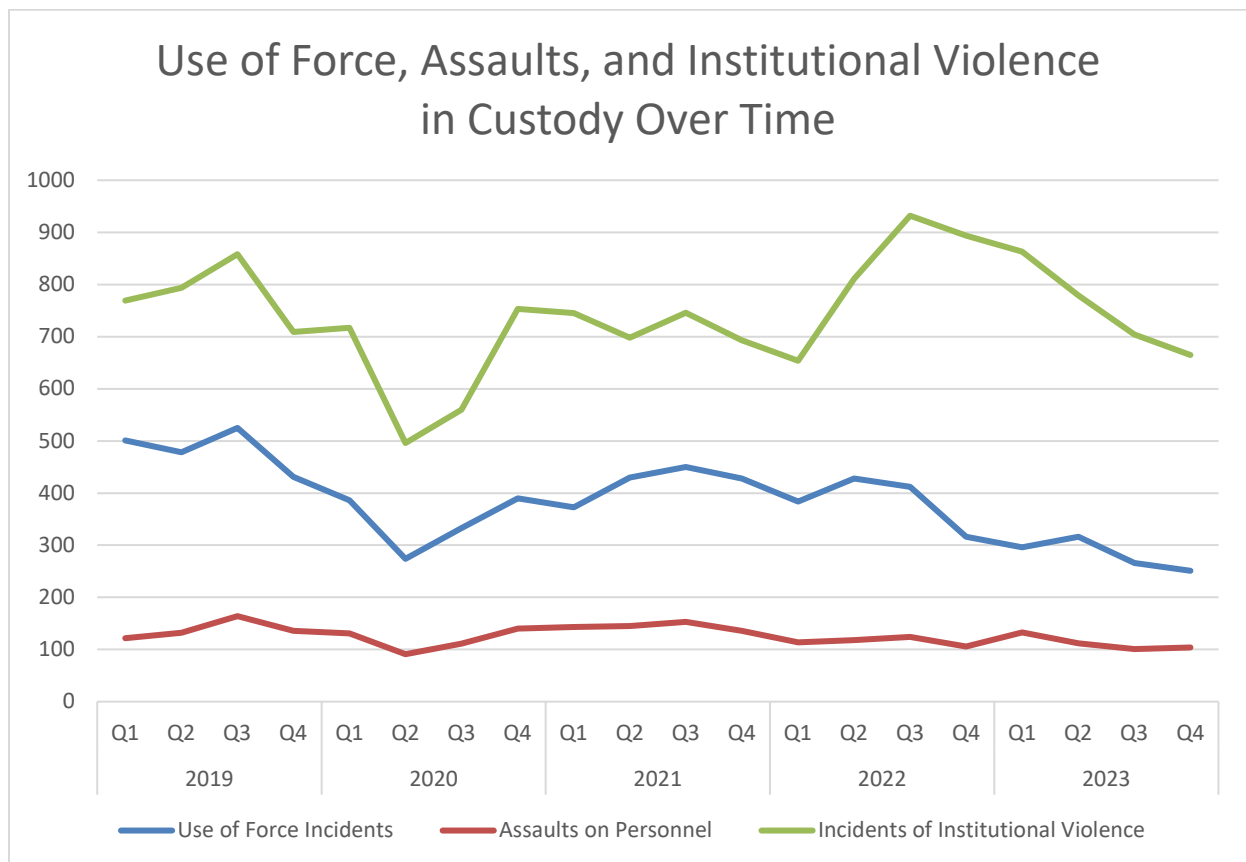
The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.²⁵ The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people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