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.

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[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]

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[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 dire 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 dire 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

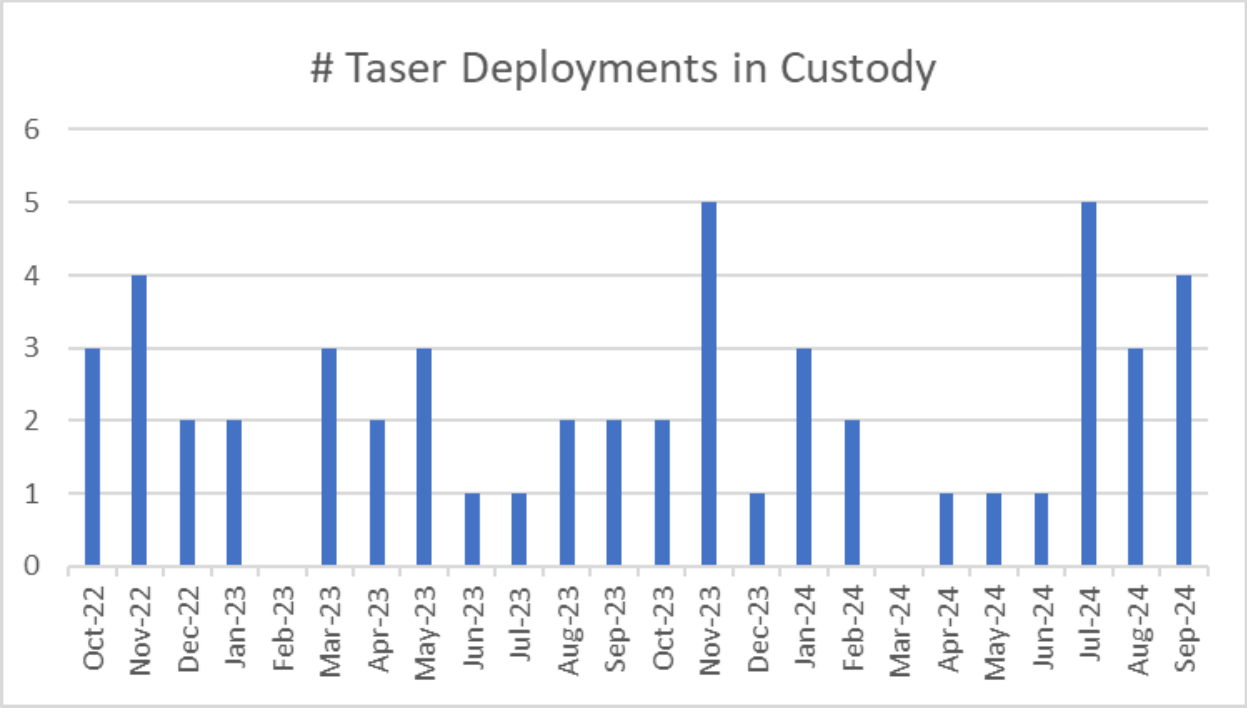
On October 3, 2023, the Board of Supervisors passed a motion instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The

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

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[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 capsicum (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

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[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

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[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."

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[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

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[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.

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[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 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

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[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 internasal 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 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]

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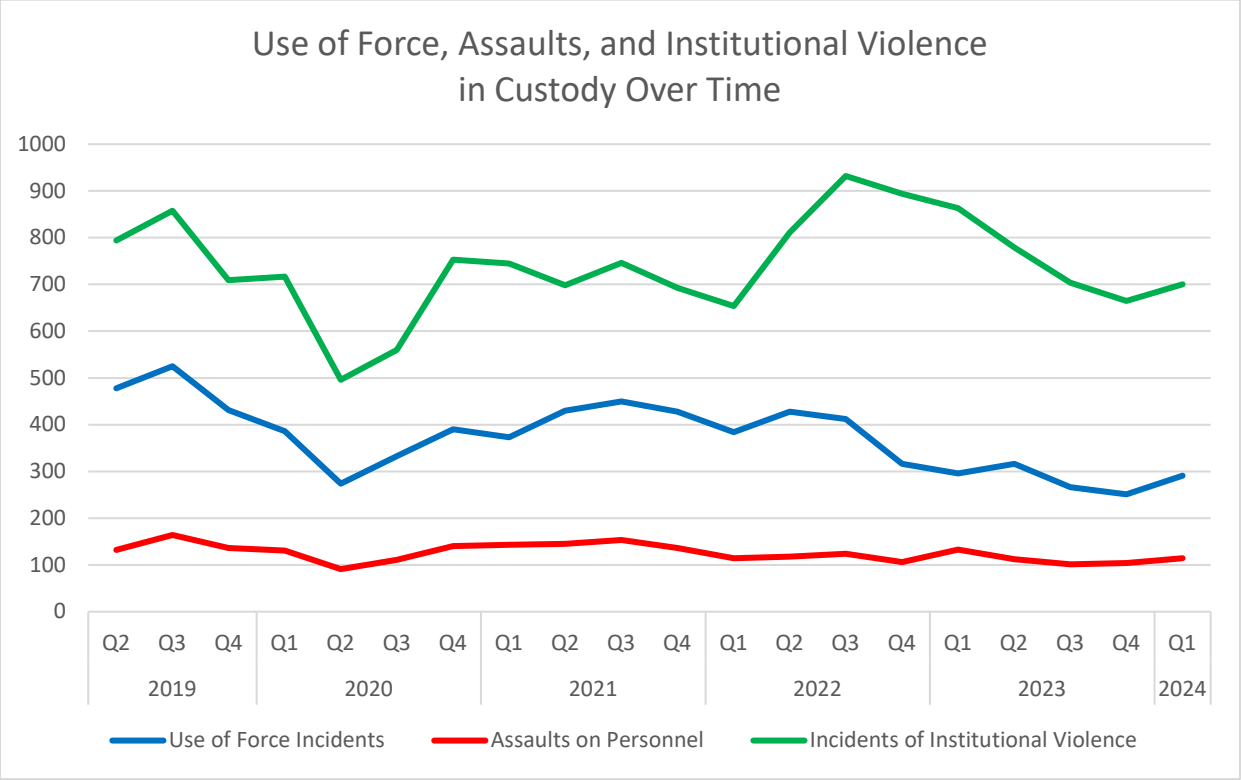
[41] These figures include site visits and meetings related to monitoring for compliance with the Prison Rape Elimination Act ("PREA").

[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	2nd Quarter	478	132	794
	3rd Quarter	525	164	858
	4th Quarter	431	136	709
2020	1st Quarter	386	131	717
	2nd Quarter	274	91	496
	3rd Quarter	333	111	560
	4th Quarter	390	140	753
2021	1st Quarter	373	143	745
	2nd Quarter	430	145	698
	3rd Quarter	450	153	746
	4th Quarter	428	136	693
2022	1st Quarter	384	114	654
	2nd Quarter	428	118	811
	3rd Quarter	412	124	932
	4th Quarter	316	106	894
2023	1st Quarter	296	133	863
	2nd Quarter	316	112	779
	3rd Quarter	266	101	704
	4th 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]

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[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,

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

APRIL TARDY
UNDERSHERIFF